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Characteristics of Trust Between African Americans and Health Care Providers

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Walden University
2024

Abstract

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MSN, Walden University, 2007

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Dissertation Submitted in Partial Fulfillment
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Abstract

African Americans (AA) are one of the groups disproportionally affected by health care disparities. Despite years of research and government funding, the health of AA continues to decline, and a variety of factors intermingle to produce this effect. Furthermore, trust has been identified as contributing to poor health outcomes in AA. There is a gap in the literature about the lack of trust between AA and health care providers (HCPs), and information about how AA define, perceive, and experience trust in interactions with health care providers and the health care system is lacking. The purpose of this qualitative study was to explore the characteristics of trust and its meaning in the building of trusting relationships between AA and HCPs. A qualitative interpretive phenomenological analysis approach was used to answer the research question. Data were collected from the 10 participants through individual, one-on-one interviews. All participants identified as AA and had experienced the phenomenon of interest. Four central themes emerged from data analysis: (a) depersonalization, (b) challenges of being AA, (c) building trust, and (d) being your own advocate. Each central theme had multiple subthemes to support it. The findings provided insights to facilitate positive social change for AA patients by empowering them to become agents of change for their health care. Additionally, the study findings may help HCPs build trust and strengthen their relationships with AA by designing interventions that enable AA patients to become engaged and proactive in their care.

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Dedication

My deepest thanks to the participants who participated in this study. I was touched by the giving of their time and willingness to share their personal stories with me. Although challenges arose during the study, participants were optimistic and encouraged that they made a long-term contribution to improving their health and those of future generations.

Acknowledgments

I thank my teachers and peers for their support during my dissertation journey. They were my cheerleading team. They encouraged me when I was discouraged. They made me believe in myself and keep pressing forward toward the goal. I thank Dr. Lewis for her insights, hard work, and motivational words of encouragement.

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Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

African Americans (AA) are one of the groups disproportionately affected by poor health outcomes. The interaction of individual, institutional, societal, and community variables has a cumulative effect and adversely impacts health over time. The morbidity and mortality rate of AA with chronic diseases is significantly higher than that of European Americans (see Cunningham et al., 2017). Furthermore, AA are more likely to develop preventable long-term disabilities related to inconsistent follow-up care and delays in treatment (see Roland et al., 2016). In combination with past historical research abuses, structural and patient-provider disparities, and the social determinants of health (SDOH), these variables contribute to the chronicity of poor health outcomes in AA. Furthermore, AA continue to experience poor health outcomes regardless of socioeconomic status (see Ferrera et al., 2016; Institute of Medicine [IOM], 2003). Therefore, it is logical to conclude that the health care system is inherently flawed because it does not provide equal access to care or the same standard of care.

Despite various health initiatives, health care disparities persist in the AA community because of the interactions between intrinsic and extrinsic factors. Consequently, understanding the experiences and perceptions of AA interacting with health care providers (HCPs) and the health care system is integral to resolving the issue. The characteristics of trust between AA and HCPs and what is most important to AA when selecting a new HCP are essential topics to explore to improve this population's health. Towards that end, I conducted a qualitative interpretive phenomenological analysis (IPA) in this study. This approach was consistent with the phenomenon of interest and focused on AA shared experiences and realities as they see them. In this way, AA could voice their positive and negative experiences regarding interactions with HCPs and the health care system while providing insights about trust formation and the development of cultural humility in HCPs.

In this chapter, I present the background, problem statement, purpose of the study, and literature gap. The nature of the research and definitions of essential terms are also provided. Additionally, I describe the study's assumptions, scope and limitations, and the theoretical framework. The chapter concludes with a discussion of the significance of the study.

Background of the Study

Bronfenbrenner (1977) created the ecology of human development theory. Bronfenbrenner (1981) believed that the building blocks for human development lie in one's perception and role within the setting, the environment, and interactions with others. Bronfenbrenner's theory was beneficial for exploring the characteristics of trust between AA and HCPs and AA perspectives on trust and building relationships with HCPs.

Cuevas et al. (2016) provided information about the indignities that AA encounter with HCPs and the health care system when seeking treatment for chronic illnesses. The authors found that AA value transparency and honesty in all interactions with HCPs. Moreover, AA patients positively view recommendations about care when HCPs do not have a paternalistic attitude, provide personalized care, and engage in shared decision making with AA patients. Cuevas et al. highlighted the challenges AA patients encounter when accessing the health care system for routine care. They found that the absence of a trusting relationship with HCPs results in noncompliance with the plan of care. Moreover, AA patients view medical interventions not openly discussed with doubt, fear, and suspicion.

Coplan (2018) provided information about utilizing an ecological model to address the health care needs of the underserved. The model is a derivative of Bronfenbrenner's ecology of human development theory because it classifies barriers the underserved encounter with access to health care at the microsystem, mesosystem, exosystem, and macrosystem levels. All systems constantly interact and influence individual actions and decisions that affect behavior; therefore, building trusting and collaborative relationships between marginalized groups and HCPs is essential for decreasing health care disparities, improving health outcomes, and giving a voice to the disenfranchised. Coplan's study supported the current study by emphasizing the importance of trust between marginalized groups and HCPs (i.e., the microsystem level).

Glover et al. (2017) studied the role of discrimination, trust, and satisfaction with care in perpetuating poor health outcomes in AA patients. The authors found that AA perceptions and experiences related to discrimination altered their views and interactions with HCPs; therefore, AA patients are suspicious of HCPs who do not discuss treatment recommendations and or do not value feedback from AA patients about their care. Real or perceived discrimination causes anxiety, defensiveness, and suspicion in AA patients; consequently, trust between AA patients and HCPs is essential to improving health outcomes, eliminating racial stereotyping, and improving satisfaction with care (Glover et al., 2017). Glover et al 's findings support the current study by showing the importance of trusting relationships between AA and HCPs.

Greaney et al. (2020) applied the socioecology framework to address health literacy in low-income minorities in Rhode Island Federally Funded Community Health Centers. They found that health literacy improves when cultural respect, collaboration, and mutual trust exist in interactions between HCPs and patients. The sociological framework aligns with the current study's research questions and methodology because it highlights the difficulties that low-income minorities encounter when accessing the health system. Building trusting relationships between marginalized groups and HCPs is also essential when working with low-income, low-health literacy minorities because it keeps the communication lines open, and patients can openly voice concerns or disagreements about treatment decisions without fear of reprisal.

Hooper et al. (2019) used the socioecology model (SEM), a variant of Bronfenbrenner's theory, to highlight the challenges that AA diagnosed with colon cancer encounter when accessing the health care system for routine care. Their study indicated that AA patients with colon cancer encounter many challenges at the individual, community, and political levels when seeking medical care. Additionally, AA long-standing distrust of the health care system, HCPs, and researchers hinders the early detection and treatment of colon cancer. Their study showed the importance of building trusting relationships between AA and HCPs.

In a study about the lack of diversity in the health professions that contributes to the prevalence of health care disparities and fosters distrust between AA and HCPs, the

IOM (2010) recommended that the health professions increase the recruitment and retention of diverse HCPs to facilitate trust in diverse patients, decrease health care disparities, and increase compliance with the care plan. The IOM's findings supported the current study by establishing the importance of building trusting relationships between AA and HCPs.

Lackland (2014) studied the prevalence of health care disparities in AA and found a lack of trust in HCPs, HCPs unfamiliarity with patients' cultures, and HCPs not being attentive to genetic factors that dictate the type of medical interventions selected for AA. HCPs that do not provide culturally congruent care, remain updated on medical guidelines, and create a sense of trust in AA patients contribute to the prevalence of health care disparities among AA. Lackland's study also shows the importance of trust between AA and HCPs.

The National Center for Health Statistics (NCHS; 2014) compiled information from multiple governmental agencies to examine the prevalence of hypertension and health care disparities in AA. Their report identified that a lack of trust between AA and HCPs contributes to noncompliance and poor health outcomes. Additionally, AA patients encounter other challenges related to health care access and equity. The NCHS recommended that HCPs create an environment conducive to building trust in AA patients to facilitate engagement, prevent noncompliance, and improve health outcomes.

Onwuegbuzie et al. (2013) provided an overview of the utilization of Bronfenbrenner's ecology systems theory to frame quantitative, qualitative, and mixed-method research. The authors stated that the different levels of Bronfenbrenner's theory could be applied to quantitative, qualitative, and mixed-method research to address individual, societal, and community issues. They provided helpful insights about using the microsystem level of Bronfenbrenner's theory that I applied in the current study to focus on interactions between patients, HCPs, and the environment.

Problem Statement

AA are disproportionally affected by health care disparities when compared with European Americans. Additionally, AA frequently experience poor health outcomes and disabilities from chronic diseases despite substantial and long-term financial investment from the federal government (see Lackland, 2014; NCHS, 2014; Roland et al., 2016). A literature review indicates that a combination of variables contributes to the prevalence of health care disparities in AA, including biological variations, discrimination, poor provider-patient communication, socioenvironmental factors, lack of health insurance, inequities in the health care delivery system, the cultural competency and knowledge of HCPs, lack of trust in HCPs, and limited access to follow-up care (see Gross et al., 2013; IOM, 2010; Lackland, 2014; NCHS, 2014; Roland et al., 2016; Vilablanca et al, 2018; Williams, 2009).

Trust is the reliance or belief in someone or something dependable and engenders a sense of hopefulness (see Merriam-Webster, n.d). Trust has been studied in many disciplines, including business, psychology, sociology, and nursing (see Rutherford, 2014). It has been described as a *thick* concept because its meaning depends on the context (see Pask, 1995). It is not enough to claim that a lack of trust in health care providers contributes to the prevalence of health care disparities in AA without understanding what trust means to AA patients or providing evidence to support the claim. As a result, I explored the meaning of trust and its role in building relationships between AA and HCPs. I hoped this study's findings could help HCPs develop culturally congruent and practical evidence-based interventions to improve health outcomes in AA patients.

Purpose of the Study

The purpose of this qualitative study was to explore the characteristics of trust and its meaning in the building of trusting relationships between AA and HCPs. I used an IPA approach to address this gap because it focuses on understanding and finding patterns among participants' personal experiences. Additionally, an IPA approach allows for the interpretation of these experiences into a broader context that reflects how individuals see, experience, make sense of, and interact with their world (see Larkin et al., 2006; Smith et al., 2021). By exploring the characteristics of trust and its meaning in building relationships between AA and HCPs, new insights can be gained about AA interactions with and perceptions of HCPs, the health care system, and the provision of culturally congruent care.

Gap in the Literature

Health care disparities have been studied in AA for over 30 years; however, a gap exists in the literature about the characteristics of trust in the interactions between AA and HCPs. These characteristics of trust are vital to AA patients because they enable the patients to form a personal connection to HCPs, determine their receptiveness to medical interventions, and participate in the self-management of chronic diseases (see Connell et al., 2019; Lewis et al., 2010; Roland et al., 2016). By exploring the lived experiences of AA through a qualitative approach, I could develop a cultural understanding of trust and identify the factors that contribute to the creation of trust between AA and HCPs.

Research Questions

RQ1: What are the characteristics of trust in the building of relationships between AA and HCPs?

RQ2: What is most important to AA when selecting a new HCP?

