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Trust-Related Health Beliefs in Medical Systems Among Black Americans Since COVID-19

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This is to certify that the doctoral dissertation by

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Abstract

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MBA, University of Phoenix, 2008

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Dissertation Submitted in Partial Fulfillment

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Abstract

COVID-19 highlighted the longstanding systemic and structural racism that produced poor health outcomes in Black communities. Black minorities in the United States were disproportionately affected by the COVID-19 pandemic, with less access to health resources, low vaccine rates, and mistrust of healthcare providers and organizations. This interpretative phenomenological analysis (IPA) explored trust-related health beliefs with medical systems among Black Americans since COVID-19. The study explored the trust-related health beliefs through the six constructs of the health belief model—perceived susceptibility, perceived severity, perceived barriers, perceived benefits, cues to action, and self-efficacy. Data was collected via snowball sampling through semi-structured interviews of six participants who identified as Black Americans and were 18 years of age and older. Data was analyzed using the seven steps of IPA to describe the analysis process based on Smith's interpretive phenomenological analysis model. From the analysis 12 group experiential themes (GET) and 52 personal experiential themes (PET) were identified surrounding health beliefs and levels of trustworthiness with medical systems. The study confirmed that understanding health beliefs was crucial in shaping an individual's perceptions of trust in medical systems since COVID-19. Further recommendations would include a larger participant pool to gauge whether experiences would vary or yield similar results. The study's outcomes have the potential to forward social change by promoting positive relationships and developing strategies with healthcare institutions, providers, and the community by understanding the unique health experiences of Black Americans since COVID-19.

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Dedication

This paper is dedicated to my parents, who are no longer here, and my amazing husband, wonderful sister, and brother, who were a phenomenal support system throughout this journey. I am thankful for my mentor, friends, and colleagues, who consistently encouraged, motivated, and supported my dream of obtaining a PhD. This is also dedicated to those individuals who lost their lives to COVID-19, such as my beautiful mom and countless others.

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Chapter 1: Introduction to the Study

Introduction

Trust in medical institutions is a complex issue with Black Americans. Medical systems have a long history of mistreating Black Americans, including differences in healthcare access and socioeconomic factors (Hamel et al., 2020). As seen during the COVID-19 pandemic, Black Americans experienced racial inequities that further created trust-related health beliefs with medical systems. During the COVID-19 pandemic, Black Americans experienced racial discrimination and microaggressions from healthcare workers that increased medical mistrust and poor patient–clinician communication (Brown et al., 2023). COVID-19 highlighted in Fall 2020 that only 42% of Black Americans were willing to receive the vaccine (Hostetter & Klein, 2021). Medical mistrust and past racial discrimination were significant predictors behind the low vaccine confidence and intentions.

This chapter focuses on exploring the trust-related health beliefs among Black Americans since COVID-19 by summarizing existing literature related to the topic and the significance of this study. The problem statement is discussed to demonstrate the need for the research. The purpose of the study is provided, followed by the research question. The theoretical framework is described, including the connection between theory and research. The phenomenon investigated is examined by reviewing the nature of the study and the methodology. Key terms are defined, and assumptions that contributed to the study are provided. Finally, the scope of the study is discussed, as well as its implications for social change.

Background

Health beliefs play a vital role in shaping an individual's perceptions of trust in medical systems. According to Thier et al. (2023), medical mistrust plays a significant role in understanding Black Americans' COVID-19 vaccine attitudes, intentions, and behaviors. Decades of torment have led to mistrust of the healthcare system among many in the Black community. Home remedies among African Americans have typically been used to manage their health instead of traditional medical approaches because of the mistrust of health and medical organizations. Discrimination, experiences around racism, and fear of experimentation are a few of the elements that contribute to mistrust and generate a negative impact on the acceptance and willingness to seek healthcare (Rusoja & Thomas, 2021). This study addressed the gap in medical systems, trust-related health beliefs, and the experiences and perceptions of Black Americans receiving the COVID-19 vaccine. Medical mistrust has an association between the Black race and the refusal to participate in vaccine trials or receive a vaccine, suggesting that general suspicion of mainstream healthcare professionals and systems may be associated with this population's continued hesitancy to the vaccine (Thompson et al., 2021).

Furthermore, Williamson and Tarfa (2022) discussed that establishing trust and vaccination decisions was connected to the trustworthiness of providers. Having trust in providers encompasses the belief that one's needs will be met if the provider is competent and will do what is best for the patient. Trust in providers has been repeatedly established as a factor in various vaccination behaviors (Williamson & Tarfa, 2022). These factors provide insight into why some Black patients may prefer Black physicians from dealing

with subpar access to healthcare and the historical trauma created by medical establishments where harm was inflicted on Black patients as seen in the historical atrocities of J. Marion Sims, Henrietta Lacks, and the Tuskegee Study, according to the research of Bajaj and Stanford (2021). These experiments highlighted much of why Black communities have a distrust in health care systems. This study was needed to explore and understand Black Americans' experiences and trust-related health beliefs since COVID-19 to improve relationships with healthcare and medical systems and increase positive health outcomes considering historical inequities, structural racism, lack of access, and health information that has led to differential treatment with this population.

Problem Statement

The academic community had a limited understanding of an interpretative phenomenological analysis (IPA) of trust-related health beliefs in medical systems among Black Americans since COVID-19. During the COVID-19 pandemic, the National Association for the Advancement of Colored People (NAACP) and its partners reported that only 14% of Black survey respondents trusted the vaccines' safety, and only 18% said they would get vaccinated (Bajaj & Stanford, 2021). According to Dong et al. (2022), Black Americans showed the lowest COVID-19 vaccine confidence compared to other racial and ethnic groups, with medical mistrust and past historical racial discrimination as significant predictors (Dong, 2022). Medical mistrust has an association between the Black race and the refusal to participate in vaccine trials or receive a vaccine, suggesting that general suspicion of mainstream healthcare

professionals and systems may be associated with this population's continued hesitancy to the vaccine (Thompson et al., 2021). Furthermore, with the disproportionate effect of COVID-19 on racial and ethnic minority groups, it is vital to place a continuous focus on improving vaccination efforts in these communities by exploring vaccine intent (Short et al., 2022). These aspects addressed the gap in medical systems, trust-related health beliefs, and the experiences and perceptions of Black Americans receiving the COVID-19 vaccine. Researching trust-related health beliefs helped to understand how Black Americans' experiences have shaped their approach toward health, medical systems, and the COVID-19 vaccine to improve future health outcomes.

Purpose of the Study

This qualitative study focused on an IPA of trust-related health beliefs in medical systems among Black Americans since COVID-19. Black Americans have experienced medical mistrust and unique healthcare-related experiences, expectations, and health-seeking behaviors (Thier et al., 2023). Historical mistreatment, as experienced with the Tuskegee syphilis study and Henrietta Lacks, as mentioned in the study by Bajaj and Stanford (2021), has created vaccine hesitancy due to a “legacy of distrust” in medical research (Scales et al., 2023). Exploring trust, mistrust, vaccine necessity, vaccine concerns, and vaccine intentions in the context of COVID-19 helped to bring awareness and educate the healthcare community and Black Americans.

Research Question

The study answered a single research question: What are the experiences of trust-related health beliefs in medical systems for Black Americans since COVID-19?

Conceptual Framework

The conceptual framework for this study was the Rosenstock (1974) health belief model (HBM). Rosenstock's HBM examines the beliefs and perceptions of individuals to understand health-related behavior. This was essential in exploring the trust-related health beliefs of Black Americans to understand their unique experiences with medical systems. The model has been consistently used in health and medical environments to explain the behaviors and beliefs of individuals toward the avoidance of disease and to explain the maintenance and change of health-related behaviors as a framework for guiding health behavior interventions and preventions (Rosenstock, 1974). Individuals will take three different actions to avoid a disease: perceived susceptibility, perceived seriousness/severity, and perceived benefits or taking action/barriers to taking action. Chapter 2 provides further explanation of these actions and how each aligned with the phenomenon of trust-related health beliefs.

Rosenstock's HBM was essential to explaining and understanding the health beliefs of Black Americans. The model is based on the theory that people's willingness to change their health behaviors primarily comes from their health perceptions and beliefs. HBM explores the beliefs and perceptions of individuals to understand what influences health-related behavior and actions through six constructs—perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and cues to action, with the last construct added in the 1980s—self-efficacy (LaMorte, 2022). The interview question guide consisted of 10 questions based on the six HBM constructs and trustworthiness of medical systems as it was relevant for exploring trust-related health beliefs in medical

systems among Black Americans. A more detailed explanation is provided in Chapter 2 that highlights the framework's elements and how each construct played a role in understanding the phenomenon.

