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Contributing Factors Affecting Health Care Access and Utilization Behaviors by Black Men in the United States

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Walden University
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Abstract

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MHSA, University of St Francis, 2006

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Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Public Policy and Administration

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Abstract

Generational racism, historical abuses, and mistreatment related to health care have long contributed to a lack of trust among Black Americans in the U.S. health system, as well as disproportionate health status due to inadequate medical care-seeking behavior. Black American men have been particularly affected, with worse health and a higher mortality rate than men and women of other U.S. ethnic groups. The causal factors that manifest and sow distrust of the medical community among Black men are not thoroughly understood. The purpose of this study, which had the health belief model as its theoretical framework, was to explore the experiences of Black men in Memphis, Tennessee, in assessing how their demographic profile and life experiences influence their health beliefs, ultimately impacting their health status. A phenomenological research design featuring investigative inquiry was used to gather data to assess how Black men's individual lived experiences impact these social phenomena. Data were collected by conducting open-ended, semi-structured interviews with nine Black American men residing in Memphis, Tennessee. The process of explication was used to interpret the collected data. The study findings highlight systemic barriers and the role of community networks in shaping the participants’ health care experiences while also emphasizing the interplay between structural factors and individual autonomy. Although views on racial concordance with providers varied, the impact of historical abuses was acknowledged by all participants. The study suggests the need for systemic reforms to boost engagement and reduce disparities in health care for Black American men.

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Dedication

This dissertation is dedicated to my Lord and Savior, Jesus Christ, whose unwavering presence has been my cornerstone. In moments of doubt and trial, my faith has been a lantern in the darkness, guiding me through the long nights of research and writing. The words of Deuteronomy 31:8 (NIV) have been a constant source of comfort and strength: “The Lord himself goes before you and will be with you; he will never leave you nor forsake you. Do not be afraid; do not be discouraged.” These words have reminded me that I am never alone in my journey.

With a heart full of gratitude, I also dedicate this work to my late father, Alonzo Pendleton Sr., who left us on September 18, 2023. Though my deepest wish was to share the joy of this milestone with you in person, I am comforted by the belief that you were aware of my impending achievement. Your journey through the health care system not served as the inspiration for this study but also instilled in me a sense of urgency and purpose. It is my hope that the anticipated social change sparked by this research will serve as a lasting tribute to your memory. As I step across this academic threshold, I sense your presence more strongly than ever, envisioning your proud smile as you witness this family's legacy being carried forward. This achievement is not mine alone but belongs to our entire ”village,” a testament to the collective support, love, and faith that have brought me to this moment.

Acknowledgments

I express my profound gratitude to my committee chair, Dr. Glenn Starks. His expertise, understanding, and patience have been pivotal to my doctoral journey. Despite my myriad challenges, his guidance and support were the beacons that helped me persevere and succeed. I am deeply grateful for his invaluable mentorship and nurturing my scholarly growth.

My thanks also extend to Dr. Lydia Forsythe, my second committee member, whose insightful feedback and unwavering support were instrumental throughout this process. Her perspectives and critiques played a crucial role in shaping the final version of this dissertation.

I am indebted to Walden University for providing the necessary resources and an environment conducive to my research. A special acknowledgment goes to the staff and my peers within in the Public Policy and Administration program whose presence during the four PhD residencies made my academic journey both productive and enjoyable.

Most importantly, my heartfelt thanks go to my family. To my mother, Brenda Pendleton, who instilled in me the value of education and offered her unconditional love and support. To my wife, LaTonya, and my sons, Jordan and Taylor, whose unwavering support made this dissertation possible. Your inspiration and the sacrifices you have made have touched every aspect of this endeavor.

This dissertation is a testament to your steadfast belief in me. Thank you.

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Chapter 1: Introduction to the Study

Throughout U.S. history, Black Americans have faced racial injustices that have affected their everyday life, up to and including death. Black people have long been subjected to abuses by global medical systems. These abuses include the denial or unequal access to medical care, lack of information regarding their care, in lack of assurances that medical care was being provided by appropriately trained and qualified medical practitioners, in addition to nonvoluntary experimentation. During the years of slavery, Black people were given substandard care at the hands of doctors whose only objective was to ensure that their slaves were well enough to perform their masters' work. Post slavery, the abuses continued, which has led to the poor health conditions and deaths of Black people. This problem has exacerbated the level of distrust Black people have for the medical system. Black people are more likely than Whites to harbor these feelings and not access necessary medical care until health conditions worsen. Even within the Black population, there are inequities in how health care is accessed, with Black men being unhealthier and not living as long as Black women.

To address these issues, officials and health care providers and advocates have established public health policies and laws to provide greater protections for Black Americans. However, it is not known whether these efforts are adequate to create a level of trust to foster greater engagement of the health system. To better understand what policies are needed to improve the overall health of Black Americans, it is necessary to first explore the contributing factors for distrust. Using a phenomenological framework, I sought to understand how individuals view and interpret phenomena through lived experiences as expressed through their narratives**.** I wanted to know whether historical abuses or other factors keep Black Americans from trusting health care providers. I focused on Black men because of the health disparities they experience. In particular, I sought to understand how the phenomenon of health care disparities affects Black men's access to, and utilization of, the U.S. medical system.

Background

Black Americans are the least healthy ethnic group in the United States (Noonan et al., 2016). According to Noonan et al. (2016), the age-adjusted death rate for Black Americans was 48% higher than the standard for the U.S. population. Their research also shows that between 2004 and 2014, the life expectancy rate for Black men decreased by 28%, as compared to White men, Black women saw an 18% decrease whereas White women saw an increase of in life expectancy of 11%. Between 2014 and 2020, there were improvements to the life expectancy of Black Americans; however, recent studies show a disastrous impact to those gains due to COVID-19, which has adversely impacted this community. More specifically, because of COVID-19 the Black population is experiencing its sharpest declines in life expectancy since 2006 (Andrasfay & Gold, 2021). According to Andrasfay and Gold (2021), the gap in the Black–White life expectancy variance grew by 40% to over 5 years.

Generational racism and historical abuses have broadened the health disparity gap between Black Americans and other ethnic groups. Black Americans are more impacted by chronic health conditions than those in other ethnic groups (Watson, 2014). Watson (2014) stated that the reason for some of these disparities is due to mistrust of the health system, which stems from numerous historical events that have caused harm to the Black community. One such event was the Tuskegee Syphilis Study, which occurred between1932 and 1972 and involved Black American men as the experimental study group. These study participants were misled regarding the nature of the clinical study, never informed they had syphilis, and received improper medical treatment. According to Watson, by the time this study was ceased over 130 Black Americans had died from syphilis or directly related complications, wives had been exposed to the disease, and many children of study participants were born with congenital syphilis. This tragic historical event is one example of generational abuses that have influenced the reluctance to seek routine medical care and other preventative services by Black Americans.

People who have a general distrust related to the receipt of health care, or who do not trust the health service provided, are unlikely to access and/or utilize these services, unlikely to adhere to guidance received, and likely to be unhealthier (Ward, 2017). Clark-Hitt et al. (2010) surveyed physicians about their perceptions on the impact of race on bias and improper medical treatment, given the increased body of evidence that highlights the problem. In their research, 29% indicated that race does impact the health care treatment received from the health system.

There are other problems that present when Black Americans do not trust the health care system. When Black Americans do not trust the health care system, they are also less likely to participate in clinical research trials and less likely to trust recommended vaccinations. As an example, according to Warren et al. (2020), Black Americans accounted for 13% of the U.S. population, but represented 21% of COVID deaths and only 3% of those participating in vaccine clinical research trials. In 2019, the U.S. Food and Drug Administration issued guidance intended to broaden criteria for minorities that have been underrepresented in clinical research trials (Swaby et al., 2021). Swaby et al. (2021) indicated that Black Americans also represent the population with the most significant disparity related to cancer disease. In comparing the incidence of breast, prostate and lung cancer across ethnic groups, Black people have the highest mortality rate. Their research shows that between 2003 and 2012, White women saw a larger decrease in breast cancer across the entire United States, as compared to Black women, who saw decreases in only 27 states. Black men experienced prostate cancer at a much higher incidence rate, compared to White men; 178.3 per 100,000 to 105.7 per 100,000. This study provides an indication of Black American men not seeking health care by the higher late-stage diagnosis of prostate cancer that is 44%–75% higher than the general population. Further, Swaby et al. identified the reasons for these disparities as socioeconomic status, poor patient physician relationship, and underrepresentation in cancer clinical research trials.

Officials have established policies with the intent of reducing health inequities. However, there is evidence indicating that over the last 40 years, public sentiment for US government intervention to support Black Americans and their health care has diminished (Williams & Cooper, 2019). In the area of health care, in particular?According to Williams and Cooper (2019), this diminished support highlights the need to raise awareness, capacity build across communities with a focus on interventions, and build greater appreciation for the significance of health inequities in the Black community.

These efforts should include support for addressing these challenges while pursuing sustainable policy action, they argued.

Problem Statement

There is a problem in the level of trust of the U.S. health system by Black Americans. Specifically, that problem is a lack of trust in the U.S. health system leading to disproportionate health status due to inadequate medical care-seeking behavior. Data show that Black Americans are unhealthier than other ethnic populations, with an increasing body of empirical evidence supporting distrust in the U.S. health care industry being a factor (Armstrong et al., 2008). Noonan et al. (2016) indicated that the age-adjusted death rate for Black Americans was 48% higher than the standard for the U.S. population. Their research shows between the years of 2004 and 2014, the life expectancy rate for Black men decreased by 28%, as compared to White men; Black women saw an 18% decrease whereas White women saw an increase of in life expectancy of 11%. How health information is sought, received, and acted upon is an essential factor in understanding the adverse health status of certain ethnic groups. According to Richardson et al. (2012), this information seeking and the extent to which it is trusted have been shown to contribute to improved health outcomes, health literacy, informed health care decisions, and improved mental and emotional status. Not accessing health information or lack of trust in the information received could produce adverse health consequences; thus, improvements in this regard could yield more positive health behavior and outcomes.

Despite the preponderance of the evidence of the impact trust has on health outcomes, research is lacking on the causal factors that manifest and sow distrust of the medical community by Black men. Using a phenomenological research framework, I sought to understand any causal factors through the realities of lived experiences. Prior research indicates that this problem impacts Black men at a higher rate. Black men are disproportionately unhealthier, do not live as long, and have a higher mortality rate than men and women of other ethnic groups. Many factors contribute to this problem, including socioeconomic status, health literacy, historical racism, and unethical experimentation on Black people. In my review of the literature, I did not find public policy that addressed the association between socioeconomic status, lived experiences, system abuses, and generational racism in the trust held by Black Americans related to the U.S. health care system. This lack of research prohibits the understanding of how distrust factors explicitly impact Black men's health outcomes in the U.S. health system.

The opportunity exists to expand research to better define medical mistrust as a central focal point of a study. This phenomenological review may clarify the association of specific contributing factors and socioeconomic status in sowing distrust in the U.S. health system and overall health outcomes. The current body of research highlights numerous factors contributing to Black men's low health status. Research substantiates that historical racism has influenced how Black men engage with the medical community (Benkert et al., 2019). There is also evidence supporting the need to have increased engagement by Black Americans in health policy development and decisions, sustained investment by the government in health literacy and social programming, and a reduction in access to care barriers that impede the utilization of needed health care services. Louis Israel Dublin, who was a significant figure in the field of health statistics and public health in the mid-20th century, concluded that by improving Black health status, as compared to Whites, there would be a more positive and holistic impact compared to no other initiative (Noonan et al., 2016).In Memphis, Tennessee, the Black community's mortality rate due to chronic conditions, such as obesity, diabetes, cancer, and heart disease, is higher than other ethnic groups. Research shows that the prevention and management of these chronic health conditions is bolstered when there is routine access, availability, and utilization of health care services. As previously shared, Black men are unhealthier than men and woman from other ethnic groups. As such, this study aims to evaluate the specific contributing factors sowing distrust in the U.S. health system and overall health outcomes amongst Black Americans. The specific research problem that I addressed in this study was the lack of research on those causal factors that manifest and sow distrust of the medical community by Black men by studying these phenomena in Memphis, Tennessee.

Purpose of the Study

The purpose of this qualitative study was to understand the causes of mistrust of the U.S. health system amongst male Blacks, specifically focusing on the geography of Memphis, Tennessee. The opportunity exists to expand research to better define medical mistrust as a central focal point of a study. I conducted this phenomenological review to better evaluate the association of specific contributing factors sowing distrust in the U.S. health system and overall health outcomes. The current body of research highlights numerous factors contributing to Black American men's low health status. Research supports that generational racism has influenced how Black men engage with the medical community (Benkert et al., 2019). Evidence supports the need to have increased engagement by Black Americans in health policy development and decisions, sustained investment by the government in health literacy and social programming and reducing access to care barriers that impede the utilization of needed health care services.

Research Question

The goal of this study was to determine the barriers and perceptions that contribute to distrust of the medical community by Black American men living in Memphis, Tennessee. The following research question was investigated in this study: What are the lived experiences of Black American men residing in the Memphis, Tennessee area with the U.S. health system and access and use of health care services?

Theoretical Framework

The health belief model (HBM) grounded this study. HBM is conceptual framework that is effective for studying behavior change and conservation (Janz et al., 2002). Additionally, as a research framework, HBM supports development of interventions to promote behavior changes related to health (Janz et al., 2002). In the past few decades, researchers have applied the HBM to study the factors contributing to individual behavior and examine how to effect positive behavior change (Janz et al., 2002). Cognitive theorists who have used the model have emphasized the role of individual perception of value in an interaction. More specifically, the use of the HBM has shown that when an individual subject has preconceived expectations on the value of an outcome, probability, or expectation of what will occur by such interaction, it will impact their behavior regarding the encounter (Janz et al., 2002). When seeking to understand the attitudes, beliefs, and actions of individuals, understanding the basis for how an individual feels and think is important for interpreting the underlying factors that drive behavior. Acar and Kıcali (2022) provided that the HBM is an ideal framework for understanding how behavior is impacted by factors such as race, gender, and socioeconomic status. According to Jiang et al. (2021), this psychological model supports researchers' efforts to understand why individuals choose to adhere to prescribed treatment or other influences that drive their behavior.

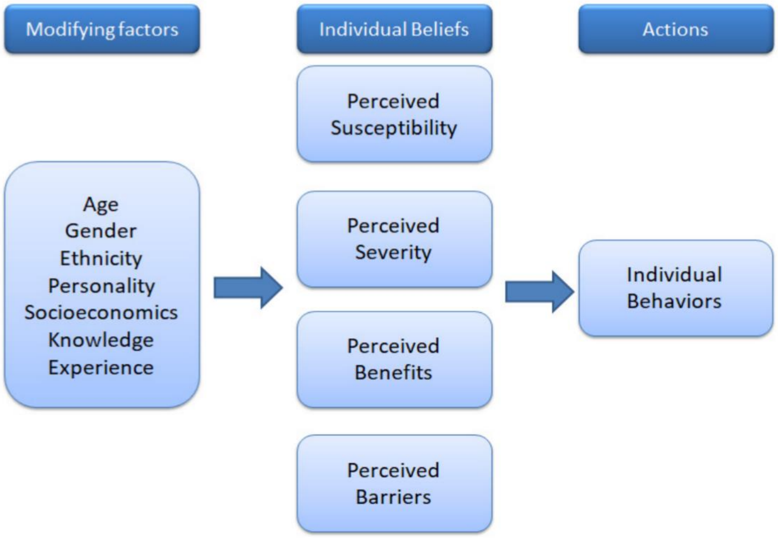
Furthermore, HBM provides a framework for assessing against five constructs that could drive an individual's behavior, which include their belief that they may develop certain diseases, their belief regarding how serious or life-threatening a disease is, their view of the benefits of specific health behavior, their perception of barriers that make it difficult to adopt said behavior change, and their belief in their ability to accomplish the prescribed behavior. Where this model provides value in this specific study is how it can be applied to the assessment of Black men, and how their demographic profile and life-experiences influence their health beliefs. Due to the aforementioned benefits, the HBM was selected to ground this phenomenological study. Use of the HBM to understand the factors underlying distrust of U.S. health system may be important to further research and the identification of policy opportunities for initiating positive social change.