Theoretical Framework

I used Bronfenbrenner's (1977) ecology of human development as the theoretical framework for this study. Bronfenbrenner's ecology of human development was derived from studies conducted with children, and in general, these studies focused on one aspect of human development (e.g., the formation of bonds between parents and children). Bronfenbrenner (1981) believed that the building blocks for human development lie in one's perception and role within the setting, the environment, and interactions with others. By carefully examining these factors, Bronfenbrenner gained insights into the interactions of the self with multiple systems described as the microsystem, mesosystem, exosystem, and macrosystem. The microsystem consists of the individual interacting with others in the environment, the mesosystem involves the connections among systems, and the exosystem involves interactions with the community. At the same time, the macrosystem considers the influence of ethnicity on individual behaviors (see Onwuegbuzie et al., 2013).

The ecology of human development framework helped me to explore the characteristics of trust and its meaning in building trusting relationships between AA and HCPs in the current study. Bronfenbrenner (1981) posited that individuals continually interact with multiple systems to change behaviors, learn, and grow to suit the context. I used the microsystem level of Bronfenbrenner's theory to explore the characteristics of trust and its meaning in building relationships between AA and HCPs. In Chapter 2, more details about the theoretical framework are provided.

Nature of the Study

I employed an IPA research design to address the research questions in this qualitative study. IPA is used to determine, explain, and understand the multiple realities, perceptions, and interpretations of individual experiences, which was the focus of the current study (see Rudestam & Newton, 2015).

Definitions

AA: One who self-identifies as Black and descended from the tribes of Africa (U.S. Census Bureau, 2020).

Chronic diseases: Any prolonged illness that lasts a year or more and alters the quality of life requires medications and frequent monitoring by HCPs (National Center for Chronic Disease Prevention and Health Promotion, 2021).

Health care disparities: Variations in health outcomes based on one's culture and origin. They are unrelated to access, personal tendencies, and the type of treatment selected (see IOM, 2003; Lynch, 2020).

Structural disparities: Archaic policies embedded in the health care system that determine access, the allocation of resources, and the quality of care provided (see Institute for Healthcare Improvement [IHI], 2016; IOM, 2003; Lynch, 2020).

Patient-provider disparities: These disparities occur in the interactions between AA and HCPs due to misunderstandings, poor communication, and limited understanding of cultural variations (see American Association of Medical Colleges [AAMC], 2020; Centers for Disease Control and Prevention [CDC], 2021b; IOM, 2003; Lynch, 2020).

SDOH: These determinants that influence health are education, employment, financial, and environmental resources (see CDC, 2021b; IOM, 2003; Lynch, 2020).

Assumptions

In this study, I assumed participants had a good memory and could answer the interview questions honestly. Another assumption was that enough participants would be readily available from community organizations to participate in the study. I also assumed participants would be comfortable with one-on-one interviews. My final assumption was that the participants would participate in the study based on the importance of the topic and would be comfortable revealing personal and, at times, humiliating and painful information to a stranger.

Scope and Delimitations

This study focused on AA adults between the ages of 18 and 65 years old with an underlying condition requiring frequent contact with an HCP. Participants were also limited to those who resided in an urban area in the northeastern region of the United States and could read, write, understand English, and participate in a one-on-one interview. The participants also had no cognitive deficits that would interfere with their participation in the study.

Limitations

I recruited participants from an urban area in the northeastern United States; therefore, the study findings do not apply to rural areas in other regions of the United States. Additionally, the study may have inadvertently caused painful emotions to emerge within participants, resulting in distress and withdrawal from the study. Participants were recruited from a nonprofit community organization; therefore, age, gender, and demographic differences were not equally distributed. As a result, the findings were limited by the setting, geographic location, and characteristics of participants. Furthermore, I experienced this phenomenon; therefore, I kept a journal and held collaborative peer debates throughout the research process to detect and monitor my biases.

Significance of the Study

A lack of trust between AA and HCPs contributes to health care disparities, poor health outcomes, and increased health care costs (see Lackland, 2014; NCHS, 2014; Roland et al., 2016). Studying AA experiences with HCPs, the characteristics of trust, and its role in building relationships with HCPs can provide a new perspective and new insights into barriers that AA encounter when interacting with HCPs and the health care delivery system. As a result, culturally congruent, practical, and evidence-based interventions can be developed to facilitate positive social change in the AA community, decrease health care disparities, and improve health outcomes.

Summary

The pervasiveness of health care disparities in AA is disturbing, and despite 3 decades of research, only marginal gains have been made in addressing these disparities. The quality of life for most AA still lags behind European Americans, and AA still struggle to find equal access, equity, and opportunity in education, employment, housing, and health care, which are all essential for good health (see CDC, 2013, 2021b; IHI, 2016). Furthermore, the archaic structure and function of the health care system and the lack of cultural humility in HCPs ensure that AA will continue to struggle for the foreseeable future (see IOM, 2003). I conducted this study to explore the characteristics of trust and its role in AA building relationships with HCPs. The generation of new knowledge in this study can help create practical, culturally based clinical guidelines that lessen the impact of health care disparities in AA while improving the population's health.

In Chapter 2, I will provide more information about the implications of historical research abuses, peripheral trauma, structural and patient-provider disparities, and the SDOH. Factors that create trust in AA patients will also be discussed.

Chapter 2: Literature Review

AA are disproportionally affected by health care disparities compared to European Americans. Additionally, AA frequently experience poor health outcomes and disabilities from chronic diseases despite substantial and long-term financial investment from the federal government (see IOM, 2003; Lackland, 2014; NCHS, 2014; Roland et al., 2016).

The purpose of this qualitative IPA study was to explore the characteristics of trust and its meaning in the building of trusting relationships between AA and HCPs. I also investigated what is most important to AA when selecting an HCP. IPA is focused on developing an understanding and giving an account of participants' lived experiences. Additionally, this approach allows for the interpretation of these experiences into a broader context that reflects how individuals see, experience, make sense of, and interact with their world (see Larkin et al., 2006; Smith et al., 2021). By exploring the characteristics of trust and its meaning in building relationships between AA and HCPs, new insights can be gained about AA interactions with and perceptions of HCPs, the health care system, and the provision of culturally congruent care.

In this chapter, I review the literature related to the characteristics of trust and its meaning in building relationships between AA and HCPs. The literature indicates that trust between AA and HCPs is essential for improving health outcomes, patient engagement, and adherence to treatment interventions (see IOM, 2003; Lynch, 2020). Trust between AA and HCPs is conducive to creating a judgment-free environment responsive to questions and concerns while encouraging open debates about the merits of treatment options. More importantly, trust between AA and HCPs decreases the prevalence of health care disparities by improving health outcomes (see AAMC, 2020; IOM, 2003; Lynch, 2020).

AA have the highest mortality and morbidity rate from cardiovascular disease, cerebral vascular disease (i.e., stroke), diabetes, and kidney disease when compared to other ethnic groups (see IOM, 2003; Lackland, 2014; Lynch, 2020; NCHS, 2014). Additionally, the complications from chronic disease are severe due to episodic care, which can result in long-term disabilities that lessen the quality of life while increasing health care costs (see IOM, 2003; Lynch, 2020; NCHS, 2014; Roland et al., 2016). Building trust between AA and HCPs enhances bidirectional communication and indirectly improves health outcomes (i.e., AA can ask their HCPs about the adverse effects of medications and the rationale for selecting a particular intervention); consequently, AA are more likely to adhere to the treatment plan and report negative symptoms as they occur to prevent acute exacerbations of chronic illnesses (see Dyal et al., 2019; IOM, 2003; Lynch, 2020).

There is a gap in the literature about the lack of trust between AA and HCPs, and this lack of trust contributes to health care disparities, poor health outcomes, and increased health care costs (see IOM, 2003; Lynch, 2020; NCHS, 2014). By studying AA experiences with HCPs, the characteristics of trust, and its meaning in building trusting relationships between AA and HCPs, I can provide a new perspective on barriers AA encounter when interacting with HCPs and the health care system. Using the findings of this study, culturally congruent, practical, and evidence-based interventions can be developed to facilitate positive social change in the AA community, alter the trajectory of chronic diseases, and improve the population's health.

AA have many barriers to overcome before seeing HCPs and gaining access to the health care system; therefore, it is necessary to understand the historical impact of research abuses and the role of health care disparities on health and explore the characteristics of trust and its meaning in building relationships between AA and HCPs. Selected peer-reviewed articles related to the characteristics of trust and its role in building trusting relationships between AAs and HCPs are described in this chapter.

Literature Search Strategies

When searching the literature, I filtered articles relevant to the current study by topic; year of publication; and application to psychology, medicine, nursing, and sociology. However, most resources were obtained from reviewing the reference section of previously read articles. Seminal articles were included in this study because they influenced the phenomenon of interest and made research contributions; consequently, this literature review includes articles published from 1995–2021.

I used the following keyword search terms to locate literature for this study: **trust, trust, and healthcare professionals and African Americans or blacks, healthcare disparities and African Americans or blacks and healthcare professionals, African Americans or blacks and trust and healthcare disparities in the United States, qualitative research or qualitative study and health disparities and African Americans or black Americans or blacks, distrusts and mistrusts and health disparities and African Americans or black Americans or blacks, *Distrust and African Americans or black*

Americans or blacks and healthcare or health care or hospital, trust and healthcare relationships, and *trust and African Americans or blacks and nurses.* The databases of APA PsycInfo, EBSCO, CINAHL, ProQuest, and the Thoreau multidatabase search were used to conduct the searches.

Theoretical Foundation

This study's theoretical framework was based on Bronfenbrenner's (1977) ecology of human development. The framework has been used to study interactions between diverse populations, the environment, relationships with HCPs, and interactions between HCPs and the health care system (see Coplan, 2018; Greaney et al., 2020). Additionally, the framework has been used to educate diverse populations about chronic conditions and identify barriers to care (see Hooper et al., 2019; Williams & Swierad, 2019).

Bronfenbrenner (1977) classified the interactions of individuals into four levels: the microsystem, mesosystem, exosystem, and macrosystem. The microsystem consists of the individual interacting with others in the environment, the mesosystem involves the connections among systems, the exosystem involves interactions with the community, and the macrosystem is used to consider how ethnicity influences individual behaviors (see Onwuegbuzie et al., 2013). The microsystem level was the focus of this study because it allowed for the exploration of interactions between AA and HCPs. Furthermore, this level emphasizes the importance of individual perceptions, experiences, the environment, and interactions with others as catalysts for human growth and development (see Bronfenbrenner, 1981). These are important considerations, especially when examining the characteristics of trust and its meaning in building trusting relationships between AA and HCPs.

Literature Review

The stories of Henrietta Lacks and the Tuskegee Syphilis Study are discussed in the following subsections. Each story personifies the dominant culture's exploitation and manipulation of a marginalized group and provides a justification for AA beliefs about and perceptions of not trusting HCPs, the health care system, and researchers (see AAMC, 2021; Bonner et al., 2017; Hooper et al., 2019; IOM, 2003; Lynch, 2020). These stories are repeated and passed on from generation to generation.