Nature of the Study

The qualitative approach for this study involved the use of the IPA by Smith et al. (2022) to respond to the research question. Smith et al. focused on explaining and providing a detailed guide to conducting IPA research. There was a comprehensive overview of the stages of an IPA research project and examples of high-quality IPA studies that addressed the research question. A review by Alase (2017) explored the history of how phenomenology evolved into IPA from qualitative research and theory.

Three minds behind the IPA approach—Smith, Flowers, and Larkin—focused on assessing how individuals reflect on their major life experiences to gauge an understanding of unique perceptions and phenomena for future research. Furthermore, the approach provided a detailed guide for future researchers to understand how this approach can best be applied to qualitative research analysis and the adaptability of the application (Alase, 2017). This study explored how participants can share their experiences without judgment or bias.

The study focused on using snowball sampling. Recruitment through email flyers or posters presented to the Walden participant pool, community centers, and social media such as Facebook, LinkedIn, Black hair salons, and barbershops occurred. Participants were identified by meeting the inclusion criteria of 18 years of age and older, identifying as a Black American, having had interactions with the healthcare system since COVID-

19, and having a minimum of a high school diploma or GED. Selected participants were contacted via email and telephone. Exclusion from participating in the study was based on individuals not identifying as Black Americans, not meeting the minimum age requirement, having not had or having interactions with the healthcare system since COVID-19, and not possessing a minimum of a high school diploma or GED. Selected participants were provided with an informed consent form, an opportunity to ask questions, and a privacy and confidentiality statement regarding the information collected, and the right to change their mind about participating in the study. Data were collected through semistructured interviews lasting around 45–60 minutes.

The IPA approach helped to understand, interpret, and amplify the participants' unique experiences. Data were analyzed for themes to gauge similarities and differences in experiences. Understanding the experiences and perceptions was meaningful, helped to make sense of the circumstance, and encouraged a positive platform for exploring the trust-related health beliefs in medical systems among Black Americans since COVID-19.

Definitions

Black Americans: For this study, this was an ethnic or racial group of individuals who identify as Americans and Black with diverse backgrounds consisting of but not exclusive to descendants of slaves, or immigrants who reside or were born in the United States (Forson, 2018).

Health belief model (HBM): The HBM is a theoretical model that guides health promotion and disease prevention programs. The model was used to explain and predict individual changes in health behaviors. It is one of the most widely used models for

understanding health behaviors (Rural Health Information Hub, 2018). The HBM uses six key factors to define what influences an individual's health behaviors: perceived susceptibility, perceived severity, perceived benefits, perceived barriers to action, cues to action, and self-efficacy.

Medical mistrust: Mistrust refers to skepticism, lack of confidence, feelings of doubt concerning the truth, truthfulness, or trustworthiness (Merriam-Webster, 2024). Medical mistrust is the tendency to distrust medical systems and personnel believed to represent the dominant culture in each society (Benkert et al., 2019).

Historical health racism: Refers to the historical accounts of structural racism in health care policy, health care coverage, and health inequities experienced by racial and ethnic minority groups in the United States. Historical racism in healthcare shaped the many ways in which the U.S. healthcare system was structured to the advantage of the White population and at a disadvantage to the racial and ethnic minority populations (Yearby et al., 2022).

Assumptions

Before this study was conducted, there were two assumptions. The first assumption was that the study would answer the research question through the anticipated interviews with participants, and that the research question would be comprehensively answered. This required a sufficient sample size to meet saturation and adequate data collection to identify all relevant themes. I also assumed that all participants would provide cooperative and honest responses to interview questions based on their unique perceptions and experiences. These assumptions were essential as each was necessary for

describing and defining the phenomenon to show the value of viewpoints to explore the issues.

Scope and Delimitations

In supporting the phenomenon of interest for this study, individuals who met the inclusion criteria participated. The scope of the study was delimited to individuals who identified as Black Americans, 18 years and up, with a minimum of a high school diploma, who were having or had experiences with medical systems to understand the trust-related health beliefs since COVID-19 with Black Americans and health care systems. To ensure that trust-related health beliefs were explored from the Black Americans' experiences, participants were limited to the qualifying inclusion criteria. Establishing these limitations helped to reduce the probability of individuals describing experiences unrelated to the phenomena. Exclusion criteria consisted of individuals who did not have experiences with medical systems, were not 18 years of age with a minimum of a high school diploma, and did not identify as Black Americans. Additionally, individuals who were unable to provide informed consent due to impairment, incompetence, or inability to make decisions were excluded.

Semistructured interviews were conducted to investigate participants' lived experiences on how their trust-related health beliefs influenced perspectives surrounding medical systems and COVID-19. The project generated data through collaboration between the subjects and me (Creswell & Creswell, 2018). The focus was on the participants' experiences and how they could be transformed into conscious experiences to encourage positive health outcomes for Black Americans in the future.

Limitations

There were several potential limitations to the study. The willingness of Black Americans to participate in the study presented challenges in having enough individuals to interview. Participants might elicit hesitancy during the recruitment process, creating less efficiency in completing the study process and having a lack of understanding of the time commitment. Participants might not have provided the necessary feedback for a more comprehensive study as the responses could have differed from how they would respond in real life. These potential limitations were addressed surrounding participants' willingness to be involved in the study by establishing and investing in developing trust between the potential participants and myself by being transparent with the details of the study, assuring participants that withdrawal from the study could occur at any time if they were feeling uncomfortable, and establishing that questions could be asked at any point during the study.

Further limitations involved a lack of participation in the interviews due to concerns about how the information might be used despite informed consent outlining the details of the study. This stemmed from a lack of trustworthiness and dependability in the data. During the interview process, I ensured genuine rapport, empathy, and flexibility as one strategy to address this limitation of uncertainty and concerns. My role as a researcher was to handle disclosure carefully to help participants be more willing to open up and share their experiences. Smith et al. (2022) stated that in these types of interviews, though it might seem best to leave personal disclosures outside of the interview, disclosure from the interviewer may help facilitate a sense of rapport, eliciting more

detailed experiences from the participants. Additionally, a careful measure of disclosure was used and information received from participants was forthcoming to ascertain truthful experiences with their health beliefs. This derived from participants' different interpretations of the questions being asked. I addressed these different interpretations through clarity of information and opportunities for questions as measures to counteract these concerns.

Biases occurred, but my role as a qualitative researcher was to ensure that participants would be treated fairly. Bourdeau (2000) established four principles to help guide the treatment of research participants and to prevent dual relationships. The first is to respect the autonomy of participants by having flexibility with understanding the independence and needs of each participant. The second is nonmaleficence, meaning do no harm. On a basic level, the research should not cause distress or harm to the participants. The third is beneficence, which is striving to work for the benefit of the participants. Last is justice through the commitment to being equitable by distributing responsibilities and rewards between researcher and participant. A commitment to justice means that researchers do not use studies to benefit themselves to the detriment of others, resulting in an imbalance of responsibility for the participant and reward for the researcher.

Significance

Black Americans showed the lowest COVID-19 vaccine confidence compared to other racial and ethnic groups (Dong et al., 2022). Medical mistrust and past racial discrimination were significant predictors of low vaccine confidence and intentions.

Concerns about safety, efficacy, side effects, and exposure to myths and misinformation also predicted low vaccine confidence (Dong et al., 2022). The study was significant as it further explored the relationships between Black Americans, trust, mistrust, vaccine necessity, vaccine concerns, and the context of COVID-19.

The research was a critical platform for programs or organizations seeking to understand and engage Black Americans to help further educate about the importance of vaccines and understand future health-related behaviors while positively affecting emotional and psychological outcomes for the Black American population, health care providers, and the healthcare community. Positive social change from this study would help in improving relationships with healthcare and medical systems and increase positive health outcomes considering historical health inequities, structural racism, and lack of access and health information that have led to differential treatment with the Black community.

Summary

Trust-related health beliefs with medical systems among Black Americans since COVID-19 were an issue to explore. Understanding the significance of this research was essential for understanding the lived experiences of Black Americans' trust during and since the COVID-19 pandemic with medical systems. Black Americans have experienced racial discrimination and microaggressions from healthcare workers that have increased medical mistrust and poor patient–clinician communication (Brown et al., 2023). Historical and systemic racism toward Black and Brown communities has persistently led to issues in establishing levels of trust between physicians and health care systems.

Failing to establish trust in the context for historical and ongoing injustice, public health authorities sowed the seeds for the terrorizing effects of COVID-19 on African Americans (Best, 2021).