Application of Health Belief Model

According to Carpenter (2010), the original purpose of the HBM was to provide a method for those interested in improving public and needed to understand the behaviors of those that were not compliant with recommend preventative measures. The premise of the HBM model is that an individual will take a specific action if they perceive it to be of benefit and accessible to them without restraint. Figure 1 illustrates the four components of the HBM that motivate an individual to pursue a medical service: perceived susceptibility, perceived severity, perceived benefits, and perceived barriers (Jones et al., 2015). HBM assumes that rational health-decision making behavior will prevail, based upon an individual's awareness or knowledge of how they will be impacted by a medical condition and negative impacts associated with that action (Ban& Kim (2020).

Figure 1

Health Belief Model



Note. This figure illustrates the components of the health belief model and how they are connected. The foundation for this model is perceived susceptibility, perceived severity, perceived benefits, and perceived barriers. These perceptions are influenced by modifying factors as well as the cues to action. Individual beliefs and actions combine to influence behavior. From "Applying the Modified Health Belief Model (HBM) to Korean Medical Tourism," by H.-J. Ban and H.-S. Kim, 2020, *International Journal of Environmental Research and Public Health, 17*(10) (https://doi.org/10.3390/ijerph17103646). CC BY.

Nature of the Study

Phenomenology research design is a qualitative research approach connected explicitly to the study of individual lived experiences and how they impact the social phenomena studied (Neubauer et al., 2019). According to Neubauer et al. (2019), a phenomenological research design offers a powerful approach to investigative inquiry pertaining to the health professions. Phenomenological researchers seek to gain a deeper understanding and meaning of a particular issue from the lens of those that have experienced the phenomena (Neubauer et al., 2019). Using this research design, and based on the population being studied, I sought participants who were Black; between the ages of 18 and 75; and residing in the Memphis. Tennessee area. Nine individuals were selected by using the social media platform Facebook and the research platform Research & Me, as well as through a local medical clinic and citywide health fair. The selected individuals participated in a one-on-one interview, lasting up to 45 min, which was conducted in person or via Zoom or similar platform. The data collected through the interview process then went through thematic analysis, which allowed for extraction of specific themes and concepts from within this primary source information. Through this research, I learned about the beliefs and perceptions of Black men regarding their health and well-being, the U.S health care system, and the reasons or influences each unique participant gave for their perceptions.

Definitions

The following terms are defined to help readers understand their context or specific meaning as used in this study:

Black Americans: For purposes of this study, individuals who were born in the United States (vs. those who immigrated into the country) and who identify as Black.

De facto racial residential segregation: Situations in which there is a separation or creation of social or cultural influences that keep other races from assimilating within their residential communities as if it were lawful or overt.

Generational racism: Discriminatory acts and prejudices towards racial groups that are experienced from generation to generation.

Informed health Care decisions: The ability of an individual to make an intelligent decision regarding their health care; this ability is made possible by the individual's being provided health care information in a consumable manner.

Intersectionality: Various influences, social factors, and identity markers that do not exist independently and therefore informs the other.

Lived experiences: An individual's personal or relational experiences and choices and what they learn from those experiences that influence their behavior or perception of something.

Preexposure prophylaxis **(**PrEP): Medicine taken to prevent the contraction of HIV.

Racial centrality: How an individual views the importance of their racial identity as a factor in who they are, their experiences, and how there are treated.

Sociocultural: The series of factors that influences the beliefs or behaviors of Black Americans, such as, but no limited to, gender identify, education, habits, beliefs, demographics, religion, and core values.

Structural/systemic racism: The historical laws, regulations, or social practices that are embedded with an organization or within society that discriminates against Black Americans

Substandard care: The delivery of medical care, medical decision making; or the lack thereof, when compared to standards expected in the normal course of medical practice. Examples could be lack of monitoring, misdiagnosis or other negligent practices by physicians or other medical personnel.

Young men who have sex with men: Black young men that identify as gay or bi-sexual and have identified as having an attraction towards and engage in sexual behaviors or have sex with other men.

Assumptions

I assumed that participants provided truthful responses with no motive to provide false or misleading information. Other assumptions includes that this study is relevant and the focus population provided sufficient responses to answer to the research question. I assumed that the instrument I used to survey participants provided an appropriate level of detail, ensuring thorough answers to questions raised during interviews. Another assumption was that all study participants were asked questions in a manner that could be understood, recognizing that they had varying degrees of education and knowledge. The final assumption was that the findings of this study would fill the current gap in the literature and provide more clarity around those factors contributing to distrust of the health care system by Black American men and lead to policy development to address this problem.

Scope and Delimitations

The scope of this study was limited to participants residing in Memphis, Tennessee, given the focus on understanding the experience of Black American men who reside in this geography. The study scope involved describing lived experiences of Black American men and how this translates to causal factors that manifest and sow distrust in the medical community by them. I established the following delimitations:

- the geography of the study,
- the target sample size of the study participant pool,
- the data collection methodology, and
- the tools used to carry out the study.

Recognizing that the nature of the study could evoke emotions that could lead to exaggeration or even false or misleading responses, I took a structured approach to create an environment that promoted trust and comfort to minimize the likelihood of false or misleading responses during interviews. Not doing so could have created barriers leading to a lack of success in collecting data to support the study.

Limitations

Limitations of narrative inquiry stem from how the data were captured and the perception of its credibility. The research community may be concerned with the authenticity of the stories shared by interviewees and/or the potential for exaggeration or misrepresentation of the extent of an experience. Intersubjectivity is a risk that the researcher maintains control of by not allowing their empathy to create unintended biases in the study (Webster et al., 2013). Additionally, smoothing is another variable whereby a researcher may invoke more positive reflections of the narrative provided than what was evident within the data captured (Webster et al., 2013).

For the study’s geographical area, I chose Memphis, Tennessee, which minimized the participant pool. Additionally, even though the COVID-19-related public health emergency ended as of April 2023, clinical practices still needed to be more cautious of engagement within their facilities to maintain appropriate public health precautions. Face-to-face, where possible, and videoconference platforms were used to conduct the interviews, based on preferences of the participants. There were transportation and technological constraints that, at times, impacted the efficiency and timeliness of interviews.

A final limitation, at the time of this study was my executive-level experience in managed health care serving as CEO for a Tennessee statewide Medicaid managed care organization with over 500,000 members. Being a Black American man and serving in a professional role with knowledge of health inequities within the community, I understood the potential for bias and strove to remain neutral on questions and interpretation of data. I took detailed notes during the interviews to reflect the participants’ views. All unaltered study notes will be maintained and made available to enforce the research's ethical veracity and serve as a historical collection of researcher reflections and the processes used to collect data for this study.

Significance

Black people are the least healthy ethnic group in the United States. Research shows that health disparities impact Black men at a higher rate than other segments of the population. Black men are disproportionately unhealthier, do not live as long, and have a higher mortality rate than men and women of other ethnic groups (Holden et al., 2012). Many factors contribute to this problem, including socioeconomic status. In a study of physicians' perceptions on the impact of race on bias and improper medical treatment, 29% indicated that race affected the health care treatment provided to certain patients (Clark-Hittet al., 2010). These statistics provide justification for this research on the drivers impacting Black male health status and the need to formulate strategies and guidance to improve the mortality rates for this population. This inequity in health status and unequal medical treatment of Black men merited further attention.

Implications for Social Change

This study contributes to the body of knowledge needed to address this problem by identifying the contributing factors that impact healthy access and utilization behaviors by Black Americans in U.S. health care system. Additionally, qualitative research is necessary to understand how distrust factors explicitly impact Black men's health outcomes in the U.S. health system. Finally, further research should test the findings of this research within other geographies. Through this research, public policy can be designed that specifically focus on addressing the determinants leading to the distrust of the health system by Black men. Through policy enhancements, increased engagement by Black men with the health system can lead to greater improvements to their health status through reduction in specific health disparities being addressed earlier before they develop or become more acute.

Summary

Black Americans are the least healthy ethnic group in the United States (Noonan et al., 2016). The age-adjusted death rate for Black Americans is 48% higher than the standard for the U.S. population (Noonan et al., 2016). Research shows that Black men are disproportionately unhealthier, do not live as long, and have a higher mortality rate than men and women of other ethnic groups. How health information is sought, received, and acted upon. There is evidence that a lack of trust in the U.S. health system is leading to disproportionate health status due to inadequate medical care-seeking behavior. Data shows that Black people are unhealthier than other ethnic populations, with an increasing body of empirical evidence supporting distrust in the U.S. health care industry being a factor (Armstrong et al., 2008) as an essential factor in understanding the adverse health status of certain ethnic groups. This study aims to evaluate the specific contributing factors sowing distrust in the U.S. health system and overall health outcomes amongst Black Americans, with a focus. More specifically, the research problem that this study addressed is the lack of research identifying those causal factors that manifest and sow distrust of the medical community by Black men in Memphis, Tennessee.

The literature review in Chapter 2 provides a synthesis of the in-depth exploration of studies on relevant topics; including theoretical foundation for which this research was grounded, in addition to the following: the prevalence of medical mistrust in the United States, causes of medical mistrust among Black Americans, mistrust in the government and health care providers, past exposure to discrimination and mistreatment, systemic racism, racial residential segregation, disparities in health care access and quality, racism in health care systems, racial centrality, education and income levels, stigma that arises from intersectionality of racism and homophobia, personal attitudes, gender disparities in mistrust among Black men and women, health-seeking habits of Black Americans consequences of health care mistrust, poor health-seeking behavior, unwillingness to save the lives of others by donating organs, and racial disparities in clinical trials.

Chapter 2: Literature Review

Black Americans in the United States are disproportionately affected by lower life expectancy, higher mortality rates, and higher prevalence of diseases compared to their White counterparts. In general, previous research pieces indicate that the general health outcomes of Black Americans are poor compared to Whites. For instance, in their review, Hewins-Marone et al. (2005) argue that compared to Anglo-Americans, Black Americans typically have less access to health care, a lower life expectancy, and in general, poorer actual and perceived health outcomes. Thus, Black Americans are a group that needs to be examined regarding their overall health statuses and outcomes.

Studies that have narrowed down their focus and have centered their work on assessing the health statuses of Black American men as a demographic also exist. One such study is Kramer et al. (2021), which points out that Black American men have higher death rates compared to other demographics in the United States, including Black women. Such findings indicate the vitality of the situation and enable us to see that it is appropriate to comprehend any barriers that hinder them from accessing or seeking health care services, which may be the only remedy to this situation. In this regard, this literature review delves into past research pieces that enabled us to comprehend the issue at hand by emphasizing medical mistrust, which aligns with the primary objective of the study.

Literature Search Strategy

A systematic search for peer-reviewed literature was conducted utilizing Walden University databases within Public Policy & Administration focal areas, and included

Political Science Complete, Public Administration Abstracts, SocIndex, Sage, ProQuest Central, and Thoreau multi databases. Searches were conducted over a period of approximately 16 months, evaluating 346 peer-reviewed articles and studies, with no significant updates to literature outside of new studies introduced due to the COVID-19 pandemics impact and exacerbation of perceived factors impacting Black health disparities. Key words utilized in the search were *African Americans*, *health care system*, *distrust*, *racial inequities*, *health disparities*, *health information seeking*, *social determinants of care*, *Black Americans*, and *health-seeking behaviors*. The scholarly literature articles focused on historical abuses of Black Americans within the health system, significant disparities in access to care, mistrust of physicians by the Black community, socioeconomic factors, variability in health status as compared to other ethnic groups, attitudes, and behaviors of Black people regarding health care access and adherence.

Theoretical Foundation

The theoretical foundation that underpinned this research was the HBM. According to Boslaugh (2022), HBM was developed in the 1950s by Godfrey Hochbaum, Irwin Rosenstick, along with their associates at the U.S. Public Health Service. At the time, these researchers were seeking to understand why there was a lack of engagement by individuals in accessing public health programs. Boslaugh provides that the most notable change to the HBM model was introduced in the 1970’s with the introduction of self-efficacy into the model, which sought to factor the degree to which a person has confidence in their ability to adhere to a targeted behavior. This model is still utilized today to not only explore public health inquiries, but more broadly to understand various health behaviors. In addition to the self-efficacy component that was added over 30 years ago, the original model included assessing perceived threats, perceived benefits, perceived barriers, cues to action, and other variables that when reviewed holistically are used to influence an individual's decision to engage in a particular action or not. The components work together to influence an individual's choice to act or not. HBM, as a policy framework, is widely used in the public health space to understand influences of behavior but has also been leveraged in other fields where communication research was necessary (Jones et al., 2015).

As such, HBM supports researchers in developing policy interventions to promote healthy behavior decisions. To do this, it is important to assess the attitudes and beliefs of individuals as a basis for understanding how they feel, think, and what drives their decision-making process about a given action. Further, Acar and Kıcali (2022) posited that HBM is important in understanding how race, gender, and socioeconomic status impact behavior; serving as an ideal construct for interpreting how these factors impact fidelity to guidance provided on a given topic.

Cognitive theorists have applied use of HBM, and in doing so have emphasized value placement on a given interaction as a key driver for an individual's decision to act or not. Specifically, Janz et al. (2022) provides that individuals develop preconceived expectations on the value of an interaction and what will occur with that interaction, which informs their behavior in seeking to engage in that encounter. This gives credence to how the model has been applied by cognitive theorists, and how HBM can be applied for the research purposes of this study.

Despite its wide use, one limitation of using HBM cited is related to variable ordering, given that its undefined and leads to ambiguity in assessing which components of the model are most important and how they interact (Jones et al., 2015). Further, it has been recommended that HBM explore amending to include variable ordering to enhance its value to theory, improving the ability to understand which components of the model are most important. For purposes of this study, the HBM's application was viable in seeking to understand any factors that may contribute to healthy health access behaviors by Black men. Celik and Kroc (2023) posit that for this reason, the HBM is an appropriate model for the development of policy interventions, leveraging the models core components with the aim of understanding and predicting health behaviors.

Literature Review Related to Key Variables and/or Concepts

Prevalence of Medical Mistrust in the United States

Research indicates mistrust in the U.S. health care system as one significant factor that pulls back individuals from seeking health care services. According to Hall and Heath (2021), health care mistrust, which entails the suspicion of health care systems, organizations, and providers, has become a significant problem in public health. In fact, only 23% of the overall American population have confidence in the American health care system (Rivard et al., 2021). This statistic indicates that about 77% of Americans distrust the health care system, which is a significantly high rate. In turn, this indicates that medical mistrust in the United States is a force to be reckoned with.

Further research indicates that while a significant portion of Americans does not trust the health care system, there are strong medical mistrust disparities between White and Black Americans. One such research is a study by Armstrong et al. (2007) which incorporated univariate and multivariate analyses of their collected data to analyze the racial variations in physician distrust in the United States. This study pointed out that Black Americans and Hispanics had significantly higher levels of mistrust compared to their White counterparts. This aspect points out that, typically minority groups are less expected to trust physicians than Whites in the United States. Nonetheless, a further study by Powell et al. (2019) discovered that among the Hispanics and Black Americans, who are both minorities, Black Americans exhibit significantly higher rates of medical mistrust compared to the Hispanics. This aspect indicates that while minority groups exhibit high levels of health care mistrust, Black Americans experience the highest mistrust levels.

