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Family, Faith/Religion, and African Americans' Decisions to Seek Lung Cancer Treatment

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Walden University
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MSEd, North Carolina Agricultural & Technical State University, 2006

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Lung cancer is the leading cause of cancer mortality in the United States, especially among African Americans, who have the lowest survival rate from this disease among all racial/ethnic groups. The aim of this qualitative study was to investigate how family support and religion/faith influence patients' decisions about seeking treatment for lung cancer. This study was guided by the medical decision-making model and used a phenomenological approach. Data were collected from male and female lung cancer patients (n = 15) who were being treated in a thoracic and cardiovascular surgery clinic in Greensboro, North Carolina using semi-structured interviews. All participants were between the ages of 18 and 75 years and spoke English, and were questioned how they made their decisions about seeking lung cancer treatment. The main themes were patients' lack of knowledge about the disease, treatment, and the length of time to live; patients' financial anxieties; the role of faith, prayer, and religion related to treatment decision-making; confidence in the physician for medical advice; and the role of emotional and financial support from family, including the church family. The study findings provide valuable information that can be used by medical and public health professionals in helping patients make medical decisions for lung cancer treatment. Further, these findings have considerable social change merits because they provide needed information about how African American patients evaluate seeking treatment for lung cancer, which can be used to develop decision-making aids and to help better facilitate communication between health care providers and patients.

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Dedication

I would like to dedicate this research to the most important people in my life, who lived with, tolerated and showed me the most unforgettable support daily and made it all possible. Thank you to my Family, Father Earnest “Sonny” Washington Dixon, my children Paris, Anthony, and Nigel, I did this not only for me, but also for all of you guys too. I have to thank my parents and my step parents for hearing about this entire process. I have to also show appreciation to my sister Italy, for allowing me to cry on her shoulder when I had long sleepless night working on my research. I also want to thank my parents, family and to all my friends for also showing their support through this process. I would also like to dedicate this to all of my grandparents (all of them are deceased), but yet would be proud of me. Last but not least, I dedicate this to my late brother Ernest Washington Dixon III (1991-2007). RIP little “Ernie” – I Love You.

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Chapter 1: Introduction to the Study

Introduction

Lung cancer is a leading cause of cancer mortality in the United States. Enewold et al. (2009) wrote “More deaths occur among individuals with lung cancer in the United States than any other cancer including colon, breast, and prostate” (p. 216). Lung cancer accounts for approximately 22.8% of all cancer deaths yearly in the United States (American Cancer Society [ACS], 2014). According to the Centers for Disease Control (CDC; 2011), there are at least 203,683 diagnosed cases and 158,683 deaths each year in the United States from lung cancer. The ACS (2011) stated that African Americans with lung cancer have higher deaths and have shorter survival rates compared to other racial and ethnic groups cancer. It is well-documented that African Americans have a lower rate when it comes to the 5-year survival for this disease; 45% of African Americans diagnosed with lung cancer will survive for at least 5 years, compared to 54% for Whites (American Cancer Society, 2011).

According to the National Cancer Institute (NCI; 2012), complex and interrelated factors contribute to the disparities in survival rates for lung cancer. These factors account for the dissimilar rates in cancer incidence and mortality between different racial/ethnic groups. For example, a lack of health care coverage and low socioeconomic status has been identified as important factors that affect rate and survival (Temel et al., 2008). A lack of early detection is also responsible: Symptoms of lung cancer usually appear when the disease has advanced. It has further been documented that African American patients refuse surgical therapy more often than their white counterparts (NCI, 2012). A vast majority of African American patients believe that tumors can spread during the time of operation or that there is a possibility of cure without surgery (Gilbar, 2009). Majority African-American patients also have a distrust of health care system and providers (Farjah et al., 2009).

Making medical decisions, especially when critically ill, is a difficult process and creates considerable anxiety for patients. Temel et al. (2008) stated “decision-making process concerning treatment and patient care is replete with uncertainty and anxiety” (p. 2319). Patients who have advanced or more aggressive stage of lung cancers are often faced with uncertainty (Zhang, Zyzanski, & Siminoff, 2010). Marino et al. (1994) suggested that “in late stages, treatment decisions need to be made within a short period because advanced lung cancer patients have an average survival time of eighteen months after being diagnosed” (p .862). Subsequently, patients have to make quick decisions about treatment, and they will rely on external factors to help them with their decisions.

There is a significant body of research on decision-making for medical treatment. How individuals make decisions for cancer treatment is not well understood and has not been well-reported in the literature (Sminoff et al., 2006). It is, however, becoming more common and expected for individuals to take a more active role in the process of decision-making for medical treatment (Koerner, 2009). Patients are consumers of health care and have a strong desire to collaborate with health care providers over decisions that affect wellness (Perneger, Berard, & Perrier, 2008). Family support, faith/religion, and physician recommendations appear to have an influence on how patients make decisions about cancer treatment (King & Wells, 2003). The extant body of research has not strongly identified how patients make decisions surrounding cancer treatment.

Zhang and Siminoff (2006) conducted a study which determined that the family unit has an important role in the decision-making process for family members diagnosed with cancer. Griffin et al. (2003) stated "Family members played an important role in the patient's choice of doctors, hospitals, treatment decisions and provisions of care and that family members may take increasingly proactive roles as decision makers when patients become further debilitated" (p. 313). Even though treatment decisions are mainly about what the patient needs and wants, the support of family members is still important in the decision-making process (Zhang & Siminoff, 2003). Patients have been found to trust their family's suggestions and judgments when making medical decisions (Ho, 2008). According to Back and Huak (2005), the "Concept of incorporating the family as a surrogate for the patient in decision-making, at the patient's acceptance, would theoretically respect both the individual's autonomy and the cultural beliefs that may exist" (p. 1053). Furthermore, Bell et al. (2008) stated that "family is an imperative factor in the decision-making for more legally defensive physicians, supporting the association between great importance of liability concerns and family preferences in health care treatment choices" (p. 916).

During my literature review, I discovered that relatively little has been written about the role of religion in medical decision-making. Patients who make medical decisions based on religion and faith are an understudied group (Vess, Arndt, Cox, & Routledge, 2009). Faith and religion are important factors that influence African

Americans when dealing with treatment choices and end of life decisions (Johnson, Elbert-Avila, & Tulsky, 2005). Silvestri and colleagues (2003) found that in South Carolina 45% of African American patients felt that faith would play a role in their decision-making and that faith in God is an important factor. According to Johnson et al. (2005), “Spiritual beliefs are important for some African Americans in understanding and coping with illness and may provide a framework within which treatment decisions chosen” (p. 467). Faith and religion can be a factor that assists patients and their families to help with decisions on deciding on treatment for cancer (Silvestri, Knitting, Zoller & Nietert, 2003). According to Ehman et al. (1999), religious beliefs play an important role in the decision-making process, and that a large number of patients report that religious beliefs are used to make medical decisions.

Collaboration between patients and health care providers is a growing trend (Frantsve & Kerns, 2007). Previous research has shown that shared decision-making has focused on patients’ who have included their share decision-making with their selected health care providers (Collins, Crowley, Karlawish & Casarett, 2004). Bell et al. (2008) suggested that physicians’ perceptions are an important element in medical decisions. According to Moulton and King (2010), physicians’ recommendations for patients seeking treatment are a major driving force for patients’ decision-making, and are more important than patient preferences.

Trust is also a significant factor among the African American population in health care decisions. African American patients tend to trust their physician’s decisions less than their white counterparts (Trachtenberg, Dugan, & Hall, 2005). A physician’s method of communication with patients is a very important factor in building trust (Flenaugh & Henriques-Forsythe, 2006). Leydon et al. (2000) found that most patients, excluding African-Americans, do not look for extra information on medical treatment options. The study found that African Americans are more likely to depend on their doctor's expertise, typically assuming that the doctor will only do what is best for the patient. The finding in this study showed that health care experts have opportunities to enhance a patients' trust and fulfillment regarding medical care and decisions. Physicians can assist patients with treatment options for ending critical disease issues, issues of trust, and showing patients that they care about their prosperity. (Lawson, Schumacher, Hughes, & Arnold, 2009).

Problem Statement

Lung cancer is a significant and life-threatening health issue that disproportionately affects the African American population (Farjah et al., 2009). African Americans have an increased death rate and a lower survival rate from lung cancer as compared to other racial and ethnic group in the United States (American Cancer Society, 2010). While earlier studies have noted that family and faith/religion can have an influence on patients' decision-making about cancer treatment, there is limited research on how these factors influence African Americans in making treatment decisions (Banks & Dracup, 2006; Lefler & Bondy, 2004). This dissertation study examined the influence of family support and faith/religion among African American patients when seeking treatment for lung cancer. I feel that it is important to understand how these factors may increase the decision to seek treatment in order to reduce the death rate and increase longevity among African Americans.

Nature of the Study

The objective of this study was to examine the influence of family support and/or faith/religion on African American lung cancer patients' treatment decisions. The primary research questions that were addressed in this study were:

1. How does family support influence whether African American patients with lung cancer seek treatment?
2. How do faith and religion influence whether African American patients with lung cancer seek treatment?

Purpose of the Study

The primary purpose of this qualitative study was to examine how family support and faith/religion influence decision-making for lung cancer treatment. It used a phenomenological approach to investigate how family support and faith/religion influence how African American patients' seek treatment for lung cancer. Phenomenology is concerned with the discovering the meaning of lived experiences by human beings as they exist in the world (Chamberlain, 2009). Phenomenology is applicable in this study because it will enable me to obtain information from individuals of the African American population who have had or have the diagnosis of cancer.

A phenomenological approach was used collect data from participants about their experience related to lung cancer and the decisions that influence treatment seeking. This data was collected using semi structured interviews that guided me to understand what influence social support and faith/religion has on the decision to seek treatment for lung cancer. Findings from this investigation assisted in bringing social change. It will allow for further studies to change attitudes, behaviors and for interventions that better reflect the values of African Americans' and their health decision opportunities.

Theoretical Base of the Study

This qualitative research study utilized a phenomenological research method. The intent of the present research study was to show an understanding of what influences decision-making among African Americans newly diagnosed with lung cancer.

Within this research medical decision-making (MDM) is defined in medical circles as the choice of a course of action after diagnosis (Ekdahl et al., 2011). Patient decision-making is an area of increasing inquiry when it relates to health care. There are three components to MDM. The first component considers the number of diagnosis or management options provided to patients. The next component accounts for the complexity of data to review. The final component takes into account risk of complications or death if the condition goes untreated. All of these components can be measured as minimal, limited, multiple, or extensive (Frantsve & Kerns, 2007). The three components of MDM reflect the intensity of the cognitive labor performed by physicians.

The decision-making process consists of a variety of factors including past experience, cognitive behaviors, age/individual differences, personal beliefs and commitment (Dietrich, 2010). According to Juliusson, Karlsson and Garling (2005), individuals make cognitive decisions for their future based on their past experiences and past choices in life. Stanovich and West (2008) stated that an individual's cognition or thinking differs due to age and lifestyle patterns and experiences. Additionally, individuals' decision-making also can be impacted by one's social economic status

(SES), which is related to their education and the type of resources available to them. Even though many people have several different factors that impact their decision-making, many patients will contribute time and money because they feel that it is a commitment to a better health outcome (Acevedo & Krueger, 2004). There is an understanding that there are elements that impact a patient's choice making process. These elements are important when it comes to figuring out what choices are made, as well as determining how the influences may impact certain outcomes (Dietrich, 2010). Siminoff et al. (2006) conducted a study at the Case Comprehensive Cancer Center and found that some patients received assistance with the decision-making process while other patients did not receive this assistance. The study found that patients who did not include their families chose to do this because they did not want them involved, or they were isolated from their loved ones and had minimal contact with them. Additionally, further evidence shows that patients prefer not to be involved in the decision-making process since patients find the decision-making process stressful (Thompson, 2001).

Definition of Terms

The following terms are defined as they relate to this study.

African American. According to the U.S. Bureau of Census (2010), "*African Americans is a term* used interchangeably; *Blacks* are individuals who racially define themselves as such so defined and treated by socially significant others and society."

Chemotherapy. Online Medical Dictionary (2010) states "*Chemotherapy is the* term used to define the medicine to treat cancer, it is injected into a vein (IV) or given a pill by mouth. A treatment with drugs to destroy cancer cells, it is often used either alone or with surgery or radiation, to treat cancer that has spread or come back (recurred) or when there is a strong chance that it could recur".

Faith. Dictionary.com (2011) states "*Faith* is defined as confidence or trust in a person or thing; belief in God or in the doctrine or teaching of religion; a system of religious beliefs".

Non-small cell cancer. Online Medical Dictionary (2010) defines "*Non-small Cell Cancer as the* most common form of lung cancer, the name comes from the way the cancer cells look under a microscope. There are several types of non-small: large-cell carcinoma, squamous cell carcinoma and adenocarcinoma".

Religion. Dictionary.com (2010) defines "*Religion* as a set of beliefs concerning the cause, nature and purpose of the universe, especially when considered as the creation of a superhuman agency or agencies, usually involving devotional and ritual observances, and often containing a moral code governing the conduct of human affairs".

Small-Cell Cancer. Medical Dictionary (2010) defines "*Small-Cell Cancer* as 10% to 15% of all lung cancer is small-cell cancer (SCLC), other names for SCLC are oat cell cancer, oat cell carcinoma, and small cell undifferentiated carcinoma. It is very rare for someone who has never smoked to have SCLC. SCLC develops and starts in the bronchi near the center of the chest, and it tends to spread widely through the body fairly early in the course of the disease".

Limitations and Delimitations

There are certain limitations of the study that should be acknowledged. The sample size was limited to African Americans with a diagnosis of lung cancer. In limiting study participants to African Americans, findings are not generalizable to other racial/ethnic groups. This study was conducted in one thoracic clinic in the Greensboro, North Carolina with African American patients diagnosed with stage 1 and 2 lung cancer. Due to location and specific study population, this study is not generalizable to other locations and populations.

Assumptions

Several assumptions underpinned this research: (a) Patients would willingly participate in this research without the stress or pressure from the clinic or by the physician, (b) participants would agree to be interviewed by the researcher, and (c) participants would provide honest answers for data collection. Another assumption of the investigation was that family support and/or faith/religion would influence African American patients' seeking treatment for lung cancer.

Significance of the Study

African Americans have the highest incidence rate from lung cancer and experience a lower survival rate of other racial and ethnic group in the United States (Cancer Facts & Figures for African Americans, 2010). The main problem seems to be that many African Americans are not receiving treatment for their lung cancer, and this research identified how family support and faith/religion influence their decision to seek treatment. This study is significant because of the high percentage of African Americans who die from lung cancer each year. Additionally, it may inform future intervention efforts that could reduce mortality in this population. Based on study findings, future interventions may be developed that will use what has been learned in this study to help

African American’s seeking treatment for their diagnosis of lung cancer to make acceptable decisions.

Summary

This chapter has provided an introduction and background to the research problem; the gap in the current health issue as it relates to the factors that may impact the decision for treatment among African American patients with lung cancer has been outlined in this study. This study has explored whether or not family and/or faith/religion influence the decisions of African Americans’ seeking treatment for lung cancer. Four additional chapters are included in this study. Chapter 2 will present a review of the literature and provide insight about what other studies have found related to factors that impact the decision of lung cancer patients to seek treatment. Chapter 3 contains the methodology used for the study, including the research design, selection of participants, instrumentation, procedures, assumptions, and data analysis. In Chapter 4, the findings of the research will be presented as each research question is reviewed. Finally, Chapter 5 will provide a discussion of the findings, conclusion, implications of the study, and recommendations for further research.