Henrietta Lacks

Henrietta Lacks, an African American female and mother of five, felt unwell for some time, so she went to Johns Hopkins Hospital for help. A biopsy was performed, and a diagnosis of cervical cancer was made. Although she received radium therapy, it was unsuccessful, and she died in 1951. The biopsied cells were sent to Dr. Gey's lab for analysis, where the doctor discovered that Henrietta’s cells were viable without a host and multiplied ″every 20-24 hours″ (see Honoring Henrietta, n.d. -a para. 2). Dr. Gey continued to take tissue samples from her body after death, and as a result, Henrietta's cells (i.e., HeLa cells) have been used in multiple experiments incessantly for decades without consent, family notification, or compensation (see Vernon, 2020). The hospital rationalized its actions by stating that collecting biopsied tissue samples from all patients with cervical cancer was routine and that informed consent was not essential to conduct scientific research (see The Legacy of Henrietta Lacks, n.d. -b).

Tuskegee Syphilis Study

The Tuskegee Syphilis Study was conducted in Macon County, Alabama from 1932–1972 and involved 400 male AA participants. Participants were rural, illiterate farmers with low socioeconomic backgrounds and minimal contact with the outside world. The U.S. Public Health Service (UPHS) chose this sample because of the high prevalence of syphilis. Additionally, the UPHS wanted more information about the progression of syphilis and its dormant stages (see U.S. Department of Health, Education, and Welfare Public Health Service [DHHS], 1972). In exchange for their *cooperation,* the men were told they would receive free treatment for themselves and their family members; however, researchers did not inform the men about the study's purpose, adverse effects, and long-term consequences. For example, the treatment of syphilis in 1932 caused severe, long-term, systemic cellular damage that can be expressed in successive generations (see DHHS, 1972). The men and their families did not receive any form of treatment to lessen the impact of syphilis; consequently, they developed permanent disabilities that shortened their lives and made it challenging to complete self-care activities. Researchers also deliberately injected syphilis into asymptomatic men (see DHHS, 1972; Vernon, 2020). Some men realized that their health was deteriorating and sought help from HCPs not involved with the study. They received a cycle of treatment that eased some of the symptoms, but the disease later reemerged with devasting consequences. Moreover, once the UPHS learned that the men sought outside help, a notification was sent to HCPs to stop all forms of treatment and not interfere with essential government research (see DHHS, 1972).

In 1972, Jean Heller, a reporter from the Associated Press, exposed the study to the public, and the Tuskegee Syphilis Study Ad Hoc Advisory Panel was established to investigate the matter (see CDC, 2021b). After months of deliberation, the panel agreed to end the study and stated the following:

> The study is deemed unethical, diverged from sound scientific inquiry, did not demonstrate due diligence or proper consideration for the rights and protection of a vulnerable group. Furthermore, the study did not make a meaningful contribution to the knowledge base of science, for the design, methodology, data analysis, and collection were seriously flawed (see DHHS, 1972, pp. 18-19).

In addition, the panel made provisions for free medical care and financial assistance to participants and their families and provided oversight for HCPs selected to treat them. As a result, HCPs were frequently monitored and evaluated by the panel to ensure that clinical decision making resulted in timely, effective, and high-quality care for participants and their families (see DHHS, 1972). This policy later became known as the Tuskegee Health Benefit Program and continued until the last participant of the Tuskegee Syphilis Study died in 2004 (see CDC, 2021b).

This study reflected U.S. society when AA experienced discrimination at every level. They had no rights, and all institutions were separate and unequal. AA were seen as subhuman; therefore, they were unworthy of being treated as sentient beings (see Williams, 2012; Williams & Purdie-Vaughns, 2016).

Peripheral Trauma

The Henrietta Lacks story and the Tuskegee Syphilis Study represent the dominant culture's gross, unethical research committed against AA. This resulted in the severe scarring of the AA psyche, and a phenomenon known as peripheral trauma has been identified to describe it. In peripheral trauma, the impact of historical research abuses exerts a powerful effect intergenerationally on AA lives, dictating how AA experience, interact with, and perceive the health care system (see Alsan et al., 2019). Consequently, it is unsurprising that AA do not adhere to treatment recommendations, rely on episodic care to treat acute exacerbation of chronic illnesses, and rarely participate in clinical research and health screenings. Furthermore, AA often fear being used in secret experiments (see AAMC, 2020; Bonner et al., 2017; Hooper et al., 2019; IOM, 2003; Lynch, 2020; NCHS, 2014).

As previously stated, the experiences of AA within the health care system significantly differ from those of other ethnic groups and result from health care disparities within and outside of the system (see AAMC, 2020; IOM, 2003; Lynch, 2020). Therefore, it is essential to understand what health care disparities mean and their contributions to the lack of trust between AA and HCPs.

Overview of Health Care Disparities

Health care disparities are variations in health outcomes based on one's culture and origin. These disparities are unrelated to access, personal tendencies, and the type of treatment selected, and they frequently occur in AA, Hispanics, Asian Americans, and indigenous peoples, resulting in poor health. Common causes include structural and patient-provider disparities entrenched within the health care system, making them difficult to eradicate (see Ferrera et al., 2016; IOM, 2003; Lynch, 2020; Powell et al., 2019).

Structural Disparities

Health care disparities occur at several levels. First, there are structural disparities inherent in the system. For example, the way an organization dictates the allocation of resources; how much time HCPs can spend with patients; and, to an extent, the availability of diagnostic testing. Organizations and insurers use outdated calculations based on cost containment instead of the quality of care delivered; consequently, AA are disadvantaged because they rely on episodic care to manage chronic conditions and usually do not have a primary care provider, receiving most of their care from emergency rooms (see IHI, 2016; IOM, 2003; Lynch, 2020).

Patient-Provider Disparities

Patient-provider disparities occur between AA and HCPs for a variety of reasons, including a lack of transparency from provider to patients; providers not giving patients a complete view of their health status when presenting information; and a lack of consideration for cultural variations, patients' level of education, and the SDOH. Discrimination and implicit biases also play a role in the interactions between AA and HCPs and adversely impact health outcomes (see AAMC, 2020; CDC, 2021a; IOM, 2003; Lynch, 2020; Powell et al., 2019).

Social Determinants of Health

SDOH are analogous to socioeconomic status and include financial, material, educational, and employment resources. Additionally, the environment in which AA live impacts their health. Other aspects of SDOH are health care access, equity, and health insurance (see CDC, 2021a). For example, many AA rely on Medicaid, Medicare, or other state and government programs to meet most health care needs; therefore, the sociopolitical climate and funding significantly influence the health care needs of AA (see IOM, 2003; York & Tang, 2021).

Poverty is linked to employment, educational attainment, and safety. Most AA work in service industries, offering low wages with minimal benefits (see CDC, 2021a; IOM, 2003; Lynch, 2020). Therefore, taking time off from work, buying food, and feeding the family while paying the rent is difficult. As a result, the jobs of AA dictate where they live and the level of exposure to crimes and pollutants, which affects their health and quality of life (see CDC, 2021a).

Educational attainment is instrumental in breaking the cycle of poverty; however, due to economic systems, AA are usually tied to an educational system that is inefficient and ineffective, often with limited resources. Therefore, it is unsurprising that some AA high school students develop behavioral issues that make learning challenging, and they are more likely than other ethnic groups to experience expulsion, suspension, and drop out of school (see National Center for Educational Statistics, 2019). Some AA who go on to college are unprepared for the demands of academic life, and most withdraw before graduation (see Banerjee, 2016; Duncan & Murnane, 2014; Wolla & Sullivan, 2017).

Furthermore, the low participation rate of AA in science, technology, education, and mathematics occupations significantly limits future earning potential and contributes to the pervasiveness of the SDOH (see National Center for Science and Engineering Statistics, 2019).

The preceding discussion highlights the many challenges AA must overcome before accessing the health care system. Furthermore, once they enter the system, they encounter additional problems exacerbated by a lack of trust in the health care system, HCPs, and health care organizations. Also, they frequently cope with discrimination and microaggression in most health care interactions (see IOM, 2003; Lynch, 2020; York & Tang, 2021).

As a result, it is essential to look at the characteristics of trust and its meaning in building relationships between AA and HCPs. This phenomenon will be explored using the microsystem level (Level 1) of Bronfenbrenner's ecology of human development theory. Bronfenbrenner believed that the building blocks for human development lie in one's perception, experiences, role within the setting, the environment, and interactions with others (see Bronfenbrenner, 1981).

Trust Between African Americans and Health Care Providers

According to Merriam-Webster (n.d), trust is the reliance or belief in someone or something that is dependable and engenders a sense of hopefulness. Trust is a concept studied in business, psychology, sociology, and nursing (see Rutherford, 2014). It has been described as a *thick* concept because its meaning is based on the setting (see Pask, 1995).

Interpersonal Trust

The trust that occurs between AA and HCPs is called interpersonal trust. This type of trust reflects the experiences, perceptions, and worldviews of AA and HCPs. Factors that affect interpersonal trust between AA and HCPs are respect, open communication, empathy, and shared decision-making. Interpersonal trust takes time and energy to build. However, once established, it instills confidence, self-worth, and collaboration between AA and HCPs (see AAMC, 2020; IOM, 2003; Lynch, 2020). As a result, AA are proactive with treatment recommendations and not afraid to seek clarification of misunderstandings, improving health outcomes and satisfaction with care.

Implicit Biases

Implicit biases are an individual's subconscious thoughts and attitudes about a group of people based on race or ethnicity. They are a classification system that filters our worldviews and interactions with others. Implicit biases are problematic in health care when they influence the clinical decision-making process of HCPs and lead to discrimination, stereotyping, and inequities in care (see AAMC, 2020; IOM, 2003; Lynch, 2020; Penner et al., 2016; Powell et al., 2019).

HCPs are unaware of these hidden thoughts and attitudes that remain hidden until triggered by environmental stressors. Consequently, HCPs revert to familiar preconceived notions about race and ethnicity derived from their background and social network (see IOM, 2003; York & Tang, 2021). For example, a qualitative study conducted with AA with sickle cell disease (SCD) and cancer found that HCPs thought AA with SCD was overly dramatic about their pain because they were drug addicts. Of course, this is a fallacy and reflects the lack of knowledge that HCPs have regarding the demands, progression, and manifestations of pain associated with SCD (see Dyal et al., 2021).

A lack of trust between AA and HCPs consists of variables that contribute to health care disparities. Moreover, HCPs must reflect on their values and beliefs before encountering AA to ensure care equity (see Ferrera et al., 2016; IOM, 2003; Lynch, 2020). The following section discusses factors that improve trust between AA and HCPs.

Factors That Contribute to Trust

Several factors have been identified that enhance trust between AA and HCPs. These factors include communication, race concordance, shared decision-making, and technical competence. AA generally prefers open and honest communication from HCPs, especially when facing a health crisis or having invasive procedures. Therefore, HCPs who are poor communicators or cannot break down important information into a culturally appropriate format are viewed as untrustworthy and trigger fears about secret experimentations (see IOM, 2003; LaVeist et al., 2000; Lynch, 2020).

Race Concordance

Race concordance means that AA and HCPs are of the same ethnicity. Ideally, this would ease communication barriers and misunderstandings because of a shared worldview. Some researchers (Cooper et al., 2006; Cuevas et al., 2016; IOM, 2003) believe that race concordance would lessen the prevalence of health care disparities by eliminating discrimination and improving adherence to treatment interventions and that race concordance is possible when there is an increased enrollment of minority students in medical schools. However, other researchers (Johnson Shen et al., 2018; Meghani et al., 2009) believe that other variables, such as the length of the relationship and the communication style of HCPs, are more critical to building trust between AA and HCPs.