Causes of Medical Mistrust Among Black Americans

Medical mistrust is a complex issue that is tied up with multiple facets within society. Researchers have sought to comprehend the complexity of the issue and have centered much attention on unravelling the causes of medical mistrust among various demographics and the United States as a whole. In this regard, a significant amount of past literature has focused on assessing the factors that result in medical mistrust amongst patients of color, more specifically the Black Americans who make up the most population of individuals that mistrust the American health care system.

Mistrust in the Government and Health Care Providers

Some studies highlight that Black Americans' lack of trust in the American government translates into mistrust in the American health care system. For instance, Bogart et al.'s (2021) study sought to analyze the reasons why many Black American men are unwilling to receive COVID-19 vaccines, which are being administered to curb the spread of the killer virus. This study highlighted that many Black Americans did not trust the government regarding how it handles the coronavirus pandemic. As most of the participants claimed, they did not believe that the information provided by the government on COVID-19 as they believed that the government knowingly withheld some information from them. As a result, most argued that those who received the vaccines would be adversely affected and thus they sought to protect themselves by not taking the vaccine. Overall, many Black American men showed extremely high levels of mistrust regarding the effectiveness and safety of the vaccine due to their mistrust of the government.

Aside from the failure to trust the government, research indicates that some Black Americans have no trust in their health care providers. Some of these studies indicate that this mistrust arises from the poor attitude that they have toward health care providers. For instance, Jacobs et al. (2006) mention that a significant portion of Black Americans did not trust physicians due to a wide array of reasons including past experiences of racism, fear that they will serve as subjects of experimentation, difficulty in communicating with foreign health care providers, and technically incompetent care. This finding is supported by Wiltshire's (2011) study which argues that the low trust that many Black Americans have in doctors is a partial contributor to the adverse health outcomes amongst Black Americans.

The cultural incompetence of the physicians has also played a significant role in cultivating the mistrust that Black Americans have in them. This aspect is vivid in Kennedy et al.'s (2007) study, which highlights that physicians usually have limited knowledge of how to interact with their patients unless they have a similar background. As a result, most health care providers may fail to know how to relate well with the Black Americans, which may, in turn, result in a misunderstanding in both nonverbal and verbal behavior of this group of patients. This facet is backed by Kramer et al.'s (2021) study, which points out that many physicians lack sociocultural awareness of the difficulties that Black Americans face in their regular lives and as a result, they may fail to comprehend the diversity and uniqueness that characterize this demographic. More specifically, the participants in this study highlighted the existence of a disconnect between non-Black health care providers and Black men.

Kramer et al.'s (2021) study categorized the poor relationships with health care providers were categorized into two areas: abstract liberalism and cultural racism. On the one hand, abstract liberalism is attributed to the lack of knowledge of physicians on how to interact with Black Americans. Kennedy et al.'s (2007) study is a clear representation of abstract liberalism. On the contrary, cultural racism is associated with racial stereotypes that non-Black providers may have on Black Americans, which hinders them from trying to build meaningful provider-patient relationships. Nonetheless, it is worth acknowledging that both factors negatively impact the level of trust that Black Americans in the health care system.

Past Exposure to Discrimination and Mistreatment

Research also indicates that past negative experiences regarding mistreatment and discrimination in the health care system are a significant contributor to the mistrust of Black Americans in the U.S. health care system. For instance, Kennedy et al. (2007) indicate that Blacks exhibited less trust in their doctors in both seeking health care services and participating in clinical research. They argue that this mistrust arose from the previous experiences that they have had within the health care system. This study is backed by Gibbons (2019), who highlights that people who had experienced medical discrimination were highly likely to report medical distrust compared to those that had not had prior experiences of medical distrust.

Another study by Williamson et al. (2019) analyzed the role of non-mediated and mediated discrimination in breeding medical distrust. According to the authors, people with previous experiences with personal or vicarious discrimination are likely to have more medical distrust compared to their counterparts. Moreover, Jaiswal (2019) pointed that men who experienced racism quite frequently were highly likely to avoid seeking medical services like blood pressure screening and routine check-ups compared to their counterparts. Also, Progovac et al. (2020) conducted a study on adults to comprehend the role that past health care discrimination has in seeking mental health treatments. In one of their findings, the authors highlighted that past experiences of discrimination result in stigma which in turn, interferes with the level of trust that a patient has in their health care provider. All these studies support the previous mention that past discriminatory experiences result in high levels of health care distrust among Black Americans.

The research is backed by Watson's (2014) study, which concluded that many Black American men mistrust the medical system because of the medical mistreatment that they have faced within the health care system in the past. In his study, Watson (2014) offers an example of the Tuskegee syphilis experiment that was characterized by the mistreatment of Black American participants. Jaiswal's (2019) study does in further details of the Tuskegee syphilis experiment and argues that this experience could be one primary driver of the mistrust that minority groups, more so the Black Americans, have on United States' medical system. These studies indicate that medical abuses, more so the Tuskegee syphilis experiment, have been ongoing for over a century. In turn, this indicates that for a long time in history, Black Americans have had adversely negative interactions with the U.S. health care system. Overall, due to the poor history that Blacks have with the health care system, many of them find it quite difficult to trust the health care system.

Systemic Racism and Racial Centrality

Research has identified systemic racism as one of the dominant factors that result in medical distrust among Black Americans. Gee and Ford (2011) define systemic racism as racism that exists across society, both between and within institutions and organizations. According to Gee and Ford, systemic racism operates in a manner that ensures that even in situations that lack individual racism, the inequalities, and adverse conditions that the minorities face will continue to exist. In their study, Cooper and

Crews (2020) point that in systemic racism, people of color are being undermined by policies that give their White counterparts the advantage over certain resources and opportunities. This aspect implies that systemic racism places Black Americans at a disadvantage in the American health care system, which, in turn, may hamper their trust in the system. In this regard, many studies have sought to analyze the role that structured racism plays in medical mistrust among Black Americans. This section delves into past literature that analyzes the systemic racism in health care.

One of the primary consequences of structural racism in the United States is residential segregation which can be described as the spatial or physical separation of social groups into metropolitan areas, countries, or municipalities based on aspects like race, income levels, and social classes, amongst others. Research indicates that racial residential segregation is one of the most fundamental causes of the distrust that Black Americans have on the American health care system. According to Cooper and Crews (2020), residential segregation is one of the government policies that negatively impact minority groups. Residential segregation has had very negative health impacts on Black Americans. That is because it has resulted in the formation of neighborhoods that place minority groups in areas that lack access to safe housing, well-paying jobs, healthful foods, education, and quality health care. This study further points out that this is the primary reason why the minority groups, more so the Black Americans and the Latinos, have little to no faith in the health care system.

Like Cooper and Crews (2020), Gibbons et al. (2019) also point that the long-standing systemic disadvantage that the Blacks have been exposed to is a major contributor to their distrust in the health care system. However, their analysis was slightly different in that it sought to analyze the differences of medical mistrust among Black Americans that resided in predominantly Black geographical locations and their counterparts. Assertively, they highlighted ethno-racial segregation as an essential component in Black American perceptions toward health care services. Their findings align with their first hypothesis which posits that if Black Americans live in neighborhoods that primarily consist of Blacks, they are highly likely to trust the health care system compared to those that resided in racially mixed neighborhoods.

Nonetheless, the primary findings of Gibbons and colleagues faced opposition from Armstrong et al.'s (2007) study, which pointed out that Blacks who resided in Black-dominated cities experienced higher levels of distrust compared to those who lived in mixed-cities. While the primary finding in Armstrong et al.'s (2007) study was that Black Americans were likely to distrust physicians than Whites, their findings also highlighted a complex pattern. That is because, across some cities, Black Americans reported higher distrust levels compared to Whites while in other cities it was quite the opposite. They offered two explanations for these geographical variations: environmental differences or the compositions of individuals living in the areas.

Aside from residential segregation, another form of systemic racism is seen in the existing racial disparities between health care access and quality. A significant portion of Black Americans is susceptible to health care disparities that often hinder their overall health care outcomes. One of the main disparities is limited health care access, which is usually linked to factors like systemic racism, behavioral factors, and poverty, among others. In line with the primary objective of this study, it is safe to mention that a vast body of research point that Black Americans face more difficulties in accessing health care compared to their counterparts (Yancy, 2020; Yerby, 2018; Okonkwo et al., 2021). In this regard, many past pieces of literature have focused their attention on analyzing the problem of health care inaccessibility as well as the impact that it has on the overall trust levels of Black Americans in the health care system.

Lacking health insurance is usually linked to higher susceptibility to health care inaccessibility. In their work, Kennedy et al. (2007) pointed that a significant number of Americans are under-insured. Amongst these people, most of them are minorities, including Black Americans. This study is backed up by Watson's (2014) study, which sought to analyze the barriers that young Black Americans face regarding health care access. Watson identified that a significant portion of Black American men lacked insurance or sufficient funds to visit the doctor to receive medical care. That is because many are unemployed, and thus, they are unable to secure themselves health insurance. For those that were lucky enough to be employed, their incomes did not give them the privilege to purchase health insurances, which are quite expensive.

Like Watson (2014), Kramer et al. (2021) conducted a study to assess the challenges that Black American men faced with health care. Their findings indicate that the primary concern of most Blacks concerns lack health care access. Also, another study by Conell et al. (2019) assessed the potential health care provision and seeking barriers among Blacks. They used Black people that resided in the rural Mississippi Delta region as their participants. This research identified the following structural barriers: rurality, lack of health care insurance, and poverty. Overall, the aforementioned studies indicate that Black have limited access to health care, which places them at a disadvantage compared to their White counterparts. In turn, this aspect increases their chances of not trusting the American health care system. That is because the health system is characterized by policies that have made health care in United States quite expensive to access.

Aside from the inadequate access to health care, Black Americans are highly likely to receive low-quality health care compared to their counterpart Whites. One determinant of health care quality is the health care outcomes of the patients. However, research pieces that indicate that Black Americans have poor health outcomes despite receiving medical care exists. For instance, A. D. Moore et al. (2013) pointed that ethnic and racial minorities usually receive lower standards of care than their counterparts even when income, health insurance statuses, and access to health care are controlled. Moreover, in their work, Kennedy et al. (2007) mention a study by Tomaseli (2003) which discovered that even when Black Americans can afford to pay for the health care services, the probability of them receiving quality care is still significantly low compared to those of Whites. In turn, the poor quality of care that Black Americans Black Americans are usually exposed to creates mistrust in the health care system.

The quality of care received is also determined by the quality of interactions between the health care providers and the patients. However, some pieces of literature indicate that a significant number of Black Americans experience poor quality interactions with their physicians. This claim is backed by Hewins-Maroney et al.’s

(2005) study, which mentioned research by the Kaiser foundation, which discovered that persons of color were highly likely to complain that the health care system has disrespectfully treated them compared to their counterparts. According to the cited study, a majority of them believe that this disrespect arises from their racial statuses or inability to pay for health care services.

In a different study by Blenson et al. (1989) cited in Hewins-Maroney, Schumaker, and Williams (2005), the authors revealed that compared to Whites, most Black Americans made the following complaints concerning their last visits to the hospital: they were not satisfied by the care they received, they had no discussions of the hospital examination or test findings; they were not told the seriousness of their injuries or illnesses; they were not told how long the prescribed medications would take to work on them, and the health care providers failed to sufficiently inquire about the pain that they faced. These findings indicate that the medical care provided to Black Americans is insensitive, inefficient, and inadequate compared to the care administered to their White counterparts. Overall, Low-quality care translates into higher levels of dissatisfaction in the health care system, in turn, resulting in medical mistrust as Jaiswal (2019) states.

Systematic racism is responsible for the racial practices within the health care systems. A. D. Moore et al. (2013) argued that many health care institutions promote racial disparities through admitting privileges, physician-to-physician referrals, education of Black physicians, hiring practices, and segregation. Moreover, these practices, procedures, policies, and patterns undermine the rights of both patients and physicians that are non-Whites. In instances where this type of racism is not addressed within institutions, there are increased odds of racism persistence in the health care system. In fact, Moorley et al. (2020) point out that nurses across multiple structural compositions, nations, and with diverse backgrounds have expressed concerns on the need to destroy the organizational structures, as well as the behaviors and views that have enabled, perpetuated, and supported the inequities, injustices, and racism that are prevalent in the health care system.

Research continues to highlight that racism within the health care systems has multiple overreaching consequences. For instance, Kennedy et al. (2007) study point out that racism in health care systems has distorted the patient-physician relationship, which is a core component to trust. Armstrong et al. (2008) analyzed the disparities in the medical distrust among White and Black Americans. The context of their research was that there are conflicting results of racial disparities in medical mistrust, as most previous literature was rarely linked to multidimensional distrust or trust measures. As a result, they conducted a cross-sectional telephone survey to test the hypothesis that distrust in physician competency played a less significant role in overall distrust in the health care system by the Blacks, compared to the distrust in racial equality within the system. After conductive a thorough research, the researchers failed to reject their initial hypothesis and concluded that perceived and actual racism played a significant factor in medical mistrust among Blacks compared to the fear of health care incompetency.

Interestingly, one does not have to face direct discrimination within the health care system to develop negative attitudes toward it. Research indicates that even hearing about racial discrimination can affect people’s trust in the health care system. For instance, as pointed by Williamson, Smith, and Bigman (2019), being exposed to stories or news that delve into the discrimination incidences can lead to medical mistrust, even when an individual has not been directly affected by discrimination. Thus, one does not have to be directly involved with racism within health care institutions to develop mistrust. Overall, based on these research pieces, it is important to acknowledge that racism within hospitals is a significant contributor to the negative attitudes that Black Americans have toward the health care system.

Racial discrimination not only affects the Black American men that seek health care services, but also the Black trainees and physicians. In their study, Wyatt et al. (2021) explored the effects of racial violence on Black physicians. This study demonstrated that even though Black physicians are not directly affected by racial violence, the fact that they have similar social identities to the targeted communities makes them vulnerable to experiencing the effects of racial violence. More specifically, they face vicarious and direct racial trauma, which affects their psychological health and well-being. In turn, this hinders their professional life. Overall, according to this study, due to the social ties to their racial community, racial violence affects Black American physicians in their practice and education.

Aside from systemic racism, there is another underrated racial component that plays a significant role in cultivating distrust among Black Americans, racial centrality. Scottham (2008) defines racial centrality as the degree to which a person normatively prioritizes ethnic group identity as a vital component of themselves. Some researchers have highlighted that racial centrality is a contributing factor to the higher levels of health care distrust among Black Americans. For instance, according to Cuevas and O’Brien (2017) Black people that strongly identified with their ethnic groups are highly likely to exhibit higher levels of physician and medical mistrust. Aside from that, Black people who believe that the other ethnic groups negatively view them are also likely to have a higher physician and medical mistrust. In line with Cuevas and O’Brien’s assertion, another research by Gibbons (2019) pointed out that people with strong senses of attachment to their communities were highly likely to experience distrust in the health care system compared to their counterparts.

Kennedy et al. (2007) assert that most patients tend to trust physicians that have a similar ethnic background to them compared to those that do not. That is because physicians that have similar backgrounds are likely to share similar societal experiences, values, and beliefs, which make the patient feel more comfortable. Another similar study by Shelton et al. (2010) was conducted to examine the psychometric characteristics of GBMMS among Black American participants in an urban area. In one of their findings, men that had higher scores of GBMMS experienced significantly high rates of health care avoidance compared due to mistrust of their counterparts. However, unlike the aforementioned studies, Jacob’s et al.’s (2006) study pointed that while the race of the physician affects the trust of some African Americans, most of them believed that the race of the physician had little or nothing to do with their mistrust of the health care system.