The goal of this research study was to explore, promote, and foster health-related strategies for Black Americans in an effort to understand and support Black communities whose members have dealt with years of historical racism with health systems. Chapter 2 provides a comprehensive literature review of relevant research on trust-related health beliefs by exploring the HBM, history of health beliefs among Black Americans, historical health racism, trust and mistrust with medical systems, differential treatment, and the influence of social media with trust-related health beliefs. Additionally, Chapter 2 highlights existing gaps in the research to help further educate about the importance of vaccines, health-related behaviors, and emotional and psychological effects for the Black community while providing a complete explanation of the conceptual framework of IPA being used as the foundation for this study.

Chapter 2: Literature Review

Introduction

Medical institutions and healthcare practitioners have an ethical responsibility to educate and inform communities about health issues, particularly during a public health crisis such as the COVID-19 pandemic (Best et al., 2021). Delivering equal and quality healthcare to patients was an expectation regardless of racial/ethnic background. However, as seen during the COVID-19 pandemic, Black Americans experienced racial inequities that further created trust-related health beliefs with medical systems. During the COVID-19 pandemic, Black Americans experienced racial discrimination and microaggressions from healthcare workers that increased medical mistrust and poor patient–clinician communication (Brown et al., 2023). Historical and systemic racism toward Black communities has persistently led to issues with establishing a level of trust between physicians and health care systems. Racial inequities have negatively impacted trust in high-intensity care scenarios and affect the quality of care received by Black patients dealing with chronic and complex medical conditions. In failing to establish trust in the context of historical and ongoing injustice, public health authorities sowed the seeds for the terrorizing effects of COVID-19 on African Americans (Best, 2021).

Black Americans showed the lowest COVID-19 vaccine confidence compared to other racial/ethnic groups, with medical mistrust and past health-related historical racial discrimination as significant predictors (Dong, 2022). Trust concerns have been generated by centuries of documented cases involving abusive medical experimentation and ongoing structural racism. The healthcare system contributed significantly to

highlighting the disparities of COVID-19 within Black communities. Black Americans did not fare well and are poorly served in the healthcare system (Hostetter & Klein, 2021). As Funk (2022) indicated, 49% of the worse health outcomes for Black individuals are derived from the healthcare system providing the least advanced medical care, with 47% of hospitals and medical centers giving lower priority to Black individuals, leading to poorer health outcomes. These levels of differential treatment within the medical systems with Black Americans created challenges with trust during and since the COVID-19 pandemic. Trust was magnified as it prevented meaningful, engaging communication of health information in encouraging the Black community to receive the COVID-19 vaccine.

These challenges impeded racially and ethnically diverse individuals in receiving the COVID-19 vaccines, particularly among Black individuals (Ojikutu et al., 2020). Medical systems have bred several layers of distrust based on the historical atrocities affecting Black individuals. Distrust refers to an individual or group's lack of confidence in systems, whether they be medical, public health, and/or governmental (Best, 2021). Best (2021) also mentioned that distrust was shown to be more prevalent among racial and ethnic minority and low-socioeconomic-status populations, especially African Americans. The disproportionate effect of COVID-19 on racial and ethnic minority groups indicated the importance of continuously increasing vaccination efforts in these communities by exploring trust-related health beliefs with medical systems.

This qualitative study involved an IPA of trust-related health beliefs in medical systems among Black Americans since COVID-19. Members of Black communities have

held the belief since the time of enslavement, with having to deal with physical, social, and mental brutalization, that their health is of little to no value (Noonan et al., 2016). Resorting to home remedy health practices in the Black community was a way to deal with concerns about health and the lack of trust from not often receiving the same quality of health care as nonminority counterparts (Cuffee et al., 2020). Black Americans have experienced medical mistrust and unique healthcare-related experiences, expectations, and health-seeking behaviors (Thier et al., 2023). Historical mistreatment, as experienced with the Tuskegee syphilis study and Henrietta Lacks experiment, created vaccine hesitancy from a "legacy of distrust" with medical research (Scales et al., 2023). Exploring trust-related health beliefs, health historical racism, and medical systems in the context of COVID-19 helped bring awareness and understanding toward the best ways of educating the healthcare community on interacting with Black Americans to promote better health outcomes.

This chapter explores aspects surrounding trust-related health beliefs among Black Americans with medical systems since COVID-19. The discussion focuses on several key areas, the HBM and the six constructs, the history of health beliefs among Black Americans through historical health racism, the three key experiments—Experiment 1 with James Marion Sims; Experiment 2 with Henrietta Lacks; and Experiment 3, the Tuskegee Syphilis Study. The research further explores the trustworthiness of the medical systems and the myth of Black immunity through the three experiments, the lack of communication and misconceptions, and the administrations of Trump and Biden. Themes of trust and mistrust highlight the differential medical

treatment among Black women and men, explore professional Black American views, and address Black Americans' trust in the media and the medical system to further explain trust-related health beliefs since COVID-19. The conclusion summarizes the research highlights to validate the study's necessity.

Literature Search Strategy

Research was conducted in the last 3 years using databases and search engines MEDLINE/PubMed, CINAHL, APA PsycInfo, SocIndex, ScienceDirect, Academic Search, Social Sciences Citation Index, Education Source, ERIC, IEEE Xplore, Emerald Insight, Directory of Open Access Journal, APA PsycArticles, APA PsycBooks, BioMedCentral, and Psychology and Behavioral Sciences Collection. The keywords and phrases used included *COVID-19*, *historical racism*, *beliefs*, *health beliefs*, *vaccination hesitancy*, *trust*, *medical systems*, *mistrust*, *vaccine*, *healthcare*, *health*, *Black American*, and *African American*.

Articles were also searched beyond 5 years to highlight historical points and information relevant to explaining the topic and for citations and a review of references in key articles. Additional research and citations from some media sources, such as videos and webinars, provided broader context when research was unavailable.

Conceptual Framework

The conceptual framework for this study was the Rosenstock (1974) HBM. It was initially developed in the 1950s and proposed by social psychologists Godfrey Hochbaum, Irwin Rosenstock, and Rosenstock and Kirscht (Ghorbani-Dehbalaei et al., 2021). The model is based on the theory that a person's willingness to change their health

behaviors primarily comes from their health perceptions and beliefs. HBM may be used to explore the beliefs and perceptions of individuals to understand what influences health-related behavior and actions.

The model has been used in health and medical environments to explain the maintenance and change of health-related behaviors as a framework for guiding health behavior interventions and preventions (Rosenstock, 2000). There are six constructs of the HBM—perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and cues to action, with the last construct added in the 1980s—self-efficacy (LaMorte, 2022). The six HBM constructs were relevant for exploring trust-related health beliefs in medical systems.

Rosenstock's HBM was essential to explaining and understanding the health beliefs of Black Americans through the concepts of the six constructs. The HBM's first construct, *perceived susceptibility*, focuses on an individual's subjective perception of risk in acquiring an illness or disease (LaMorte, 2022). The vulnerability variation tends to depend on an individual's emotions toward an illness or disease. The stronger perceived susceptibility leads to an increased motivation to engage in health-promoting behaviors (Straub, 2019). Individuals with low perceived susceptibility may deny the gravity of the situation and continue to engage in unhealthy behavior, whereas individuals with a high perceived susceptibility will attempt to reduce the risks (Rosenstock, 1974). Perceived susceptibility of trust with medical systems and Black Americans has been noted as having a positive correlation with vaccine hesitancy. Individuals are more likely to be vaccine-hesitant if they have a high perceived

susceptibility to COVID-19 (Limbu et al., 2022), which was indicated through Black Americans' concerns about COVID-19, but a susceptibility of the beliefs in healthcare systems.

HBM's second construct, *perceived severity*, may be used to explore an individual's feelings surrounding the intensity of contracting an illness or disease. As LaMorte (2022) stated, an individual's feelings of severity will cause an individual to consider the medical and social consequences when evaluating the severity of a situation or circumstance. The possibility of death is a typical element of assessment with severity and consequences (Janz & Becker, 1984). As indicated by Hita et al. (2022), the severity of contracting COVID-19 ideally would encourage individuals to receive the vaccine; however, trust issues with medical institutions caused many Black Americans to question the COVID-19 vaccine's effectiveness despite the risk of death.

The HBM's third construct, *perceived benefits*, relate to an individual's perceptions of available resources to reduce the threat of disease or illness. If an individual feels that their health belief behavior will be beneficial and effective for prevention and reduction surrounding the severity and susceptibility of the disease, they will be likely to engage in behavior to reduce the seriousness or effectiveness of the action (Rosenstock, 1974). Perceived susceptibility was used as a consideration and evaluation tool to weigh health action's benefits. For example, an individual thinking about the likelihood of contracting the COVID-19 virus would take action dependent on low or high perceived susceptibility to the virus.