Chapter 2: Literature Review

Introduction

This chapter provides a review of literature related to influences on the decisions of African Americans and other racial and ethnic groups when seeking treatment for lung cancer. This chapter also provides a concise synopsis of the current research literature that establishes the importance of the problem. Lung cancer is a significant problem and life-threatening issue in the general population of the United States and among the African American population in particular (Farjah et al., 2009). This study examined the influences of family and faith/religion on the decision-making processes on patients seeking treatment for their lung cancer. The review being presented in this chapter are shown to support this qualitative work.

Literature Search Strategy

I conducted a scholarly review of the pertinent literature using electronic database searches in the EBSCO database, MEDLINE, Academic Search Premier, ProQuest SAJA Journals, OVID-SP, and Google Scholar. I also examined selected related articles to support the topic. The keywords used for the search included these terms used were searched by individual terms and in combination to find the articles to support the research. Research articles published from 2004 through 2013 were included and reviewed.

The literature has been analyzed based on the thematic content. This section will be divided into three broad sections: (a) influences on treatment seeking, (b) influence of family input in decisions to seek treatment for lung cancer, (c) influence of faith/religion input on decisions to seek treatment for lung cancer.

The search criteria were selected to focus the search on literature related to patients with a diagnosis of lung cancer and the factors that influence their decisions for seeking care. These searches yielded more than 200 abstracts and full-text peer-reviewed articles. These search criteria produced results following three general themes:

1. Peer-reviewed articles that focused on how family input influences the decision-making for patients with lung cancer.
2. Peer-reviewed articles that focused on how faith/religion input influences the decision-making for patients with lung cancer.
3. Peer-reviewed articles that focused on how physician recommendations and input influence the decision-making for patients with lung cancer.

The exclusion criteria included:

1. Studies that did not address African Americans only on an individualized study to show how these outcomes affect this population on an individual basis. Many of the studies combined other races or cultures but very limited on the African American as a whole.
2. Studies focused on all cancers and not lung cancer as an individual topic.
3. Studies focused on decisions factors as related to the end of life.
4. Studies focused on the importance of beliefs and spiritually, rather than faith and religion.

Review of Literature

Lung Cancer Prevalence and Survival

Lung cancer is the leading cause of cancer-related deaths in the United States and a major public health problem (Siegel, War, Brawley, & Jemal, 2011). More than 90,000 people die from lung cancer every year and nearly 200,000 are diagnosed annually in the United States (CDC, 2011). The ACS reported that each year the estimated numbers of new cases and deaths expected in the United States from lung cancer are rising (American Cancer Society, 2014). The most common causes of death in women are lung bronchus cancer, colorectal cancer, and breast cancer. The most common causes of death in men are cancers of the lung, bronchus, prostate, and colorectal system (see Figure 1). In 1987, lung cancer followed by breast cancer as the leading causes of death for women; this same trend continues in the present (Siegal et al., 2011).

Estimated New Cases*

Males			Females		
Prostate	240,890	29%	Breast	230,480	30%
Lung & bronchus	115,060	14%	Lung & bronchus	106,070	14%
Colon & rectum	71,850	9%	Colon & rectum	69,360	9%
Urinary bladder	52,020	6%	Uterine corpus	46,470	6%
Melanoma of the skin	40,010	5%	Thyroid	36,550	5%
Kidney & renal pelvis	37,120	5%	Non-Hodgkin lymphoma	30,300	4%
Non-Hodgkin lymphoma	36,060	4%	Melanoma of the skin	30,220	4%
Oral cavity & pharynx	27,710	3%	Kidney & renal pelvis	23,800	3%
Leukemia	25,320	3%	Ovary	21,990	3%
Pancreas	22,050	3%	Pancreas	21,980	3%
All Sites	**822,300**	**100%**	**All Sites**	**774,370**	**100%**

Estimated Deaths

Males			Females		
Lung & bronchus	85,600	28%	Lung & bronchus	71,340	26%
Prostate	33,720	11%	Breast	39,520	15%
Colon & rectum	25,250	8%	Colon & rectum	24,130	9%
Pancreas	19,360	6%	Pancreas	18,300	7%
Liver & intrahepatic bile duct	13,260	4%	Ovary	15,460	6%
Leukemia	12,740	4%	Non-Hodgkin lymphoma	9,570	4%
Esophagus	11,910	4%	Leukemia	9,040	3%
Urinary bladder	10,670	4%	Uterine Corpus	8,120	3%
Non-Hodgkin lymphoma	9,750	3%	Liver & intrahepatic bile duct	6,330	2%
Kidney & renal pelvis	8,270	3%	Brain & other nervous system	5,670	2%
All Sites	**300,430**	**100%**	**All Sites**	**271,520**	**100%**

*Figure 1***.** Ten leading cancer types for the estimated new cancer cases and deaths by sex, 2011. From Siegel, Ward, Brawley and Jemal (2011). Copyright 2011 by John Wiley and Sons. Reprinted with permission.

The cancer survival rate for African American men and women is lower than that for White men and women (Siegel et al., 2011). Research shows a 5-year relative survival rate between African Americans and whites in during different stages of diagnosis for nearly every cancer site (see Figure 2).

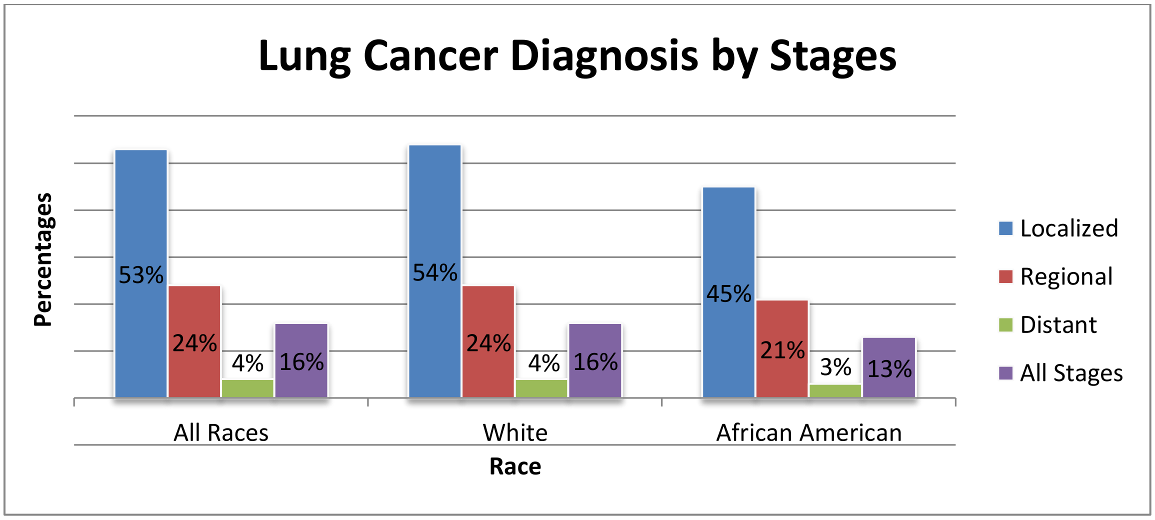

Figure 2. Five-Year Relative Survival Rates Among Patients Diagnosed With Selected Cancers by Race and Stage at Diagnosis, United States, 1999 to 2006. From Siegel, Ward, Brawley and Jemal (2011). Copyright 2011 by John Wiley and Sons. Reprinted with permission of the publisher.

Most lung cancers found in patients are in the early stages of diagnosis (Hammerschmidt & Wirtz, 2009). The four major types of lung cancer are: (a) squamous, (b) adenocarcinoma, (c) non-small lung carcinoma, and (d) small lung cancer carcinoma. Squamous lung cancer, also called epidermoid carcinoma, forms in the lining of bronchial tubes and accounts for 30% to 40% of lung cancers (ACS, 2014). Adenocarcinoma, which accounts for 25% to 30% of lung cancers, is the most common form of lung cancer in the United States among both men and women (ACS, 2014). Non-small lung carcinoma, which accounts for less than 10% of lung cancers, occurs in four stages: (a) Stage I, it can be located in the lungs, not in the lymph nodes; (b) Stage II, cancer is in the lungs nearby the lymph nodes; (c) Stage III, cancer is found in the lungs and the lymph nodes in the middle of the chest also known as advanced stage of cancer, and (d) Stage IV, is the most advanced stage, cancer has spread to both lungs and to other parts of the body such as the liver or other organs (ACS, 2014). Small cell lung carcinoma, which accounts for 15% to 20% of lung cancers, is often associated with smoking (ACS, 2014). Small cell lung cancer can grow more rapidly and spread to other parts of the body earlier than non-small cell. It is more responsive to chemotherapy (ACS, 2014).

Studies have shown that the incidence of advanced lung cancer has increased in most race/ethnic groups; the greatest increase has been seen within African Americans (Blackstock et al., 2002). In 2007, out of 100,000 individuals, 95.1 African American men were diagnosed with lung cancer compared to 43.4 Hispanic men, 47.1 Asian Pacific islander men, and 49.3 American Indian/Alaska native men (CDC, 2011). Also reported, that out of 100,000 individuals, 48.0 African American women were diagnosed with lung cancer compared to 27.5 Hispanic women, 29.0 Asian Pacific, and 38.0 American Indian/ Alaska native women (CDC, 2011).

The National Institutes of Health (NIH; 2010), reported that lung cancer is the deadliest form of cancer for both men and women. Lung cancer is rare in individuals under the age of 45 years old and is more common in individuals over the age of 45 years old (Ward et al., 2004).

Influence of Decision-Making Process on Treatment

In the past, health care decisions were mainly made by the physician and dictated to the patient, but now, patients and their families are more involved in medical decisions (NIH, 2010). Older adults who have more than one disease, such as diabetes mellitus, coronary heart disease or hypertension, are faced with making decisions for other conditions that may affect treatment. Elderly people with co-morbidities must focus on decision-making for all of their medical conditions (Ekdahl, Anderson, Wirehn & Friedrichsen, 2011). A cross-sectional study that was conducted in a Swedish hospital used patients 75 years' old and older to complete a questionnaire along with a telephone call, to measure each participants' preference of treatment and impact of their medical decision-making. Findings from the study determined that 35% of patients would willingly choose to have a passive role in their health care decision-making. They also found that 21% of patients wanted to have a very active role in their health care.

Influence of Family Input in Decisions to Seek Treatment

Families play a significant role in the process of making decisions about the care of adult cancer patients (Siminoff, Rose, Zhang & Zyzanski, 2006). Not only does the decision-making processes impact the patient, but also affects the patient's families (McKenna, Collier, Hewitt & Blake, 2010). Many individuals involved in cancer treatment and recovery rely on family caregivers for a great deal of support (Bevan & Pecchioni, 2008). A study that was conducted in Flanders, Belgium, using random coefficient analysis, recruited 128 patients over a 1-year period from 13 different hospitals to explore the decision-making process that involved family of lung cancer patients. The patients were diagnosed with non-small cell lung cancer, Stage IIIb or IV; these patients' were recruited by pulmonologists and oncologists. The patients were interviewed by trained interviewers using a structured questionnaire. Questionnaires were given to the patients every two months and again every four months until six interviews had been completed with each participant. During the interview, patients were asked about including and involving others in their medical decision-making processes. The choices given were nurses, doctors, family/close friends, no one or others. Patients provided answers to the questionnaire assuming that they were competent and also answered to the extinct if they were ever to become incompetent. The outcome from the first interview showed that when competent, 68% of the patients wanted family to be involved in their medical decision-making, zero percent wanted nurses input, 1.6% wanted input from others, and 29.7% wanted no one involved (Pardon et al., 2010). A total of 93.6% of the patient's wanted involvement of others when found incompetent, 0.8% of them wanted nurses input, and 6.4% wanted no one's involvement with the decision-making process. The study revealed that 22.6% of patients would desire input from their primary care physician. Another 40.9% of patient's desire input from both their families as well as their physician. The study also revealed that 36.5% of the patients interviewed preferred to only incorporate their families in the decision-making process. Although findings showed that family involvement was wanted, this study had several limitations.

An additional study analyzed difference of opinions between cancer patients and the caregivers in regards to treatment and patient care decisions (Gabriel et al., 2008). A convenience sample from hospitals in Cleveland, Ohio recruited 184 lung cancer patients and 171 primary caregivers to participate in a telephone interview to answers questions using a semistructured questionnaire. The study used nonparametric tests and regression analysis to examine differences between groups. The outcome of this study showed that patients and caregivers reported significant differences on treatment decisions for advanced lung cancer diagnosis.

In conclusion, the literature review has shown that family medical decision-making behavior for minor children and incompetent adults required to terminate treatment has not been widely studied. These are important issues that warrant further study (Sminoff et al., 2006).

Influence of Faith/Religion Input on Decisions to Seek Treatment

The role of religion and faith is not well understood in medical decision-making (Vess, Arndt, Cox, Rutledge & Goldenberg, 2009). Past research has revealed that faith and religion play an important factor among African American patients with serious conditions such as cancer, heart disease, and depression (Dessio et al., 2004). According to Brooks and White (2004), they state that “People must have a social center and that center for African Americans has traditionally been the church. Since the emancipation, the African American church has become more organized as a government with a head faith or religious leader who can influence every aspect of life.”

Historically, spirituality has played an important role in health and medical decision-making among African Americans communities. (Figueroa, Davis, Baker, & Bunch, 2006). A study that was conducted in the Mid-West that surveyed 1700 older adults focused on how spirituality rather than faith and religion had more of an impact on treatment seeking behaviors (Puchalski, 2001). Conducted in Hampton, Virginia, focus group methodology was used to understand what role spirituality has. There were three separate focus groups that consisted of African Americans, 12 men and 22 women; there were between 11-12 individuals in each group that totaled 34 participants. The age ranges for these participants were 30-80 within the focus groups. There was a structured interview guide to facilitate the group. After the focus groups had been completed, the data was transcribed and analyzed selecting phrases exemplifying common themes. The findings showed that African American have a strong belief in spirituality.

Limited research has been conducted with African Americans and other racial ethnic groups on how they perceive religion and spirituality influence cancer treatment decisions (Johnson, Elbert-Avila, & Tulsky, 2005). Of the research published, it is evident that spiritual beliefs are important to African Americans (Belzen, 2010 & Puchalski, 2001). Spiritual beliefs potentially provide a way to help explain how and why African Americans may make decisions about treatment. Johnson et al. (2005) stated that "Understanding and coping with illness and may provide a framework within which treatment decisions are made" (p. 712).

A study was conducted to examine how religion and spirituality influenced cancer treatment decisions (Koffman et al. 2008). The study consisted of 26 Black Caribbean and 19 White British patients. In this study, the investigator's investigated how religion and deep sense of being affected their experience with cancer and decision-making about treatment. This study identified that patient’s form both ethnic groups appeared to derive benefits from their religious faith and belief in God.