Interestingly, research pieces highlight the need to take advantage of racial centrality in reducing the rates of health care distrust among African Americans. For instance, Grande et al. (2013) highlighted that brotherhood is a significant support mechanism for many Black men who are going through tough times or decision-making processes. This is attributed to the following factors: they face social conformity pressure, they respect shared learning, and generational views, they identify themselves with the group, and they respect the group views. Typically, brotherhood is one of the aspects that arise due to racial centrality in the Black community. Many Black American men identify themselves with other Black American men, who they perceive to be their brothers and they highly value these relations. Overall, research indicates that the priority that Black American men give to brotherhood can be used to serve as a point of advocating for better health care choices among these men.

Education and Income Levels

Research also indicates that education levels play a significant role in shaping the level of distrust of Black in the U.S. health care system. For example, Idan et al. (2020) conducted a study on Black men who resided in East Bay to determine their levels of medical mistrust. This study revealed that education and income were significantly correlated to mistrust. More specifically, men with lower levels of education or income were highly likely to have a negative attitude toward the health care system compared to their counterparts. However, other research pieces find no correlation between education and level of trust in the health care system. For example, Hammond (2010) lacked a significant association between the levels of education and medical mistrust. However, they identified that the more educated Black American men had frequent contacts with health care systems than their counterparts. This finding posits that the education and socioeconomic statuses of individuals play a significant role in determining access to health care.

Income levels are also a significant determinant of a person’s trust levels in the nation’s health care system. That is because having a low income increases one’s susceptibility to lack of access to quality care. As stated by A. D. Moore et al. (2013), having a stable source of care and insurance is directly correlated with high patient satisfaction, as it ensures easier access to health care. It is also worth noting that low-income levels are correlated with a significant number of problems. For example, homelessness is a major problem that people with low-income levels in the United States face. According to research, homelessness is positively correlated to lower levels of trust in the health care system.

Homelessness affects a significant portion of Black American men who reenter their communities after being subjected to incarceration (Chandler et al., 2021). Hendersen et al. (2021) argued that homelessness, alongside other factors, like limited social support, unemployment, and housing insecurity increases the odds of poor health outcomes and lack of health care access. Moreover, most people who identify as homeless are likely to experience discrimination in not only their interpersonal relationships but also throughout their health care. Thus, overall, these pieces of research associate low incomes with poorer health outcomes, which, in turn, result in lower trust levels among the affected groups of people.

Stigma That Arises From the Intersectionality of Racism and Homophobia

Stigma is one of the major contributing factors of distrust of the U.S health system by Black Americans. One major cause of stigma among African Americas is racism, which has been discussed in the previous sections. However, it is worth noting that some groups of Black Americans are susceptible to double discrimination. This includes lesbian, gay, bisexual, transgender, and queer (LGBTQ) people of color. Regarding health care disparities, many researchers have delved into the double discrimination that LGBTQ men face and how it impacts their trust in the health care system: both racial and sexual orientation discrimination. For instance, in their study, Hsueh et al. (2021) examined the prevalence of health care distrust among young Latino and Black men who have sex with men. This study highlighted that this group of people experiences both internalized and actual homo-negativity, which makes them stigmatized. In turn, this triggers their distrust in the health care system. However, this study also highlights that racism was a more dominant factor in health care distrust as opposed to internalized and actual homo-negativity.

In line with Hsueh et al. (2021), Cahil et al. (2017) mention that Black Americans who are gay or bisexual account for the majority of those exposed to stigma. The situation further worsens as they are more likely to contract HIV infections since PrEP uptake is limited among these groups. Cahil et al. (2017) further connect the situation to the 2015 CDC report that 70% of new HIV infections came from gay and bisexual individuals. Citing Berstein et al. (2008), Cahil and colleagues mention that the main barrier that contributes to distrust among these groups is nondisclosure of their sexual orientation. Black gay or bisexual men tend to distrust the U.S health care system because of the negative profiling and perceptions. Fear of being stigmatized alone creates high levels of distrust and uncertainty or aversion of health care services among these groups.

Stigma is also associated with poor diagnosis, treatment and therefore, hinders the realization of successful health outcomes. For instance, Williamson and Bigman (2018) revealed that medical mistrust is a major barrier to health outcomes and stigma acts as a catalyst. Similarly, Nyblade et al. (2019) explained that unjust actions against individual groups may be experienced by people from all spheres of life and but stigma in health care has egregious weight and can affect people negatively as many will not be free to seek medical attention even when under vulnerable conditions. Therefore, the substandard medical care or outcomes among Black American men can be tied to the cases of stigma due to health conditions, sexual orientation, or even perceived differences.

Connell et al. (2019) assert that stigma contributes to interpersonal barriers and most Black Americans consider disease prevention as a low priority due to fear and the overwhelming need of responsibility to provide rather than seeking medical care. Individuals that are vulnerable to stigma will also fear revealing their condition or orientation to others. Besides, Black American men in Connell et al.'s study were reported to live in fear of learning about the severity of their condition which could also expose them to stigma in their communities as others would perceive them as “less than” or potential failures. Lack of awareness on the consequences of stigma seems to facilitate the high levels of distrust of the U.S health care delivery among Black American men.

There is a mechanism that forms underlying paths as drivers of stigmatization and stereotyping of groups and individuals, but all have universal characteristics. Apart from the theme of stigma, unintended outcomes have also been attributed to distrust of the U.S. health system among the group under discussion.

Personal Attitudes

Personal attitudes that are unrelated to race can also impact a person’s trust level in the health care system. That is because a person’s mental predisposition toward a situation is a very strong factor in predicting their behaviors or attitudes toward a particular situation. In this regard, studies point that some individual characteristics of people can affect their levels of trust in the health care system. For instance, A. D. Moore et al. (2013) discovered that religion played a significant role in determining patient satisfaction levels. More specifically, the more religious Black Americans exhibited higher patient satisfaction levels compared to their counterparts.

James (2021) assessed the implicit and explicit consequences of hardiness on the general, mental, and dental health-seeking behaviors of health care services among Black American adults. As the article describes, hardiness is the overall tendency of an individual to have a positive attitude toward changes by considering it an interesting and normal part of life. Typically, hardiness-oriented individuals tend to view stressful life situations like those that can be changed with the right steps. This study identified that hardiness was positively correlated with positive perceptions of health care services. More specifically, hardiness-oriented Black Americans were highly likely to seek professional health care services compared to their counterparts.

Consequences of Health Care Mistrust

Most of the pieces of literature that have been discussed indicate that there is a significant level of medical mistrust among the Black American demographic. However, previous research is not only centered on establishing the levels of medical mistrust among African Americans. That is because studies highlight effects of medical mistrust on Black Americans also exist. The two major consequences of health care mistrust that have been identified by these studies are poor health-seeking behaviors, Unwillingness to Save the Lives of Others by Donating organs and racial disparities in clinical trials.

Growing research directly associates high medical mistrust levels with poor health-seeking choices. For instance, Jacob's et al. (2006) points out that medical mistrust affects the health care-seeking behavior of many African Americans. More specifically, a significant portion of them ended up withdrawing from forms of treatment including surgery, or not seeking any treatment at all. Idan et al. (2020) also mention that Black Americans with higher levels of mistrust were less likely to seek health services compared to their counterparts. In support of these studies, Williamson et al. (2019) also highlighted that failure to trust the health care system decreases the odds of partaking in multiple health-seeking behaviors. Gibbons (2019) also points a significant connection between health care mistrust and poorer health care outcomes, which adds to the disparities in health care outcomes of the minority groups compared to their White counterparts.

Medical mistrust has also been linked to poor choices regarding securing future health. For instance, advance directives are legal agreements that enable someone to plan beforehand for their end-of-life care. This aspect indicates that advance directives are something that every individual needs to think about. Unfortunately, research also indicates that health care distrust among Black Americans has negatively impacted the rate at which they partake in advance directives, which are usually helpful in the long run. This aspect can be seen in Bazargan et al.'s (2021) study, which purposed to assess the disparities in partaking in advance directives among White and Black adults. As this study indicates, Black Americans were less likely to participate in the completion of advance directives compared to their White counterparts. The authors attributed this finding to the discrimination and high health care mistrust levels among Black Americans. Nonetheless, this is a clear indication of poor health-seeking behaviors, which, in turn, further aggravates the health care outcomes of Black Americans as a whole.

The aggravated health outcomes can be usually experienced at both individual and societal levels. This aspect has been vividly represented by research that is centered on the impacts of health care distrust on the Black Americans amidst the coronavirus pandemic. For instance, according to Best et al. (2021), institutional distrust, alongside the longstanding environmental, economic, political, and social injustices play a significant role in the unbalanced proportions of coronavirus infections and deaths amongst Blacks. This study points that when trust in the health care system lacks, little can be done by the public health authorities to protect the health and well-being of the Black Americans amidst the pandemic. As a result, it points to the dire need of rectifying the public health issue of patient mistrust before it gets out of hand.

Research has also associated health care mistrust with the unwillingness of individuals to donate their organs. For instance, a study by Rusell et al. (2011) was conducted to comprehend the relationship between medical mistrust and the intentions of Black Americans to donate their organs. In their review section, the authors pointed a study by Callender (1982), which identified reasons why most Black Americans resisted donating their organs. These reasons include perceived and actual racism, fear of the premature announcement of deaths of the donors, lack of trust in the medical community, religious misperceptions and myths concerning organ donation, and last, insufficient knowledge of how organ transplantation works. In their actual study, Rusell and colleagues discovered that Blacks with higher medical mistrust levels were less likely to express their intent to donate their organs compared to those with lower mistrust levels. This may be attributed to the fact that if a person does not trust the health care system with their life, they may not be able to make peace with organ donation because it is a potentially life-threatening procedure. As a result, they may see no need to express their organ donating intentions both verbally and through written communications.

Various factors, including one's race, significantly influence how they can relate to certain treatment plans, medical devices, and drugs. In this regard, it is important to ensure that all races are equally represented in clinical trials to minimize the occurrence of biased results. However, research has indicated that health care mistrust among Black Americans hinder their participation in clinical research. For instance, Swabyet al. (2021) also analyzed the under involvement of Blacks in cancer-related research. At first, they express their concerns on the habitual underrepresentation of Black Americans in the clinical trials. As a result, they sought to determine the potential reasons for these low rates of participation than other groups. The main reasons that they identified were mistrust of health care practitioners, high literacy, family concerns, and provider-related issues.

In a different study, Durant et al. (2011) state that typically, Black Americans exhibit mistrust in clinical research compared to their White counterparts. In this regard, they conducted a study to obtain insight into the racial disparities in societal or interpersonal distrust in clinical trials among White and Black Americans. The results of their study indicate that Whites exhibited significantly less societal distrust compared to their Black counterparts. However, they indicated no ethnic variations regarding individual interpersonal distrust. However, in further analyses, the authors highlighted that other factors like awareness of the previous history of Black discrimination, experiences with previous discrimination, and failure to trust one's physician did not significantly impact their willingness to participate in clinical trials.

Furthermore, Kennedy et al. (2007) pointed out that Black Americans had less will to participate in medical research because they believed they would be taken advantage of and used as guinea pigs only to be disposed of later. The authors also highlighted that Black Americans feared participating in the study because they feared that the physicians would not fully explain the reasons why they are participating in the study. However, they also point that Black Americans participation in clinical trials needs to increase. This assertion is supported by Randolf et al. (2021) who argue that there is a dire need to increase the use of Black American men in conducting health care research.

Based on the previously mentioned fact that race plays a significant role in medical outcomes, it is important to heed the advice presented by these research pieces and seek strategies to enhance the partaking of Blacks in clinical trials.

Gender Disparities in Mistrust Among Black Americans

Other studies offer gender-based research on the level of medical mistrust by analyzing Black American men against their female counterparts. For instance, Wiltshire et al. (2011) analyzed the gender disparities in mistrust of physicians among Blacks. In their literature review, Wiltshire and colleagues highlighted studies by Berrios-Rivera et al. (2006), Ahern et al. (2003), and Kemper et al. (1996), which highlighted that the mistrust that Black American men have on the health care system is significantly higher compared to that of their female counterparts. However, they also mentioned a contradicting study by Jacobs et al. (2006), which argued that age, education, and gender are insignificant contributors to Black’s perceptions of distrust or trust in physicians. Nonetheless, upon carrying out their research, Wiltshire and colleagues identified that generally, men had lower trust in physicians compared to their female counterparts which resonate with most studies in their review section. Idan et al. (2020) supported Wiltshire et al. (2011) study by concluding that in general, women have significantly lower levels of mistrust compared to men.

While research indicates that Black American men exhibit significantly high levels of medical mistrust, further research highlights that other underlying factors cause disparities among Black American men, with one of these factors being age. For instance, Hammond (2010)'s study discovered that in general, older Black American men exhibited higher levels of medical mistrust compared to the younger African Americans. They supported this finding by highlighting that this disparity may have arisen from the fact that older men have had more encounters of racial discrimination, and thus, they have developed a negative attitude toward health care over time. However, Idan et al. (2020) do not find age as a significant factor in determining the levels of mistrust among Black American men.

Health-Seeking Habits of African Americans

Some researchers have centered their work on analyzing the general habits of Black American men in seeking health care. Khumalo et al. (2021) conducted a qualitative study to analyze the attitudes of young Black men regarding poor health care-seeking characters and health care barriers. The main type of medical care that was highlighted in this study are sexual health services to enhance sexual health among university students. This study identified that even in instances where medical care was accessible, many men avoided or delayed seeking medical care. The major highlighted reasons include negative experiences with the health system, fear, lack of privacy, negative attitudes and perceptions, and lack of awareness. In support of Khumalo et al.'s study, Lindsey et al. (2012) stated that Black American men are less likely to seek medical help, more so those related to mental health. Their findings indicated the following reasons as to why most of them are reluctant to seek both mental and health care: perceptions that they would rather handle their own issues than seek medical help somewhere else and the inability to trust mental health care providers. Overall, these findings highlight the need to increase awareness of the vitality of seeking medical care services on overall well-being.

Summary and Conclusions

Overall, this review establishes that Black Americans as a demographic exhibit high rates of distrust of the American health system compared to the other minority groups. It has discovered the following primary causes of medical mistrust among Black Americans: lack of trust in health care providers and the government; past exposure to discrimination and mistreatment; systemic racism; racial centrality; income and education levels; stigma due to double discrimination; and personal attitudes. Under systemic racism, this review has also identified the following sub-factors: racial residential segregation, disparities in health care access and quality, and racism in health care systems. The availability of a wide array of medical distrust determinants indicates that the situation at hand is quite complex, and it may be quite difficult to solve.

Further, into the review, it was established that many research pieces also highlight the existence of gender disparities in mistrust among Black American men and women. More specifically, most of the reviewed pieces indicate that Black men exhibited higher levels of medical mistrust compared to women. This aspect indicates that amongst all demographics within the nation, Black American men exhibit the highest rates of medical distrust. As a result, when addressing the public health issue of medical distrust, they should be given an upper hand. Last, this review highlights the following repercussions of medical distrust: poor health-seeking behaviors, unwillingness to save the lives of others through organ donation and racial disparities in clinical trials. Overall, these repercussions negatively impact the general health outcomes at both individual and national levels.

All in all, this review has pointed that the majority group that do not trust the U.S. health care system are the Black American men. This implies that they do not believe that their health care providers can act in their best interests. However, this is also the group that is characterized by lower life expectancy, higher mortality rates, and higher prevalence of diseases compared to their White counterparts. This indicates the vitality of further analyzing their attitudes toward the U.S. health care system. In turn, this would enable us to come up with strategies that can be used to remedy this situation.

Most pieces of reviewed literature offer gender-combined findings of the factors that affect the attitudes of Black Americans towards the U.S. health care system. However, there is an inadequacy in recent studies that analyze the factors that contribute to the higher medical mistrust levels among Black men. Moreover, there is a limitation in the studies that recommend ways that can be used to combat the mistrust levels among Black American men. Therefore, a research gap exists. This implies that the topic needs to be addressed by covering the existing research gap. In this regard, this study will analyze the factors that contribute to the high mistrust levels among Black American men and the possible strategies that can be used to combat the high distrust levels in this demographic.