The HBM's fourth construct, *perceived barriers*, involve an individual's feelings about the obstacles to being able to perform a recommended health action. In this construct, a cost and benefit analysis was conducted for an individual to weigh the effectiveness of the actions against the perceptions of the cost, risk, unpleasantness, time, and inconvenience. The barriers and costs can be physical, psychological, and financial (Rollins et al., 2018), particularly in dealing with historical trust-related issues among Black Americans. An example occurs when individuals assess the overall cost and access to health resources to prevent illness and maintain health. Another example is weighing the lack of time with work, family obligations, and daily hassles in maintaining regular physical activity.

HBM's fifth construct, *cues to action,* is an activation of health behavior through external events that prompt a desire to make a health change. A cue to action encourages an individual to move from wanting to make a health change to making the change. The cues or triggers can be external or internal (Janz & Becker, 1984). Physiological actions are examples of internal cues, whereas events, people, circumstances, and media are examples of external cues. The intensity of cues varies between individuals in prompting action (Rosenstock, 1974). In a study by Tsai et al. (2021), nursing students discussed how the media influenced more preventative measures toward COVID-19 based on concerns of transmission and high mortality rates globally. The media was an external cue that triggered nursing students toward a health behavior action in dealing with COVID-19.

The HBM's sixth construct, *self-efficacy*, involves a person's belief in their ability to make a health-related change. Self-efficacy is "the conviction that one can successfully execute the behavior required to produce the outcomes" (Bandura, 1977. p. 79). This construct was used in many behavioral theories as it directly relates to whether a person will perform the desired behavior (LaMorte, 2022). During COVID-19, research by Huang and Gerend (2024) found that higher self-efficacy among African Americans led to an increased chance of receiving the COVID-19 vaccine.

The constructs of the HBM were used to devise questions to explore the health beliefs of trust in medical institutions among Black Americans since COVID-19. Several studies have highlighted the value of HBM in understanding health behavior. The HBM involves the assumption that the six constructs of perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy must be successfully explored to achieve optimal behavior change. Several studies and research have supported this. Research by Huang and Gerend (2024) explored how the HBM was used to understand hesitancy to receive the COVID-19 vaccine. In a study by Champion and Brown (2008), HBM constructs were used for community-based intervention designs to encourage adherence to health recommendations among underserved groups. Additionally, other studies demonstrated that studying HBM beliefs has been effective in promoting positive health behaviors, with perceived benefits and barriers playing an important role in shaping an individual's intentions of receiving the COVID-19 vaccine, followed closely by perceived severity and susceptibility (Limbu et al., 2022). The study of trust-related health beliefs among Black Americans with medical institutions since

COVID-19 added to the research by exploring the experiences that fostered the behaviors of hesitancy toward the COVID-19 vaccine. Furthermore, the research encouraged improved health communications in minority environments and preventive health measures to educate the healthcare community and Black Americans on building stronger medical support systems in future health crises.

Literature Review Related to Key Concepts

History of Health Beliefs Among Black Americans

The health beliefs among Black Americans stemmed from years of historical and cultural mistreatment. Home remedies among African Americans have typically been used to manage their health instead of traditional medical approaches. A study conducted by Parry et al. (1996) on the health beliefs and actions of 20 African American diabetic individuals with plantar ulcers indicated that extensive use of herbs for treatment—specifically, garlic and water, juice from boiled string beans, aloe tea, and Caribbean herbs, to name a few—supported the use of home remedies for health instead of trusting in medical systems. Many traditional practices are generational and involve ignoring prescribed treatments, misuse, or disapproval of the quality of care. Black Americans often experienced racial discrimination with conventional medicine and navigated toward complementary and alternative medicine (CAM) to address health needs and concerns. CAM is a method of expanding, supplementing, or diversifying health care options that includes a diverse array of treatments outside of conventional medicine such as homeopathy, mind-body medicine (tai chi, yoga), biologically based practices (herbal remedies), manipulative and body-based practices (chiropractic, massage), and energy

medicine (Shippee et al., 2012). Spiritual practices are part of CAM and cultural approaches, such as prayers, spiritual healers, herbs, plants, and mineral sources (Easom, 2006).

According to Robinson (2016), slavery significantly influenced several aspects of life for African Americans, including their beliefs, traditions, nutrition, health, and well-being, resulting in culture having a greater impact on the lives of African Americans. The percentages have consistently highlighted the beliefs Black Americans have toward health. Thirty percent of African Americans believe that their health is dependent upon fate or destiny, with only 50% feeling that their health is a high priority (Noonan et al., 2016). The remaining 20% was not clarified in the study. A cross-sectional study conducted by Cuffee et al. (2020) from 2006 to 2008 using the TRUST study examined social and behavioral factors, including trust, self-efficacy, and medication adherence in a sample of Black and White adults with hypertension focused on Black people and hypertension. The results indicated that the most used home remedies among Black participants were vinegar (19%), garlic (12%), and mustard (6%), and, within the study sample, 12% reported using at least one home remedy, and 14% reported using two or more (Cuffee et al., 2020). The remaining percentage was not calculated as the results were based on 28% of the sample reporting.

Over 400 years of oppression since the first slaves were brought to America have resulted in the poor health status of African Americans (Thomas & Casper, 2019). In a study on African American health that examined the main social determinants of health and main health disparities; risk factors; and leading causes of morbidity, mortality, and

access to health services for Blacks in the United States, African Americans have often been forced to live in physical and social conditions where health was of little value (Noonan et al., 2016). One of the main findings from the study highlighted that despite expanded healthcare access, African Americans remain the least healthy ethnic group in the United States from dealing with racial and social justice. These findings continue to influence health and contribute to health disparities. As Funk (2022) highlighted, the complex history of traditional healthcare practices still involves less access to quality healthcare, which in the United States has generally led to worse health outcomes for Black Americans. These disparate health outcomes have consisted of Black Americans being most likely to die from diabetes complications, suffering serious pregnancy-related conditions, dying during and after pregnancy, and suffering with breast cancer and other treatable conditions (Radley et al., 2021). The COVID-19 pandemic exacerbated things, specifically with average life expectancies for Blacks and Latinx/Hispanic populations in comparison to Whites (Thompson, 2021).

Historical Health Racism

The disparities of health inequities experienced by racial and ethnic minority groups in the United States have persisted for years. Disturbing beliefs were not long-forgotten 19th-century relics. Many medical students and residents have harbored false health beliefs since 2016 (Sabin, 2020). According to a 2016 study, 40% of 1st- and 2nd-year medical students endorsed the belief that Black people's skin is thicker than White people's (Hoffman et al., 2016). Historical atrocities of medical experiments, including James Marion Sims, Henrietta Lacks, and Tuskegee experiences—that elevated the

everyday racism Black communities face (Bajaj & Stanford, 2021) show how medical systems have treated Black Americans poorly.

Historical Health Racism and James Marion Sims

The James Marion Sims experimentation and mistreatment of enslaved Black women with forced sterilization highlighted the atrocities of health racism starting in the 1840s. James Marion Sims, who was hailed as the father of gynecology, was a White doctor in Montgomery, Alabama, who performed painful experiments without anesthesia on enslaved Black women, while other doctors observed with the racist belief that Black people did not feel pain (Equal Justice Initiative, 2019). From 1845 to 1849, Sims was known to experiment on at least seven enslaved Black women and girls. Consent was received by the women's owners, not the women, in developing a technique to repair a chronic complication of childbirth referred to as vesicovaginal fistula. Owners had a strong financial interest in keeping Black women patched up to produce and reproduce for them or the women were deemed useless (Holland, 2018). In 2018, after several years of activism, the statues of James Marion Sims erected in the 1890s were removed. A plaque was created to educate the public on the origins of the monuments and the controversy behind the nonconsensual medical experiments on women of color (Holland, 2018).

Historical Health Racism and Henrietta Lacks

Henrietta Lacks contributed unknowingly to numerous important scientific advances, specifically the use of her cells as the source behind the HeLa cells. However, the use of her cells was unauthorized and highlighted another instance in history of Black

individuals exposed to unethical treatment and experimentation. Henrietta was a young, poor mother of five children who visited one of the few hospitals in 1951 that treated poor African Americans—The Johns Hopkins Hospital (Johns Hopkins Medicine, 2024). She had complained of vaginal bleeding and upon examination, a gynecologist Dr. Howard Jones discovered a large, malignant tumor on her cervix, which turned out to be cervical cancer (Johns Hopkins Medicine, 2024). A sample of her cancer cells was retrieved during a biopsy and sent to a lab. It was discovered that Mrs. Lacks' cells were unique as other cells would die, but hers doubled every 20 to 24 hours (Johns Hopkins Medicine, 2024). Lacks was unaware her cervical cells would be used for future scientific experiments as there was no informed consent detailing the use of her cells. Researchers have since had access to HeLa cells and continue to use them, but many are unaware of the history of the woman behind the cells (Baptiste et al., 2022).