Unfortunately, there is a paucity of empirical research regarding psychosocial or quality of life outcomes among survivor of colorectal or lung cancer (Clay, Talley, & Young, 2010). The lack of adequate data on colorectal and lung cancer survivors and quality of life outcomes, such as spirituality or spiritual well-being, must be addressed because these cancer sites account both for a significant portion of annual incidence of cancer and the overall proportion of survivors (American Cancer Society, 2008). Koffman et al., (2008) suggest that that numerous studies have depended on specimens drawn from white populaces, and little is thought about the implications of religion and deep sense of being among racial and ethnic minorities. Research has shown that spirituality may play a major role in coping with cancer, adjusting to life after a cancer diagnosis and treatment, physical functioning and quality of life in cancer survivors (Hills, Paice, Cameron, & Shott, 2005; Tarakeshwar, 2006).

Literature Related to Methodology

As noted throughout this chapter, the majority of the studies reviewed were qualitative and very few were quantitative. In this proposed study, qualitative method was selected instead of quantitative because this study is seeking to understand what influences African American patients to seek treatment for their cancer. Quantitative research focuses on counting and measuring specific aspects in turn producing estimations of averages and differences between groups (Frederuksin, Chamberlain & Long, 1996). Established initially in social science, qualitative research focuses more on understanding why people behave as they do. Aspects included are their knowledge, attitudes, beliefs, and fears (Johnson & Webb, 1995).

Qualitative Methods

There are five basic approaches that can be useful when conducting qualitative research in health related studies. According to Creswell (2006), the qualitative approaches are phenomenology, ethnography, grounded theory, case study and narrative research. According to Creswell (2006), narrative research and ethnography and case study are similar due to the unit of analysis is a single individual. It stands correct that any of the three approaches can study a single individual, but the process in which the data is collected and analyzed would be different. The narrative approach gives emphasis to stories told by an individual. The stories are collected and then arranged in chronological order (Creswell, 2006)). In ethnography, the focus is on the setting of the individual's stories within the context of their culture and culture-sharing group (Patton, 1990). Case study research is composed of a single case and it typically selected to illustrate the issue, and then the researcher organizes a detailed description of the setting for the case (Creswell, 1998). Grounded theory research develops a theory in data from the field and grounding the views of the participants (Pope et al., 1997). Grounded theory is a process that studies many individuals (Creswell, 1998). Phenomenology is the understanding essence of the experience of the individual and the study of several individuals that have shared the experience (Creswell, 2007) Phenomenologists focus on analyzing what participants have in common as they experience a phenomenon (Creswell, 2006).

Macfarlane and Alpers (2009) led a qualitative study utilizing an ethnographic approach to examine how knowledge as well as health belief systems impact treatment decisions. In the Macfarlane and Alpers study, two hundred participants in Papua New Guinea were interviewed to understand their decision-making in regard to febrile sicknesses and skin conditions. The study revealed consistencies amongst the various study participants. These consistencies were discovered in areas associated with a patient's convictions about the disease, the type of treatment that is desired, and their reaction to the illness.

In another study, Matthews et al. (2002) conducted a qualitative study that used focus groups to collect information to explore factors that may influence medical information seeking and treatment engagement among African American cancer patients. This study examined why African American patients between the ages of 45 to 78 choose not to seek treatment and if they do what influences their decisions. The outcome of the study found that the patients believe in faith and religion as an influence factor. One of the outlining factors of the study included religious beliefs and faith. Religion and faith have been identified as a major resource for coping in the African American population and the inhibitor to seeking medical information and medical treatment. The current study investigated how religion influences patients to seek treatment

A study that was conducted in the United Kingdom used an ethnographic approach to investigate the culture of intensive care and also studied how the medical staff made clinical decisions. Coombs and Ersser (2003), in their study, used the medical decision-making model (MDM), to show the emerged data of knowledge for clinical decision-making and roles in the clinical decision-making. The majority of the patients in the study were able to identify and rate a medical decision. This study shows the feasibility of using an ethnographic approach as well as MDM.

Matthews et al. (2002) conducted a qualitative study to explore factors that may influence medical information seeking and treatment engagement among African American cancer patients and used a case study approach. The study interviewed 55 men and 45 women whom were all African American, majority of the patients felt as if their family and faith played an important part in their medical decisions. One of the outlining factors of the study included religious beliefs and faith. Religion and faith have been identified as a major resource for coping in the African American population and the inhibitor to seeking medical information and medical treatment. The study that I conducted used a qualitative approach and explored how patients seek treatment and what influences their medical decisions.

Summary

This chapter has presented a review of the literature addressing how family and/or faith/religion have had an influence on African American patients with lung cancer and their seeking treatment for their disease. Many of the studies that were cited in this chapter did not examine African Americans exclusively, but included multiple racial/ethnic groups in their attempt to understand what influence family support has on making decisions about seeking treatment for lung cancer. There is a need for continued research that focuses on the African American population and will allow for a better understanding of important factors that influence patient's decisions when seeking treatment. I have attempted to show the reader how family support and faith/religion can influence the patient and have a higher incidence rate and lower survival rate for this population. Promoting medical decisions for patients with disease is in the control of the patient and identifying these factors that will help promote will help not only the patient but the medical practitioners target the appropriate treatment and care for these patients.

Chapter 3: Research Method

Introduction

This study examined the relationship between family support and faith/religion and the influence that is has on African American patients when seeking treatment for lung cancer. This chapter discusses the methodology, research design, data collection, sampling and data analysis that were used. The chapter also discusses my role as the researcher conducting the study, as well as recruitment and the ethical protection of study participants.

Research Design and Rationale

The research questions addressed were:

1. How does family support influence whether African American patients' with lung cancer seek treatment?
2. How does faith/religion influence whether African American patients' with lung cancer seek treatment?

This study used in-depth interviews to collect the data to answer the research questions proposed for this study. This qualitative research approach enabled me to study the African American culture in their context and of individuals through experience. According to Creswell (1998), qualitative research aims to understand methodological traditions association with a social or human problem, which is achieved by using an inquiry process. Creswell (1998) states "qualitative studies, the researcher can build a complex, holistic picture, analyzes data, reports detailed views of informants, and conducts the study in a natural setting" (p. 110).

Social scientists employ qualitative research methods to explore social or human problems from the perspectives and experiences of people who experience them directly. This information is used in order to understand human behavior and to determine what factors influence them (Ulin, Robinson, & Tolley, 2005). Phenomenology is the understanding essence of the experience of the individual and the study of several individuals that have shared experience (Creswell, 2007). Phenomenologist primary focus is on analyzing what participants have in common as they experience phenomenon (Creswell, 2006). Furthermore, Creswell (2007) recommended interviews as a method of data collection in ethnographic research and, as is the case with grounded theory, these methods are inappropriate to the group dynamic, which is why this study will be conducted by doing individual in-depth interviews.

Role of the Researcher

I served as the primary researcher and the principal investigator for this study. One of my responsibilities was to make the initial contact and recruit participants from Triad Cardiac and Thoracic Surgery clinic. I also conducted the in-depth interviews, transcribed the data, analyzed the data and summarized the results. I established a rapport with the clinic and the participants in order to recruit and conduct the interviews.

Methodology

Setting and Sample

Study participants consisted of both African American men and women with confirmed Stage 1 or Stage 2 lung cancer diagnoses who reside in the Greensboro, North Carolina area. All participants were at least 18 years of age and were recruited from a cardiovascular and thoracic surgery clinic in the area. This clinic provided me with a list of patients that have been diagnosed with stage 1and 2 lung cancer, which I used to invite patients to participate in the study. Criterion-based sampling was used to select participants. Criterion-based sampling is used to ensure that the selected participants have experienced the phenomenon (Creswell, 2003). Since the African American patient population at the clinic was small, I only used 15 participants that agreed to participate and were recruited over a five months.

Instrumentation and Materials

Researchers are the principal instrument of data collection in a qualitative study (Kvale, 1996). In this the research I used twenty-one open-ended questions to explore the experience of the participants (see Appendix D). The questions were taken from Fact-L and have been used in a previous research study (Gridell et al., 2014). Fact-L is a tool that was created and has been useful in other studies to collect data from patients with lung cancer (Kawahara et al., 2011). The questions asked about the family support and the influence it had on seeking treatment and questions also asked about how faith/religion had with the influence on seeking treatment. The demographic information obtained from each participant included age, race, gender, marital status, religion, salary, and level of education.

Data Collection and Analysis

Data Collection

I received approval (#1510) from Cone Health Institutional Review Board and approval (#02-01-13-0144924) from the Walden University Institutional Review Board (IRB) prior to conducting the interviews and data collection process. After IRB approval was received, I used convenience sampling to recruit study participants. I contacted the potential participants prior to their medical appointments by using an appointment list provided by the clinic. I called the participants and explained the study and asked if they would participate. For each person who agreed to participate, I designated a time and location to conduct an interview and allow the participant to sign the consent forms. The data that was collected from the interview consisted of note-taking by and authorized recordings of the interviews. These recordings enabled me to identify any missing information and to compare my notes taken during the interview with the recorded data.

Data Analysis

Data analysis provides order structure, and organization of the data in order to categorize common themes and relationships among participants. This is accomplished through analysis of responses to specific statements and themes by study participants. Qualitative data analysis of recorded verbal data was conducted for this study and consisted of seven basic steps: recording, transcription, reading transcripts and field notes, coding, displaying, reducing and interpreting. I transcribed the recorded data for each interview immediately or soon after each interview. I also asked each participant for their permission to be recorded as well as took detailed notes to capture the responses to each of the questions that I asked during the interview. I listened to the recording more than once to ensure that all data is captured. The questions focused on whether family or faith/religion influences their decision to seek treatment for their lung cancer diagnosis. The outcome of the interviews allowed ne to collect information on help clarify the role of the family and faith to see which factor plays a role in the decision to seek treatment within the African American population

After transcribing the recordings, I used QSR International's NVIVO software (2007) to organize and analyze the textual data. NVIVO is a software program designed and used to analyze phenomenological research (Gay, 2000).

Ethical Protection

This study received prior approval from the Cone Health Cancer Center, the Institutional Review Board (#1510) from Cone Health Hospital as well as the Walden University Institutional Review Board (#02-01-13-0144924) (see Appendix E). Each participant was informed of their complete anonymity, the confidential treatment of their identity, and that no identifying information would be asked of them on the survey. Each participant signed a consent form, one copy of which was provided for them to keep and one copy of which I retained. I explained the consent form to each participant and informed them of their rights and privacy. The consent included the researcher's name and contact information as well as the information of the dissertation committee. Data collected was entered into a researcher's personal computer, which has security measures. All data was stored on a password protected flash drive and any paper documents (survey and consent forms), and is in a locked file cabinet in the researcher’s home office.

Validity and Trustworthiness

Whittemore, Chase and Mandle (2001) state the ability to develop validity standards in qualitative research is challenging due to necessity to incorporate rigor, subjectivity, and creativity into the scientific process. Creswell (2003) asserted validity has different connotations in qualitative research than it does in quantitative research. Qualitative research acquires a vast amount of detailed data using information provided by study participants. This research used the following strategy suggested by Creswell to check for the accuracy: member checking; rich, thick, description and debriefing. In this study I also used member checking to clarify the accuracy of the qualitative findings that will require the participants to review a copy of the final report (Stake, 2010).

In addition to the research, the trustworthiness showed the validity of the study. According to Gay and Airasian (2000), advised researchers to use strategies such as extending the study, including additional participants, recognizing one’s bias, and allowing participants to review the notes in which the researcher recorded verbally and electronically for accuracy and meaning. The accuracy was reviewed for the final report.

This chapter has provided an overview of the methodology, the research design, data collection and analysis that was used in the study. In the next chapter, study findings are presented.

Chapter 4: Results

Introduction

The purpose of this study was to examine how family support and faith/religion influenced treatment decisions of African Americans with lung cancer. This chapter presents themes and findings that examine how these factors influence decision-making about seeking treatment among African Americans. I collected data by conducting semi-structured interviews and then summarized the data to identify the findings. The first section of this chapter characterizes the study population and the demographics of participants. The second section of the chapter describes data collection and reliability. The third section outlines the results of the research, and finally, the last section presents a summary of findings and conclusion.

The following research questions formed the foundation for this study:

1. How does family support influence whether African American patients' with lung cancer seek treatment?
2. How does faith/religion influence whether African American patients' with lung cancer seek treatment?

This research used a qualitative approach to obtain data for the study. Creswell (2003) states, "The data collection steps include setting boundaries for the study, collecting information through unstructured or semi structured observations and interviews as well as establishing the protocol for recording information" (p. 185). The study used a phenomenological approach. According to Creswell (2007), phenomenology is the method used to understand the essence of the experience of the individual and the study of several individuals that have shared experiences.

Setting

This study examined on a small sample of the African American population in Guilford County, North Carolina. The study participants were African Americans who were recruited from the Triad Cardiac and Thoracic Surgery Clinic in Greensboro, North Carolina. These study participants were recruited by flyers that were left in the physician's clinic waiting room or in the patient exam rooms. The patients either called the contact number on the flyer to sign up for the study or they told the clinic staff that they were interested and left their contact information for me to follow up and set up a time to conduct the interview. The clinic provided me a list of patients that have been diagnosed with Stage 1 and Stage 2 lung cancer. Once I contacted a patient, I set up a time and date to meet at the clinic to complete the semi-structured interview in the clinic's conference room. The participants recruited for this study had all previously received diagnoses of lung cancer.

Demographics

The individuals that participated in this this study were all African American, of both genders and between the ages of 30 and 75. All of the participants have been diagnosed with lung cancer, and were either deciding on their treatment or had already received treatment. Each participant completed a short demographic survey and returned it to me after signing the consent form. The demographic survey was used to obtain discrete information on the personal history of the respondent. Data gathered from the demographic surveys were used to compare the background of each participant. Most of the participants were female (53%). In terms of the participants' highest education level, 33% had some high school, 27% had high school graduation only, and 40% had some higher education. Three categories of religion were recorded in the survey responses: Methodist (40%), Baptist (20%), Holiness (20%), and Non-denominational (20%). Ninety-three were or had been married at some time, 27% were unemployed full-time, and 53% were retired. Fifty-three percent had been diagnosed with stage 1 lung cancer (see Table 1).

Data Collection

A total of 15 face-to-face, semi-structured interviews were conducted at the medical practice conference room of the clinic. The instrument that was used for the interview was adopted from a previous study by me and approved by the Cone Health IRB department and by the physicians at the clinic. Some of the interview questions had been used in a previous study as part of the Fact L survey instrument. The interview consisted of 21 questions for each participant. The questions were related to their family, faith/religion and how it impacted the decisions to seek treatment for their lung cancer disease.