In Chapter 3, I will provide the research methodology used in this study, inclusive of research design, how the data were analyzed, how the sample size will was determined, the tools and instruments used in gathering the research data, and how study participants were recruited and assured of their privacy. This was a qualitative research design, exploring common themes found in individual interviews using the phenomenological research method. According to Neubauer et al. (2019), the phenomenology research design is a powerful approach to investigative inquiry to gathering data regarding phenomena and is positioned well to support health professions research. A phenomenology study aims to assist researchers by gaining a deeper understanding and meaning of a particular issue from the lens of those that have experienced the phenomena (Neubauer et al., 2019).

Chapter 3: Research Method

Medical mistrust has been a significant area of concern in the United States' public health sector because it negatively impacts the health-seeking behaviors of the affected parties. In Chapter 2, I highlighted that based on previous literature, Black Americans exhibit high medical distrust rates not only when compared to Whites but also other minority groups. I also highlighted that the main factors for this mistrust were personal attitudes, stigma due to double discrimination, income and education levels, racial centrality, systemic racism, past exposure to discrimination, and distrust in the government and the health care providers. Most previous studies offer gender-combined findings of the factors that result in medical mistrust among African Americans. This aspect implies that it is vital to conduct research that focuses primarily on the factors that result in medical mistrust amongst men.

The general purpose of this research was to determine the factors that contribute to the high levels of medical distrusts in the U.S. health care system among Black American men. To achieve this objective, this study sought insight into the health-seeking behaviors of Black American men; the beliefs and perceptions of Black American men regarding their health and well-being, and the health care system of the United States, and last the reasons that they give for their perceptions toward the U.S. health care system.

In this chapter, I discuss the qualitative research methods that I used to attain the objectives of this study. More specifically, this section gives insight into the approaches I employed to collect and analyze data to respond to both the secondary and primary research objectives. To ensure that these objectives were realized, it is important to focus this section on establishing the credibility of the summarized findings of past literature. In other words, this section outlines the procedures that were used to assess whether the findings of previous research regarding the factors that cause medical mistrust in Black Americans, more broadly, are also similar among Black American men as an exclusive focal point of this research. To achieve this aim, insight is being provided into the study design and rationale, selection of participants, data collection and analysis methods, the issue of trustworthiness in the research, as well as the ethical considerations in conducting the research.

Research Design and Rationale

As Taole and Van Wyk (2015) stated, a research design is a blueprint that guides an investigator through the data collection, evaluation, and analysis process. It is indeed a reasonable demonstration approach that helps the investigator deduce causal relationships between the variables under consideration. The research design selected for this study provided a solid ground for the analysis and interpretation of these variables and indicate how they relate. Based on this aspect, this research relied on a qualitative phenomenological research design to effectively comprehend the driving forces behind the high levels of medical mistrust among Black American men. By using this design, I was able to answer the research question for the study, which was the following: What are the lived experiences of Black American men residing in the Memphis, Tennessee area with the U.S. health system and access and use of health care services?

According to Neubauer et al. (2019), a phenomenological research design is a qualitative research approach connected explicitly to studying individual lived experiences and how they impact the social phenomena studied. This research design is powerful in investigative inquiry to gather data regarding phenomena and is positioned well to support research in the health profession. It typically assists researchers in gaining a deeper understanding and meaning of a particular issue from the lens of those that have experienced the phenomena (Neubauer et al., 2019). As Crowe et al. (2016) state, this approach entails collecting profound discernments and data via inductive techniques like interviews and the observation of participants. The collected data is then represented in the viewpoint of the research subjects, that is, the participants of the study. Due to this aspect, this design l significantly aligned with the study's general objective, as it was very effective in illuminating the issue of medical mistrust among Black American men by identifying its possible causes, based on the perceptions and first-hand experiences of the study participants.

Role of the Researcher

Simon (2011) posited that the role of the researcher in quantitative studies is theoretically non-existent. However, he continues to point out that this is quite different in qualitative research, where the researcher is the most important instrument in the study process, specifically in the data collection and analyses processes. He also states that a good qualitative researcher is aware of their roles alongside the vitalities of performing their roles effectively, as well as the consequences for failing to perform their roles effectively. As the researcher for this study, my general role was ensuring responsibility in maintaining the credibility and regard of the multiple research aspects. I understand that because this was a qualitative study, the overall integrity of the research will be determined by my performance as a researcher and the study population. According to Vanderstoep et al. (2008), this arises because qualitative research designs lack various protections against errors that are usually offered by quantitative approaches. Thus, my integrity as a researcher will directly translate into research integrity. Therefore, to ensure integrity in my research, I tried as much as possible to be honest, open, and competent through the various research processes.

As this study's primary researcher, I was also responsible for selecting the study design, sending invites to viable participants, selecting participants by using an inclusion and exclusion criterion, collecting the data, processing, and analyzing data, and finally, writing the report. My most significant role as a researcher was to ensure that I was competent enough to undertake the responsibilities mentioned above. In essence, I had a role in developing competence in the approaches I used for the study. It is likely for one to assume that qualitative research is easier to conduct than quantitative research because it does not entail any complex statistical techniques.

However, this is not the case as qualitative research also requires the researcher to correctly implement specialized skills to ensure that the research is valid and credible. In this regard, I needed to ensure that I was competent enough on vital processes like the interpretation and analysis of data, handling data based on the selected design, selecting appropriate journals to back up my analysis, making appropriate observations during the study, and effectively conducting interviews by ensuring that they aligned with the design. Specific measures were established to safeguard the quality of data collection and interpretation to ensure this research is free of researcher bias in the study results. Additionally, detailed records will be maintained to ensure no mistakes were made in the analysis and for peer review and future research validation.

Methodology

A qualitative methodological approach and phenomenological research design were the guiding frameworks for this study. In line with the study objective, for the study population I targeted Black American men who resided in urban cities in the United States. Urban cities tend to be more segregated by race than other areas of the country. As discussed in Chapter 2’s literature review, previous researchers have posited that such segregation significantly affects the attitudes of Black Americans toward the U.S. health care system.

Participant Selection Logic

To ensure easier access to the target group, I selected Memphis, Tennessee, as the location for the research. I selected this area mainly because its primary population consists of Black Americans. Data from 2019 showed out that approximately 62.8% of the population in Memphis were Black (DataUSA, n.d.). Asian (non-Hispanic), White (non-Hispanic), White (Hispanic), and other races respectively constituted approximately 2.09%, 25.9%, 4.46%, and 2.89% of the population. These statistics clearly indicate that more than half of the population in Memphis are Black, implying that Memphis is a predominantly Black city. Aside from the fact that it is de facto racially segregated, Memphis is characterized by high poverty rates among Blacks. More specifically, most

Black Americans have lower socioeconomic statuses than their White counterparts (Frank & Kiel, 2018). Therefore, Memphis was a suitable area for this study because it is characterized by a high population of Black Americans, with a significant portion of individuals with low socioeconomic statuses.

Sampling Method and Selection of Participants

It is typically impossible to conduct studies on the entire population of the target group. Therefore, a researcher needs to incorporate a sampling method, which will allow them to infer information of a specified population from its subset without necessarily researching every one of its members. According to Morse (2000), this aspect is important not only because it minimizes the workload and costs involved but also because it increases the odds of obtaining high-quality information. Based on this study's primary objective and its qualitative nature, a purposive sample was drawn. In purposive sampling, the researcher is supposed to select their participants from a sampling frame mainly because they fit the researcher's inclusion criterion. According to Gill (2020), purposive sampling is a crucial sampling strategy as it provides the opportunity to be more intentional about reaching the target population. Based on this aspect, I believe that it was appropriate to apply the purposive sampling method to select candidates for this study.

The study participants were selected from the target group of this study. In this case, because I was researching the factors that result in medical mistrust among Black American men using a phenomenological approach, I needed to include participants that are only Black American men born in the United States, implying that they must be U.S.

citizens by birth. In line with this criterion, this research excluded those identifying as Black that have immigrated into the nation, including the Hispanic and the Afro Caribbean Blacks. The age range for the selected participants will be between 18 and 75 years. Noticeably, the selected age included only adults. Also, in the selection of participants, I selected my participants in a manner that minimized researcher bias. To achieve this, there were no prior established social or professional relationships with the study participants before I started conducting the research. Thus, no social, business, or familial relationships between me and any of the study participants existed.

To recruit participants, I designed a specific outreach criterion to identify the volunteers that have lived experiences, either their own experiences or those of others, as it would be very advantageous to the study. Study participants were sought using three methods: Facebook, Research & Me, and recruitment at a local federally qualified health center. I advertised on Facebook to target a specific audience by age, race, gender, and geography. Research & Me is a platform that provides for the distribution of research studies to engage prospective candidates in the target geography. Research & Me was also utilized as the landing spot for interested volunteers to register for the study. Thus, a link to the study registration page was included on all digital and physical advertising medium.

Finally, a Memphis area federally qualified health center was the other source used for recruitment, whereby research study recruitment posters were placed strategically within the facility. The search for study participants ceased once the target sample size had been achieved, regardless of the recruitment source. While the goal was to study 12 appropriately identified participants, the final determination of the most credible sample size was ultimately determined by achieving a saturation point where using more participants would not achieve additional or substantive insights from the interview questions. Those who were selected and participated in this study received a $50 Visa gift card as compensation for their time.

Instrumentation

I used primary sources to obtain the data to be analyzed. At first, I thought about employing questionnaires to collect my data, as I wanted to save on the overall time and costs that I would use in this research. That is because, typically, questionnaires are fast and cheap ways of obtaining huge amounts of data from a wider range of people. However, upon further assessment, I discovered that conducting interviews could yield the best results for this study based on its phenomenological nature. Unlike questionnaires, interviews present an opportunity to assess non-verbal cues and clarify how the respondent should respond to the questions in situations where they do not understand (Ryan et al., 2009). Therefore, because this is a phenomenological study based on the experiences of Black Americans, conducting interviews was the best option.

More specifically, I relied on the use of open-ended interviews, which allowed the participants to give their free-form responses. I preferred using open-ended questions because they allowed the interviewee to respond less stringently, elaborating on specific areas that they found meaningful, which ultimately enables the participant to take the conversation into areas that one hopes will naturally lead to unexpected findings to help understand lived experiences and influences (Rubin & Rubin, 2012). This approach guided the conversation into the areas necessary to collect meaningful insights for the research.

To develop the interview questions, I utilized a framework and methodology developed by Mark Bevan, which structures phenomenological interviews into 3 phases. Bevan (2014) posits that while it may fall outside the norm for phenomenological interviews to have structure, the structure does help ensure the researcher can more methodically guide their interview towards the answers they seek. Bevan's model structures interviews into three domains; Contextual relevance, trying to apprehend the phenomena, and explaining the phenomena (Bevan, 2014, pp. 138-139). Essentially, these domains also help in the interview flow so that the interview questions can gradually build off each other.

In the first domain, the goal of the interview questions was to assess how the participants feel about health care in general. This was important because it would eliminate the bias of generalizing the perceptions of all Black American men regarding the U.S. health care system. This domain also included health-seeking behaviors, in which the participants were asked questions to show whether they value their health or trust the U.S. health care system. In other words, this indicated whether their personal health was important to them and their frequency of accessing services from the medical community. Next, the questions focused on their perceptions of the U.S. health care system, which was the second secondary objective of this study. Finally, the questions centered around specific experiences directly or indirectly impacting their perceptions and level of trust as it relates to their access, utilization, and compliance with the health care system.

Procedures for Recruitment, Participation, and Data Collection

Before conducting the interviews, I first sought the approval of my interview guide and research protocol from Walden University's Institutional Review Board. Upon approval, I invited participants to participate in the research via email, which was the primary means of communication. However, to increase the pool of participants, I also invited other participants to participate in the study through various channels, including flyers and social media announcements. This was crucial as it enabled me to reach those that cannot be accessed via email. To obtain informed consent during the invitation, I first introduced myself and invited the participants to be part of the research study. The details that I provided here included my name, institution, and the program I am undertaking. I then explained the primary research purposes and the activities that would be involved in the research. This also included the role they would be playing in the research.

Next, I described to them any benefits of the research in terms of what I hope to learn since probably no direct benefits to the research subjects existed. Afterward, I explained my confidentiality procedures to the participants and convinced them that their privacy and confidentiality are taken seriously. I also allowed them to ask any questions that I could respond to before they were offered their informed consent. I then asked them to provide their personal details, including confirmation of Memphis or Shelby County residency, email addresses, phone numbers, age, gender, and race. If one was comfortable with all the information I provided, I then asked them if they were willing to partake in the investigation. If one agreed to partake in the study, they were provided with their informed consent. Overall, getting the informed consent was the major concern in the invitation process as it enabled the participants to comprehend what they are signing up for.

Once participants gave their informed consent, it was confirmed that they meet the inclusion criteria and express further interest. Afterward, I sent them a formal invitation to take part in the study. Subsequently, each participant was required to set a specific date within a specified time frame, which would be more convenient for them to participate in the interview. I believe that working with the participants' convenience was vital as it ensured that they were comfortable when responding to the questions, which, in turn, improved the overall quality of the collected information. In the actual interview processes, I followed six steps:

1. Contacted the participants that had provided their consent via their telephone numbers, which they would have provided upon giving their informed consent and asked them to get ready for the interview process.
2. Sent them a link to join a video call in a video-calling platform that they preferred the most. Examples of video calling platforms that we used included Zoom, Google Meeting, and Microsoft Teams.
3. As soon as they accepted the invitation, I continued the interview by asking them again for their informed consent. Here, I posed the following question: “With your permission, I would like to interview you for my research, and I

would like to record this interview so that I can make a more precise transcript for my data. Are you okay with that?"

4. After their verbal acceptance, I then began recording the interview by clicking the record button.
5. I then started asking the questions in a specific order and gave the respondents enough time to reflect before responding to their questions.
6. I ended the interview process by thanking them for their participation and advising on how/where they would be able to obtain info that resulted from the research.

In the first part of the interviews, I requested each participant to give their demographic information by responding to brief sets of questions. This information included their ages, sexual orientations, employment statuses, income levels, education levels, and duration of stay in Tennessee. This part was important as it helped create a descriptive portrait of the sample that would be used in the study. The next parts of the interview focused solely on responding to the primary research question: What are the lived experiences of Back or African American men residing in the Memphis, Tennessee area that contribute to distrust of the U.S. health system and is also a factor in their access and use of health care services? Responses to this question proved fruitful in determining the contributing factors of distrust of the U.S. health system by Black American men. A secondary objective of this research was to obtain a general overview of the health-seeking behaviors of Black American men who reside in Memphis, Tennessee.

The next secondary objective of this study was to assess the perceptions and beliefs of Black American men regarding health care. Here, I asked the participants a set of inquiries to assess whether they view the U.S. health care system positively. Last, I asked the participants to provide their reasons for the responses that they would have provided in the previous section. To avoid biases, strict guidelines were adhered to, complying with the interview questions guide, to not deviate from the primary study plan. Suppose during the interview; I established that one of the selected participants is someone that I had previously interacted with socially or professionally. In that case, this person would have been excluded from the study to minimize researcher bias in data collection. All in all, in the data collection research phase, my aim was to collect quality and sufficient data to be analyzed in the next research step.