Communication

Effective communication between AA and HCPs is essential for good health. AA values honesty and transparency when communicating with HCPs. Therefore, they need to understand their current health status, recognize the adverse effects of medications, and report on the effectiveness of treatment interventions to HCPs. If effective communication does not exist between AA and HCPs, AA will only say what HCPs want to hear or remain silent (see IOM, 2003; Lynch, 2020).

Shared Decision Making

Shared decision-making is another variable that contributes to building trust between AA and HCPs. In shared decision-making, AA and HCPs collaborate to improve health. Additionally, the lines of communication are always open between AA and HCPs. AA can openly question treatment recommendations and voice concerns without recrimination. As a result, AA feel valued and have input about their care. Thus, AA are more satisfied with their care and are more likely to adhere to the treatment plan (see IOM, 2003; Lynch, 2020).

Technical Competence

Technical competence is based on the knowledge and skill of an HCP. Also, it reflects their training and ability to analyze, interpret, and utilize patient and diagnostic information to improve patient outcomes (see IOM, 2003). AA indicate that the race and ethnicity of HCPs are unimportant if they have a high degree of technical competence and engage in shared decision-making (see Cuevas et al., 2016; Peek et al., 2013).

Summary

Historical research abuses have caused long-term peripheral trauma within the AA community. As a result, AA have many misconceptions about HCPs, the health care system, and the quality of care they receive. Inequities in care are related to a heightened awareness of discrimination and perceptions of unfair treatment when interacting with HCPs. In either case, a need exists to understand AA perspectives regarding building trust in relationships with HCPs and how it impacts the care they receive. In this way, delivering culturally congruent care can help eradicate health care disparities and improve the health status of the African American community. This qualitative study will explore the characteristics of trust and its meaning in building trusting relationships between AA and HCPs. Chapter 3 will provide more information about the methodology, data analysis, and collection of the sample population.

Chapter 3: Research Method

The purpose of this qualitative study was to explore the characteristics of trust and its meaning in the building of trusting relationships between AA and HCPs. I employed the IPA research design in this study. IPA is focused on understanding and giving an account of participants' experiences and allows for the interpretation of these experiences into a broader context that reflects how individuals see, experience, make sense of, and interact with their world (see Larkin et al., 2006; Smith & Fieldsend, 2021). By exploring the characteristics of trust and its meaning in building relationships between AA and HCPs, new insights can be gained about AA interactions with and perceptions of HCPs, the health care system, and the provision of culturally congruent care.

In this chapter, I discuss the methodology used for data collection and analysis. The chapter includes descriptions of the research design and rationale, my role as a researcher, the study's trustworthiness, and ethical research conduct. I present the research process and how the study was conducted.

Research Design and Rationale

IPA was the most appropriate research design for this study for several reasons. First, it helps researchers learn about individuals' perceptions, experiences, and realities as they interact with their world. Second, the verbatim accounts of experiences and the researcher's interpretation of those experiences allow one to get an *insider's* view of participants' lives to detect patterns and explore phenomena that cannot be readily defined or understood (see Larkin et al., 2006; Smith & Fieldsend, 2021). Therefore, paying attention to verbal and nonverbal nuances provides clues to the researcher about the impact of these experiences on participants' worldviews and how their responses differ depending on the circumstances (see Patton, 2015; Rubin & Rubin, 2012).

I did not consider other qualitative approaches for this study because the literature indicated that IPA is the most appropriate design for exploring personal, abstract, and multidimensional phenomena that impact the daily lives of individuals (see Pietkiewicz & Smith, 2014; Smith & Fieldsend, 2021). In addition, the quantitative method was unsuitable for this study because it is used to break down data by numbers and disregards the value of personal experiences and perceptions, so it does not lend itself to the consideration of the multiple realities of the individual or how these realities influence one's worldview (see Patton, 2015; Saldana, 2016).

Research Questions

RQ1: What are the characteristics of trust in the building of relationships between AA and HCPs?

RQ2: What is most important to AA when selecting a new HCP?

Role of the Researcher

My primary functions in this study were that of researcher and interpreter. I was a researcher trying to address a complex issue affecting the access, equity, and quality of health care services in providing care to AA. The lack of trust between AA and HCPs is a long-standing issue within the AA community and helps perpetuate inequities in care that result in poor health (see IOM, 2003; Lackland, 2014; Lynch, 2020). Additionally, this issue could be better understood through the lens of participants and IPA. IPA uses a double hermeneutic approach, which enabled me to understand the uniqueness of individual experiences, see the commonalities and differences, and interpret the world as participants live it (see Nizza et al., 2021; Smith & Fieldsend, 2021). Through a circular process of reviewing the transcripts, creating themes, being authentic to the data, and seeking clarification from participants about the accuracy of my interpretations, I could tell their stories effectively and meaningfully.

Furthermore, as a researcher of African American descent and a registered nurse, I have experienced the phenomenon under study, which has changed how I interact with colleagues and diverse patients. I was often bewildered by colleagues' erroneous assumptions and paternalistic attitudes toward me. To the extent possible, bracketing was used to control and monitor my biases. Another way of preventing my preferences from interfering with data analysis and collection was to maintain a journal of the research process to record my thinking and explore my interpretations while engaging in collaborative peer debates (see Ravitch & Carl, 2016).

Methodology

IPA is focused on understanding and giving an account of participants' experiences. Additionally, IPA allows for the interpretation of these experiences into a broader context that reflects how individuals see, experience, make sense of, and interact with their world (see Larkin et al., 2006; Smith & Fieldsend, 2021). By exploring the characteristics of trust and its meaning in building relationships between AA and HCPs, new insights can be gained about AA interactions with and perceptions of HCPs, the health care system, and providing culturally congruent care.

In this section, I explain how the study was conducted to enable replication by future researchers. I also describe the selection and recruitment of participants, instrumentation, and data collection and analysis processes.

Participant Selection Logic

This study focused on AA adults between the ages of 18 and 65 years old. I used purposeful sampling to recruit participants from community organizations. The participants had a chronic illness that required frequent contact with their HCP. Purposeful sampling is frequently used in IPA research because it enables the researcher to select participants who have experienced the phenomenon, uses a relatively homogenous sample, and allows for the researcher's in-depth exploration of the topic (see Smith & Fieldsend, 2021).

Exclusion Criteria

Individuals were excluded from this study if they were not 18 years of age or AA and did not understand, read, or write English. In addition, participants did not have cognitive deficits that hindered their comprehension, memory, or recollection of past events.

Ten participants were selected for the study. The sample size was appropriate given the objectives, topic, methodology, and time allotted to complete the study. The study continued until data saturation occurred. Data saturation is reached when no new information emerges, and sufficient information is available to replicate the study (see Fausch & Ness, 2015). In addition, the small sample size enabled me to immerse myself in the data and depict participants' experiences authentically (see Nizza et al., 2021;

Smith & Fieldsend, 2021). In this study, I triangulated the data by reaching data saturation, using a researcher journal to create an audit trail and data immersion throughout the research process.

Instrumentation

I conducted open-ended interviews to obtain information from the participants. The interviews followed a guide based on the research questions (Appendix A). Consequently, the interview questions examined the interactions between AA and HCPs and their staff, the setting, and the provision of culturally congruent care. The same interview questions were asked of every participant. Open-ended questions enabled participants to take the interview in any direction. Participants' responses guided follow-up questions. They were modified in light of participants' responses, allowing me to enquire about other areas related to the research questions that may arise (see Smith et al., 2009). Furthermore, researcher prompts and exploratory notes were placed in the interview guide's left margin to keep the interview focused and document my impressions of participants' responses (see Pietkiewicz & Smith, 2014). In this way, I gained insights into the contextual nature of participants' experiences while prompts were used to clarify or obtain additional information (see Patton, 2015; Ravitch & Carl, 2016; Rubin & Rubin, 2012).

Data Collection

I began collecting data for this study after receiving approval from the Walden University Institutional Review Board (IRB). One interview was conducted with each participant. The duration of each of the interviews was approximately 3–60 minutes. The interviews took place at locations that ensured the participants' privacy and convenience. During the interviews, I restated the purpose and objectives of the study, reminded the participants that the interview was being recorded, provided my contact information, and told the participants to take a break to refocus their thoughts if they become anxious or experienced emotional pain at any time during the interview. Before the interview began, I used a warm up to establish rapport between myself and the participant (see Laureate Education, 2016a; Pietkiewicz & Smith, 2014; Rubin & Rubin, 2012). After that point, the interview guide was followed.

At the end of the interview, I solicited participant feedback to head off potential problems and ambiguities and refine the interview questions for future use. Furthermore, participants could provide insights about what was missing or should have been asked during the interview (see Patton, 2015; Pietkiewicz & Smith, 2014). Participants were thanked for participating and given my contact information again.

Data Analysis Plan

The data collected from participants were sorted and coded for emergent themes. Although data analysis and collection are described separately in this chapter, they were ongoing. They coincided with accurately depicting the data, documenting my initial impressions, and understanding the meaning of experiences to participants. Thus, the interactions between the participants and researchers reflect IPA's idiographic and double hermeneutic foundation (see Saldana, 2016; Smith, 2019).

Data immersion is mandatory in IPA; consequently, I listened to audio recordings of the interviews and transcribed them verbatim. Hard copies of the transcripts were compared to the audio recordings to support the fidelity of the data. I used Microsoft Word to list participants' responses line by line and highlighted repeated and divergent phrases. The highlighted phrases were then placed in an outline with subcategories. I derived the emerging themes from participants' responses and supported them with interview extracts. This data analysis process continued until saturation occurred (see Laureate Education, 2016c; Smith, 2021).

Issues of Trustworthiness

According to Lincoln and Guba (1985), a study's quality significantly improves when the trustworthiness criteria are met, including credibility, transferability, dependability, and confirmability. A synopsis of each requirement is provided in the following subsections.

Credibility

Credibility refers to the authenticity of the study. To establish credibility, the researcher documents participants' experiences as they describe them, uses strategies to enhance engagement, and seeks clarification when areas of confusion arise (see Laureate Education, 2016a; Smith, 2019). The researcher can also share their impressions, interpretations, and conclusions with participants to enhance credibility (see Smith, 2019). Thus, the coding of the data is derived from the importance attributed to it by participants.

Transferability

Transferability means the generalizability of study findings to different contexts. For enhanced transferability, the researcher provides sufficient details about the characteristics of a study to allow its replication, including how the study was conducted, descriptions of the participants, and where the interview occurred. Additionally, rich and thick descriptions of participants' experiences allow the reader to see the interconnections among various study components and develop empathy for participants (see Creswell & Creswell, 2018; Laureate Education, 2016b; Smith, 2021).

Dependability

Dependability refers to the stability of the data. The dependability criterion is met in qualitative research when documentation related to data collection and analysis exists. I kept a journal to document the research process and record my initial impressions and interpretations of participants' responses. Memos also help document unexpected events during the research process (see Creswell & Creswell, 2018; Laureate Education, 2016b; Ravitch & Carl, 2016). The journal is an audit trail to guide future researchers.

Confirmability

Confirmability refers to the impartiality of the researcher. I am of AA descent and have experienced the phenomenon under study; therefore, I needed to bracket my thoughts and emotions to not overemphasize with participants. Moreover, I had to engage in reflective thinking and collaborative peer debates to remain neutral and monitor my thinking throughout the research process (see Creswell & Creswell, 2018; Levitt et al., 2016; Ravitch & Carl, 2016). Utilizing a journal throughout the research process helped accomplish the tasks listed above.