Data Analysis

I analyzed data collected from the participants and then summarized the data findings. The descriptive and rich data that was collected was used to identify the most important themes that answered the research questions. Data from the 15 interviews conducted were coded based on the 21 semi structured questions, as suggested by

Table 1

Characteristics of Study Population (N=15)

Patient Characteristics	Total	%
Gender		
Male	7	47%
Female	8	53%
Education		
Some HS	5	33%
HS Grad	4	27%
Some College	1	7%
College Grad	1	7%
Trade/Technical	2	13%
Some Post Grad	1	7%
Post Grad	1	7%
Marital Status		
Single/never married	1	7%
Married	6	40%
Divorced	3	20%
Separated	2	13%
Widowed	3	20%
Employment	3	20%
Full-time	4	27%
Not employed	8	53%
Retired		
Stage of Cancer	8	53%
Stage 1	1	7%
Stage 2	1	7%
Stage 3	1	7%
Stage 4	3	20%
Stage 1-A	1	7%
Stage 2-B		

Thomas (2006; see Appendix D). I analyzed the data in four stages: (a) listening to the audiotapes immediately after the interviews but prior to transcribing, (b) transcribing the audiotapes, (c) forming linkages of existing and new data, and (d) categorizing by coding and identifying the common answers from the participants. I used the software program NVivo to facilitate central data storage and to help categorize the interview responses. I also took notes during the interview to capture the body language and any other responses that could not be captured in an audio recording. The data analysis and the collection of the data were done simultaneously, i.e., I started analyzing each interview while collecting the data. All recorded and written data retrieved from the study were stored according to the data storage procedure discussed in Chapter 3.

Evidence of Trustworthiness

This study used the member-checking strategy suggested by Creswell (2009) to check for the accuracy. Each interview was audio-recorded and I also took notes, allowing for the collection of data on the body language and emotions of the participants. The data was transcribed immediately after each interview. During the interviews, I was able build the rapport with each participant in order to obtain the honest and best response for the interview questions. The way I built a rapport was by allowing a general conversation between me and the patient to allow them to feel relaxed and comfortable with me. I also used member checking by mailing the transcripts to each individual patient to check for accuracy. No study participant contacted me to identify any errors in what was transcribed or said during the interviews. This provided cross verification of the accuracy of the data collected. The recordings were also replayed three times to check for accuracy and clarity of the findings.

Results

This study's primary goal was to identify what role family support and faith/religion had in decision-making. The interview questions investigated what role family, friends or other individuals had on their treatment decisions, as well as questions related to the faith/religion and its importance. Findings indicated that family support was an important part in the decision-making process. Discussions with study participants revealed that support from third parties gives patients both moral and psychological comfort when making decisions. The findings also indicated that faith/religion was an important factor in the decision-making about lung cancer treatment. Participants also used it as a method of comfort during their illness. Several principal themes emerged from the interviews.

Theme 1: Lack of Knowledge About the Disease, Treatment and Length of Time to Live

All of the participants in this study had a confirmed diagnosis of lung cancer, although the exact stage of lung cancer varied. When asked about their stage, the majority just spoke about it generally and did not really comprehend as if stage 1 to 4 made a difference. One participant stated, "Yes my doctor said that I have stage II, but it does not bother me because God will heal me and I won't have a stage at all" (Participant 3). Another participant stated, "I have stage I-A, so I feel that at my stage I can be treated and cured" (Participant 2). When conducting the interviews, many of the patients stated at diagnosis they felt their lives would drastically change. Treatment was another item discussed during the interview and questions 6 thru 9 on the interview guide were related to this topic. When asked about the type of treatment and if they would have it or not, many reported feeling as if God would heal them, though they also would listen to what the physician would have to say as well. Some had already had surgery.

Theme 2: Confusion and Fear About Treatment Options

Even though no emotions were shown during the interview, some of the patients stated that the diagnosis of cancer is overwhelming, and had those patients asking questions to their doctors. One patient stated, “When my results came back about me having lung cancer, it was too much for me to handle and I was really confused because I have never smoked a day in my life. I was scared but I knew that God was in control” (Patient 8). Several of the patients reported feeling overwhelmed when they had to think about treatment options and whether or not to have it. One patient stated, “I worry about whether or not to have surgery because I have been told that when you have surgery, it (the cancer) will spread worse and you might die (Patient 10). Other patients were overwhelmed to think about their treatment options. Some felt that having surgery would make matters worse and others had a sense that the cost of treatment would be a major issue to their finances. One patient stated, “So I am thinking that if I have surgery it might cause me to have other health issues that I have never had before and this is going to be a major expense” (Patient 13).

Theme 3: Extreme Financial Anxiety

One patient stated, “I guess I will spend the rest of my retirement money on medical bills, now that I have lung cancer” (Patient 1). Many of the patient’s responses were focused on how they were going to pay for medical care, treatment, and survive with their day-to-day living. Another patient stated, “I am on a fixed income and I can barely pay my bills; now that I have been diagnosed with lung cancer, I don’t know how I can even pay the co-pay to see my doctor” (Patient 11). Another patient stated, “My husband is also very sick and all of our money now goes towards his medical bills and medications monthly, I just don’t see how I can pay for this, I can’t afford another bill (Patient 7).

Theme 4: Faith, Prayer and Reliance on God

Several of the patients relied on their faith to oversee the treatment options. One participant stated, “I had surgery and it went very well, but my God pulled me through and I faith in him, so I am healed now” (Participant 14). Another participant stated, “I have not had surgery yet, but I am praying that when they do another follow up that they will no longer see the cancer, my God is a healing God, and I believe in miracles, so maybe I will not have to have surgery at all” (Participant 8). Majority of the participants interviewed all trusted God about their treatment decisions whether they have had surgery or still waiting. There were no emotions when asked about this topic, and the words ‘God’ and ‘Faith’ were an important part of their responses.

Data showed that faith/religion were important factors that patients relied on when making medical decision about lung cancer treatment. When discussing faith/religion, many of the participants showed that they were very enthusiastic about this topic and had strong held beliefs in faith. For instance, several participants raised their hands up in the air to show their belief in God and faith.

When discussing faith/religion, the patients' answers were often similar. One female patient stated "Oh Lord Jesus, my faith is very important and without faith you have nothing, I rely on the faith of God to get me through every day, oh Lord Yes" (Patient 3). She also stated that she has always prayed to the God for anything in her life and he has not failed her yet. She relies on support for her God. One male participant stated "My faith and religion is first and foremost in all my life decisions and especially in my medical decisions, I rely on prayer and God getting through and making the right decisions" (Patient 6). This patient also elaborated how this was instilled in him as a child, and how his entire family takes the same approach. A female patient stated that, "My religion is very important any and every time I have life difficulties and decisions to make regarding my life I always rely on my faith and my religion. Another patient with a supporting answer for this research question stated that, "Faith, there's a God somewhere, with the doctor's education and experience which is fine but the good Lord is the best and I pray every day for everybody and everything. God is my healer" (Participant 5).

Theme 5: Confidence in the Physician for Medical Advice

Though the central theme that emerged was a reliance on God, many individuals also rely on a physician's knowledge and recommendations when making health decisions. One participant stated, "Yes, my oncologist is smart and I do understand the he did go to school and is well trained, but he is not God, so even though he is telling me that I should have surgery, he does not have the final word. God is my healer" (Participant 6). Majority of the participants would listen to their physician along with having their family support to assist through this difficult time. One patient stated, "I understand and listen to my doctor, but I also take my family's suggestions into consideration about what I should do, I have a lot of support from my family and they are involved in all my medical needs, (Patient 12). When asked about trust, patients had trust in their physician by knowing that they were well educated and skilled in this area of cancer made them feel good. One patient stated, "My doctor has been in this field for over 25 years so I comfortable with his choices and I know of others who have had him as a doctor" (Patient 3). Some of the patients stated that the doctors referred them to look at their websites to read others opinions on the physician's credibility. One patient stated "My doctor told me to go on his clinic website to see the testimony's from other patients so it will ease me a little (Patient 2). Physician's recommendation is a topic that many individuals rely on, but with the interviews that were conducted within this research many participants felt as if their physicians were knowledgeable, but God still held a greater power. Majority of the participants would listen to their physician along with having their family support to assist through this difficult time. When asked about their trust for the physician, many felt as if trust was not a huge factor, but knowing that the physician was educated and skilled in this area of cancer made them feel good. One patient stated, "My doctor has been in this field for over 25 years so I comfortable with his choices and I know of others who have had him as a doctor" (Patient 3). Some of the patients stated that the doctors referred them to look at their websites to read others opinions on the physician’s credibility.

Theme 6: Emotional and Financial Support From Family, Including the Church Family

While interviewing the patients, family support seemed to be a common factor that was discussed by study participants. Many patients were happy to talk about their family and how much support they have had. Emotions also varied when discussing the support they received from their families. Many patients had smiles on their faces, while others showed their emotions through tears. I asked several why they were crying and some replied that it was tears of joy, while others felt disengaged from their family and expressed that they had no support which caused them to feel sad and alone in many cases.

I investigated the role that family had on support in conducting the 15 interviews; patients had similar responses and shared similar experiences. Most of the responses from study patients revealed the importance that family had in making treatment decisions. One female patient stated the “Family support is very important, I am family oriented and we are all very supportive in many situations in each other’s life, especially to health related issues” (Patient 8). She stated that her family is so supportive that when she has to go to any appointments and follow-ups, usually there is a family member that is there with her. This patient also stated that her family held family meetings and discussed what should be done, many of them would agree and disagree, but would come to a conclusion and would finally come to a consensus together. Her family agreed for her to have surgery because it would save her life. When conducting another interview, one female patient also shared a similar story. The patients stated that, “Who else can you rely on if you can’t rely on family, family should always be there because your medical issues could also impact their health due to genetics” (Patient 11). Another patient also had a similar answer, “Family is 100% important to me especially when it comes to health and medical issues that call for decision-making , because what could affect me could also affect a family member and they need to be involved in all aspects” (Patient 6). Another patient stated, “Family can give you moral support because they are here until the end, and friends are not always here forever, friends come and go” (Patient 14). This patient stated that his family not only collectively supported his decision to have chemotherapy, but each individual family member took time out of their busy schedule to take turns going to the many doctors’ appointments and physician meetings regarding treatment choices. Even when he started going to his chemotherapy sessions, there was always a family member there during the treatment times.

This reliance on family included fellow church members, who are regarded as family in many African American populations. As one interviewee reported, “I have a very good relationship with my pastor and my church family and they will pray for me if I ask for it” (Patient 8).

Family support was reported to be both emotional and financial. One patient stated: “During the time I was diagnosed I was living on a fixed income and could barely afford my monthly bills so to add on medical expenses was stressful and thanks to my family they did assist with my medical bills which helped me tremendously” (Patient 12).

Theme 7: Family Support as a Cause of Stress

When patients are diagnosed with life threating illnesses it not only affects the individual, but it affects the family as a whole. When patients have to make critical medical decisions it can be a stressful for their family as well as for the patient. At the same time, family can support can alleviate some of the stress. Family support can assist as guidance in terms on what treatments to choose, and family can be advocates to the medical staff for the patient. Several families had discussions not only with the patient but also with the medical staff working with the patient, and this sometimes led to tension when trying to decide on the best recommendation for the patient. One patient reported: "My family can really stress me out when they argue about what should be done with my health and all the yelling really sends me in a crying mode". However, this patient also stated that the support of her family coming together to discuss the pros and cons of the benefit of having surgery to extend her life was very important to her. She felt overwhelmed to know that her life is very important to her family and that the time and money spent was not an issue, but her life was more important.

Theme 8: Family Support Not Being Available or Important

When discussing the importance of family support and their opinions in making medical decisions, many participants agree that family is important, as discussed in the previous section. However, one participant did discuss that family support was not instrumental in his decisions. When asked interview questions related to how important is family when making medical decisions, one male patient stated that, "It is not, family is not that important, and the reason I say that is because I am not close to my family and

I choose not to share my medical issues or decisions" (Patient 1). This patient was not close to his family and did not have family in the area. When answering the question he seemed to hesitant and seemed desolate when talking about the family. He stated "You know family is a very touchy subject for me, because we are not close and they never call or visit to see how I am doing, it's like I don't even exist" (Patient 1). He stated that his family has always been very argumentative, and does not ever agree on anything and when it comes to health issue that is not a topic that anyone in his family likes to discuss.

Interview questions that were used in the research also provided additional analysis. The additional topics that were developed from the interview questions were: diagnosis, treatment, and role of physician.

Summary

This qualitative study showed that majority of African American individuals interviewed believe that family support is important when making decision about lung cancer treatment. This study also discussed how patients used faith/religion as a source for medical decision-making about treatment. Majority of the individuals had significant support from families and others and shows that family support was a strong factor in medical decision-making. The principal themes were: a lack of knowledge about the disease, treatment and length of time to live; confusion and fear about treatment options; extreme financial anxiety; faith and reliance on God; confidence in the physician for medical advice; emotional and financial support from family, including the church family; family support as a cause of stress; and family support not being available or important. Overall, the results show that African American patients are influenced by family support, and utilize their faith/religion, when seeking treatment for lung cancer disease.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

This chapter provides an overview of why this study was conducted and an interpretation of the research findings. In addition, the limitations of the study, the study recommendations, the implications of social change and the conclusion of the study are also presented. This chapter includes my reflections, findings, and a list of the insights gained through conducting this particular study.

The purpose of this qualitative study was to examine how family support and faith/religion influence African American patients who seek treatment for lung cancer. This study was important because it outlined how individuals utilize family support and faith/religion in making medical decisions. The findings from this current study can possibly inform future intervention efforts that could reduce mortality among this population.

The study used a phenomenological approach, because phenomenology is concerned with discovering the meaning of lived experiences by human beings as they exist in the world (Chamberlain, 2009). In this case, the population was a sample of African American men and women most with high school as their highest level of formal education who are faced with a diagnosis of lung cancer. The study collected rich and descriptive data by conducting face to face, semistructured interviews in which the participants' answers were recorded and then transcribed and analyzed.

The research questions that this study attempted to answer were:

1. How does family support influence whether African American patients' with lung cancer seek treatment?
2. How does faith/religion influence whether African American patients with lung cancer seek treatment?

Interpretation of the Findings

Since this research used an ethnographic method by focusing on individuals within a particular culture, it was possible to analyze similar values that they share related to medical decisions, and how family influences their decision-making about treatment. This phenomenological approach was used to analyze the experiences of African Americans regarding lung cancer, and to research how their family support and faith/religion influence decisions to seek treatment. Findings showed that these African American patients use family support and faith/religion as influential factors when making treatment decisions about lung cancer, trusting the physicians' recommendations, and coping with the emotional and financial stress of their situation.

The study findings suggest that the African Americans in the study population sought family support to help with medical decisions about lung cancer treatment. The use of family support has previously been noted as a cultural phenomenon. Belzen (2010) states, "Culture is best understood as a system of signs, rules, symbols and practices that individuals share and understand" (p.330). However, culture is also not stagnant; it is reconstructed and transformed continuously (Belzen, 2010). Cultural phenomena in modern societies are said to be the result of an individual's decrease in identification with the same culture group, and increasingly the result of an individual's personal history

(Tourinho & Vichi, 2012). Historically, family support has been well documented in the African American community by family members being the sole caregiver for their loved ones during critical times such as end of life stages, palliative care or for basic family support needs (Steinhauser et al., 2000).

Family Support Including the Church

In another study, Taxis (2006) stated "Roles of the culture, family, and church are strong influences in shaping African American values and choices at the end of life" (p.78). A survey conducted by Cicirelli (1997) examined 388 blacks and whites in two medium-sized Midwestern cities, noting that blacks of lower socioeconomic status were ten times more likely to have a greater subjective religiosity than other races. This subgroup also had less fear of the dying process but more fear of suffering in comparison to their white counterparts. Reese et al. (1999) found that African Americans are the least likely demographic to go outside of their families for assistance with medical caregiving and decisions due to a preference to place their trust in close family members when making end-of-life decisions.