Historical Health Racism and Tuskegee Syphilis Study

The infamous Tuskegee Syphilis study of 1932 targeted 600 Black men—399 infected with syphilis and 201 who did not have the disease, being left untreated even with penicillin care becoming available highlights the historical mistreatment of Blacks in the American medical system (Miller & Miller, 2021). The participants were primarily sharecroppers, and many had never visited a doctor. The men were monitored by health workers and only given placebos such as aspirin and mineral supplements, even though penicillin was the recommended treatment for syphilis (Nix, 2017). Researchers provided no effective care as the men died, went blind, insane, or experienced other severe health problems due to the syphilis being untreated.

Black Americans have consistently had their pain overlooked and ignored, conditions misdiagnosed, and imperative treatment withheld from physicians (Hostetter & Klein, 2021), as indicated in the Lacks, Sims, and Tuskegee experiments. Though some Black Americans may be unaware of the historical mistreatments, each Black individual experienced personal challenges in navigating healthcare institutions and dealing with subtle mental assaults highlighted in medical institutions (Bajaj & Stanford, 2021). The results of these experiments are reminders of how the medical system has treated African Americans and contribute to issues of trust with the system.

Trustworthiness of Medical Institutions

Systemic inequities have often led to inferior health care. Black individuals were not receiving the same level of quality health care as their White counterparts, and this second-rate health care was shortening their life spans by delivering fewer effective treatments (Bridges, 2015). Though there has been a long history of medical mistreatment, many Black Americans have positive assessments of the quality of care. Trust has been expressed in medical researchers' competency in doing a great job from Black Americans, however, there are still concerns about the potential for research misconduct and accountability (Funk, 2022). These concerns stemmed from the less-than-optimal health care experienced by socially disadvantaged populations, as seen in Black communities. Studies have demonstrated that Blacks exhibit less trust in the health care system for a variety of reasons that come from personal experiences with racism, knowledge of the history of racism in the health care system, and social and cultural distance between Black patients and White physicians (Musa et al., 2009). An example of

this was noted with Sickle Cell Anemia, a common disease among Blacks, discovered more than 100 years ago, where only two medications were approved for treatment of the disease, indicating that little attention was received on the research and funding necessary for better treatment as the disease was associated with Blacks (Lee et al., 2020).

The historical instances highlighted some of the trust issues with medical systems among Black Americans stemming from systemic racism and unjust distribution of treatment and experimentation. During the COVID-19 pandemic, there were large disparities seen in mortality rates, hospitalizations, and diagnoses with Black Americans (Andraska et al., 2021), as previous health racial atrocities generated a lack of trust toward information concerning the COVID-19 vaccine. According to Harris et al. (2023), COVID-19 vaccine receptibility of the vaccine was low due to historical and contemporary experiences of systemic racism against the Black community, along with structural barriers surrounding inaccessibility to vaccination sites and lack of accurate information from trusted community and public health officials solidified suspicion with medical institutions. Exploring the myth of Black Immunity, mortality rates, differential treatment, trust, and mistrust of medical systems helped in understanding the trust-related beliefs among Black Americans surrounding medical systems since COVID-19.

Myth of Black Immunity

Trust issues of healthcare providers and systems among Black Americans have persisted from a lack of communication, less transparency, and erroneous misconceptions surrounding the myth of Black immunity (Hostetter & Klein, 2021). This unsubstantiated myth argued that Black/African Americans are more resistant to diseases like COVID-19

(Asare et al., 2020). This myth created a fallacy of health security within the Black community as well as exacerbating unique social conditions of the COVID-19 pandemic that caused the medical community to respond differently to Black Americans based on years of the belief that biological differences exist between Black and White individuals (Hostetter & Klein, 2021). Some Black Americans started to believe the narrative during the COVID-19 pandemic with the influx of misinformation. As early as 2020 some African Americans boldly asserted that melanin, the dark brown-to-black pigment in the skin, was a counter-agent to COVID-19 (Spigner, 2020).

Black immunity theories continued to emerge, particularly in Philadelphia, in the late eighteenth century during the Yellow Fever outbreaks. Prominent Declaration of Independence signatory and abolitionist, Dr. Benjamin Rush, ardently believed that African Americans were immune to the disease due to their purportedly acclimatized bodies (Carter & Sanford, 2020). In exploring the myth, ideas surrounding it have contributed to how the medical and healthcare community perceived Black Americans during COVID-19. As Carter and Sanford (2020) emphasized, assertions of Black immunity to COVID-19 represent the persistent afterlife of slavery and the pervasive power of White supremacist thought. In another incident at the start of the pandemic, Trevor Noah, a black South African comedian and political commentator, unveiled the origin of this myth on his *The Daily Show* by featuring footage of African Americans making statements asserting that Black people could not catch the disease due to the melanin in their skin (Spigner, 2020). There appeared to be no evidence of Black victims of COVID-19 at the time. The absence of Blacks as COVID-19 victims in the

media was deemed by many African Americans as *prima facie* evidence of black immunity (Spigner, 2020). The suggestion was that Black people's unique abilities were a sign of fitness, health, and longevity, protecting them from contracting COVID-19.

Myth of Black Immunity and the Three Experiments—J. Marion Sims, Henrietta Lacks, Tuskegee Study

Black Americans have consistently had their pain overlooked and ignored, conditions misdiagnosed, necessary treatment withheld from physicians and been involved in medical experimentation. The longevity of beliefs that physical differences exist between Blacks and Whites provided justification to conduct unethical medical experiments (Hogarth, 2019). Three historical experiments—J. Marion Sims, Henrietta Lacks, and Tuskegee Study—highlighted many of the issues with trust in health care systems. The historical traumas surrounding these experiments showcased the everyday prejudices that have created mistrust of the medical system (Sullivan, 2020). J. Marion Sims repeated, painful procedures multiple times on three documented enslaved African American teenage girls, known as Anarcha, Betsy, and Lucy, and more, Henrietta Lacks, a Black woman, unauthorized use of her cancer cells that helped in developing the HeLa cell line and continued medical research without her family's acknowledgment or consent, and the infamous Tuskegee study that involved 600 Black men who did not have the disease, being left untreated even with penicillin care available—are part of why levels of trust with the Black community occurred during the pandemic (Bajaj & Stanford, 2021). In all three experiments, Black individuals were treated and perceived as

subhuman things, less than human. This set the groundwork for the conscription of Black people as experimental specimens (Miller & Miller, 2021).

Myth of Black Immunity With Lack of Communication and Misconceptions

Systemic racism in healthcare and medical research contributed to medical myths affecting Black people, such as the Myth of Black Immunity with the misconceptions about pain tolerance and that Blacks are not biologically the same (*Medical Myths That Hurt Black People and How to Overcome Them*, 2023). This lack of communication in understanding that Blacks are human and are not biologically different has fueled several misconceptions. Studies have found that Black Americans are consistently undertreated for pain relative to White patients; one revealed half of medical students and residents held one or more false beliefs about supposed biological differences between Black and White patients, like the former have higher pain tolerance than the latter (Hostetter & Klein, 2021). This fallacy in thought has led to trust-related health beliefs among Black Americans with medical institutions.

As noted by Bazargan et al. (2021) medical mistrust can greatly influence the communication of sensitive medical history and information between patients and healthcare clinicians. Further studies have indicated that if communication is improved, communities of color receive better care when cared for by providers who share their racial and cultural identity (Johnson-Agbakwu et al., 2020). This can help in transforming the communication gaps about the health of Black Americans. According to Johnson-Agbakwu (2020) to advance health equity for Black Americans, institutions must build capacity to serve communities of color by first propelling the development of pipeline

training programs for healthcare professionals representing the ethno-cultural and linguistic diversity of the local communities served. The improvement of communication can address the inherent biases of Black people, gaps in education, care and treatment inequities, and underrepresentation of minorities in the medical community (Johnson-Agbakwu et al., 2020).

Black Immunity Myth—Trump and Biden

Some African Americans believed and asserted that melanin, the dark brown-to-black pigment in the skin, was a protectant against COVID-19 (Spigner, 2020). The COVID-19 pandemic showed otherwise, highlighting racial and ethnic disparities within the healthcare system, and that the virus did not discriminate with race, particularly with Black communities. Several studies indicated that Black Americans were aware of being undertreated, along with the false beliefs surrounding biological differences between White and Black patients (Hostetter & Klein, 2021). These concepts showed how the Black immunity myth has been embedded in not only Black American's thoughts but also highlighted how Trump and Biden approached COVID-19 with the Black community.