Intra- and Intercoder Reliability

I completed the data analysis process, which included exploratory notes, experiential statements, clustering, and the four central themes that emerged; thus, inter-coder reliability was consistent. Moreover, my committee chair and committee member reviewed my analysis of each interview to increase reliability and achieve consensus.

Ethical Procedures

The duration of the interviews was between 3–60 minutes. All interviews occurred in a private and secure location to minimize distractions and enhance the participants privacy. Once I received approval from Walden University IRB, participants were recruited for the study (IRB Approval No. 08-18-22-0034135). All participants were clients of and recruited from a nonprofit community organization. Organizational emails were sent out to all clients to generate interest in the study. Additionally, I delivered a PowerPoint presentation at the community organization with staff members to inform them about the purpose and objectives of the study and gave them my contact information. At the end of the presentation, staff members agreed to distribute study flyers to clients who expressed an interest in the study. Incentives were not offered to participants; participants voluntarily shared their health care experiences to improve health outcomes among AA patients.

I met with clients during their wellness visits at the community organization. The inclusion criteria were used to select potential participants. After potential participants expressed their interest in the study, arrangements were made to set up convenient interview times.

Before the interviews began, I reviewed the informed consent form, the purpose and objectives of the study, my affiliation and contact information, and the demographic questionnaire with participants. I explicitly stated that participants could withdraw from the study anytime for any reason. They were also notified that a digital audio recorder would be used during the interview. I used the audio recordings to transcribe the interview verbatim for data analysis. Participants were also notified that all personally identifiable information would be removed from transcripts and interview notes and replaced with pseudonyms (see Ravitch & Carl, 2016). The transcript and audio recordings are stored on an external hard drive and uploaded to cloud storage. Both the hard drive and cloud storage are password protected and encrypted. The hard drive will be erased at the end of 5 years, and all files uploaded to the cloud will be deleted.

Summary

In this chapter, I explained my role as a researcher and described the research design. I provided a rationale for my selection of IPA and the utilization of Bronfenbrenner's ecology of human development theory for the interview guide to explore the building of trust between AA and HCPs. Moreover, I outlined my data collection and analysis plans.

Trust is generally mentioned in the literature as contributing to poor health outcomes in AA; however, information about trust and its meaning to AA patients was lacking. Furthermore, the building of trust between AA and HCPs is influenced by their experiences, perceptions, history, and interactions with HCPs and the health care system. This study provides valuable insights into building trust between AA and HCPs from a cultural perspective and may help HCPs improve their relationships with AA. In the next chapter, I will discuss the setting, participant demographics, data collection and analysis, evidence of trustworthiness, and results.

Chapter 4: Results

The purpose of this qualitative study was to explore the characteristics of trust and its meaning in the building of trusting relationships between AA and HCPs. I conducted an IPA to address this gap because the design focuses on understanding and finding patterns among participants' personal experiences. Additionally, IPA allows for the interpretation of these experiences into a broader context that reflects how individuals see, experience, make sense of, and interact with their world (see Larkin et al., 2006; Smith et al., 2021). By exploring the characteristics of trust and its meaning in building relationships between AA and HCPs, new insights can be gained about AA interactions with and perceptions of their HCPs, the health care system, and the provision of culturally congruent care. The research question for the study was: What are the characteristics of trust and its meaning in the building of relationships between AA and HCPs? The interview questions were: What are the characteristics of trust in the building of relationships between AA and HCPs? What does trust mean to you? What happens when you see your doctor? What is most important to you when you select a new HCP?

In this chapter, I describe the study setting and participant demographics. A synopsis of the data collection process is presented, including the number of participants, where data collection occurred, and how the data were recorded. I also provide an overview of the unusual circumstances encountered during the study and elaborate on the data analysis process and how the IPA approach was utilized to identify emergent themes. Then, a description of how credibility, transferability, dependability, and trustworthiness were maintained during data collection and analysis is provided. Finally, the study results are presented, including the themes and subthemes that emerged during data analysis and excerpts from the participants' responses to support each theme.

Setting

The scheduling of the one-on-one participant interviews took time and patience to coordinate because some participants had personal and or professional obligations that limited their availability to participate in the study. Several interviews had to be rescheduled because of participants' limited access to transportation. I informed participants that the interview duration was between 45 and 60 minutes. All interviews occurred in the conference room of a nonprofit community organization. The conference room was well-lit with comfortable tables and chairs. The solid wooden door at the room's entrance was closed during the interviews to minimize distractions and enhance privacy.

Demographics

All participants were AA, clients of the nonprofit community organization, and had chronic conditions that required frequent monitoring by HCPs. Participants completed a demographic questionnaire before the interview (Appendix B). Participants were between the ages of 34 and 74 years old. There were eight female participants and two male participants. Three participants were single, and three participants were divorced. One participant was married, while another was a widow. One participant was separated, and one wrote “neither” to being divorced, married, or single.

Table 1

Participant Demographics

Participant number	Age (in years)	Gender	Marital status	Education level
1	34	Female	Single	1st year college
2	65	Male	Divorced	12th grade
3	64	Male	Divorced	12th grade
4	74	Female	Divorced	12th grade
5	65	Female	Married	12th grade
6	64	Female	Widow	12th grade
7	59	Female	Separated	11th grade
8	43	Female	Single	8th grade
9	44	Female	Single	12th grade
10	43	Female	Neither	12th grade

Data Collection

I recruited 12 participants for the study; however, two were disqualified for failing to meet the eligibility criteria. Open-ended interviews that allowed participants to be flexible and expand their responses in any direction were used to obtain data for the study. The duration of the interviews was between 3 and 60 minutes. I followed an interview guide and asked participants about their lived experiences and perceptions related to their interactions and perceptions of HCPs. Additionally, I sought information about what trust meant to them (Appendix A). Based on participant responses, I had the opportunity to seek clarification and solicit more details about their experiences and perceptions.

Ten participants were interviewed for the study. I spent 10–20 minutes at the beginning of each interview reviewing informed consent and asking participants if they had any issues or concerns. Once the informed consent form was signed, the demographic questionnaire completed, and rapport established, the interview began. The same interview guide was used for all interviews. Additionally, I made minimal notations on the interview guide of some participants during the interview to remind myself of an interesting fact about a participant. For example, the length of the doctor-patient relationship or what they liked most about their doctor. Participants agreed that I could contact them by telephone for clarification and follow up if necessary.

Interviews were conducted once a week over two consecutive weeks on different days at the nonprofit community organization. They began in the morning and continued until the afternoon to accommodate participants' professional and personal obligations. All interviews were digitally audio recorded. During the interviews, I reminded participants that they were being audio recorded. The recording stopped at the end of each interview. I transcribed the interviews manually and verbatim using Microsoft Word. Personal and identifiable information was removed from the transcripts and researcher notes. To maintain confidentiality, participants were classified as P1–P10.

Unusual Circumstances

I encountered unanticipated problems during data collection. The first issue was that some participants were unfamiliar with the HCP acronym. They immediately understood once I explained that it meant health care or primary care providers. Before completing the demographic questionnaire, I reiterated to participants that HCPs and primary care providers meant the same thing (Appendix B).

Another problem during data collection was that some participants used Southern slang to express their thoughts verbally. These slang terms were difficult to decipher and unfamiliar to me; therefore, I would pause the interview and ask participants to clarify a phrase or repeat what was previously said.

Finally, the study was delayed by a month because of the difficulty recruiting participants. Participants did not respond to organizational emails and study posters given to them by the staff or placed on bulletin boards. Therefore, I used a $20 gift card as an incentive to recruit study participants.

Data Analysis

I used the IPA approach for data analysis to explore the building of trusting relationships between AA and HCPs and determine what trust means to AA. One-on-one participant interviews were the primary data sources for the study. I digitally audio recorded and transcribed all interviews verbatim using Microsoft Word. Then, printed copies of the transcripts were used to identify key phrases from participants that were highlighted in different colors. I created a two-column table using Microsoft Word. The left column contained quotations from the transcripts describing participants' perceptions or experiences related to their interactions with HCPs. The right column contained my initial impressions of the participants' quotes.

IPA is used to understand individuals' experiences, perceptions, and realities as they interact with their world. Determining the participants' experiences and perceptions allows the researcher to get an insider's view of participants' lives to detect patterns and explore phenomena that cannot be readily defined or understood (see Larkin et al., 2006; Smith & Fieldsend, 2021). Data analysis using IPA in the current study occurred in four phases: data immersion, exploratory noting on the transcripts, creation of experiential statements, and clustering and connecting experimental statements to develop emerging themes (see Smith et al., 2022).

Phase I of the process is data immersion. For example, I listened to the digital recording of participants three different times. I re-read the transcripts two to three times to ensure that I understood the participants' experiences and that my interpretation of those experiences was accurate. Moreover, I constantly compared the digital recording to the transcripts to maintain the authenticity of participants' responses. Exploratory notings were made on the transcripts to brainstorm about experiential statements (see Smith et al., 2022).

In Phase II of data analysis, the exploratory noting on the transcripts led to the creation of experiential statements. I derived experiential statements from a word or phrase from the transcript that was meaningful to participants. The word or phrase was a direct quotation from the transcript in response to the research question being asked. I created a two-column table using Microsoft Word with the left column labeled Experiential Statements and the right column containing my initial impression of the data. I asked questions about the data (see Smith et al., 2022).

Phase III of the process was the creation of experiential statements. Experiential statements are direct quotations of participants taken from the transcripts. These quotations are shortened into essential phrases that provide a synopsis of the exploratory notations; therefore, the researcher's interpretation and participants' experiences constantly evolve and interact to authentically present the data (see Smith et al., 2022).

The last data analysis phase is clustering and connecting experimental statements to develop emerging themes. I derived themes from participants' responses on the transcripts that I interpreted. Experiential statements were reviewed to eliminate redundancy and improve the classification process. Once redundancy and the classification process were complete, I grouped experiential statements according to similarity to generate themes. This process was repeated for all interviews (see Smith et al., 2022). I then searched for connections across experiential statements. I re-read individual transcripts to identify potential themes. Then, I connected the transcripts to identify occurrences, patterns, similarities, and differences across cases (see Smith et al., 2022). These steps resulted in the identification of themes and subthemes.

Four themes emerged from data analysis and are discussed in detail in the Results section (Figure 1). The themes were (a) depersonalization, (b) challenges of being AA, (c) building trust, and (d) being your own advocate.

Figure 1

Emergent Themes

Evidence of Trustworthiness

Credibility

In qualitative research, credibility refers to the authenticity of the study and corresponds to validity in quantitative research. I documented participants' experiences as they described them, was attentive and sensitive to what they had to say, and did not ask leading questions or interject my opinions to sway their responses (see Patton, 2015; Rubin & Rubin, 2012; Smith et al., 2022). If their responses were unclear, I asked participants for clarification or used relatable examples to further their understanding of the question being asked. For instance, I might ask participants how they would build trust in a friendship. As a result, they began to understand the parallels between building trust with friends versus building trust with HCPs. I transcribed all participant responses verbatim using Microsoft Word and compared the transcripts to the digital recordings to ensure that I captured what participants said. Next, I listened to the digital audio recording of the participants three different times and re-read the transcripts two to three times to see the world as they lived it. Additionally, themes and subthemes were extracted from transcripts (see Saldana, 2016; Smith et al., 2022).