Family support is a significant influence on health when it relates to individual family members with medical conditions (Brittain, Taylor & Caldwell, 2012). Family support system is a critical component associated with the decision-making process of patients. This is seen especially with patients who are receiving advice about a near end of life stage of a particular disease (Stajduhar, Funk & Outcalt, 2013). Physicians encourage family members and care givers to have a role in the decision-making process for their dying loved ones. This allows patients to begin to take responsibility for their care (Staduhar et. al., 2013).

Family Support and Decision-making

Family support is very important in the medical decision-making process. This study found that it was an important factor among African Americans, a finding similar to that of Steinhauser et al. (2000). Although it is not clear how family support operates, it is believed that family support enhances communication between individuals and their physician and medical staff when a patient cannot communicate due to the severity of their illness or understanding. One older woman interviewed for this dissertation study stated, “I wanted my family members to be a part of my treatment decisions so that I would not feel alone and, because some of them are a lot more knowledgeable about lung cancer than I am” (Patient 7). Having the support of family can also provide a patient with a sense of peace (Steinhauser et al. 2000).

My findings parallel other studies’ findings that family support is an important to patients when making medical decisions. It also aligns with extant literature about African Americans and lung cancer that have stated that family support is an important factor. Family support has been identified as an important factor that aids decision-making process among patients (Zhang et al., 2003). A study conducted at the Albert Einstein Cancer Center and the Cancer Center Hospice program analyzed data from White and Black study participants who had advanced stages of lung and colon cancer. It investigated the differences in attitude, preferences, and behaviors regarding end of life in terminally illness and treatment. The investigators in this study found that African

American patients, when compared to their White counterparts, utilized life-sustaining measures and desired the family input for their treatment decisions (Zhang et al, 2003). A study conducted by Tilden et al. (2001), in Portland, Oregon used medical records to show that family members who cared for ill patient family members assisted them with medical decisions, and that these family members did this in part to relieve stress off of the patient. Similarly, a study conducted by Griffin (2003) used semistructured interviews to examine what factors influenced patients to choose one type of treatment over another. Griffin (2003) found that support from family decreases the stress the many patients have when dealing with medical decisions. This study used two main conceptual variables that examined in a study that compiled of 102 patients and 139 family members from four large urban hospitals. One study variable examined family members' stress (Griffin, 2003).

Faith and Reliance on God

This study also found that that African Americans use faith to help in medical decision-making about lung cancer treatment. This use of faith has also been noted as a cultural phenomenon and has been well documented in the African American community. This usage, including the church community, is a traditional form of social and familial involvement (Tate & Brown, 1991; Williams, 2003). Faith and religion both have assisted families in coping with life and social stressors, such as economic and racial inequalities (Williams, 2003). Since study participants showed a high reliance on faith, it showed how it influenced one to seek treatment and possibly live longer. It also gave the individuals a peace of mind about their medical condition and comfort on their treatment decisions. One older male participant stated, “Putting my faith in God, took the worrying off of me because it is now in his hands” (Patient 1).

Although faith has been shown to be important, faith may also prevent people of seeking care since they believe it’s in God’s hand. This can be critical in a life-threating illness and one fearing the outcome of treatment or not. Another problem is fear and other psychosocial barriers to treatment. Peek, Sayad and Markwardt (2008) state “That patients, who seek treatment, may fear that the system will deny then due to their social economic status, which may incur an adverse result to any treatment received” (p.1848). Therefore, if individuals just rely on faith then they may not have the opportunity to seek the interventions from their physicians or other treatment options to better their health.

The majority of participants of this study had a religious affiliation. Out of the 15 interviews conducted, 14 participants agreed that their lives would be nothing without having faith and or religion. Although participants within the study had different religious affiliations, participants shared similarities with how the they used faith/religion to derive a medical decision.

There are several factors that influence decision-making. Within the African American community there is limited research on factors such as religion and spirituality, health/risk behavior, and cancer screenings. A study conducted in 2003 asked African American participants to rank factors that influenced treatment decisions (Phipps, 2003). The main finding of the study was that a patient’s faith did influence treatment decisions. In fact, faith was so important that when compared to treatment efficacy, faith was more important in the Phipps. This supports the current study findings because participants in the current study also stated that faith was an important factor when seeking treatment decisions in their health care. However, the current study did not ask participants to rank if religion was the most important factor. In the Phipps study, study participants were solicited to rank the several factors: specialist suggestions, confidence in God, capability of treatment to cure infection, symptoms, family specialists' proposal, companion's proposal, and children's suggestions. More research is warranted to examine how these factors may impact African American decisions regarding lung cancer treatment.

A study conducted using African American men and women from 6 churches within a large urban community in the Midwest collected data anonymously by leaving an envelope in a basket and allowing anyone who wanted to participate to take, complete and return to the basket, (Fann & Powell, 2006). The purpose of the exploratory study was to examine how religion/faith and spirituality impact decisions among African Americans. A total of 471 African American congregants participated in the study and 72% of the study participants indicated that their approach to life and medical decisions are based on their religion and faith. There was no significant difference between men and women in the study. In my study, I found that both males and females provided similar responses about how religion and faith influences their decision-making.

Past research has also revealed that faith and religion has influenced African American patients with serious conditions such as cancer, heart disease, and depression (Dessio et al., 2004). This study has shown a similar comparison to past studies about family and faith/religion support when it comes to medical decision-making for treatment for diseases. Matthews et al. (2002) also found patients within the African American population and with lung cancer or another life threating illness have strong beliefs in faith. The majority of individuals that I interviewed stated that faith and religion plays an important factor in their medical decisions. Families play an important role in decision-making process when it comes to care, especially with adult cancer patients (Siminoff et al., 2006). Similarly, findings from the present study found that family support plays a huge influence on participant's decisions to seek treatment. During the end of life conversation, patients have a greater understanding of how a physician's perceptions may affect their treatment choices. This allows the physician to offer clarification during the decision-making process (Bell, Somogyi-Zalud, Masaki, Fortaleza-Dawson & Blanchette, 2008).

According to Moulton and King (2010), physician recommendation for patients' seeking treatment was a major driving force for patient's decision-making, rather than patient preferences. Studies demonstrated that African-American patients trust their physician's decisions for medical treatment less often than their White counterparts. This was found to be more evident following an initial visit with a surgeon or oncologist (Trachtenberg, Dugan & Hall, 2005). This distrust was hypothesized to be linked to non-supportive communication from physicians (Flenaugh & Henriques-Forsythe, 2006).

Financial and Emotional Family Support

The results confirmed that family support was important but also stressful. Most described that the decision-making was one of the hardest things that they had to ever do. According to Tilden et al., (2001), the patients used such terms as “difficult”, “painful,” and “exhausting” as they reported the impact of decision-making. Additionally, Tilden et al. (2001), family support can alleviate the stress on the ill patient when making decisions and may extend their life. Rabow et al., (2004) suggest that families play an important role in decision-making at the end of life. The findings of this research show this also. It appears from study participants that family support released the burden of making critical and life threating decisions alone. Having the family to agree together about treatment made decisions easier.

Medical Decision-making

This study used the medical decision-making (MDM) model as a framework that guided the researcher. MDM refers to “the choice of a course of action (action, for short) following a diagnosis of a patient’s condition (Ekdahl et al., 2011). There are three components to MDM. The first component involves the number of diagnosis or management options provided to patients. The next component is the amount or complexity of data to review. The final component is risk of complications or death if the condition goes untreated. All of these components can be measured as minimal, limited, multiple, or extensive (Frantsve & Kerns, 2007). In addition, there are also several factors that may influence decision-making. The first is known as past experience, which is avoiding or repeating past mistakes. Another factor that influences decision-making is cognitive bias. Cognitive bias is known as ones thinking patterns, memory or judgment. The patient’s age may also serve as an influential factor. Individual difference or personal beliefs is also a factor associated with decision-making. The final factor that may influence decision-making is personal relevance. Personal relevance is ones learning or educational experience (Juliusson, Karlsson & Garling, 2005.)

When determining how decisions are made, it is important to understand the factors that influence the decision-making process and how these factors impact the outcome (Dietrich, 2010). For lung cancer, patients have multiple treatments options. Although these are discussed with their health care provider, the MDM provides a broader explanation of what influences decision-making. This study found that a family centered approach played a significant role in health care decision-making. MDM states that external influences can change the outcome decisions of the patient's medical choices solely. In this case, family was an important factor that helped patient's make medical decisions. Unfortunately, this study did not examine the level of importance of this factor in comparison to others, and therefore, does not provide an actual weight of this variables importance in medical decision-making for lung cancer treatment. Similarly, the study also found that faith/religion was another factor that played an important role in the decision-making process. Again, as supported by MDM, faith/religion is an external influence that affects decision-making. Like family support, it is not known what weight this variable has in the decision-making process. It is known that individuals due rely on the faith/religion in making treatment choices even though they may be faced with increased illness or maybe even death, although relatively little is known about this factor in decision-making (Miller, 2011).

Although this study specifically set out to examine the role of family support and faith/religion, the study did examine what influence health care providers have. A considerable amount of research in MDM has focused on the provider-patient interaction. However, as this study has identified, there are many factors that are external to this interaction solely. These outside factors are important because it shows that decision-making is a complex process that involves multiple factors. MDM gives a perspective modification in decision-making, in addition to external influences. It is important to understand the complexity of decision-making in this study because it can be a life treating situation for some of the patients. The complexity of medical decision-making includes the risk of significant complications with the patients present diagnose state, the number of diagnosis and health management options for the patient and the diagnostic procedures and treatment for the patients disease. The medical decision-making theoretical model was used in the research to show how patients make decisions in complex situations with this issue being related to the diagnoses of lung cancer that can be a critical and life threating issue.

Limitations of the Study

As with all research, this study had several limitations that should be acknowledged. First, this study only included African Americans. Therefore, inferences about how other racial/ethnic groups made decisions about lung cancer treatment cannot be made. Further, there was no stratification for demographics such as education, age, gender, or economic background, which could have influenced findings. Analysis was also performed on a small sample size. With the in-depth nature of the questions from the interview the data analysis would have been practical if a larger sample size and to include other ethnic groups. The study findings are limited due to the small number of participants and nature of study. Since participants were recruited from one clinic, findings are restricted to how patients from this clinic made decisions and should be cautiously generalized to other settings. Similarly, since the study exclusively used lung cancer patients, findings may not be generalizable to other medical conditions. There was also some limitations that surround how the study was conducted. Qualitative research inherently includes potential for personal perception bias interpreting data results. Lastly, by me being the individual conducting the interviews and by also being an African American female, this could also have had a bias on the results of the study. I say that because in some cases it can be difficult to analyze individuals within in your same culture background. Additionally, this study was narrowed since the interview guide restricted the investigator's ability to ask more in-depth and probing questions the questions could have been better designed to elicit rich, thick data, which would have allowed me to probe more with the questions being asked.

Recommendations

Through this research with African Americans who have lung cancer and their decisions to seek treatment, I would make the following recommendations. First, future studies with African American using a larger sample size are needed. I would also recommend the inclusion of other racial/ethnic groups to compare the data to see if there are cross-cultural differences in decision-making.

For this study, 15 participants were obtained through a local clinic. A more diverse sample size needs to be included as well. The researcher recommends including more than one clinic to recruit and interview patients. This would allow for a larger population from different areas in the community and it would also allow for a wider range in age. Another recommendation would be to include another geographical location to compare with the Guilford County, NC location. I would also recommend that future qualitative research have broader questions and explore the topic with broader perspective. This study explored the role of social support and faith/religion; future studies should explore other variables that influence medical decision-making. Although a qualitative study was used in this current study, a future quantitative study could also be conducted. This will allow for specific hypothesis to be tested and with a larger sample size. Further, future studies can examine how these influences affect decision-making and their relative strength. An additional recommendation would be to utilize an ethnographic approach to better understand how culture may play a role in decision making. Although my study focuses on two cultural aspects, family support and race, an ethnographic analysis could provide a better understanding of how culture possibly shapes medical decisions for patients with lung cancer. Finally, a future study should also examine the role of gender and socioeconomic status on decision-making. The current study did not examine the effects of gender, income, or educational background on how people make decisions about seeking treatment for lung cancer. It is possible that these factors play an important part in the decision-making process. Current study findings could be different had findings been analyzed by gender or socio-economic status. Another recommendation is that while the patient and families are going through this critical time, and dealing with the diagnosis of lung cancer, advance care planning is an important topic to discuss and finalize. Advance care planning is “the discussion held with a patient in anticipation of a future deterioration of the patient’s condition” (p. 27).

Implications of Social Change

Upon conducting the literature review there were only a few published studies that focused on African Americans and family support and faith/religion when seeking decisions for lung cancer treatment. This present study provides more insight that can help address the disparities seen for lung cancer among this group. The results from this study indicated that family support and faith/religion have an influence on patients' decisions for medical treatment. It may educate the medical profession and other individuals on how patients seek treatment decision for lung cancer due to the influence of family support. The results may be used by clinicians when working with lung cancer patients on decisions on treatment and to understand how the patients may be influenced. The results can other factors such as the patients understand and knowledge base about the topic. This study showed how African Americans seek treatment and not only rely on the physician for decision outcomes. This will also provide the information to physicians and clinical staff when communicating to patients and to have a better understanding on how this population makes medical decisions. The implications for social change in this study included an increased understanding of how family support, and how it is important when making medical decisions. Data from this study can lead to the increased awareness about the influence of medical decisions from family members to give courage, strength, faith, hope towards making decisions for treatment. Furthermore, implications for this study enlightens medical providers working with the patients with lung cancer, more knowledgeable and how understanding on patients make medical decisions.

Conclusion

The major findings of this investigation were that the African Americans who participated in this study stated that family is an important factor in seeking treatment for medical decisions. The 8 themes that helped answer the research questions were: a lack of knowledge among patients about the disease, treatment and length of time to live; confusion and fear about treatment options; extreme financial anxiety; faith and reliance on God; confidence in the physician for medical advice; emotional and financial support from family, including the church family; family support as a cause of stress; and family support not being available or important. These provided a better understating of the role of faith and family as important factors that influence African American patients when seeking treatment for lung cancer. Majority of the individuals in the sample provided statements that support how these factors play an important key role in seeking treatment for their lung cancer. Faith/religion in particular plays a major part in the patient's decision-making about treatment, because majority believes that it will provide the healing with or without treatment.

In today's society, individuals have different options when seeking treatment, and family support and faith/religion can relieve some of the individual stress that patients may have. Providing patient centered care allows for patients' views to be accounted for, and this study shows the importance of faith and family for African Americans making decisions about lung cancer treatment.

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Appendix A: Request Letter to Use Figures and Graphs

Carla D. Williams, BSW, MSEd (PhD Candidate)
9 Archer Glen Court
Greensboro, NC 27407

January 24, 2012

Dr. Ahmedin Jemal, DVM, PHD
Surveillance Research, American Cancer Society
250 Williams Street, NW
Atlanta, GA, 30303-1002
Dear Dr. Ahmedian:

I am a Doctoral Student at Walden University. I am in the process of preparing a dissertation for publication and am seeking permission to include the following material in my publication. A copy of the work from the Cancer Statistics, 2011: The Impact of Eliminating Socioeconomic and Racial Disparities on Premature Cancer Deaths. It was published in the CA Cancer Journal for Clinicians, 2011; Volume 61, pages 212-236. doi:10.3322/caac.20121.