Data Analysis Plan

Before commencing the data analysis process, it is vital to reassert the aim of this qualitative research is to determine the contributing factors of mistrust in the U.S. health system amongst Black American men. Based on this study's primary purpose, the analysis sought to respond to the following research question: What are the lived experiences of Black American men residing in the Memphis, Tennessee area with the U.S. health system and access and use of health care services? It is also worth pointing out that the research analysis process needed to align with the selected design for this study, which was an exploratory phenomenological design. Grooenewald (2004) cautions researchers to be careful when analyzing phenomenological data because the analysis can give various meanings to collected data, which would, in turn, result in the loss of phenomenology. Thus, as Groenewald advises, researchers need to adhere to the process of explication, which implies investigating to interpret the collected data. Five key elements make up the process of explication. They include

1. Engage in bracketing and phenomenological reduction.
2. Determine the units of meaning.
3. Group the units of meaning based on themes.
4. Summarize and validate the interviews.
5. Create of overarching summary from themes drawn from all interviews.

The primary process that I used to evaluate the collected data was thematic analysis. In Anderson et al.'s (2000) work, content analysis is defined as the technique of quantitatively quantifying content using mutually exhaustive and exclusive criteria. A researcher can use this data analysis procedure to look for recurrent data patterns in the data they've collected. My data analysis method started with reviewing and transcribing the recorded interviews. The initially proposed framework was followed to the letter during the analysis of the transcribed interviews. As a result, my next step involved coding the transcribed interviews. Since the sample size permitted manual coding of the data, the analysis process employed hand coding instead of qualitative data analysis software to minimize the risk for bias in thematic coding.

Thus, the participants' responses were managed and manually coded using Microsoft word. The recordings from the interviews were listened to repeatedly and analyzed using the grounded theory framework. Conferring to Timmermans and Tavory (2012), grounded theory plays a significant role in the identification and categorization of themes which can then be used to create conceptual models. The data analysis process utilized thematic analyses. Riger and Sigurvinsdottir (2016) define thematic analyses as the process in which a researcher identifies patterns and themes within groups of texts. Generally, in the first round of the analysis process, I listened to the audio recordings while taking down notes of the reliable responses in a Microsoft Word document. I then relistened to the recorded interviews while rereading the notes to look for codes and any emerging themes. Afterward, I compiled my code list and made instant comparisons before sorting them into themes. Here, if I identified any key theme in a specific interview, I looked for similar themes and wordings in other interviews and put them under one topic.

All in all, I ensured that I replied to the following questions during the data analysis process:

- Am I addressing the research problem while analyzing the collected data?
- Does my analysis align with the study's primary objective?
- Does my analysis flow logically from the beginning to the end?
- Am I making any explanations for any arguments that I am making in my research?
- Am I presenting the results neatly?
- Based on the presented facts, is there any call to action?

Although these questions may look quite basic, I believe that reflecting upon them while making my analysis provided a solid ground for my analysis. It is also worth acknowledging that, since nine is still a fairly large number for a phenomenological interview, it increased the odds of data saturation in conducting research analysis. Data saturation can occur when there are no new codes identified from the data analysis (Mason, 2010). In other words, when the researcher reaches the point of redundancy in the analysis process, where the shared experiences are repeated, the analysis has arrived at the point of theoretical saturation. According to Rahi et al. (2019), the point of theoretical saturation is usually established when the point of redundancy in the interviews has achieved a 95% confidence level. If the study realizes this point, it will imply that enough information has already been collected, and thus, there is no need to continue coding the rest of the interviews. Nonetheless, while a large sample size increased the likelihood of data saturation, it ensured that all themes that related to the study objective were identified and that the sample could represent the entire population under study.

Issue of Trustworthiness

Trustworthiness is an essential issue in qualitative research. As Williams and Hill (2012) suggest, trustworthiness denotes the process of strengthening the authenticity of study results and guaranteeing that the research has been well and methodically carried out from conception to conclusion. The four major aspects that establish the trustworthiness of a researcher include confirmability, transferability, dependability, and credibility.

Transferability

In qualitative research, transferability is referred to as the extent to which the conclusions of the study can be used in other studies and other contexts outside the study.

It is worth acknowledging that as a researcher, I cannot establish that my research findings will be applicable in other contexts. However, it is my job to provide pieces of evidence that indicate its potential to be applicable. According to Lincoln and Ungar (2003), a researcher can achieve transferability by giving a thick account of the phenomena under study. Thick description is defined as a strategy in which a researcher gives a detailed and robust description of their experiences during the data analyses and collection processes. In line with the recommendation above, I observed and provided details of the following aspects during data collection: Discussing the contexts of the interviews, the morale of the participants during the interview (determines the quality of the responses), and many more factors that I perceived worth highlighting. Overall, I believe that by providing this information, I will be able to help the reader picture the context of the study and place them in a position of making transferability judgments.

Dependability

The notion of dependability denotes the degree to which the study's results can repeatedly occur in the findings of other researchers if they follow the same procedure outlined in the study. Dependability asserts that if another individual decides to replicate the research, the report should provide sufficient information that would allow them to find similar results from the replicated studies (Guest et al., 2012). To establish the dependability for my research, I ensured that I used an inquiry audit, which refers to an outside party to help me examine and review the processes involved.

Confirmability

Confirmability is referred to as the degree to which the study findings are neutral. Confirmability typically occurs when the outlined findings correspond with the responses provided by the participants and not a personal motivation or potential bias of the researcher. I acknowledge that one of the factors that can result in personal bias as a researcher is confirmation bias, which arises from the influence of the findings of previous research pieces. Confirmation bias can be defined as the inclination to seek out or interpret data in a way that validates one's views, resulting in interpretational inaccuracies. However, because I am fully aware of this fact, I put in much effort to analyze my raw data as it was before comparing it with previous research findings.

Credibility

Credibility can be defined as the confidence of the researcher in the research findings that they provide. Credibility is an essential component in establishing trust because it typically requires a researcher to ensure clarity in their findings by linking them with reality to show that the reported findings are true (Guest et al., 2012). I ensured credibility in my research by acknowledging the presence of any study limitation that may have resulted in research bias. I also account for any personal biases that may have arisen while conducting the research. In doing so, I have provided a critical reflection of my methods, ensuring that I have indicated my confidence levels in my research findings.

Ethical Procedures

Ethical considerations offer guidelines for doing studies responsibly. They also educate and supervise researchers to ensure that they maintain a high ethical code. The first ethical procedure that I undertook in this study was seeking permission from Walden University’s Institutional Review Board before I embarked on the study. This aspect is important because this research was primarily conducted using human subjects, and as a result, it ensured that the volunteers of the study were adequately protected. The study received Institutional Review Board approval under number A00748513. After receiving this approval, my next ethical goal was to seek the informed consent of the participants through email during the invitation process. Getting the informed consent of participants is particularly crucial as it ensured that every participant who volunteered for the study was fully aware of their roles and any risks involved before partaking in the study.

During the study itself, the first ethical principle that I have upheld in this study is confidentiality. In research, confidentiality refers to the agreement made between the researcher and the participant regarding how easily recognized information like names will be managed in the research process. The main advantage of ensuring confidentiality in research is that it ensures the protection of the privacy of all participants, which, in turn, establishes research integrity. One significant ethical concern in this research is related to unwanted solicitation, intrusion, or participant observation in public establishments. Given the importance of privacy, care was taken to interview the study participants one by one, ensuring that each participant had a one-on-one conversation with the researchers. Also, even though the participants provided their names, their names were removed from the research. In essence, they were referred to as Participant A, Participant B, Participant C, and so forth.

Another ethical principle that I upheld was carefulness. First, due to the study topic's sensitive nature, the first ethical consideration was related to the psychological stress that could be caused by the study being more significant than the participant would experience in their daily life. The interviews conducted for this research may have elicited strong emotions and distress as participants reflected on their living experiences or close family members. Discussions about race, abuse, and inappropriate treatment at the hands of medical professionals, or the industry, can be upsetting to discuss by those impacted directly or indirectly. Therefore, I handled the interviews with caution to ensure that I provoked no participant in the study. I also avoided negligence and carelessness by critically examining my work and keeping excellent records of the entire process to ensure that I did not make a mistake that could affect the overall trustworthiness of my research.

The next ethical principle that this research upheld is honesty. As the researcher, I was honest in reporting the procedures used and the results obtained in the study. I did not, at any instance, intentionally misinterpret, falsify, or fabricate any data to make my research look more appealing. Another ethical principle that I upheld is integrity. I acted with utmost sincerity throughout the research process. I ensured objectivity by avoiding bias in pieces of evidence, proposal drafting, subjective judgments, peer assessment, and analysis of data. This aspect is necessary as enabled me to elaborate precisely on the nature of the phenomenon in the actual world. Overall, while I acknowledge that I faced a significant number of ethical difficulties in my research, I believe that adhering to the defined ethical roles, I was able to surpass these challenges and ensure trustworthiness in my research.

Summary

The general objective of this study was to explore the factors that contribute to the high levels of medical distrusts in the U.S. health care system among Black American men. This chapter has outlined the various research methods that were used to attain the objective of this research. In summary, the research design that this study employed was a phenomenological research design, which sought to gain insight into the lived experiences of Black American men. This chapter also describes the target population for this study, which were Black American men, and preferably residing in de facto racially segregated region. Furthermore, it highlights the research procedures that were used in this research. More specifically, it highlights the sampling method and participant selection, processes involved in data collection regarding aspects like the used instrument, and the data analysis process. It proceeds to elaborate on how the research ensured trustworthiness concerning confirmability, transferability, dependability, and credibility. Last, it illustrates the ethical procedures and principles that I adhered to while conducting this research. Overall, upon following the outlined procedures and guidelines, I was able to obtain and analyze data before proceeding to the next chapter of this research, which entails an in-depth elaboration and explanation of the research findings.

Chapter 4: Results

In this qualitative study, I explored Black American men's lived experiences with the U.S. health system, specifically focusing on their access and utilization of health care services in the Memphis, Tennessee, area. While the HBM is the theoretical framework guiding the study, this research delved deeper to understand the diverse influences on health care behaviors among this group. A wealth of perspectives was unveiled through nine semistructured interviews, identified as Participants A through Participant I. Their experiences navigating interactions with health care providers exposed both impediments and aids to obtaining care. Perceptions of individual barriers mingled with acknowledgments of societal drivers in illuminating the complex interplay between personal and external factors molding health-related decisions. The rich insights unveiled varying viewpoints, some highlighting specific hurdles, while others were more complex, interweaving an array of interconnected pieces in the health care access puzzle. This chapter aims to describe the setting of the research, characteristics of those involved, and methods used to gather and analyze the information. Specifically, it will cover the initial and subsequent coding rounds for organizing data, as well as examine matters involving trustworthiness. In closing, a summary of the results will be provided.

Main Study

This study consisted of in-person and video interviews with nine participants who, with one exception, were unknown to me. The one known volunteer participant was recently met during a Walden University residency and ironically lived within the Memphis, Tennessee, area. Additionally, this participant met the criteria for participation.

The phenomenological approach guiding this research study initially targeted ten participants to share their lived experiences with the investigated phenomenon. This figure followed phenomenology’s focus on profoundly understanding individuals’ subjective worlds through their narrations. As Creswell (2013) posits, phenomenological research emphasizes richness over size, with smaller pools providing substantive exploration of first-hand experiences. Similarly, Moustakas (1994) stresses engaging thoroughly with each participant, implying that fewer, more concentrated interviews can provide comprehensive insight.

Despite meticulous planning, recruiting proved more difficult than expected, culminating in nine interviews. This minor divergence did not compromise research integrity; however, by the seventh interview, there was a noticeable repetition in emerging themes. This observation aligns with Guest, Bunce, and Johnson’s (2006) findings that data saturation often surfaces by the sixth interview in qualitative phenomenological work.

Additional confirmation of sufficiency stems from the diversity across participants’ experiences and the depth of their reflections, which underwent thorough phenomenological analysis to obtain an appreciation of their lived experiences. This served the aim of uncovering the phenomenon under investigation. While one interview was fewer than intended, the nine phenomenological discussions provided a rich, in-depth examination of the phenomenon, culminating in theme saturation and robust conclusions. This study’s approach and results thus align with phenomenology’s prioritization of depth over quantity in illuminating human experiences.

Various methods were attempted, including ad placement on Facebook, posting within a local health clinic, soliciting volunteers during a public citywide health fair, and leveraging Research & Me, which is a platform for streamlining the process related to research studies, such as study posting, recruitment, and management of volunteers, and also participation in a local health fair. Ultimately, securing volunteers from the health fair garnered the best response.

Memphis, Tennessee, serves as a unique backdrop for this study, with its distinct health disparities, socioeconomic challenges, and a predominantly Black American population. The participants, Black American men aged 19 to 62 years, provided diverse perspectives that reflect various experiences with the health care system. The interviews lasted between 15 and 35 min, which lengths can be attributed to varying lived experiences to be shared in addition to general laypersons' knowledge of the topic and associated questions. However, each participant brought forth stories of personal health experiences, interactions with health care professionals, and the perceived impact of race, economics, and social factors on their health decisions.

Setting

This study was conducted in the vibrant and historically rich city of Memphis, Tennessee, a locale characterized by deep cultural southern roots in American music, food, diversity, and contrasts in socioeconomics. The health care landscape of Memphis is a mix of urban and semi-urban settings, from large hospitals to smaller clinics, reflecting challenges nationwide, like inequities in access, quality, and outcomes, especially for Black communities. These disparities are compounded by higher rates of poverty, unemployment, and underinsurance in some areas, collectively posing barriers to health care access and use.

The substantial Black American population further justified the choice of Memphis for the research. This demographic reality, along with socioeconomic dynamics, provides fertile ground for exploring Black men’s lived experiences navigating health care access and use complexities. Focusing on this specific geography allows a nuanced understanding of how place-based factors like infrastructure, conditions, and networks influence health behaviors and perceptions.

Conducting the research in Memphis also facilitated direct engagement with the target population in their community, enabling more profound insight into personal, familial, and community factors shaping health beliefs and practices. This setting offered a vivid context for participants’ narratives, revealing intricate ways the physical and social environment impacts health care access and use among Black men. Despite having trouble recruiting volunteers for this study, once that barrier was resolved, there was an ideal mix of participants interested in sharing their lived experiences and perspectives and doing so in both in-person and video conference settings.

In summary, the research setting of Memphis, Tennessee, is critical to understanding the complex interplay between race, health, and geography. This setting allowed a rich exploration of barriers and facilitators to health care access and use as experienced by Black men within a city, embodying broader challenges and disparities of the American health care system.

Demographics

The varied composition of participants in this study provided a rich tapestry of the lived experiences of Black American men residing in Memphis, Tennessee, shedding light on their health care access and use. This focused research intentionally recruited a diverse group of Black American men to capture the full spectrum of perspectives and realities, thus deepening the meaning and relevance of the outcomes. Participant ages spanned from 24 to 58, encompassing generations that offered insight into how age shapes health care views and behaviors. This intergenerational range facilitated examining health care access and use across life stages, highlighting differences between eras in needs, preferences, and barriers.

Educational backgrounds among participants were widely varied, with some graduating high school while others attained vocational certifications, college degrees, and postgraduate studies. This variation in schooling provided a way to see how education impacts health care literacy, decision making, and access. Higher education often correlated with stronger navigation of the health care system, whereas less formal schooling presented more significant obstacles.

A broad array of employment conditions was represented, from full-time employed to part-time employed, self-employed, and unemployed participants. This diversity allowed exploration into how job status and the associated health insurance coverage influence health care access and habits. Employment providing health benefits eased health care access, contrasting with challenges faced without steady work or insurance from an occupation.

The socioeconomic status among participants was varied, providing insight into how financial factors shape health care access and use. Those from lower socioeconomic backgrounds reported more substantial barriers to care, including cost burdens and transportation difficulties. In contrast, higher socioeconomic status emphasized the role of coverage and ability to choose providers as major facilitators.