Transferability

Transferability in qualitative research is similar to external validity in quantitative research. All participants in the current study were AA and experienced the phenomenon of interest by interacting with HCPs and the health care delivery system. Furthermore, their experiences were unique and stated in their voices. Building trust between AA and HCPs is another lens through which to view inequities in care, health outcomes, and satisfaction with care. The inclusion/exclusion criteria, context, participant demographics, and location limited the transferability of the study; however, understanding participants' experiences can help clarify the AA perspective towards health.

Dependability

Dependability refers to the stability of the data and is related to reliability in quantitative research. I created a journal to document the research process and record my initial impressions of participants' responses and the challenges I encountered during the study. The transcription of interviews was a laborious and intense process necessary to maintain the authenticity and fidelity of the data (see Nizza et al., 2021).

Confirmability

Confirmability refers to the impartiality of the researcher and is comparable to objectivity in quantitative research. I am of AA descent and have experienced the phenomenon under study. Although I tried not to become emotional and bracket my thoughts, I was not always successful. I relied on collaborative peer debates and reflective thinking to detect and monitor biases during these times.

Results

The literature review offered a generalization of the importance of trust in delivering care to AA patients (see Lackland, 2014; NCHS, 2014; Roland et al., 2016). Furthermore, there is a lack of specific information related to AA experiences with HCPs, the characteristics of trust, and its role in building relationships with HCPs. Thus, a new approach is needed to address the multifactorial challenges AA patients frequently encounter when accessing the health care system.

Bronfenbrenner's (1977) ecology of human development framework was used to guide the development of the interview questions for the study. Bronfenbrenner classified the interactions of individuals into four levels. These levels include the microsystem, mesosystem, exosystem, and macrosystem. The microsystem consists of the individual interacting with others in the environment. The mesosystem involves the connections among systems. The exosystem involves interactions with the community, while the macrosystem considers how ethnicity influences individual behaviors (see Onwuegbuzie et al., 2013).

This study is focused on the Microsystem level because it allows for exploring interactions between AA and HCPs. Furthermore, it emphasizes the importance of individual perceptions, experiences, the environment, and interactions with others as catalysts for human growth and development (see Bronfenbrenner, 1981). These are important considerations, especially when examining the characteristics of trust and its meaning in building trusting relationships between AA and HCPs.

The themes that emerged from the data are consistent with the literature. The themes were (a) depersonalization, (b) challenges of being AA, (c) building trust, and (d) being your own advocate. Table 2 lists emerging themes based on participants' responses.

Table 2

Themes Based on Participants' Responses

Participant Number	Depersonalization	Challenges of being AA	Building trust	Being your own advocate
Participant 1			X	
Participant 2	X	X	X	X
Participant 3			X	X
Participant 4			X	X
Participant 5	X	X	X	X
Participant 6	X	X	X	
Participant 7	X	X	X	X
Participant 8	X		X	X
Participant 9	X	X	X	X
Participant 10			X	X

Theme 1: Depersonalization

Six out of 10 participants described feelings of depersonalization while interacting with HCPs. They expressed feelings of inadequacy and worthlessness based on verbal and nonverbal cues from HCPs. Additionally, they felt disrespected and that concerns about their care were often ignored. For example, one participant felt disconnected from the doctor during an office visit for a health complaint. The doctor avoided all physical contact and did not perform a physical examination. She expressed feelings of being treated as *contagious.* On the other hand, the doctor concluded that the health complaint was insignificant and could be resolved with a prescription. Thus reinforcing the perceptions of AA that most HCPs and the health care system are not concerned about the well-being of AA. Instead, AA are used to generate profits for physicians and pharmaceutical companies (see Cuevas et al., 2016; Ferrera et al., 2016; Vernon, 2020; York & Tang, 2021).

The commonalities among participants during analysis resulted in the emergence and identification of three subthemes. The subthemes were: (a) I’m being dismissed, (b) I’m not worth your time, and (c) I’m not being heard because of who I am (see Table 3).

Table 3

Subthemes and Responses Theme 1: Depersonalization

Subthemes	Quotes
1a. I'm being dismissed	P2-Ah, not come and do the basic—take my temperature, and my weight, and blood pressure, listen to my heart and all that and say all right, I'll see you in two or three weeks. P5-You know, it's like they come in and they tap, tap here and there, but you ain't explain anything, but now you gonna write me out a prescription and tell me, you know, take this here. P9-And then you have doctors that just don't care. It's like, oh well, I'm getting paid at the end of the day, so I really don't have to take care of you.
1b. I' not worth your time	P2-But if you trying to rush me through so you could see the next one, so you can say you did your day's job, I can't trust you because I'm a human. P7- I just don't like it when I talk to you, and you give me this medication without doing any investigation, and that's what my doctor does. P8-And I think it makes people frustrated when you brush them off because you're not hearing them, and you don't know what they're going through P9-Because of the way they (doctors) act, you know, when they come into the room, they don't really take time out wanting to get to know you, to even really take time out to see what's wrong with you.
1c. I'm not being heard because of who I am	P2-Treat me like I'm your own, just like I'm giving you respect, at least respect my feelings, P5-If I walk into the doctor's office and the doctor is like his back turned and asking me questions or whatever, you know, and not looking at me and not relating things back to me, like he or she should. P6-I have seizures. So, I fell out into the street. They (EMS) automatically took me to the detox place like if I fell out from drugs, only to find out that I had no drugs in my system. P10-They be making me wanna tell them something because they don't wanna hear. They try to tell me something when I'm trying to tell them this is what I'm seeing different there, so.

Theme 2: Challenges of Being AA

Participants know and experience the inequities in the health care system daily. They know that inequities within the system hinder access and quality and increase health-related services' costs. Injustices such as structural and patient-provider disparities, implicit biases, and the SDOH all contributed to participants' feelings of being outsiders trying but never fitting in.

This theme resonated with participants in different ways. Some participants felt intense anger, confusion, disappointment, and sadness while recalling past experiences with HCPs and the health care system. Other participants relied on their faith to cope with discrimination and microaggressions. Additionally, participants believed that their faith strengthened them to overcome the challenges of daily life. Table 4 shows the subthemes and responses for Theme 2.

Table 4

Subthemes and Responses Theme 2: Challenges of Being AA

Subthemes	Quotes
2a. Lack of personalized care	P2-You might get another one (doctor). Ah, they switch worse than you switch your pants P5-And my question to that doctor was, how can you know what's wrong with me, but you never touched me? P7-I lost my leg because I fell. And the medicine had me falling, then they turn around and give me a cousin of the same thing. And it had me having like I was having seizures. P9-So, it's like we being looked over. So, it's like, okay, you don't have no money. I don't have time for you.
2b. Insurance dictates the type of care received	P2-Ah, we live in a society where you get basic insurance, and they (doctors) only do basic stuff because if you don't have the insurance, they're not gonna take care of you anyway. P5-But if you don't (have medical insurance), then it's like, you know, a lot of the time, they just want to push people through the system. P9-It's like if you don't have good insurance or you don't have money, it's like you're not being heard.

Theme 3: Building Trust

AA need to build trust with HCPs for several reasons. A trusting relationship with an HCP decreases distrust related to historical research abuses and mistreatment (see Cuevas et al., 2016; Cuevas et al., 2019; Netemeyer et al., 2020). Furthermore, building trust is crucial for adherence to medical interventions and improving quality of life (see Cuevas et al., 2016; Hooper et al., 2019; IOM, 2003). In the short term, this enables successful self-management of chronic illnesses. At the same time, the long-term goal is to decrease the prevalence of health care disparities to improve population health overall.

All participants agreed that building trust with an HCP was essential to their mental and physical health. Limited financial resources, inadequate health insurance, and poor patient-physician communications increased the frequency of negative experiences with HCPs and the health care system. For example, one participant stopped seeing an HCP because of communication barriers. The HCP had a thick accent, resulting in delayed transmission and understanding of information. Additionally, the information had to be repeated until the participant understood it.

Six subthemes emerged after the analysis of participants' responses. The subthemes were (a) listening is important to trust, (b) confidentiality is important to trust, (c) comfort with a trusted doctor, (d) I'm being heard, (e) being trustworthy is important to trust, and (f) relationships are important to trust. Table 5 shows the subthemes and responses for Theme 3.

Table 5

Subthemes and Responses Theme 3: Building Trust

Subthemes	Quotes
3a. Listening is important to trust	P1-Cause, umm, they sit down and listen to me and be like okay, so you did this and that. It's like, well, okay, you know. P2-And once I found out they listening to me and trying come up with an answer or solution to the problem, I could trust you. P7-When I tell you something, they listen, and they move on what I say. P9-Dr. Y, he listens to me and Dr. X, she listens to me. She's my doctor, but she's more my friend and my doctor. Dr. Y he's more my friend and my doctor.
3b. Confidentiality is important to trust	P1- I can tell them anything but don't tell nobody. P6-What I say to you stays with you. I'm very keen on that. If I trust you to do something for me, I trust that it's gonna get done. P7-If I tell you something, to you not say nothing. I'm hoping that you keep it
3c. Comfort with a trusted doctor	P4-Well, when I see my doctor, I explain to him what happened and what I want him to do.

Subthemes	Quotes
	P5-How they treat me. How they examines me. How they explain things back to me to make sure that I understand them and respect.
	P7-Oh, I trust him to make sure he's doing the right thing, make sure he's doing the right thing.
	P8-But my doctor (nurse practitioner) it's very good because she call me right back. Like sometimes even over the weekend. She'll make sure that I still be able to get what I need, and I like that.
	P10-She's not no judgmental doctor. She's not a doctor that be like oh, dada, dada, you know. Some doctors, you'd be like, you know what, I will just stay sick. Not her, I can call.
3d. I'm being heard	P5-Well, how they treat me as person, and then, how they treat whatever problem that I have.
	P8-They was, how can I say, caring. Like they checked up on me, make sure I was doing the right things, made sure that I got what I needed.
	P10-She hear me out. If I tell her my legs hurting. If I tell her this is going on with me, she'll have a solution for it, so yeah.
3e. Being trustworthy is important to trust	P4-Trust mean to me everything; if you can't trust nobody, it's no good. I want to know I can trust people to tell me the truth.
	P5-No harm will come to you that you believing in what they saying to you. So, you kinda trusting in what they saying.
	P8-It (trust) means a lot because if you can't trust them, you can't rely on your doctor.
	P10-Trust means I can trust that person to the fullness, and I won't be like, oh no. But it means I have that trust. They don't fail me. They don't turn back on me.
3f. Relationships are important to trust	P2-You gotta have a doctor-patient relationship where the doctor ain't all about being in charge.
	P3-By talking and opening up to him and you know, opening up to me doctor.
	P6-And a doctor I could feel comfortable to tell whatever is happening.
	P8-We have a history. That's all I can say. We have history. I have a lot of history with them (doctors).
	P10-Trust comes from having a relationship with the person. That's how you build it.