The work will be used in the following manner: To explain the estimated new cases of lung cancer among men and women. The publication information is as follows: Lung Cancer in the African American Population: What impacts Their Decision to seek Treatment?

Please let me know if there is a fee for using this work in this manner.

Please indicate your approval of this request by signing the letter where indicated below and returning it to me as soon as possible using electronic email and a hard copy mailed if possible. Your signing of this letter will also confirm that you own the copyright to the above-described material.

Very truly yours,

Carla D, Williams, BSW, MSEd, PhD Candidate
336-588-5404

For copyright owner use:

PERMISSION GRANTED FOR THE USE REQUESTED ABOVE:

By:

Title:

Date:

Appendix B: Permission Letter to Use Figures and Graphs

Dear Ms. Carla Williams,

Thank you for contacting Copyright Clearance Center's RightsLink® service. Per your request as an attachment I'm sending your license

If you have any further questions, please contact a Customer Service Representative at 978-646-2777, Monday-Friday 8:00 AM to 6:00 PM Eastern Time, or email customercare@copyright.com.

Sincerely,

Gregory Prusisz

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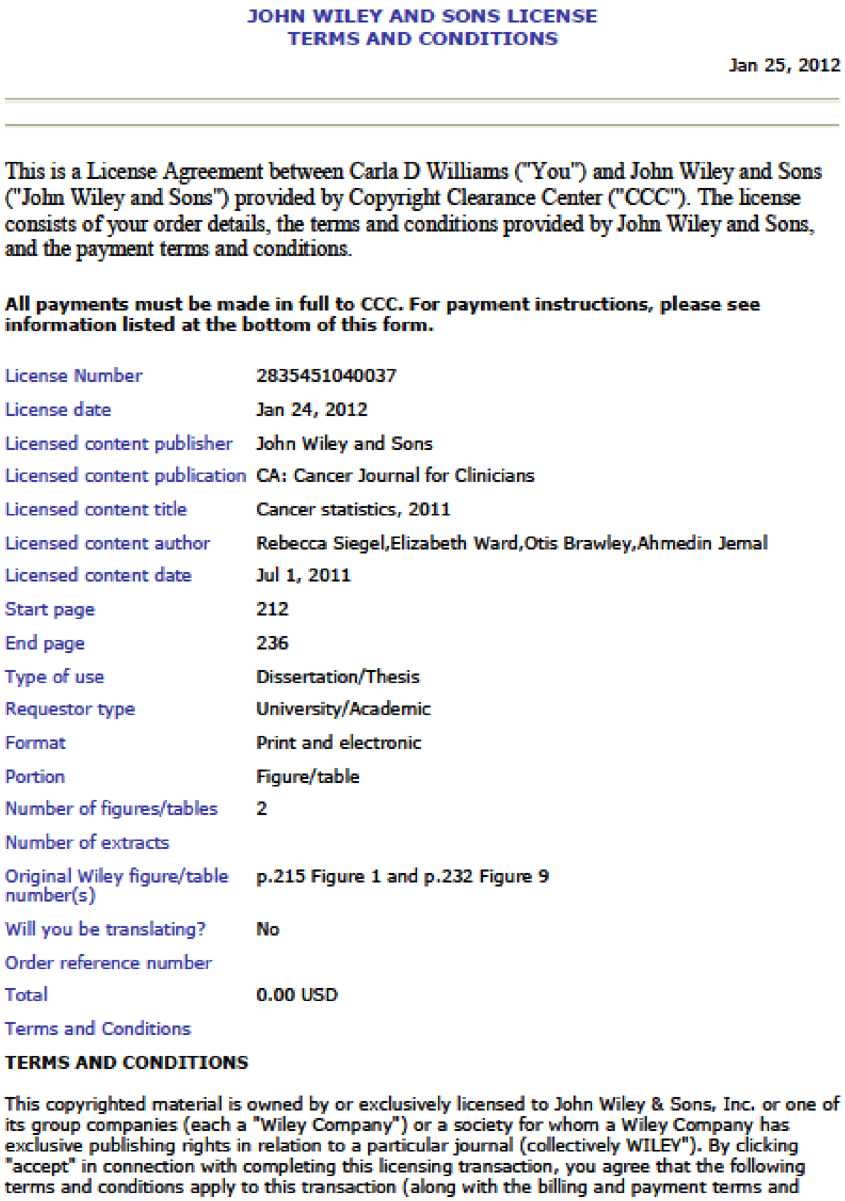

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Appendix C: Letter to Request Permission to Conduct Survey at Study Site

Carla D. Williams
#9 Archer Glen Court
Greensboro, NC 27407
Tel: 336-588-5404
Email: carla.williams3@walenu.edu
carla.williams@conehealth.com

December 6, 2011

Dear: Dr. Patrick Burney and Physicians of TCTS:

I am writing to request your permission to interview **30-35** of your patients from your practice for my doctoral dissertation. I propose to explore information pertaining to the factors that influence the decisions for African American patients to seek treatment for their diagnosis for lung cancer. My research is focusing on the three factors of family and faith/religion and to analyze if these factors have an influence the patients decisions to seek treatment.

The target population for this study is lung cancer patients, males and females over the age of 18 who have been diagnosed with stage I and II lung cancer, and who need some type of treatment for their disease.

I have selected this topic because I have a passion for individuals with lung cancer, and have also had the opportunity to work on a lung cancer disparities project with Dr. Sam Cykert, whose study included patients from your practice as well. For the data collection process, this research will employ a semi structured interview with the patients that will be recorded for then transcribed for analyzing.

In conclusion, I'd like to ask your permission to interview some of your patients for this research.. I have already contacted the Cone Health IRB department. My IRB number is #1510, and this will be an expedited research review. I have also attached a copy of the Human Subject Committee application as well as my invitation, sample of the survey, and the informed consent for the research. Should you have any questions or concerns regarding my letter or research, please contact me at the email address or the above contact number.

I would greatly appreciate your consent in the form of a letter that I can submit to The Cone Health IRB department along with my application.

Sincerely,

Carla Williams
PhD Candidate

Enclosure

Appendix D: Interview Questions and Demographic Questions

Thank for participating in my research to answer questions related to your lung cancer diagnosis and experience. My study is focusing on factors that that influences cancer patients when deciding to seek treatment for their diagnosis. The purpose of this interview is to collect information from African American patients to gather deeper and richer answer to support the outcome of the study.

Your answers to each question will add value to the research so please feel free to be honest and to provide as little or a much information that you can .There are no wrong or answers. The goal of this interview session is to gather as much information from you to be able to see if the factors or family or faith/religion influence the decision to seek treatment. Now let's begin

Interview Questions

1. Tell me a little bit about yourself and please include where you grew up.
2. How did you learn you had cancer?
3. Can you describe your feelings about your cancer diagnosis?
4. When you were diagnosed with cancer, who did you immediately share the information with? What were their thoughts and concerns?
5. What stage is your cancer?
6. Have you already had treatment for your cancer or are you seeking treatment?
7. If you have had treatment, what type of treatment did you receive?
8. If you have not had treatment, have you been explained your treatment options?
9. What type of treatment will you receive?
10. What role did your physician play in your decision-making?

11. Who or what is your support system when seeking treatment for your disease?
12. How important is family support and their input on your treatment decisions?
13. What role did your family play when making decisions for treatment?
14. What concerns if any did your family have about your disease and treatment decisions?
15. Are you comfortable talking to your family about your disease and treatment options?
16. How important is faith/religion in your treatment decisions?
17. What role does prayer play in your decision-making for treatment and to cure your disease?
18. What role does God play in your decision-making for treatment and to cure/heal your disease?
19. Do you or have you sought support from a religious leader regarding you treatment decisions? If so, what role does that individual play in your decision-making for treatment?
20. Who are at least 3 people that you must talk to before making treatment decisions, if any? How do these individuals play a role in your decision-making for treatment?
21. Are there any other comments you would like to add to this interview.

Demographic Questions

1.) What is your gender?

○ Male

○ Female

2.) What is your age?

○ 18-29 years old

○ 30-49 years old

○ 50-64 years old

○ 65 years and over

3.) What is the highest level of education you have completed?

○ Some high school

○ High school graduate

○ Some college

○ Trade/technical/vocational training

○ College graduate

○ Some postgraduate work

○ Post graduate degree

4.) What is your religious preference?

○ Baptist

○ Methodist

○ Roman Catholic

○ Muslim

○ Seventh-Day Adventist

○ Jewish

○ Something else (please specify)________________________________

5.) What is your household income?

○ Under $20,000

○ $21,000 to $30,000

○ $31,000 to $40, 000

○ $41,000 to $50,000

○ Over $51,000

6.) Are you now employed full-time, part-time, not employed or retired?

○ Full-time

○ Part-time

○ Not employed

○ Retired

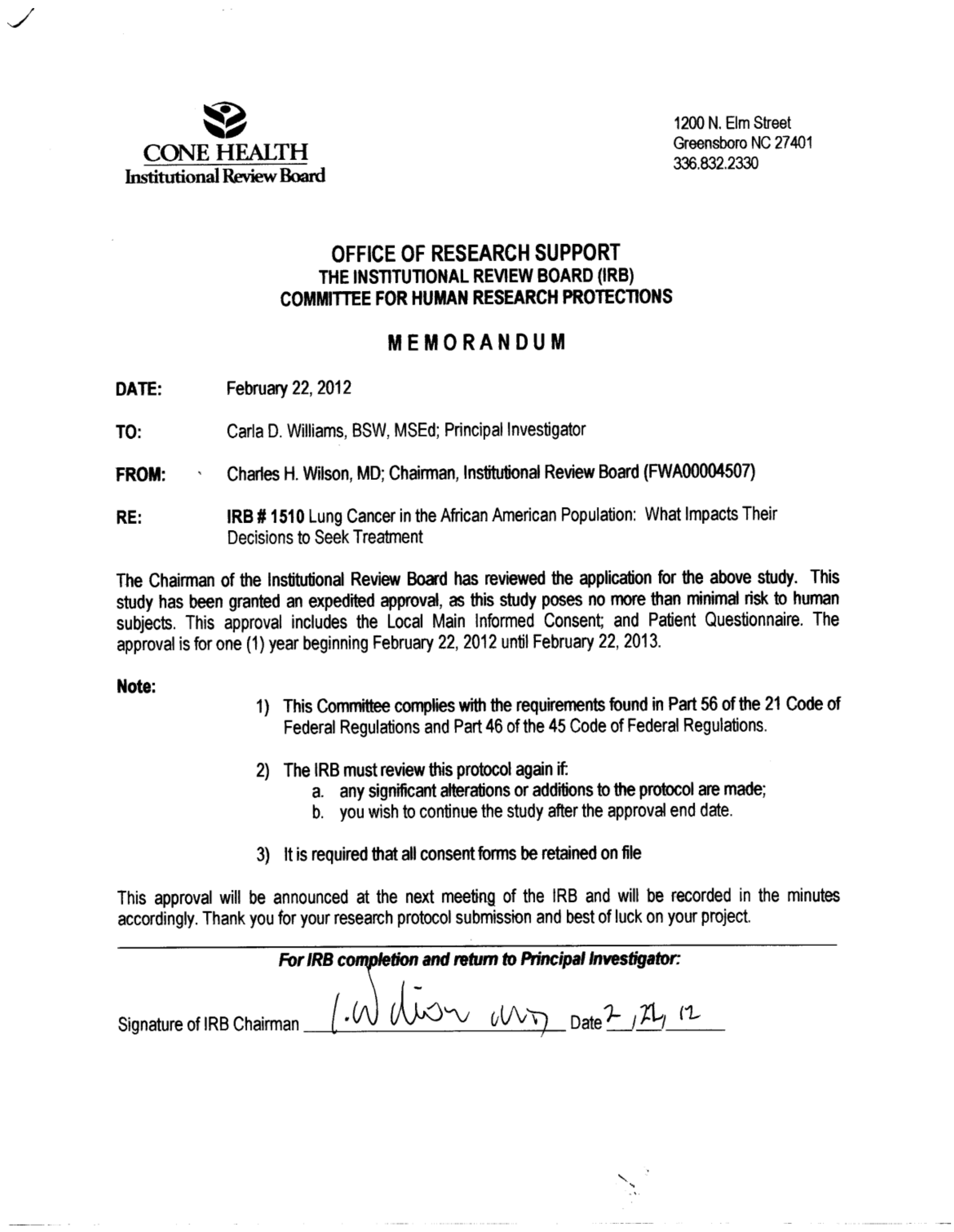
7.) Including yourself, how many people live within your household?

(______)

8.) What is your marital status?

- ○ Single/never been married
- ○ Married
- ○ Separated
- ○ Divorced
- ○ Widowed

Appendix E: IRB Permission



CONE HEALTH
Institutional Review Board

1200 N. Elm Street
Greensboro NC 27401
336.832.2330

OFFICE OF RESEARCH SUPPORT
THE INSTITUTIONAL REVIEW BOARD (IRB)
COMMITTEE FOR HUMAN RESEARCH PROTECTIONS

MEMORANDUM

DATE: February 22, 2012

TO: Carla D. Williams, BSW, MSEd; Principal Investigator

FROM: Charles H. Wilson, MD; Chairman, Institutional Review Board (FWA00004507)

RE: **IRB # 1510** Lung Cancer in the African American Population: What Impacts Their Decisions to Seek Treatment

The Chairman of the Institutional Review Board has reviewed the application for the above study. This study has been granted an expedited approval, as this study poses no more than minimal risk to human subjects. This approval includes the Local Main Informed Consent; and Patient Questionnaire. The approval is for one (1) year beginning February 22, 2012 until February 22, 2013.

Note:

1) This Committee complies with the requirements found in Part 56 of the 21 Code of Federal Regulations and Part 46 of the 45 Code of Federal Regulations.