Insights gleaned from participant demographics illuminated the multifaceted nature of health care access and use among Black American men in Memphis. Age, educational background, employment condition, and socioeconomic status emerged as pivotal intersecting factors influencing health care behaviors and experiences. This overview underscores considering a holistic range of dimensions when addressing disparities and designing interventions to improve community health outcomes. Table 1 provides a breakdown of the characteristics of the participants of this study.

Table 1

Participant Characteristics

Participant identifier	Age	Education level	Occupation
1. Participant A	36	Trade school	Barber
2. Participant B	35	Some college	Airline handler
3. Participant C	25	Bachelor’s degree	Trader
4. Participant D	62	Bachelor’s degree	Recreational assistant
5. Participant E	43	Master’s degree	Assistant director, youth residential center
6. Participant F	55	Master’s degree	Computer engineer

7.	Participant G	19	College student	Student-athlete
8.	Participant H	50	PhD	Retired warden (prison system)
9.	Participant I	28	High school diploma	Assistant manager, fast-food restaurant

Data Collection

Data collection for this dissertation study had been deliberately designed to thoroughly gather penetrating insights into the health care access and utilization behaviors of Black American men dwelling in Memphis, Tennessee. Employing a qualitative research methodology, the study primarily leveraged semistructured interviews to explore the lived experiences and viewpoints of the interviewees, identified as Participants-A through Participants-I. These interviews proved pivotal for comprehending the nuanced outlooks and experiences within the focus demographic. Prior to launching the main data accumulation phase, the interview questions and format were refined during a test study. This initial step confirmed that the interview style was both exhaustive and sensitive to the participants' experiences, optimizing the principal study's information accumulation process.

Consistent with the original design phases, participant interviews unfolded as planned, highlighting the effectiveness of the preparatory work. The study engaged nine participant-interviewees, each devoted 15 to 35 min to the research process. Six interviews were conducted using the Zoom videoconferencing platform, which provided a flexible and accessible medium for participants. Three interviews were conducted face-to-face and in settings of the participants' choosing; these considerations ensured inclusiveness and participant comfort during the interviews. To enhance the accuracy and efficiency of data capture, each Zoom session utilized the Otter.ai auto-transcription tool. This innovative technology provided both audio and transcribed representations of the interviews, significantly streamlining the coding and analysis phases by allowing direct access to the audio from the transcription. Participant consent for recording was obtained before initiating each session. Simplifying the scheduling process, participants were invited to select interview times that suited their schedules. Participants' consent was rigorously documented, with each participant signing a Consent Form before their interviews, underscoring the study's commitment to ethical research practices. The nine participants who volunteered for this research study qualified based on the inclusion criteria. To meet the inclusion criteria, participants must identify as male or of Black or African American descent, must reside currently in the Memphis, Tennessee area to allow for exploration of the unique health care challenges facing this community, and be aged 18 years or older. The recorded interviews used a semi structured process.

This comprehensive approach to data collection, using a phenomenological direct interview approach, ensured a rich and multi-dimensional understanding of the research topic. The use of technology like Zoom and Otter.ai, coupled with thoughtful participant engagement strategies, exemplifies the study's innovative and participant-centered data collection methodology.

Data Analysis

To analyze the health care access and utilization behaviors among Black American men in Memphis, Tennessee, I employed a thematic analysis within the framework of the HBM. This nuanced approach systematically identifies and organizes major themes from the interviews through an intricate coding process, enabling a layered exploration of how various health beliefs spanning Perceived Susceptibility, Perceived Severity, Perceived Benefits, Perceived Barriers, Cues to Action, and Self-Efficacy to understand how they influence medical choices.

The meticulous thematic analysis of phenomenological interviews with Black American men in Memphis manifested diverse and intricate perspectives. An exhaustive manual coding approach aimed to methodically distill these insights into core themes resonating with constructs from the HBM.

Initial Coding

Initial coding involved exhaustive identification of diverse articulated perspectives, including encounters scheduling appointments and reliance on preventive practices. However, distrust in doctors and utilization patterns shaped by past experiences manifested concerns over costs and negative interactions. Dependence on online information and community narratives for health advice accompanied experiences of perceived racial prejudice and difficulties accessing nearby medical services amid the perceived complexity of navigating the health care system. Moreover, the impact of social determinants on individual outcomes, the importance of trust and rapport in relationships, and skepticism of preventive measure's role alongside insurance coverage facilitating care and stigma of mental health assistance. Economic barriers also impeded access to necessary services amid personal experiences with bias within the domain.

This wide-ranging identification formed a comprehensive foundation for understanding the complex medical experiences encountered amid exhaustive coding of diverse observations, emotions, and outlooks articulated amid wide-ranging initial aspects beyond those stated herein.

Second-Level Coding: Thematic Refinement Aligned With the Health Belief Model

Following initial coding, a focused effort was put into categorizing initial codes into broader themes. This second-level coding aimed to uncover deeper patterns and insights directly answering the overarching question. Crucially, themes organized coherently with HBM domains:

- perceived susceptibility and severity: Encompassed codes related to participants' perceptions of their vulnerability to certain health issues and the severity of potential health outcomes. Codes such as challenges in scheduling appointments, experiences of racial bias, and the impact of social determinants on health were pivotal in forming this theme.
- perceived benefits and barriers: Focused on participants' beliefs regarding the benefits of accessing the health care system versus the barriers they face, including economic obstacles, issues with insurance, and a general distrust of health care providers.
- cues to action: Identified cues that motivated participants to seek health care or alter their health behaviors, and were influenced by factors such as community advice, past health care experiences, and the significance of provider-patient relationship.

- self-efficacy: Highlighted the confidence participants have in managing their health and navigating the health care system, underscored by their reliance on online information, personal health care practices, and their strategies for dealing with the complexity of navigating the health care system.

Through rigorous manual coding, each theme underwent numerous validations and refinements, to authentically represent narratives and alignment effectively within the theoretical framework. This judicious approach facilitated rich, in-depth exploration, revealing critical health care experience and perception insights of Black American men in Memphis through the HBM theoretical lens.

Evidence of Trustworthiness

Credibility

To capture participant voices directly and enrich the narrative's authenticity, an emphasis was placed on manual coding during analysis. This approach permitted the preservation of expressions and terms used by participants in their own words. Moreover, interviews were designed flexibly to allow exploration of experiences and insights freely. This semistructured methodology facilitated deep understanding of perspectives on health care access and use, reinforcing credibility.

Transferability

Despite sharing geography and identity as Black American men, participant narratives revealed a diversity of health care experiences. Commonalities and differences in access and use behaviors underscore both individual realities and a collective landscape. The study achieves transferability through highlighting universal themes alongside unique stories. This comprehensive view of the Memphis health care environment for Black American men provides insights applicable elsewhere while also noting where experiences diverge, guiding future research.

Dependability

Consistency ensured dependability, starting with a standardized introduction used at each interview refined after piloting. Additionally, questions-maintained structure while permitting elaboration. This balance of structure and flexibility made the process replicable and reliable, contributing to dependability.

Confirmability

A conscious effort was made to ensure that the study's findings emerged from the participants' data rather than the researcher's bias. However, the interpretative nature of qualitative research makes total objectivity an unrealistic expectation. This study incorporated different research methods and included extensive unedited quotes from participants to guide the findings back to the data to support confirmability.

Results

The findings from the thematic evaluation of phenomenological interviews conducted with Black American men living in the Memphis, Tennessee region was guided by a core research question: What are the lived experiences of African American men residing in the Memphis, Tennessee area regarding the U.S. health care system and access to and use of health care services? This question aimed to uncover the nuanced realities this population faces, providing insights into their interactions with, views of, and behaviors toward the U.S. health care system. Comprehending the lived experiences of African American men in Memphis in the context of health care access and utilization is crucial for addressing systemic inequalities and enhancing the effectiveness of health services. The analysis, grounded in the HBM, sought to dissect these experiences into identifiable themes that resonate with the constructs of perceived susceptibility and severity, perceived benefits and barriers, cues to action, and self-efficacy. Herein, I delve into how these themes emerged from the narratives shared by participants, reflecting the multifaceted nature of their experiences with the U.S. health care system.

The insightful dialogues with African American men in Memphis uncovered profound insights about their medical experiences, viewpoints, and behaviors. This segment presents the findings organized around the constructs of HBM, specifically perceived susceptibility and severity, perceived benefits and barriers, cues to action, and self-efficacy. These motifs describe the intricate interplay of factors that sway health care choices and interactions within this community.

Perceived Susceptibility and Severity

The participants expressed a nuanced understanding of their vulnerability to health problems, regularly impacted by personal and relatives' medical histories. For many, widespread persistent conditions within their neighborhood and family heightened their sense of endangerment. The severity of likely health outcomes was a recurring issue, notably in the context of systemic and social determinants of health that exacerbate these risks. One participant shared, “I've seen too many people wait too late... it's like a ticking time bomb if you ignore your health.” This statement reflected a prevalent sentiment about the critical need for proactive health management.

Perceived Benefits and Barriers

The analysis revealed a keen awareness of the benefits of engaging with health care services, mixed with significant barriers. Participants appreciated the importance of preventative care and the potential of regular health check-ups to reduce likelihood of severe health outcomes. However, economic barriers, mistrust towards health care providers, and perceived racial biases often undermined their engagement with the health care system. A participant recounted, “Even when I know I should see a doctor, thinking about the bill, the attitude I might get... sometimes, it just doesn't seem worth it.” This statement captures the dilemma faced by many participants, weighing the benefits of care against the mental and financial costs of accessing services.

Cues to Action

Cues to action varied widely among participants, with many citing adverse health events within their family or social network as key motivators for seeking health care. Importantly, the role of community and familial advice emerged as a significant cue, guiding decisions around when, how, and where to seek care. “My brother's diagnosis was a wake-up call for me. Made me think about my own health differently,” remarked one participant, highlighting how personal connections often serve as a catalyst for health-seeking behavior.

Self-Efficacy

Participants demonstrated a diversity of self-efficacy in managing their health and navigating the health care system. Although some felt empowered by accessing information online or leveraging community networks for health advice, others expressed frustration with the complexity of the health care system. One participant noted, “I do my research, ask around... I try to stay on top of things. But sometimes, the system makes you feel powerless.” This statement reflects the dual reality of self-efficacy experienced by participants - a sense of empowerment from personal agency, tempered by systemic challenges that could not be overcome by any single person.

The interviews provided for diverse reactions from participants on two topics: their awareness of the historical abuses of Black Americans by the medical community and the importance of their doctor's race. Views on these issues were nearly equally divided. In review of the transcripts and the question related to knowledge of historical abuses of Black Americans by the medical community was explicitly mentioned in three instances. These occurrences highlight a varied awareness among the participants regarding the history of medical abuses against Black Americans, which is an essential factor influencing trust in the health care system. Here’s a summary of the mentions:

Examination of the dialogues uncovered three overt references to past injustices endured by African Americans due to medical misconduct. Such acknowledgment of prior wrongdoings highlighted differences in understanding of exploitation Black people confronted in health care across history. Trust in medical institutions remains threatened considering this backdrop. Participant E discussed having knowledge about historical abuses, such as the Tuskegee experiments and other forms of medical experimentation on Black Americans, citing military experience and academic studies as sources of this knowledge. Participant G also mentioned the Tuskegee Airmen experiment specifically and noted a lack of education on this topic in schools, indicating that their knowledge came from family discussions. Through interactions within their fraternity, which included members who were Tuskegee Airmen, Participant H also learned about the Tuskegee experiment. This participant highlighted how such historical knowledge contributes to apprehension about being treated as "guinea pigs" by the medical community.

Although an awareness of past injustices shapes perspectives and behaviors among some in the Black community, not all allow historical harms to define their current experiences. Those who drew upon such knowledge evidently see it as instrumental in understanding their approach to managing their health care and how and when they seek out a physician for care. Nevertheless, redressing earlier wrongs and cultivating a medical landscape wherein all patients of color feel heard, respected, and cared for remains an urgent priority. Progress demands recognition of past faults alongside present efforts to foster care, compassion, and confidence for people of all backgrounds. Table 2 presents a detailed analysis of participant responses categorized by age.

In the participant transcripts reviewing, the importance of having a physician of a specific race (Black or White) was mentioned with varying perspectives across different participants. Participant C expressed a preference for a Black female doctor, associating this preference with caregiving qualities traditionally associated with women. However, Participant C ended up with a White male primary care doctor since birth, indicating that the insurance policy might have influenced the selection process or that there was a lack of intent to change. Participant D relayed a second-hand experience of discrimination from White doctors perceived by a cousin, suggesting that a Black doctor might have offered better care under the assumption of shared racial experiences. However, Participant D also emphasized that personal qualities and trustworthiness in a doctor were more critical than race. Participant B mentioned a preference for a doctor of the same race, believing that a Black doctor would better understand the health issues prevalent within the Black community. However, this participant also acknowledged that it's the understanding and experiences shared, not just the race, that mattered.

Participant A shared mixed feelings, indicating experiences with good doctors of various races, including Black and White, but also hinted at a belief that Black doctors might better understand certain health issues prevalent among Black Americans. This participant suggested that personal care and attention from the doctor, regardless of race, were significant. Participant I had a nuanced view, suggesting that while race might play a role in the level of empathy and understanding (especially highlighted by interactions with Black nurses), the competency and actions of doctors mattered more in their assessment. They recounted a mixed experience with doctors of different races, where the quality of care did not seem to correlate directly with the doctor's race. Participant H explicitly stated a preference for an African American doctor, citing a trust level and comfortability in being open about health concerns with someone of the same race. This participant highlighted personal experiences and comfort with an African American doctor as key factors in seeking care.

These perspectives indicate a range of views on the importance of a physician's race in providing care to Black Americans. Some participants expressed a clear preference for Black doctors, associating this with better understanding and empathy. Others focused more on personal qualities, trust, and the quality of care, suggesting that these factors were more important than the race of the physician. These varying viewpoints highlight the complexity of patient preferences and the factors influencing the patient-physician relationship, suggesting areas for further exploration in ensuring culturally competent and empathetic health care delivery. Table 2 presents a detailed analysis of participant responses categorized by age.

Table 2

Participants' Perceptions of Importance of Doctor's Race and Knowledge of Historical Abuses

Participant identifier	Age	Perceived importance	
		Doctor's race	Doctor's knowledge of historical abuses
1. Participant A	36	Yes	No
2. Participant B	35	No	No
3. Participant C	25	Yes	Yes
4. Participant D	62	No	No
5. Participant E	43	Yes	Yes
6. Participant F	55	No	No
7. Participant G	19	No	Yes
8. Participant H	50	Yes	Yes
9. Participant I	28	Yes	No

Summary

While the findings provided valuable insights, questions remained regarding translating understanding into meaningful change. The multifaceted health care experiences of Black American men in Memphis were underscored not only by rational constructs but also by the emotional toll of persistent barriers. Economic hardship, complex policies, and implicit biases have made it hard to get straightforward health care. Moreover, the bonds of community and human connection proved significant. Personal relationships inspired health care engagement and navigated its complexities, serving as lifelines for those cautious about seeking care. By acknowledging such social determinants of health, resources can focus on lifting collective burdens rather than accusing or excusing individual behaviors.

In Chapter 5, I further discuss these issues including their broader scope. The following chapter includes discussion of the implications of the research findings for the scope of health care policy, community-oriented proposed strategies, and social determinants of health. Furthermore, the study evidences the need for comprehensive, community-based intervention to drive positive changes in health care access and outcomes for Black American men in Memphis. Additionally, Chapter 5 will critically analyze the compatibility between the evidence reviewed and the frameworks and theories published in existing works on health care accessibility and determinants of health. It will allow the findings to be validated and the gaps in knowledge be exposed, thus suggesting additional areas for inquiry. Finally, the chapter will describe specific recommendations for policymakers, health care professionals, and community leaders, turning the evidence obtained through the analysis into specific interventions facilitating better health care access and engagement.