Theme 4: Being Your Own Advocate

AA must overcome many challenges before gaining access to the health care system. Challenges such as structural racism, implicit biases, stereotyping, and peripheral trauma contribute to health care disparities and poor health outcomes. Additionally, AA must contend with overt and covert microaggressions and discrimination from HCPs that results in misdiagnosis and treatment delays (see Cooper et al., 2006; Cuevas et al., 2016; Ferrera et al., 2016; Hooper et al., 2018; IOM, 2003).

These challenges helped participants to seek clarification and ask questions of HCPs that enabled them to address health concerns while holding HCPs accountable for the type of treatment options selected. For example, several participants questioned HCPs rationale for adding or changing medications. Another participant refused to be rushed through an office visit by an HCP when unanswered questions remained about his care. After analysis of participants' responses, three subthemes emerged. The subthemes were (a) don’t accept whatever they tell you, (b) ask questions, and (c) be proactive in your care. Table 6 shows the subthemes and responses for Theme 4.

Table 6

Subthemes and Responses Theme 4: Being Your Own Advocate

Subthemes	Quotes
4a. Don’t accept whatever they tell you	P2-And people have to understand that we have a tendency as Black, African Americans, whatever they tell us we just go buy it. P5-I don’t let them basically just tell me or just write out a prescription, you know. P9-Some doctors, I feel like (long sigh) they’re trying to prove a point that doesn’t need to be proven.
4b. Ask questions	P4- I’ll ask him, doctor, what’s the matter with me? Am I gonna die now? Do I have any kind of sickness that you don’t want to tell me? P5-But also, too, like I’ve noticed that Black people they don’t ask questions about their health, you know, it’s like whatever the doctor tell them that’s what they figure that is wrong. P10-I just ask her. And she just be upfront with me.
4c. Be proactive in your care	P2-Speaking up for yourself is the only way we gonna get anything done today. It don’t take a whole army; just take one individual, yourself. P4-I tell them look I want to know what’s going on in my life. Let me know, okay, because I don’t want to wait until I get more sick, then she gonna say, okay, I didn’t want to tell you because I afraid because you know when doctor tell people this happened. P5- (…) I always have a thing (a list of questions) I ask them what is the side effects? So, they can explain the side effects of the medicine and let me know, you know, I have to follow up on it and giving me little appointments to see how I’m progressing.

Outliers

I identified three interviews as outliers during the analysis. Two participants had experienced adverse events that could have resulted in death. The third interview recounts the hurt and disappointment experienced during interactions with some HCPs. The interviews highlight AA patients' difficulties when seeking help and guidance from HCPs for health-related issues. The interviews were not sufficiently depicted in the main themes of the study.

P7 is a 59-year-old female with comorbidities and is on dialysis three times a week. She had two significant interactions with HCPs that adversely affected her health. The first event occurred in the hospital when she was given medications that caused dizziness and hallucinations. Although she and her family reported the event to the medical staff, the problem was not corrected until she fell. After the fall, she developed a blood infection that led to the amputation of her left leg. The other interaction involved the Emergency Room (ER) staff. She visited the ER multiple times for the same ailment but was sent home hours later each time. Eventually, it was discovered that she had four heart attacks within a month. Also, she developed the flu during one of these episodes.

P2 is a 65-year-old male with comorbidities and is on dialysis three times a week. He recounts an experience he had with the hospital. The medical staff was preparing him for discharge home. However, he told them that he felt unwell, had severe pain, and that ″something was going on″. This triggered HCPs to perform additional diagnostic testing. The test results revealed that the infection around his heart persisted. Consequently, a more potent antibiotic was ordered, and he remained in the hospital until the infection cleared.

P9 is a 44-year-old female with multiple issues related to the heart and blood vessels. Because of these issues, she requires close monitoring and specialized care. Repeated interactions with HCPs and the health care system have made her very distrustful. Indeed, she describes the health care system as ″pure garbage‶ and that it needs a lot of work. ″ Moreover, she feels powerless to influence decisions regarding her care due to power struggles and the paternalistic attitudes of some HCPs.

Summary

The purpose of this qualitative study was to explore the characteristics of trust and its meaning in the building of trusting relationships between AA and HCPs. By studying AA experiences with HCPs, the characteristics of trust, and its meaning in building trusting relationships between AA and HCPs, new insights can be gained about the barriers that AA encounter when interacting with HCPs and the health care system. Health care providers must be mindful of African Americans' cultural perspectives and experiences that influence their perceptions and responses to treatment to decrease health care disparities. The themes that emerged from participants were (a) depersonalization, (b) challenges of being AA, (c) building trust, and (d) being your own advocate. The theme and subthemes identified in the study can be used to guide the interactions between AA and HCPs to build trust. This is crucial to improve health outcomes and satisfaction with care for a historically marginalized group.

In Chapter 5, study results will be examined, and how the data can be used to guide the development of culturally congruent care for AA patients. Additionally, study results can help guide the interactions between AA and HCPs to build trust and improve patient satisfaction.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative study was to explore the characteristics of trust and its meaning in the building of trusting relationships between AA and HCPs. The lack of trust between AA and HCPs is often mentioned in the literature as contributing to poor health outcomes; however, the specifics about the experiences, meanings, and perceptions of trust between AA and HCPs and its impact on health are lacking. A lack of trust between AA and HCPs contributes to the prevalence of health care disparities and increases the morbidity and mortality rates from chronic illnesses (see IOM, 2003; Lackland, 2014; NCHS, 2014; Roland et al., 2016). Therefore, it is vital to understand the AA perspective on health and how they define, experience, and perceive trust in health care interactions. The research questions for the study were:

> RQ1: What are the characteristics of trust and its meaning in the building of relationships between AA and HCPs?
>
> RQ2: What is most important to AA when selecting a new HCP?

Summary of Findings

Trusting relationships between AA patients and HCPs must exist before health care needs can be addressed holistically. This is a requirement to overcome the negative perceptions and experiences AA patients have had with the health care system and HCPs. Moreover, HCPs who are approachable, consistent, honest, respectful, and trustworthy are in an excellent position to influence good health outcomes in AA patients for the long term. The study findings elucidate the AA experience of being an outsider who always tries but never fits in. The health care system has not acknowledged that societal, institutional, and systemic racism continues to impact the health of AA patients adversely; consequently, AA patients will continue to experience depersonalization and encounter challenges and obstacles beyond their control that impede the attainment of good health.

Interpretation of Findings

The prevalence of health care disparities in AA is a grave concern for the AA community, the federal government, and HCPs. Health care disparities contribute to the high mortality and morbidity rates from chronic illnesses seen in AA (see IOM, 2003; Lackland, 2014; NCHS, 2014; Roland et al., 2016). My review of the literature indicated that limited information was available about trust formation between AA and HCPs. When trust is mentioned in the literature, it is vaguely presented, and examples of how it impacts the relationship between AA and HCPs are lacking. Additionally, a gap existed regarding the characteristics of trust and its meaning in the building of trusting relationships between AA and HCPs. Addressing this gap may help improve trust and the building of relationships between AA and HCPs, indirectly improving health outcomes.

African Americans still struggle to access affordable, equitable, and quality health care-related services. AA are not treated fairly and routinely encounter discrimination, microaggressions, and delays in care when interacting with HCPs and the health care system (see Cuevas et al., 2016; Ferrera et al., 2016; Vernon, 2020; York & Tang, 2021). As a result, they experience depersonalization as well as feelings of inadequacy and worthlessness based on verbal and nonverbal cues from HCPs.

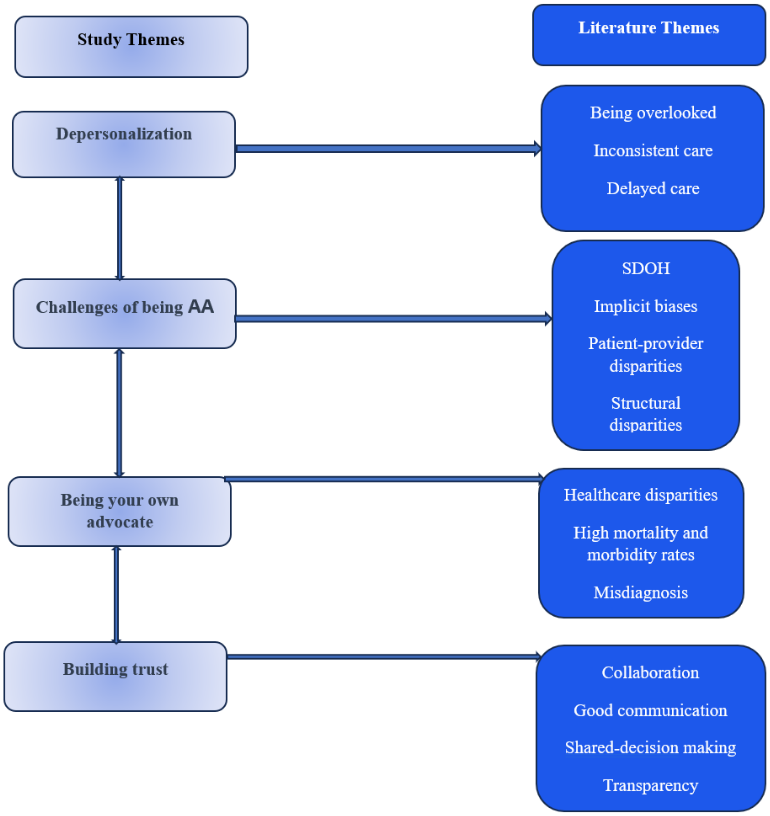
The feelings of depersonalization reflect the challenges of being AA. The AA experience and perspective on health has been greatly influenced in the United States by a series of degrading historical and societal events that have created intergenerational peripheral trauma and long-term distrust (see Aslan et al., 2019; Cooper et al., 2006; Cuevas et al., 2016; Ferrera et al., 2016; IOM, 2003; Vernon, 2020). As a result of depersonalization and the challenges of being AA, participants developed two means of coping with a lack of trust in HCPs: building trust with HCPs and becoming advocates for their health care. Building trust with HCPs is crucial for the long-term management of chronic conditions and improving the quality of life and patient satisfaction (see Cuevas et al., 2016; Hooper et al., 2019; IOM, 2003). Building trust with HCPs also makes participants feel their voices are heard and creates relationships with HCPs. On the other hand, being their own advocate gave participants a sense of control over their health care by creating an environment conducive to trust, shared decision making, and transparency in treatment decisions (see Cuevas et al., 2019; Ferrera et al., 2016; IOM, 2003; Lynch, 2020; NCHS, 2014).

The themes that emerged from participants' responses were (a) depersonalization, (b) challenges of being AA, (c) being your own advocate, and (d) building trust. The findings suggest that a disconnect remains between AA, HCPs, and the health care system. This disconnect will remain until societal, institutional, and systemic racism are acknowledged and addressed. These biases are embedded in the health care system and increase the risks of AA patients having negative interactions with HCPs and the potential for medical errors to occur. Study findings are consistent with those reported in the literature.

The study findings may help HCPs strengthen their relationships with AA by building trusting relationships and designing practical interventions that foster self-confidence and shared decision making. Much work remains to be done to improve health outcomes in AA. This study provides valuable insights into building trust between AA and HCPs from a cultural perspective. Figure 1 shows the consistency between the literature and study findings.