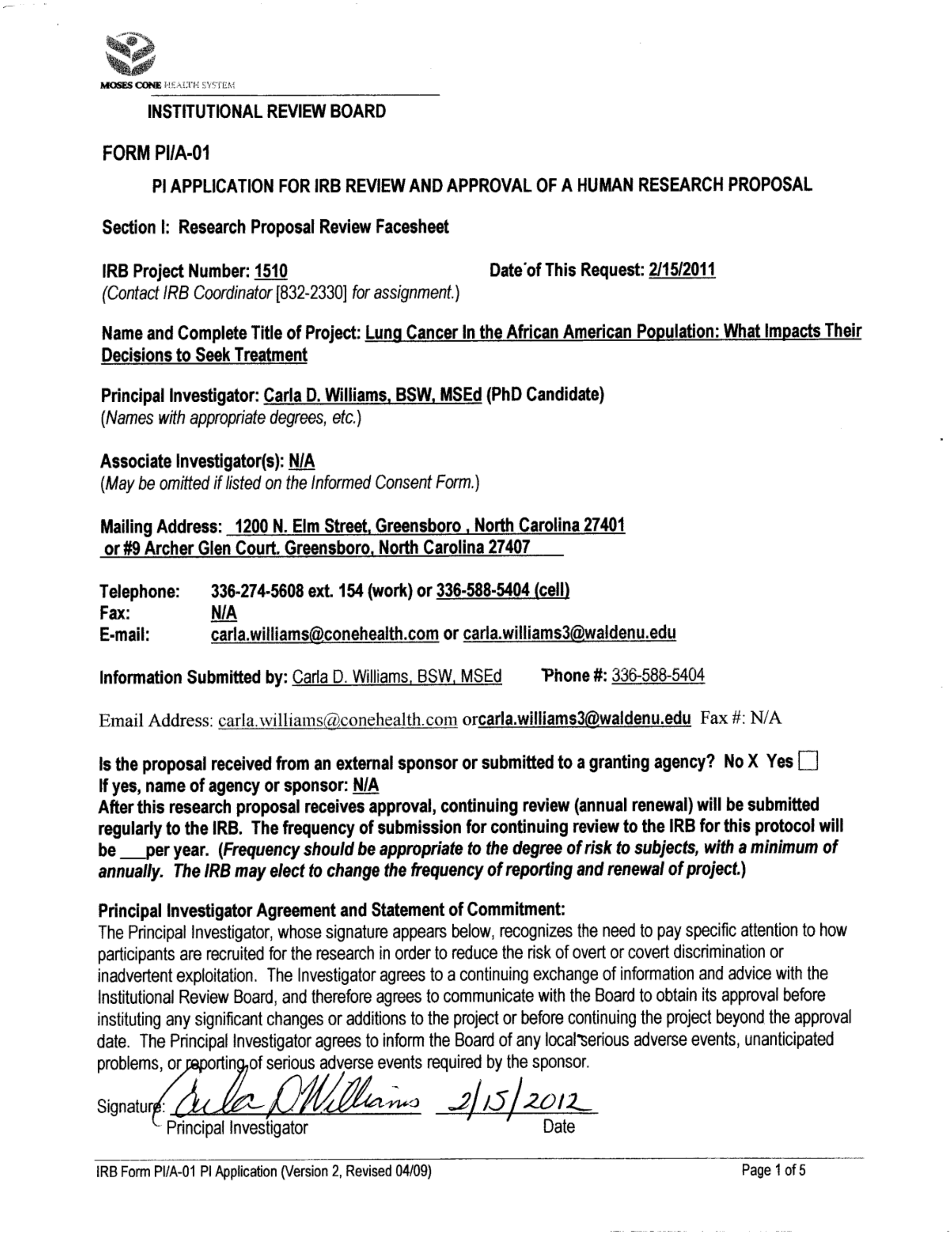
2) The IRB must review this protocol again if:
   a. any significant alterations or additions to the protocol are made;
   b. you wish to continue the study after the approval end date.

3) It is required that all consent forms be retained on file

This approval will be announced at the next meeting of the IRB and will be recorded in the minutes accordingly. Thank you for your research protocol submission and best of luck on your project.

For IRB completion and return to Principal Investigator:

Signature of IRB Chairman C.W Wilson MD Date 2/24/12



MOSES CONE HEALTH SYSTEM

INSTITUTIONAL REVIEW BOARD

FORM PI/A-01

PI APPLICATION FOR IRB REVIEW AND APPROVAL OF A HUMAN RESEARCH PROPOSAL

Section I: Research Proposal Review Facesheet

IRB Project Number: **1510** **Date of This Request:** **2/15/2011**
(Contact IRB Coordinator [832-2330] *for assignment.)*

Name and Complete Title of Project: **Lung Cancer In the African American Population: What Impacts Their Decisions to Seek Treatment**

Principal Investigator: **Carla D. Williams, BSW, MSEd (PhD Candidate)**
(*Names with appropriate degrees, etc.*)

Associate Investigator(s): **N/A**
(*May be omitted if listed on the Informed Consent Form.*)

Mailing Address: **1200 N. Elm Street, Greensboro , North Carolina 27401**
or #9 Archer Glen Court. Greensboro, North Carolina 27407

Telephone: **336-274-5608 ext. 154 (work) or 336-588-5404 (cell)**
Fax: **N/A**
E-mail: **carla.williams@conehealth.com or carla.williams3@waldenu.edu**

Information Submitted by: Carla D. Williams, BSW, MSEd **Phone #:** 336-588-5404

Email Address: carla.williams@conehealth.com or**carla.williams3@waldenu.edu** Fax #: N/A

Is the proposal received from an external sponsor or submitted to a granting agency? No X Yes ☐
If yes, name of agency or sponsor: N/A
After this research proposal receives approval, continuing review (annual renewal) will be submitted regularly to the IRB. The frequency of submission for continuing review to the IRB for this protocol will be ___per year. (*Frequency should be appropriate to the degree of risk to subjects, with a minimum of annually. The IRB may elect to change the frequency of reporting and renewal of project.*)

Principal Investigator Agreement and Statement of Commitment:
The Principal Investigator, whose signature appears below, recognizes the need to pay specific attention to how participants are recruited for the research in order to reduce the risk of overt or covert discrimination or inadvertent exploitation. The Investigator agrees to a continuing exchange of information and advice with the Institutional Review Board, and therefore agrees to communicate with the Board to obtain its approval before instituting any significant changes or additions to the project or before continuing the project beyond the approval date. The Principal Investigator agrees to inform the Board of any local serious adverse events, unanticipated problems, or reporting of serious adverse events required by the sponsor.

Signature: Carla D Williams 2/15/2012
Principal Investigator Date

IRB Form PI/A-01 PI Application (Version 2, Revised 04/09) Page 1 of 5

MOSES CONE HEALTH SYSTEM

INSTITUTIONAL REVIEW BOARD

Section II: Considerations to Assure Protection of Human Subjects and Personnel.

Please indicate on the following checklist the presence of any of the following situations in your study:

RESEARCH STUDY INCLUDES THE FOLLOWING PROCEDURES AND/OR SITUATIONS:	YES	NO
Ionizing radiation; radioactive isotopes		X
Experimental devices, instruments or machines		X
Recombinant DNA research		X
Fetal tissue		X
Surgical pathological tissue		X
Drugs under investigation		X
Placebo(s)		X
Protocol approved at collaborating institution	X	

* Please mark "yes" if the research adds <u>any</u> additional risk for Human Subjects beyond that which would be entailed by conventional and/or routine clinical diagnosis and therapy; otherwise mark "no".

SITUATIONS INCLUDED IN RESEARCH STUDY	INVOLVED		AT RISK *	
	YES	NO	YES	NO
Personnel exposure to hazardous substances		X		X
Patients as experimental subjects	X			X
Pregnant subjects		X		X
Non-patient volunteers		X		X
Students and staff as subjects		X		X
Minors (less than 18)		X		X
Non-English speaking subjects**		X		X
Mentally incompetent subjects**		X		X
Prisoners and parolees as subjects		X		X
Subjects at other institutions		X		X
Videotaping, filming or voice recording of subjects		X		X

** Explain (in informed consent document) methods to be used to obtain reasonable, legal and understood informed consent from such subjects (or legal sponsor). In special circumstances when alternative forms of obtaining informed consent are used (e.g., audio/videotape; telephone calls; special proxy or witnesses), attach to consent document a full explanation with appropriate signatures for Board review and approval.

INSTITUTIONAL REVIEW BOARD

Section III: Summary Statement of Proposed Research
Include the following items in order:

1. **Description of project (100 - 400 words): An explanation of the purpose and rationale of the research study, using lay terminology. Remember that not all members of the IRB are health professionals.** Lung cancer is a significant problem and life threatening issue among the African American population. African Americans have the highest death rate and shortest survival of any racial and ethnic group in the United States for most cancers (American Cancer Society, 2010). Although studies have been conducted examining the reasons for the short life expectancy among African Americans, but little has been proven to see the reasons why and what factors impact the decisions of African American patients and their choice of treatment. The current study will address the gap in seeing which factors such as family support, faith/religion and or physician recommendation, and its impact on assisting African American patients with lung cancer and their decision in seeking treatment.

   The target population is to 219 patients to complete the survey. This will be a quantitative study. The method used to collect data will be survey only; it will be a 20-question questionnaire.

2. **Procedures: Give a comprehensive explanation, in lay terminology, of all procedures, treatments, drugs and devices that will be utilized in the study. Note expected duration of study.**
   N/A

3. **Description of subjects eligible for participation including number, age*, sex, inclusion/exclusion criteria, how recruited and any inducements for participation.**
   (* If children are involved, refer to the page headed Children as Research Subjects).
   The participants will be recruited from Triad Cardiac and Thoracic Surgery, (Dr. Patrick Burney). Participants will include male and Females, 18 years of age and older These participants will be English speaking and who have been diagnosed with lung cancer.

   Items 1 through 3 are essential to this section, as all members of the IRB will read this summary statement of the project. Items 4 through 7 may be omitted, as they should be covered in the consent form to be included in the application and which will also be studied by the IRB.

4. **Anticipated benefits to subjects and/or society.** There are no real benefits for the participants but the benefit will assist individuals in the health care profession in understanding what factors impact the decision for lung cancer patient seeking treatment.

5. **Risks to subjects and safeguards to minimize risks.** There are no physical risks to be in this study. This study will only assist the PI in understanding what factors have an impact on patient's decision to seek treatment for their lung cancer diagnosis.

6. **Statement indicating how confidentiality will be maintained.** Every effort will be taken to protect the identity of the participants in this study. However, there can be no guarantee that the information cannot be obtained by legal process or court order. No subjects will be identified in any report or publication of this study and its results.

7. **Specify what costs will be borne by subjects. If none, so state. Indicate that some insurance companies may be unwilling to cover charges they deem to be supportive of research; therefore, patient should contact insurance carrier if there are questions concerning payment of charges generated while on study.**

   There will be no costs that will be borne by subjects

8. **If using monetary inducement for participation in study please indicate the amount.**
   This study will not use any type of monetary inducement for participation.

Section IV: Informed Consent Document for this Research Proposal

Instructions: The consent form must have a top margin of 1.5 inches in order to receive the stamp of IRB approval. Please use a clip to attach the study's original informed consent document to back of this application. (Please refer to OHRP's Consent Form Checklist; OHRP's Informed Consent Tips; the Moses Cones' "Standards for Informed Consent Documentation for Human Research Projects"; along with the Moses Cone IRB template of recommended language for an informed consent document, contained in the Appendices of the IRB Procedures Manual)

Part B. For multicenter and cooperative research projects with other institutions and research organizations (e.g., national oncology and cardiology studies) which have received scientific review and approval by the NIH, NCI, or FDA; or in the case of academically-based peer review groups (UNC-Chapel Hill School of Medicine; UNCG School of Nursing), the PI should complete this section of the form:

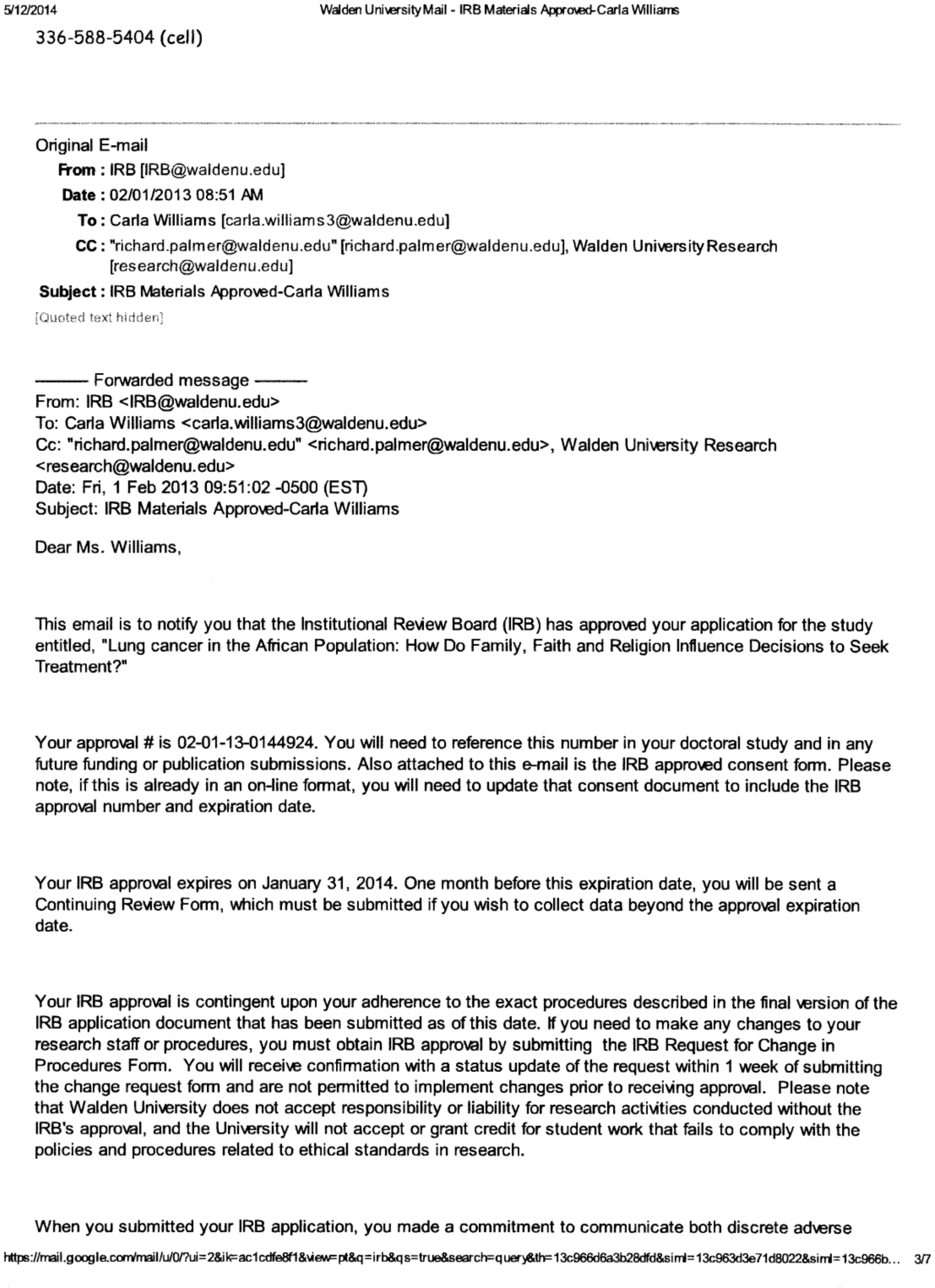
Organization that reviewed and approved the project: _____

Date of review (if available): _____

Signature of P.I.: ________________________________ **Date:** __________________

Section VI: Administrative Advance Approval of Proposed Research

If the research is to be carried out in a division, department or unit of Moses Cone Health System, (e.g., Pharmacy Division; Emergency Department; Nursing Unit) the unit manager must be consulted in advance. Approval to pursue the project must be obtained so as to assure that there are no conflicts in the use of human or financial resources of the unit.