At the start of the pandemic, Donald Trump, who was president, and his administration had a narrow view on understanding why Black Americans were dying of COVID-19 at a higher rate than Americans of other ethnicities (Collins, 2020). Though the Trump administration was aware of this challenge, the Black community was ignored and made to be uniquely vulnerable to the coronavirus by this administration. As Himmelstein and Woolhandler (2021) noted Donald Trump’s assault on health exhibited

injustices, racist rants, and flawed social policies that set the stage for his ascendance. There were things the Trump administration could have done to improve health outcomes for Black Americans and to reduce their risk of dying due to the virus, such as reducing the hesitancy to respond instead of relying on each state to look out for itself, taking a more proactive role in managing resource allocation of the COVID-19 vaccine in areas with limited access, increasing data collection to better understand how various populations were affected by COVID-19 (Collins, 2020). Though Trump promised further research and studies on how the coronavirus affected Black Americans, and stated more data would be available to address needed resources, critics argued more could have been done. Dr. Fauci who at the time of the Trump administration was the Director of the National Institute of Allergy and Infectious Diseases emphasized to Trump that COVID-19 was another attention to a crisis that showed how unacceptable the actions being taken that affected Black Americans disproportionately, and how health disparities would still need to be addressed beyond the coronavirus (Collins, 2020).

After being elected as president after Trump, Joe Biden, and his administration took a different approach vowing to ensure that Black and Brown individuals would have better access to the COVID-19 vaccine after the Trump administration's egregious plans that lacked respect for science. Though Biden was dealing with a lack of trust among marginalized groups, a five-point plan was created to place federally supported vaccination centers in high-risk neighborhoods, set up mobile vaccination sites in medically underserved areas, administer the vaccine at independent pharmacies, partnering with community health centers and ensuring high-risk facilities such as

jails and homeless shelters have access to the vaccine (Ellis, 2021). He initiated a more aggressive approach, however, a level of skepticism existed from past historical healthcare atrocities and the Trump administration's delayed COVID-19 response to Black Americans. The unequal impact of the coronavirus highlighted long-standing systemic issues and an equitable pandemic strategy requires expansive relationships with state officials and local communities to root out racism and inequities in coronavirus-specific treatments and in government systems overall (PBS NewsHour, 2021). Biden initiated stronger attempts to balance the COVID-19 disparities among Black Americans and garnered more trust with Black Americans, but areas of needed improvement remained. Biden along with leaders of other high-income nations, refused to treat COVID-19 vaccines as a global public good, rejecting in February 2021, waivers of intellectual property rules that obstruct widespread, low-cost vaccine manufacture, even with an appointed official to help mobilize the global COVID-19 vaccine for low-income and middle-income countries, the available funding is barely a third of what was needed (Himmelstein & Woolhandler, 2021).

Trust and Mistrust With Medical Systems

Trust was vital to establishing valuable healthcare experiences. Black people tend to have lower levels of trust in comparison to White people in organizations and institutions (Hamel et al., 2020). Persistent racial disparities with health care systems, historic and ongoing racism, and discrimination are several of the factors surrounding trust-related issues with medical systems. These factors provided insight into why some Black patients prefer Black physicians from dealing with subpar access to healthcare and

the historical trauma created by medical establishments where harm was inflicted on Black patients. Recent research has indicated there is a strong need for racial diversity among healthcare providers in the United States. Black patients were six times more likely to place trust in medical information by Black physicians than White physicians (Murez, 2023). However, despite issues in the healthcare system, 51% of Black Americans believe that medical researchers do a good job most of the time, with 46% stating some of the time, though doubt still exists with medical researchers admitting and taking responsibility for mistakes (Funk, 2022). The information showed there was some reverence of trust in the medical institution, however, trust is complex among Black Americans from years of historical health mistreatment, lack of information, access to resources, and individual negative health experiences. As Padamsee et al. (2022) expressed constant exposure to institutionalized racism in healthcare may continuously cultivate distrust of healthcare professionals and researchers, despite facets of trustworthiness.

Differential Medical Treatment Among Black Women and Trust in the Medical System

Black communities have experienced years of neglect and inadequate treatment in healthcare settings (Padamsee et al., 2022). There were well-known cases of medical abuse among Black women, such as Serena Williams, a well-known tennis professional. In 2017 in undergoing an emergency cesarean section to deliver her daughter, Serena experienced shortness of breath related to being diagnosed with pulmonary embolism in 2011. She communicated her concerns, with many of the medical professionals on her treatment team being dismissive until a computed tomography (CT) scan confirmed

Serena's diagnosis, and a heparin infusion was done (Miller & Miller, 2021). She had to advocate for herself, but had she not been in a position to strongly do so, the outcome may have been catastrophic. As Funk (2022) stated, a large majority of Black women reported having negative healthcare experiences. These experiences encourage trust issues with medical systems. In a study by Snipe (2022), Black women often feel not heard and that their symptoms are not taken seriously as they are less likely to receive adequate pain treatment in comparison to other patients. Navigating through the healthcare system for Black women remains a challenge as false beliefs persist among medical students that Black people's skin is thicker than White people's and that Black patients are less sensitive to pain. Research by Washington and Randall (2022) illustrated several experiences with Black women where one participant discussed the challenges of her sister being diagnosed with cervical cancer stemming from previous perceived discriminatory encounters in healthcare with another participant having to be vigilant by being overly prepared for health visits and being a strong advocate for themselves when expressed health concerns are ignored.

Differential Medical Treatment Among Black Men and Trust in the Medical System

Black and White providers have shared reflections about Black men as being scary, violent, unreliable, less educated, and noncommunicative, based on the negative perception portrayed in the media (Plaisime et al., 2016). These perceptions have impacted how Black males are viewed in receiving treatment. Black males are more likely to receive less access to quality care and have worse health outcomes than White males (Funk, 2022). Historical atrocities such as the Tuskegee Study of untreated syphilis

in Black males highlighted medical exploitation and neglectful treatment. The life expectancy for Black males in comparison to White males with health treatment and outcomes tends to be significantly low from diminished rates of health engagement that include structural barriers impacting access, and social forces dissuading participation (Kramer et al., 2021).

Biases continued to showcase an unfortunate shadow on differential healthcare treatment among Black males. In a 2015 Implicit Association Test (IAT) taken by physicians that measured implicit biases by linking images of Black and White faces with pleasant and unpleasant words under intense time constraints, White faces were associated with more pleasant words than Black faces (Bridges, 2015). The test indicated several aspects. The lack of cultural competency and environmental awareness of Black men's hardships has led to explicit racial biases in how they are treated in the healthcare system (Kramer et al., 2021). Black men had cited or experienced instances where healthcare providers displayed insensitive behavior toward Black patients. As quoted by a White male physician, "Well I regret to say [that Black Males are] not met with great fairness. I think that the medical establishment by and large is hierarchical, conservative, fearful, and not ready to relinquish its power" (Plaisime et al., 2016). Research by Funk (2022) expressed that 46% of Black men have had at least one of six negative experiences with doctors or other health providers. A Black male participant in a study conducted by Kramer et al. (2021) discussed how physicians' inability to understand their daily life circumstances greatly impacted their care, with providers' lack of awareness of the unique environmental challenges faced.

Professional Blacks' Trust in the Medical System

Black Americans' trust in the healthcare system was complex even to professional blacks with higher levels of education and careers in the medical field. Hostetter and Klein (2021) stated that mistrust of the healthcare system persists even among some Black medical professionals, particularly in dealing with their own experiences. Black medical professionals such as Oni Blackstock, M.D., a primary care physician, researcher, and former assistant commissioner of New York City Health Department's Bureau of Human Immunodeficiency Virus (HIV) expressed concern when having to take her seven-year-old son needed to the emergency department (ED) for a skin abscess (Hostetter & Klein, 2021). Her last experience of taking her son to the emergency department involved a White orthopedist resetting her son's bone without receiving a painkiller. The experience left some level of mistrust in the medical system, and she instead phoned her twin sister, an Emergency Department physician, who connected her to a trusted colleague to treat her nephew (Hostetter & Klein, 2021).

Black adults with higher levels of education showed more trust depending on their level of education. Higher levels of education in Blacks than those with lower levels of education were more inclined to point to a variety of trust factors as major reasons for worse health outcomes among Black people. Black Postgraduates, 78%, and college graduates, 76% stated less access to quality medical care as a major reason for worse health outcomes in comparison to Blacks with some college experience at 68% and Blacks with a high school diploma or less at 51% (Funk, 2022). Black college graduates and Black medical professionals will typically have more trust and positive assessments

of the medical system in comparison to Blacks who are less educated, with some college, or experience outside of the medical field. This does not mean there are no instances of challenges with trust as illustrated in the example of the primary care physician and statistics provided from research by Funk (2022).