Figure 2

Study Themes Versus Literature Themes



The study's theoretical framework was based on Bronfenbrenner's (1977) ecology of human development. Bronfenbrenner classified the interactions of individuals into four levels: the microsystem, mesosystem, exosystem, and macrosystem. The microsystem consists of the individual interacting with others in the environment, the mesosystem involves the connections among systems, the exosystem involves interactions with the community, while the macrosystem is used to consider how ethnicity influences individual behaviors (see Onwuegbuzie et al., 2013).

The microsystem level guided the development of the interview questions for this study. The microsystem level focuses on the evolution and adaptation of the individual through experiences, perceptions, and interactions within a setting. Thus, the individual is constantly processing and analyzing information for reflection, to inform their worldview, and to adapt to environmental changes; the different phases of individual adaptation and evolution are interconnected and overlap (see Bronfenbrenner, 1981).

In this study, participants verbalized feelings of depersonalization that challenged their self-worth. These feelings are directly related to historical and societal trauma inflicted on a marginalized group by the dominant culture, as evidenced by the persistence of racism, discrimination, inequities in care, and inadequate access to health care resources. Thus, participants' perceptions of themselves have become altered and ingrained according to societal standards.

Personal experiences with HCPs and the health care system further reinforce these altered perceptions. For example, participants stated that they were ignored or encountered paternalistic attitudes of some HCPs when verbalizing concerns about treatment and their health. Additionally, some HCPs refused to touch participants during physical examinations. As a result, participants developed long-term distrust for HCPs and the health care system. They expect to encounter challenges when accessing the health care system because it is a routine part of being an African American.

Participants knew about health care disparities that affect the AA community. This, in combination with their experiences and perceptions of HCPs and the health care system, resulted in two responses. First, they become more engaged in their care (i.e., they ask questions, challenge HCPs, and do not automatically do what they are told). For example, some participants prepared a list of questions to ask HCPs during office visits, while others continued to ask questions about their care until they were satisfied. Second, they learn from past experiences and seek out HCPs who are approachable, honest, respectful, and trustworthy. Participants also value consistency between what an HCP says and does. These traits are important to participants because they act as pathways for building trust and relationships. Some participants reported having had the same HCPs for 2–33 years.

Participants' experiences and perceptions impact their roles and interactions with others within the health care setting. For example, participants who have a trusting relationship with their HCPs routinely discuss health and personal issues without hesitation or prompting. A high degree of reciprocity occurs within the relationships between AA and HCPs. Participants are comfortable being themselves and will contact the HCP office to report the side effects of medications and the early stages of illness or request follow-up care from a specialist for further evaluation and treatment.

Another benefit of trusting one's HCP is that participants' voices are heard. Some participants felt the HCP cared about them as a person and would not cause harm when they felt the most vulnerable. For example, several participants described their HCPs as friends who listened to them, guided them to make better decisions, connected them to resources to resolve a pressing need, and followed up to check their progress and make changes as needed. Notably, a friend is reliable and always willing to help.

However, the opposite can also be said. Participants who had repeated negative encounters with HCPs and the health care system had difficulties building trust. They are guarded when discussing health and personal issues with HCPs and will listen silently without contributing to the discussion. Their silence is not a sign of agreement but rather a sign of dissension; thus, alone at home, they will address health issues as they deem fit.

Limitation of the Study

Study and design limitations are beyond the control of the researcher. Credibility in qualitative research refers to the authenticity of the study, and it corresponds to validity in quantitative research. In qualitative research, a study's credibility relies on the researcher's credibility. Additionally, the researcher becomes an instrument of the study (see Smith et al., 2022). As a result, there is a potential for biases to occur. Credibility was demonstrated in the current study by utilizing emphatic interviewing, being aware of personal biases, and giving participants time to tell their stories in their voices (see Rubin & Rubin, 2012).

Other limitations of the study were the methodology and small sample size. Qualitative researchers seek to learn in-depth about participants' lived experiences, perceptions, and realities from a small sample, and these abstract concepts cannot be readily measured (see Smith et al., 2022). Unlike quantitative research, which is regimented and focuses on statistical analysis for data interpretation to explain and correlate results (see Patton, 2015; Saldaña, 2016). I used purposeful sampling to select participants who had experienced the phenomenon of interest; consequently, the transferability of study findings was limited by the setting, geographic location, and participants' characteristics.

Another limitation of the study was the rigor of the data analysis. I thoroughly followed the IPA process and used participants' responses from the transcripts to share their experiences and develop emerging themes. My chair and committee member also engaged in peer review and oversight to build consensus during the data analysis process; however, the data analysis and results are based on my interpretation of the data.

Recommendations

The characteristics of trust and its meaning in the building of relationships between AA and HCPs are vital to understanding and improving health outcomes. The study findings provide valuable insights about the AA perspective on health, including their experiences, perceptions, and responses to treatment. Additionally, the interactions between AA, HCPs, and the health care system greatly influenced participants' attitudes toward treatment and satisfaction with care; therefore, HCPs with high-value traits can demonstrate cultural humility by lessening the feelings of depersonalization and appreciating the challenges of AA living in a Eurocentric society while building trusting relationships with AA patients.

HCPs have the most significant impact on AA health. The HCPs approach and how they interact with AA patients determines the patient's level of engagement in their treatment plan; therefore, HCPs should critically and honestly reflect on the assumptions that they have about AA, which includes an honest appraisal of preconceived notions, the role of discrimination in perpetuating the SDOH, and health care disparities in AA patients. HCPs must also move beyond cultural humility to understand the daily obstacles AA encounter. Health care providers who lack experience working with AA patients can ask and learn about their culture from AA patients to develop practical and achievable interventions to facilitate good health outcomes. Importantly, HCPs must be aware of community health resources available to assist AA patients and integrate these resources into the treatment plan to decrease costs and improve compliance. Once community health resources have been identified and integrated into the treatment plan, the HCP must consistently follow up to adjust the treatment plan as needed. Future research should focus on the role of HCPs in fostering trust and relationships with AA patients to improve health outcomes and satisfaction with care. Additionally, HCPs with high-valued traits should be routinely evaluated for their effectiveness in treating AA patients. Their input might lead to creative innovations that enhance health outcomes in AA patients. The current study findings may help HCPs build trust and strengthen their relationships with AA by designing interventions that enable AA patients to become engaged and proactive in their care.

Implications

Social Change Implications

AA continue to experience health care disparities. Moreover, the prevalence of health care disparities results in poor health and high morbidity and mortality rates (see IOM, 2003; Lynch, 2020; NCHS, 2014; Roland et al., 2016). Although many factors coexist, intermingle, and overlap to produce this result, a lack of trust between AA and HCPs is essential to address, understand, and correct to meet AA patients' present and future health care needs. HCPs are the primary guardians of AA health; consequently, the HCPs' approach, response, and interactions with AA patients impacts AA long-term perceptions of and experiences with the health care system, illnesses and diseases, and level of participation in self-management of chronic diseases.

The current study provided insights to facilitate positive social change in AA patients by empowering them to become agents of change for their health care. The themes identified in the study contribute to the discussion about the importance of trust between AA and HCPs. The study also revealed the meaning of trust as experienced and perceived by participants. Participants emphasized the importance of HCPs being approachable, consistent, honest, respectful, and trustworthy. These high-valued traits help participants collaborate and participate in shared decision making with HCPs. Participants were less fearful and anxious when this occurred and remained engaged in all aspects of their care.

Methodological, Theoretical, and Empirical Implications

The qualitative research methodology with an IPA approach helps learn in-depth about participants' experiences, perceptions, and realities. Furthermore, these abstract concepts cannot be readily measured (see Smith et al., 2022). IPA is focused on understanding and giving an account of participants' experiences. Additionally, IPA allows for the interpretation of these experiences into a broader context that reflects how individuals see, experience, make sense of, and interact with their world (see Larkin et al., 2006; Smith & Fieldsend, 2021).

The study provided information about the characteristics of trust between AA and HCPs. Also, study participants described how they define, perceive, and experience trust with HCPs and the health care system as African Americans. The themes of the study are consistent with the variables identified in the literature as contributing to a lack of trust and poor health in AA. The study provided insights and an understanding of the obstacles AA patients encounter and overcome when accessing health-related services. Moreover, participants offered great insights about interactions with HCPs that affected their perceptions of health and themselves while building trust.

Recommendations for Practice

The actions of HCPs have a profound effect on the health of AA patients and influence responses to treatment. Unfortunately, the health of AA patients continues to decline. A contributory factor is the lack of trust between AA and HCPs. Therefore, it is essential to explore the characteristics of trust and its meaning in building trusting relationships between AA and HCPs. This study highlighted how AA define, perceive, and experience trust with HCPs and the health care system. Furthermore, the study shows AAs' daily multifactorial challenges in accessing health-related services. Participants described feelings of depersonalization that result from their interactions with HCPs and the health care system. Furthermore, they routinely experience discrimination, microaggressions, and inadequate care as a consequence of being African American. These challenges can be ameliorated by building trusting relationships with HCPs and self-advocacy. The following clinical recommendations are based on the results of the study:

- HCPs should honestly assess and reflect on their views about AA patients.
- HCPs should be clear, concise, and respectful when communicating with AA patients.
- HCPs should engage in shared decision-making, transparency, and reciprocity with AA patients to build trust and relationships.
- HCPs should be mindful of how AA patients perceive verbal and nonverbal cues.
- HCPs should collaborate with AA patients to achieve health goals and be aware of individual, community, and financial resources.
- HCPs should provide all the necessary information about their health to AA patients so that they can make informed decisions.
- HCPs should not take the silence of AA during discussions as a sign of agreement but rather as a need for further clarification and information.

Conclusion

Poor health continues to be an issue for AA. Consequently, AA must contend with community, societal, and institutional challenges, not of their making. These challenges have left an indelible mark on the AA psyche and dramatically altered their view of themselves, health-related issues, HCPs, and the health care system. The characteristics of trust and its meaning in the building of relationships between AA and HCPs provide information about how participants define, build, and perceive trust to form relationships. Also, participants provided rich and detailed information about their experiences and interactions with HCPs, creating four central themes. The themes are depersonalization, the challenges of being AA, building trust, and being your own advocate. Participants identified high-valued traits such as approachability, consistency, honesty, respect, and trustworthiness as necessary when interacting with and selecting HCPs. Furthermore, participants will gladly collaborate with HCPs with these high-value traits to address health concerns.

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Appendix A: Interview Guide

Interview
Date:
Time:
Interviewee Code#:
Location of Interview:

Parts of Interview	Interview Questions
Introduction	• Hello this is Carol Thank you very much for taking time out of your schedule to speak with me. The purpose of the interview is to understand interactions with your HCP and your perceptions of the interactions. The interview should last 45-60 minutes. After the interview, I will transcribe the interview word for word. A copy of the interview will be sent to you to see if my interpretations are correct or clarify your statements. I will not identify you in any documents, and no one will identify you from the information you have provided. You can choose to stop the interview at any time. Also, I need to let you know that this interview will be recorded for transcription purposes. • Do you have any questions? • Are you ready to begin?
Question 1	What are the characteristics of trust in the building of relationships between AA and HCPs? • What happens when you see your doctor? • What does trust means to you?
Question 2	What is most important to you when you select a new HCP?

Appendix B: Demographic Questionnaire

Please answer the following questions about yourself:

What is your race?

How old are you?

Are you married, single, or divorced?

What is your highest level of education?

Do you have any chronic conditions?

How often do you see your HCP for treatment of your condition?