Chapter 5: Discussion, Conclusions, and Recommendations

In this research study, I explored the lived experiences of African American men within the U.S. health care system, specifically focusing on those residing in the Memphis, Tennessee area. Fundamentally, the analysis hoped to understand the intricate dynamics of medical care accessibility and utilization of this group, unraveling the complex interplay between individual perceptions, systematic obstacles, and the broader societal context. Conducted against a backdrop of documented disparities in health care outcomes and access, this study was propelled by the necessity to illuminate under-examined facets of health care participation among African American men, a demographic that has been historically marginalized within the health care narrative. The objective of this analysis was not only to articulate the explicit health care experiences of this demographic but also to analyze these experiences through the lens of the HBM. By doing so, the investigation aimed to add to a more nuanced comprehension of how perceived susceptibility and severity of health issues, perceived benefits and barriers to health care access, cues to action, and self-efficacy influence health care behaviors within this community.

The thematic analysis of interviews revealed several multifaceted insights into the complexity of health care experiences among Black American men in Memphis.

- varied views on impact of a doctor's race: Participants disagreed on whether their doctor's race significantly impacted care. While some stressed racial congruence enhanced empathy and understanding, others prioritized qualifications and quality above all else.

- uneven awareness of historical abuses: Knowledge of past medical abuses also manifested in diverse ways. Whereas certain men cited such abuses as substantial barriers, others were unaware or did not see influences on current choices.
- prevalence of economic hardships and system complexities: Financial difficulties and convoluted systems emerged as preeminent obstacles to access. Issues like insurance, costs, and navigating care frequently hampered engagement.
- vital roles of community and relationship support: Support networks provided crucial motivation and guidance for overcoming intricacies. Family and friends offered the encouragement necessary to engage despite complex challenges.

These findings reveal multifaceted and intricate perspectives within the community. Both individual qualities and systemic factors shape experiences and behaviors in diverse ways. Responses regarding a doctor's race and history especially signal a more diverse array of influences than typically acknowledged.

Interpretation of the Findings

This research study delves into the multifaceted health care experiences of Black American men, illuminating their perspectives on physician race and cognizance of historical abuses. The investigation confirms, challenges, and expands current conversations in engagement, drawing on recent discoveries while also acknowledging seminal works. Varied views on provider race align with studies showing improved trust and satisfaction with racial matching. According to C. Moore.et al. (2023), their study on concordance showed that 83% of their study participants preferred a provider that looked like them. However, enduring impacts of past wrongs of the medical system are well-documented, highlighting lasting effects on perceptions. Emphasizing financial and structural barriers over historical abuses challenges the prevalent narratives that primarily blame disengagement on historical distrust. This proposes more intricate factors influence behavior, necessitating exploration of dynamic influences Health care complexity results from an array of determinants including economic hardships, policy complexities, and community/personal networks, offering deeper comprehension of engagement supported by social health determinants' access/use impacts (Ellis & Jacobs (2021).

This study's findings are analyzed through the HBM, with particular emphasis on perceived susceptibility and severity, perceived benefits and barriers, cues to action, and self-efficacy, as influenced by individual experiences and systemic factors.

- perceived susceptibility and severity: The mixed perceptions regarding health care engagement align with recent interpretations of the HBM, emphasizing the role of personal and systemic influences on health perceptions (Garcia et al., 2020).
- perceived benefits and barriers: Recognition of the benefits of health care engagement against systemic and bias-related barriers aligns with findings from Jones et al. (2015), who highlight the complex negotiation between perceived benefits and barriers in health care decision-making.

- cues to action and self-efficacy: The significance of community support and proactive health management strategies resonates with recent expansions of the HBM to include broader sociocultural factors (Lee & Choi, 2018).

By weaving the empirical findings of this study with both contemporary and seminal literature within and beyond the HBM framework, this analysis enriches the discussion on health care engagement among Black American men. The inclusion of recent studies alongside seminal works ensures a comprehensive understanding that reflects the evolving nature of health care perceptions and behaviors. Future research is encouraged to continue this exploration, utilizing a blend of historical insights and contemporary findings to fully capture the multifaceted influences on health care access and utilization as experienced by this demographic.

Limitations of the Study

Credibility

Despite efforts to maintain credibility through rigorous data collection and analysis using in-depth interviews and iterative manual coding, the possibility of subjectivity in the interpretation still presents an opportunity for bias. The researcher's considerations and prejudices could subconsciously impact the analysis and interpretation of the information. While this was minimized through reflexivity, the limitation remains inherent in the study design.

Transferability

This research study was limited to the experience of Black American men in Memphis, Tennessee. While detailed information was obtained on the experience of this demographic, the information may be limited regarding its applicability to other groups of the same race or other racial categories in different geographical areas. To assess transferability, detailed descriptions of the research context were provided.

Dependability

Due to constant changes in health policies and sociocultural attitudes regarding health and race, the dependability of the research findings may be limited over time. The study focused on a snapshot based on the dynamics at the time and the participants' recollections, which are bound to change in the future and limit the long-term relevance of the findings. An audit trail was included in this study to enhance dependability, which is evident in the documentation of the research process and decisions.

Confirmability

A conscious effort was made to ensure that the study's findings emerged from the participants' data rather than the researcher's bias. However, the interpretative nature of qualitative research makes total objectivity an unrealistic expectation. This study incorporated different research methods and included extensive unedited quotes from participants to guide the findings back to the data to support confirmability.

Means of Addressing Limitations

This research study put in place several measures to enhance trustworthiness, including triangulation, member checking, audit trail, and reflexivity. These measures aim to enhance credibility, transferability, dependability, and confirmability, recognizing that while they enhance the quality of the research, they do not eliminate the inherent limitations of qualitative inquiry.

Recommendations

The current study focused on Black American men in Memphis, Tennessee, so future research should consider other urban and rural locations to determine potential differences in health care experiences. The literature review indicated the importance of geographic origin in health care access and quality, and expanding the research's reach may provide a more comprehensive understanding of the regional peculiarities that supplement the existing insights.

Because health care policies, societal attitudes, and individual behaviors constantly change, longitudinal research regarding health care engagement seems especially justified. Such research may provide valuable insights for integrating external factors and life events that influence deviance and a more nuanced understanding of these trends. While the current study focuses on Black American men, it may be possible to correlate data from women or other racial or ethnic demographics within the examined community to determine how they interact with the health care system. As demonstrated explicitly in the literature review, the correlation of factors like the intersection of race, gender, and socioeconomic status may yield essential and generalizable findings across different communities. Additional research is required regarding the doctor's race and its effect on patients, as the current study offered mixed results, and some recommendations still need to be made more explicit. Factor analysis might help determine the main trends and a health provider meta-change can be designed based on those findings. Finally, the analysis can recommend potential recruitment or training policy changes for the particular focus group or the health care sector.

The economic and systemic barriers mentioned above deserve special attention, as conducting a more comprehensive analysis of the four systemic factors that prevent Black American men from following the recommendation would be especially important. Potential solutions and recommendations that can be made based on such a study may make a significant contribution to solving the issues. Furthermore, the policy amendment may become a valuable result of such a study.

Given the reliance on online information for health advice identified in this study, further research could examine the role of digital health literacy in influencing health care behaviors and outcomes. Investigating online health information's quality, sources, and impact could offer guidelines for improving health communication strategies and digital resource development. These recommendations are drawn from this current research's strengths and limitations, and the extensive literature review presented in Chapter 2. Addressing these issues in future investigative inquiry allows the development of policy research to a new level based on the present study's findings.

Implications

The findings from this study have the potential to foster positive social change at multiple levels—individual, family, organizational, and societal/policy—by highlighting the nuanced health care experiences of Black American men in Memphis and addressing the barriers they face in accessing health care services. Within the study boundaries, the implications for social change emphasize actionable insights and strategies that can be implemented to improve health care equity and outcomes.

Individual and Family Level

The study has implications at the individual and family level in two key areas:

- empowerment through education: By increasing awareness and understanding of health care rights, available services, and navigation strategies, individuals can be empowered to make informed health care decisions. Workshops and informational resources on preventive care, mental health, and navigating the health care system can enhance self-efficacy and proactive health behaviors among Black American men and their families.
- community support networks: Encouraging the development of support networks can provide emotional and logistical support for individuals navigating health challenges. These networks can also serve as platforms for sharing experiences and strategies for overcoming barriers to health care access.

Organizational Level

Social change at the organizational level may occur as a result of the following:

- cultural competency training: Health care organizations should implement comprehensive cultural competency training for all staff to improve patient-provider interactions, reduce biases, and enhance the quality of care for diverse populations. This training can lead to more empathetic, respectful, and effective health care services.

- inclusive policy development: Organizations, including hospitals and clinics, can review and revise policies to ensure they address the specific needs of Black American men. This approach may involve creating more accessible appointment scheduling systems, transparent billing practices, and patient advocacy programs.

Societal/Policy Level

Change at the societal/policy level may be achieved through the following:

- health policy reform: The study’s findings can inform policymakers about the need for reforms addressing economic and systemic health care access barriers. Advocacy for policies that expand insurance coverage, reduce health care costs, and ensure equitable access to quality care is crucial.
- public health initiatives: Public health campaigns can be designed to specifically target health disparities and promote health care access among Black American men. These initiatives could focus on preventive care, mental health awareness, and the importance of regular health check-ups.

Methodological, Theoretical, and Empirical Implications

Methodological

Future researchers should consider employing mixed methods to triangulate findings and provide a comprehensive view of health care experiences among Black American men. This approach can enhance the depth and breadth of understanding these experiences.

Theoretical

This study reinforces the applicability of the HBM in understanding health care behaviors but also suggests the need for integrating perspectives from social determinants of health theories. This combined theoretical framework can offer a more holistic view of the factors influencing health care access and utilization.

Empirical

Empirically, the study contributes to the body of literature on health care disparities by providing specific insights into the barriers and facilitators of health care access among Black American men. It underscores the importance of considering individual perceptions and systemic factors in addressing health disparities.

Recommendations for Practice

Based on the findings, I recommend changes in three areas:

- health care provider training: Beyond cultural competency, training for health care providers should also include modules on implicit bias, communication skills, and strategies for building trust with patients from diverse backgrounds.
- policy advocacy: Stakeholders, including health care professionals, researchers, and community leaders, should collaborate to advocate for policy changes based on the study’s findings. Emphasis should be placed on policies that tackle the root causes of health care disparities.
- community engagement: Health care institutions should actively engage with their communities through outreach programs, health fairs, and partnerships

with local organizations. These efforts can bridge the gap between health care providers and the community, fostering trust and collaboration.

By implementing these recommendations, the potential for positive social change at various levels can be realized, leading to improved health care access, experiences, and outcomes for Black American men in Memphis and potentially other similar communities.

Conclusion

This study illuminates the complex and evolving history of health care experiences among Black American men in Memphis, revealing a narrative that transcends the traditional discourse on health care disparities. The research uncovers a nuanced interplay between individual perceptions, systemic barriers, and the profound influence of sociocultural dynamics on health care access and utilization. Despite challenges, from economic hardships and systemic complexities to the lingering shadows of historical injustices, these men navigate their health care journeys resiliently, informed by a deep-seated desire for dignity, understanding, and equitable treatment.

The message illuminating this study is clear and compelling: True progress in health care equity requires more than policy shifts and access improvements. It demands a holistic approach that acknowledges and addresses the layered realities of Black American men’s lives — their fears, hopes, and unwavering quest for a health care system that sees, hears, and serves them with the respect and quality care they rightfully deserve. This study calls for reevaluating health care practices and policies and a renewed commitment to fostering trust and empathy within health care interactions. By embracing the insights from this research, stakeholders may begin to bridge the gaps, heal the wounds of the past, and pave the way for a future where health care equity is not an aspiration but a reality for all.

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Appendix A: Study Recruitment Flyer

Volunteers Needed for Research Study on Black Men's Health.

This research study seeks to advance knowledge of Black men's health by assessing the health behavior and health-seeking behaviors of Black men

You May Qualify If You

- Are a Black American male, between the 18 and 75 years old
- Reside in Memphis, Tennessee

Potential Benefits

- While there are no direct benefits to the volunteer, your participation is supporting the advancement of knowledge intended to improve the overall health status of Black men.

Participation Involves

- **One-on-one interview, lasting approximately 45 minutes, that will be conducted via Zoom or similar platform.**
- **A $50 VISA gift card will be given to study participants as compensation for participating in study.**

To register visit
https://www.researchandme.com/*StudyLinkToBeGeneratedUponMaterialApproval*

Appendix B: Interview Protocol

INTERVIEW PROTOCOL
WALDEN UNIVERSITY

Start Time:	Record Start Time here.
End Time:	Record End Time here.

PART I.

Please know that your participation in this research study is voluntary. You have every right to withdraw from this interview process without harm at any time. Nothing you share with me today will be identifiable back to you.

OPENING

My name is Alonzo Pendleton. Thank you for speaking with me today. I expect our time together to last approximately 45 minutes. We are going to talk about your experiences and thoughts regarding healthcare. This discussion is confidential. Your name, nor anything you say, will be identifiable to you. There are no right or wrong answers, therefore it is important that you say what's on your mind and accurately reflect how you feel.

TAPE RECORDER INSTRUCTIONS

This interview will be recorded, but please know that this recording will not be distributed for public consumption. The reason for recording the interview is to ensure that I can remain focused on our conversation while also capturing pertinent details of your responses.

PREAMBLE/CONSENT FORM INSTRUCTIONS

Since we are conducting this interview virtually, please verbally indicate for the recording of record that you acknowledge understanding and agree to move forward with this interview.

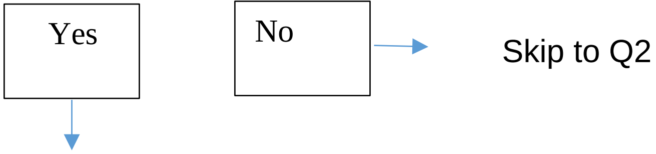
Thank you and let us begin.

INTERVIEW QUESTIONS

Initial base-setting questions

Q1 To start, tell me a little about yourself:

Are you from the Memphis area?



a. Really, what High School did you attend?

b. Did you grow up in that area?

Q2 How did you (and family, if applicable) end up in Memphis?

Q3 Would you mind confirming your age?

Q4 What is your highest level of education?

Q5 What is your occupation?

Q6 How important is your physical health to you?

Q7 How would you describe your physical health?

Q8 Do you regularly visit a primary doctor for routine medical care or annual physical exams?

Q9 What race is your primary doctor?

Q10 Do you believe that the race of your doctor is important to their ability to provide efficient medical care or medical advice to you?

Main Questions

Q11 What are your feelings about the medical community as it relates to trust?

Q12 Tell me what you think about when the subject of seeking medical care is mentioned.

Q13 What do you know about the historical abuses of Black people by the medical and science community?

Q14 Can you tell me about your experience interacting with the medical community?

a. Share with me how you feel about visiting a doctor.

b. When your doctor tells you to do or take something, how do you respond?

Q15 What informs your willingness to follow the medical advice provided by your doctor (or any doctor)?

Q16 Talk to me about your influences when it comes to seeking healthcare information.

If Influences are negative

a. How do you validate those concerns?

Q17 Without sharing any names, can you share a story you've heard from family or friends that influences your perception of the medical community?

Q18 What personal characteristics or skills do you think a doctor needs to provide effective healthcare to Black Americans?

Closing

I appreciate the time you took for this interview. Is there anything else you think would be helpful for me to know so that I can accurately reflect your thoughts, perceptions, and experiences related to this topic?

I should have all the information I need. Would it be okay if I contact you if I have need to verify the information provided in this interview? I'd like to remind you that if you have desire to review a transcript of the information obtained in this interview, or if you would like access to final research, please contact me and you will be provided with a copy.

Thanks again for your willingness to participate in this research study.