Media and Blacks' Level of Trust in the Medical System

The media at the beginning and during the height of COVID-19 were not transparent with the effects of the virus, making it difficult for the Black community to trust information. Hate and racist speech on social media often encouraged bullying, microaggression, and violence toward different racial communities (Al-Jarf, 2021). For example, in the United States, Trump who was president at the start of the pandemic called COVID-19 the Chinese virus, a former Italian Deputy Prime Minister, wrongly linked COVID-19 to African asylum seekers, calling for border closures, and a man in the United Kingdom spat on a Black woman, told her he had corona, then intentionally killed her (2021). CNN, MSNBC, and Fox News provided little to no reporting regarding the racial dynamics inherent in COVID-19 (Spigner, 2020) causing some Black Americans to believe the virus could not affect them and it was not that serious.

Several individuals in the media noted the irresponsibility of the media with the Black community. An African American cable news commentator Van Jones, reported on how African American prisoners and staff in United States prisons were put at extraordinary risk for the highly infectious COVID-19 disease due to the required proximity of inmates and guards with some African American prisoners believing the myth of being immune to the disease (Spigner, 2020). Furthermore, Trevor Noah, the

black South African comedian, and political commentator featured disturbing film footage of African Americans making statements cloaked in a tone of authority, asserting that black people could not catch the disease due to the melanin in their skin (Spigner, 2020). One young confident Black male stated to name Black individuals affected by COVID-19 as evidence. The absence of Blacks as COVID-19 victims in the media was deemed by many African Americans as *prima facie* evidence of black immunity (Spigner, 2020). Issues of trust were apparent with lack of information, misinformation, and nontransparency. Michael Che, one of the stars of *Saturday Night Live* had mixed feelings about the COVID-19 vaccine. He stated that with him being Black, he naturally did not trust it but being on a White television show, he might receive the real COVID-19 vaccine (Hostetter and Klein, 2021).

Churches played a role in the media's establishing levels of trust with Black Americans. Churches and faith-based organizations were a trusted resource for Black communities in the United States and played an influential role amidst coronavirus-19 (COVID-19) recovery efforts (Brown et al., 2022). With the Black community being negatively impacted by COVID-19, it was crucial to make genuine connections with the Black community to show a genuine understanding of their emotions, motivations, fears, and needs with trust-related beliefs regarding the healthcare environment.

Summary and Conclusions

The COVID-19 pandemic presented several challenges with trust-related health beliefs as highlighted throughout this chapter. The failure to establish trust in the context of historical and ongoing injustice, and public health authorities sowed the seeds for the

terrorizing effects of COVID-19 on African Americans (Best, 2021). Historical and systemic racism toward Black communities impacted the health-related beliefs of Black Americans toward the COVID-19 vaccine. The racial inequities generated issues of trust in healthcare scenarios between physicians and healthcare systems, greatly affecting the quality of care received by Black patients.

Though Black Americans were shown to have mixed views of the progress toward improved health outcomes with medical systems, doubts still existed. According to Funk (2022), 47% of Black Americans' state health outcomes have gotten better over the past 20 years, while 31% say they have stayed about the same and 20% think it has become worse. The exploration of trust-related health beliefs, health historical racism, and medical systems in the context of COVID-19 will help bring awareness and understanding toward best practices in educating the healthcare community on interacting with Black Americans to promote positive health outcomes for future pandemics.

The study highlighted a gap in understanding the trust-related issues surrounding Black Americans' health beliefs with medical systems since COVID-19. Discrimination, experiences around racism, and fear of experimentation are a few elements that have contributed to issues with trust and hurt the acceptance and willingness to seek healthcare (Rusoia & Thomas, 2021). Furthermore, the Black immunity myth, current issues of Black women and men with differential healthcare, and understanding the role of the media with fallacies of Black Americans were factors that contributed to challenges with trust in receiving healthcare. Trust in providers is based on the belief that an individual’s needs and concerns would be met if the provider was competent and would do what is

best for the patient. As Williamson and Tarfa (2022) noted, trust in providers has been repeatedly established as a factor in various vaccination behaviors.

Chapter 3 focused on a qualitative interpretative phenomenological approach to explore health beliefs in understanding how trust-related issues with medical systems played an important role in Black Americans and COVID-19. The study described the number of participants and background information, the sampling procedure, the methodology, and the questions asked during the interviews. The data and themes were conducted manually. The informed consent, participant confidentiality, protections, and IRB protocols were provided, as well as the recruitment methods.

Chapter 3: Research Method

Introduction

The purpose of this qualitative research study was to conduct an IPA of trust-related health beliefs in medical systems among Black Americans since COVID-19. Historical and systemic racism toward Black communities has persistently led to issues of mistrust with medical and healthcare systems. Discrimination, experiences around racism, and fear of experimentation are a few of the elements that contribute to mistrust and hurt the acceptance and willingness to seek healthcare (Rusoja & Thomas, 2021). These experiences continue to shape the beliefs Black Americans develop toward healthcare. According to Thier et al. (2023), Black Americans have experienced medical mistrust and unique healthcare-related experiences, expectations, and health-seeking behaviors. Medical mistrust has an association between Black Americans and the refusal to participate in vaccine trials or receive a vaccine, suggesting that general suspicion of mainstream healthcare professionals and systems may be associated with continued hesitancy toward the COVID-19 vaccine (Thompson et al., 2021). Exploring trust, mistrust, and health beliefs in the context of COVID-19 would bring health awareness, educate the healthcare community, and gauge the unique experiences of Black Americans in dealing with medical systems.

Chapter 3 begins with a review of the research design and rationale. A discussion of the role of the researcher follows. Next, the methodology is examined, including the population, sampling strategies, and data collection plan. Finally, trustworthiness issues are addressed, including dependability, confirmability, and ethical considerations.

Research Design and Rationale

Research Question

This study focused on an IPA of trust-related health beliefs in medical systems among Black Americans since COVID-19. Based on the problem and purpose of the research, a central research question was addressed: What are the experiences of trust-related health beliefs in medical systems for Black Americans since COVID-19?

Central Phenomenon of Study

The qualitative study brought awareness to understanding how health beliefs play a significant role in trust with medical systems and further educated the healthcare and medical community by conducting an IPA of trust-related health beliefs in medical systems among Black Americans since COVID-19. Black Americans have experienced medical mistrust and unique healthcare-related experiences, expectations, and health-seeking behaviors (Thier et al., 2023). Historical mistreatment, such as the Tuskegee syphilis study and Henrietta Lacks, has created years of vaccine hesitancy due to a "legacy of distrust" in medical research (Scales et al., 2023).

Research Tradition

I chose the qualitative method of inquiry. This approach provided an in-depth exploration of social phenomena in a natural rather than experimental setting. The qualitative approach enabled a deeper understanding of an individual's experiences through exploring the how and why of lived experiences. The ability to explore the experiences, perceptions, and behaviors of individuals, as well as the meanings attached to them (Merriam & Tisdell, 2016), helped to achieve the research goals. Through this

study, I aimed to gather data and interpret themes to explore trust-related health beliefs to improve health awareness, educate the healthcare community, and gauge the unique experiences of Black Americans in dealing with medical systems. The qualitative approach was suitable as basic research tends to be the most common form and is motivated by an intellectual interest in this phenomenon to extend knowledge (Merriam & Tisdell, 2016).

Rationale for Chosen Tradition

The study had a qualitative approach with a phenomenological design. This qualitative approach aligned better with the specific population as the focus was on the trust-related health belief experiences of medical institutions with COVID-19. A need existed to bring awareness and educate the healthcare community and Black Americans about the health beliefs that have generated levels of mistrust with medical systems since COVID-19. As Padamesee et al. (2022) demonstrated, beliefs among Black Americans derived from historical racism and racism in healthcare were shown to lessen trust with healthcare professionals and medical institutions, driving vaccine distrust and hesitancy.

There are several qualitative approaches, including phenomenology, grounded theory, ethnography, narrative analysis, and case study. The research questions differed depending on data collection, selection of participants, and sample size. Phenomenological was the best approach as it allowed me to explore the essence and underlying structures of the phenomenon, whereas grounded theory navigates beyond understanding and building a substantive theory about the phenomenon (Merriam & Tisdell, 2016). Ethnography focuses on understanding the interactions beyond others, as

well as cultural influences. Narrative analysis is about exploring the stories of individuals to analyze and gauge the experiences revealed from the stories. A case study in qualitative design involves a unit of analysis with boundaries—typically a bounded system—encompassing a single person, program, group, institution, or community (Merriam & Tisell, 2016).