336-588-5404 (cell)

Original E-mail

From : IRB [IRB@waldenu.edu]

Date : 02/01/2013 08:51 AM

To : Carla Williams [carla.williams3@waldenu.edu]

CC : "richard.palmer@waldenu.edu" [richard.palmer@waldenu.edu], Walden University Research [research@waldenu.edu]

Subject : IRB Materials Approved-Carla Williams

[Quoted text hidden]

——— Forwarded message ———
From: IRB <IRB@waldenu.edu>
To: Carla Williams <carla.williams3@waldenu.edu>
Cc: "richard.palmer@waldenu.edu" <richard.palmer@waldenu.edu>, Walden University Research <research@waldenu.edu>
Date: Fri, 1 Feb 2013 09:51:02 -0500 (EST)
Subject: IRB Materials Approved-Carla Williams

Dear Ms. Williams,

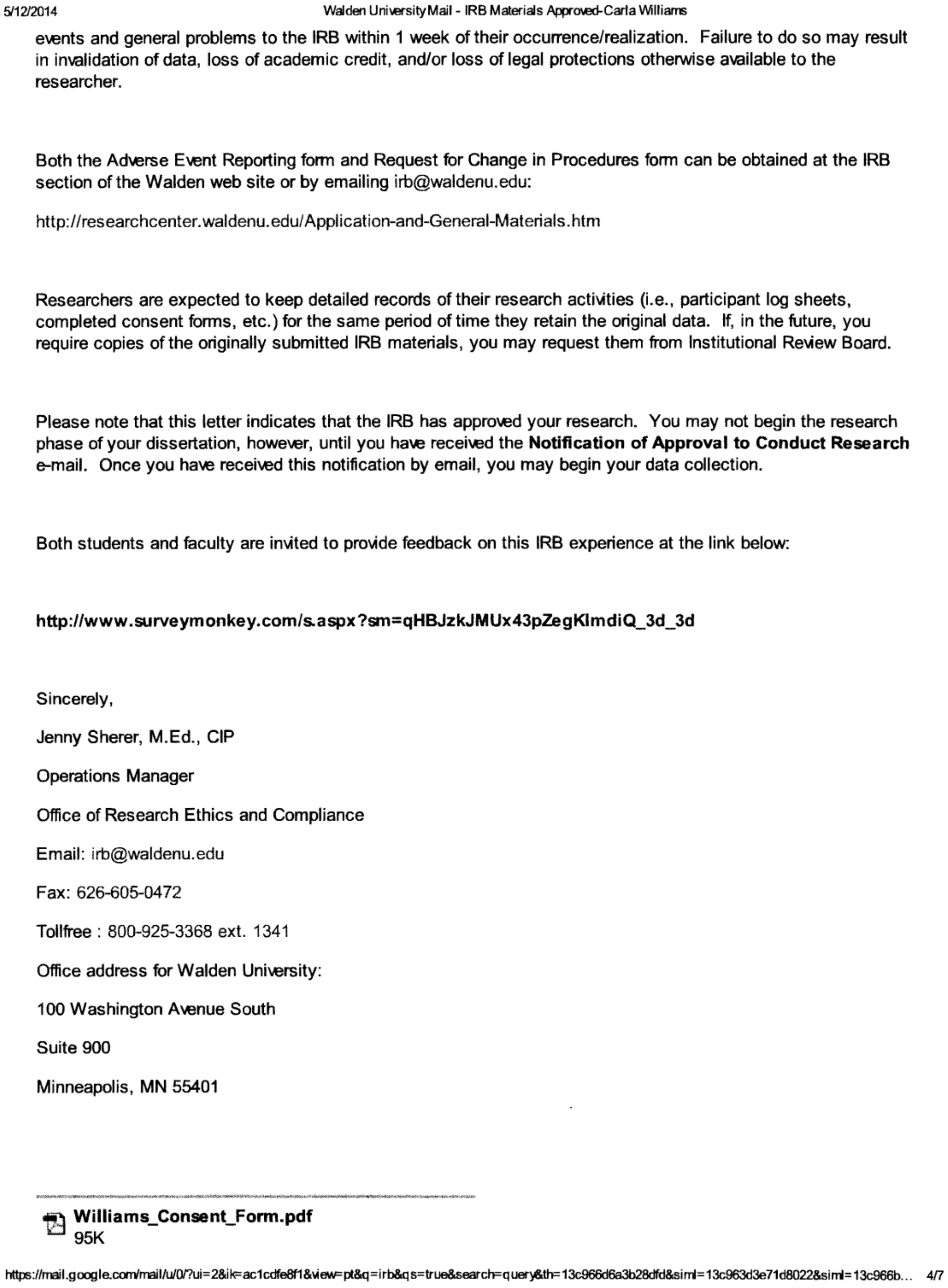
This email is to notify you that the Institutional Review Board (IRB) has approved your application for the study entitled, "Lung cancer in the African Population: How Do Family, Faith and Religion Influence Decisions to Seek Treatment?"

Your approval # is 02-01-13-0144924. You will need to reference this number in your doctoral study and in any future funding or publication submissions. Also attached to this e-mail is the IRB approved consent form. Please note, if this is already in an on-line format, you will need to update that consent document to include the IRB approval number and expiration date.

Your IRB approval expires on January 31, 2014. One month before this expiration date, you will be sent a Continuing Review Form, which must be submitted if you wish to collect data beyond the approval expiration date.

Your IRB approval is contingent upon your adherence to the exact procedures described in the final version of the IRB application document that has been submitted as of this date. If you need to make any changes to your research staff or procedures, you must obtain IRB approval by submitting the IRB Request for Change in Procedures Form. You will receive confirmation with a status update of the request within 1 week of submitting the change request form and are not permitted to implement changes prior to receiving approval. Please note that Walden University does not accept responsibility or liability for research activities conducted without the IRB's approval, and the University will not accept or grant credit for student work that fails to comply with the policies and procedures related to ethical standards in research.

When you submitted your IRB application, you made a commitment to communicate both discrete adverse



events and general problems to the IRB within 1 week of their occurrence/realization. Failure to do so may result in invalidation of data, loss of academic credit, and/or loss of legal protections otherwise available to the researcher.

Both the Adverse Event Reporting form and Request for Change in Procedures form can be obtained at the IRB section of the Walden web site or by emailing irb@waldenu.edu:

http://researchcenter.waldenu.edu/Application-and-General-Materials.htm

Researchers are expected to keep detailed records of their research activities (i.e., participant log sheets, completed consent forms, etc.) for the same period of time they retain the original data. If, in the future, you require copies of the originally submitted IRB materials, you may request them from Institutional Review Board.

Please note that this letter indicates that the IRB has approved your research. You may not begin the research phase of your dissertation, however, until you have received the **Notification of Approval to Conduct Research** e-mail. Once you have received this notification by email, you may begin your data collection.

Both students and faculty are invited to provide feedback on this IRB experience at the link below:

http://www.surveymonkey.com/s.aspx?sm=qHBJzkJMUx43pZegKlmdiQ_3d_3d

Sincerely,

Jenny Sherer, M.Ed., CIP

Operations Manager

Office of Research Ethics and Compliance

Email: irb@waldenu.edu

Fax: 626-605-0472

Tollfree : 800-925-3368 ext. 1341

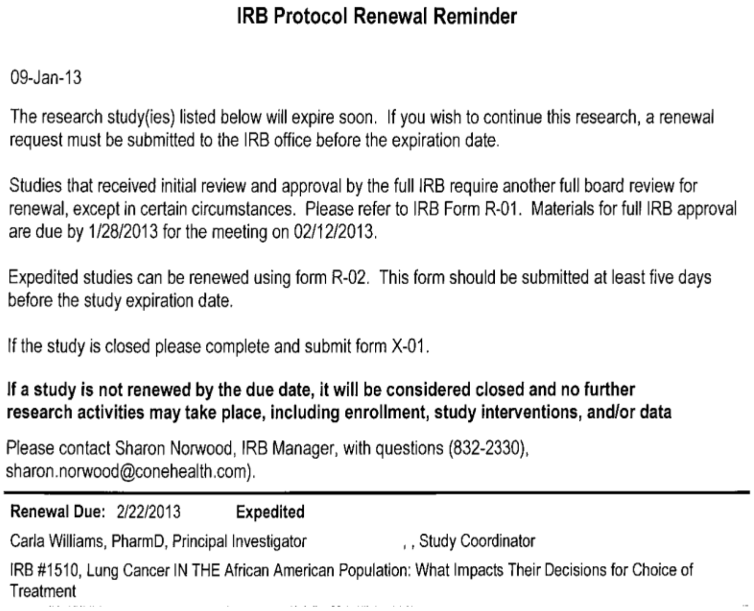
Office address for Walden University:

100 Washington Avenue South

Suite 900

Minneapolis, MN 55401

Williams_Consent_Form.pdf
95K



IRB Protocol Renewal Reminder

09-Jan-13

The research study(ies) listed below will expire soon. If you wish to continue this research, a renewal request must be submitted to the IRB office before the expiration date.

Studies that received initial review and approval by the full IRB require another full board review for renewal, except in certain circumstances. Please refer to IRB Form R-01. Materials for full IRB approval are due by 1/28/2013 for the meeting on 02/12/2013.

Expedited studies can be renewed using form R-02. This form should be submitted at least five days before the study expiration date.

If the study is closed please complete and submit form X-01.

If a study is not renewed by the due date, it will be considered closed and no further research activities may take place, including enrollment, study interventions, and/or data

Please contact Sharon Norwood, IRB Manager, with questions (832-2330), sharon.norwood@conehealth.com).

Renewal Due: 2/22/2013 **Expedited**

Carla Williams, PharmD, Principal Investigator , , Study Coordinator

IRB #1510, Lung Cancer IN THE African American Population: What Impacts Their Decisions for Choice of Treatment

Curriculum Vitae

Carla D. Williams, BSW, MSEd
3 Archer Glen Court
Greensboro, NC 27407
(336) 588-5404
cdwilliams0718@aol.com

Education:

2008-present **Walden University**
Graduate Studies
PhD Public Health specialization in Community Education

2006-2008 **North Carolina Agricultural and Technical State University-School of Graduate Studies**
M.S. Rehabilitation Counseling
(15 Hours left for completion of this degree)

2004-2006 **North Carolina Agricultural and Technical State University-School of Graduate Studies**
MSEd in Adult Education with concentration in Community Education

1991-1998 **Bennett College for Women**
BSW in Social Work

Experience:

Bennett College
Greensboro, NC
Project Coordinator **January 2014-Present**

- Organizing the coordinated community Response team (CCR), distribution and implementation of response protocols, provide immediate crises support.
- Organize training with NCCASA fir campus judicial board, public safety/campus Police, residential life, staff and students.
- Implement bystander/upstander education program for all incoming students.
- Monthly meetings with Principal Investigators and other project coordinator to create prevention action steps and discuss barriers and troubleshoot any concerns that may arise.
- Sponsor campus events focused on preventing sexual violence and stalking.
- Build partnerships with organization in the community.
- Develop systems to collect data that measure program results.
- Generate required reports to submit to OVW (Office of Violence against Women).

- Ability to effectively convey information to consortium members and partners.
- Travel to trainings as needed.

Cone Healthcare System May 2009-October 2013
Greensboro, NC
Study Coordinator/ Genomics Project

- Coordinate and initiated the recruiting research of subjects and collecting and managing research data as a part of the clinical implementation phase of the Guilford Genomic Medicine Initiative (GGMI).
- Conducting baseline interviews with participants and to ensure compliance with HIPPA and regulations within the clinical practice.
- Serves as a liaison to physicians and to the genetic counselors regarding patient participation and enrollment.
- Report to the Project Director and to the Principle Investigator (PI) for the research project. Collaborated with major grant writing and funding applications to continue research project.
- Strategic planning for the project and collaboration for developing current projects and future projects.
- Implementation of educational strategies to inform patients and the community of health awareness.
- Educating patients on genetic outcomes and completing referrals for genetic testing.
- Supervised interns during their learning and internship hours.
- Managed the research project independently within the physician practice.
- Trained new researched associates and coordinators.

Moses Cone Healthcare System January 2007-May 2009
Greensboro, NC
Research Associate/ Medical Research

- Led and coordinated the research efforts of faculty members in the Department of Internal Medicine.
  Search for patients to participate in the research survey and prepare material for presentations. Complete editing manuscripts and grants for publication and submission. Manage electronic medical records and documentation.
- Independently moderate and facilitate focus groups for purposes of data collection for research purposes. Assist project manager with ongoing projects.
- Conduct pilot studies and moderate and facilitate focus groups for research studies.

Evergreens Senior Healthcare System November 2004 – August 2006
Greensboro, NC
Social Worker

- Assist clients using knowledge of human behavior and social work principles common to the elderly, disabled, and families.
- Participates in administrative processes for new patients.
- Assist on an interdisciplinary team to provide an assessment of care plans that address

the psychosocial well-being of clients; Coordinate discharge planning.

United Child Development Services **December 1999 - August 2004**
Greensboro, NC
Social Worker/ Family Advocate

- Collaboratively worked with parents of the Head Start program to assess various needs expressed through Partnership Agreements.
- Worked with community agencies to link families to needed resources.
- Reported all incidents of abuse or misappropriations of client rights.
- Identified and responded appropriately with crisis interventions.
- Adhered to agency policies and procedures, as well as mandated state and federal regulatory guidelines.

Neighborhood Community Resource Center **March 1999 -December 1999**
Greensboro, NC
Executive Director/ Community Coordinator

- Grant Proposal Writing;
- Developed and implemented programs for neighborhoods that addressed housing, schools, and crime related issues.
- Demonstrated and encouraged appropriate problem solving methods.
- Collaborated with neighborhood representatives and city officials to help residents gain knowledge of social and economic issues, and helping them to become self-sufficient.

Professional Development:

- Works well independently or with others.
- Use appropriate decision-making skills to determine appropriate plans of action.
- Strong verbal and written communication skills
- Exemplifies Leadership skills and ability, Self-Motivated, & dependable

Publications/Presentations:

Cykert S, Freeman(Williams) C, et al. Radical differences in lung cancer: do poor numeracy skills represent a modifiable factor for decisions against care. JGIM 2008; 23(Suppl 2): 388. (Abstract)

Cykert S, Walker P, Bunton A, McGuire F, Edwards L, Monroe M, Sigounas A, Freeman (Williams) C. 2009. Racial differences in lung cancer surgery: what factors can be modified to optimize care in early stage disease/ Submitted to the National Society of General Internal Medicine for publishing.

Teaching and Supervisor Experience:

- Conducted focus groups to collect information for research studies (Understanding medication research study)
- Dissemination of outcome of research studies, presentation to physicians within the research department.
- Completion of online classes masters and doctoral program (over 122 unit credits
- Trained others on research procedures and how to interview and collect data for research projects.
- Supervised students and interns during internship time period

Affiliations/Memberships:

2013-Present People of Excellence Committee for Cone Health
2012-2014 Board of Directors- GCAPP Guilford Coalition on Adolescent Pregnancy Prevention
United Way- Funding Objective Review Committee Member since 2012
United Way- Focus Area Committee Member (Healthcare) since 2012
NCRE- National Council on Rehabilitation Education
NCCA- North Carolina Counseling Association
ACA- America Counseling Association
Alpha Kappa Alpha Sorority, Inc. Sigma Kappa Omega Chapter, Greensboro, NC
National Association of Black Social Workers (NABSW)
National Association of Social Workers (NASW)
American Public Health Association (APHA)

COMPUTER SKILLS:

Efficient in Microsoft Word, Microsoft Excel, ACCESS, Power Point, Microsoft XP, Windows 98,Apple Mac Software OS System EMR- Electronic Medical Record, EPIC and CITRIX.