IPA was the qualitative approach used for the study to help develop an in-depth understanding of the lived experiences of individuals. According to Smith and Nizza (2022), IPA is a comprehensive exploration that requires digging deep to reveal the meaning of experiences that are not clear. IPA offered a rich qualitative methodology to explore, investigate, and interpret the lived experiences of research participants (Alaze, 2017). IPA provided a platform to connect with study participants on a deeper level to understand better how their experiences influenced health beliefs surrounding COVID-19. Developing a rapport with selected participants helped during the interview process. Alase (2017) stated that the researcher should try to develop rapport so interviewees will lighten up and feel relaxed about the process. This approach provided an opportunity to receive rich, detailed information when the participant was at ease and felt free to share their lived experiences.

Four major phenomenological philosophers have contributed to this approach—Husserl, Heidegger, Merleau-Ponty, and Sartre—to show that it is not just a singular but also a pluralist endeavor (Smith et al., 2022). Husserl focused on carefully examining human experiences, particularly understanding the participant's experience as it connects to the phenomenon. Husserl’s phenomenology involves the individual stepping outside of

everyday experiences—a *natural* attitude, as he called it—to a *phenomenological* attitude of one's perception of the world (Smith et al., 2022). Heidegger was a student of Husserl, who had a more worldly perspective centered around the hermeneutic approach. Hermeneutics refers to the process of interpretation, a nonlinear style of thinking (Smith et al., 2022). Merleau-Ponty had much of the same concept as Heidegger except for exploring the nature of an individual's relationship to the world that leads to an individual's unique perspective on their environment. Sartre aligned many of his ideas with Heidegger, focusing more on the developmental, processual aspect of a human being. Sartre believed that people always become themselves through ongoing experiences (Smith et al., 2022). These ideas aligned well with exploring trust-related health beliefs with medical systems among Black Americans since COVID-19, as this research focused on the descriptions, emotions, meanings, and interpretations of people's experiences. For this study, I gained insight by exploring trust-related health beliefs and the unique experiences and perceptions surrounding medical institutions that affected the perceptions of receiving the COVID-19 vaccine from the Black community.

Role of the Researcher

As the sole researcher for the study, I was an observer while remaining neutral and objective to reduce biases and understand the unique experiences of Black Americans with medical systems. In a qualitative approach, the researcher is both the instrument of data collection and the interpreter of the data (Florczak, 2022). I sought to interpret and explain the experiences of participants with trust-related health beliefs by accessing the thoughts and feelings of the participants surrounding the phenomenon. There were no

anticipated relationships with the participants beyond being the sole researcher and an observer of the participants' responses to the questions. As the researcher, it was important for me to establish and maintain an objective approach to prevent biases and power relationships. As Florczak (2022) noted, biases can lead to an unfair position that is not based on truth but on personal viewpoint. To remain objective and mitigate the risk of biases and power relationships, the research questions were carefully composed to reduce biases during the interview process; the principles and precepts of the theories that support the research process were explained to ensure reliability and validity surrounding the phenomenon. Florczak (2022) noted that in explaining the theory, a rationale is provided for the findings and is an assurance that such findings are not solely subjective. Possible ethical issues occur if participants are obtained from the work environment; however, to mitigate this and reduce conflict of interest or power differentials, participants were obtained from external environments that were not personally connected to me as the researcher.

Methodology

Participant Selection

The qualitative study explored the experiences of Black Americans' trust-related health beliefs with medical systems since COVID-19. Purposeful sampling was used to achieve this, specifically the snowball sampling strategy. The snowball sampling strategy starts with one or a few relevant information-rich interviewees who provide additional contacts relevant to different or confirming perspectives (Patton, 2015). The study focused on a specific experience among Black Americans; the sample was homogeneous.

The criterion was based on the participant's experience with the phenomenon, though characteristics and individual experiences varied. The population consisted of individuals who identified as Black Americans, and this population was the focus of understanding the phenomenon. The inclusion criteria consisted of participants 18 years of age and older who identified as a Black American, were having or had interactions with the healthcare system since COVID-19, and had a minimum of a high school diploma or GED. I reviewed and verified the inclusion criteria with the participant to ensure that the potential participant met them. Exclusion criteria included participants who did not meet the inclusion requirements, including participants younger than 18 years of age, participants who did not identify as Black American, participants who did not have a high school diploma or GED, participants who had had no interactions with the healthcare system since COVID-19, and participants who had a legal guardian.

I aimed to recruit six to 10 Black Americans, with a minimum age of 18 years, from various backgrounds who identified as Black/African American. According to Smith et al. (2022), a sample size between six and 10 is appropriate for saturation. The size reflected and represented the homogeneity in better gauging and understanding the overall perceptions of the participants. Recruitment occurred through email flyers (see Appendix A) or posters on both a local and national level by being presented to community centers, Black salons, and barbershops in the Southwest region, specifically Texas. On a national level, recruitment occurred through the Walden participant pool and social media such as Facebook, Instagram, LinkedIn, and Research&Me. Participants were identified by meeting the inclusion criteria and were contacted via email and

telephone. Before scheduling a Zoom interview, selected participants were provided an informed consent form, an opportunity to ask questions, and a privacy and confidentiality statement regarding the information collected, and the participants had the right to change their minds about participating in the study. Once participants agreed, a Zoom link with the scheduled date and time was emailed.

IPA studies are conducted on small sample sizes and are particular to a specific experience (Smith et al., 2022). This is recommended as this approach requires significant time. Smith et al. (2022) noted that the detailed case-by-case analysis of individual transcripts takes time, with the aim of the study involving detailed written perceptions and understandings of the participants. This accounted for why using the snowball sampling strategy was conducive to this study. Saturation in qualitative research refers to the point in data collection when no additional issues or insights are identified, and data begin to repeat so that further data collection is redundant, signifying that an adequate sample size has been reached (Hennink & Kaiser, 2022). The saturation of the sample size was reached when participants' data indicated similar patterns and themes in their responses to the questions.

Instrumentation

The purpose of an IPA study is to explore the participants' deeper lived experiences through the researcher's detailed account. This typically happens through interviews, observations, documents, and data review (Merriam & Tisdell, 2016). Participants were identified by meeting the inclusion criteria of being 18 years of age and older, identifying as a Black American, having or having had interactions with the

healthcare system since COVID-19, and having a minimum of a high school diploma or GED. Once identified, participants were contacted via email and telephone. Exclusion from participating in the study was based on individuals not identifying as Black Americans, not meeting the minimum age requirement, not having had interactions with the healthcare system since COVID-19, and not possessing a minimum of a high school diploma or GED. Prior to scheduling a Zoom interview, selected participants were provided an informed consent form, an opportunity to ask questions, and a privacy and confidentiality statement regarding the information collected, and the participants were informed of their right to change their minds about participating in the study. Once participants agreed to participate, a Zoom link was emailed with the scheduled date and time. For this study, I conducted semistructured interviews with 10 questions for about 60 minutes. Using the semistructured interview method, I collected rich and in-depth experiences of trust-related health beliefs in medical systems among Black Americans since COVID-19. Observational notes were captured in the interview guide note section corresponding to each question.

In qualitative research, interviewing is a standard mode of inquiry. Interviewing highlights the perceptions and interest in the experiences of others and connects to how an individual attributes meaning to those experiences and perceptions. Interviewing allows an opportunity for the researcher to gain a deeper understanding of an individual's behavior and the phenomena. In IPA research, interviewing allows participants to share their unique stories, reflections, thoughts, and feelings. As a researcher, my goal was to create an interview environment that felt safe, comfortable, and free of biases, where the

conversation would flow naturally, with the participant mostly talking through skillful guidance. An interview guide with questions and a clear understanding of interview techniques was used to achieve this. Interview guides are necessary for directing the researcher to ensure that questions are simple, clear, and concise toward the research question. The preparation of the interview guide ensured that the questions were structured appropriately to gather the information needed and be able to handle the sensitivity of the information. As Smith and Nizza (2022) stated, this helps the researcher be well-prepared and relaxed for the interview. The sufficiency of data collection was a crucial step in the research process. The instrument for data collection was a key element of traditional questionnaires, which helped to investigate various topics of interest aimed at assessing and measuring phenomena. As Smith and Nissa (2022) noted, the wrong choice of an instrument can compromise the internal validity of a study, producing misleading results, which will lead to not answering the research question.

Researcher-Developed Instruments

The interview question guide (see Appendix B) was guided by input from the dissertation committee and existing literature surrounding health beliefs, COVID-19, historical health discrimination, and trust-related issues with medical systems. Semistructured interviews with open-ended questions were developed with guidance from the literature and committee to help establish content validity. This type of interview provides flexibility with some guidance from the researcher. The protocol consisted of 10 questions.

The six HBM constructs were used to construct and answer the research question to explain and understand the health beliefs of Black Americans. Interview question 1 focused on the HBM's first construct, perceived susceptibility. HBM's first construct, perceived susceptibility, is about an individual's subjective perception of risk in acquiring an illness or disease (LaMorte, 2022). The vulnerability variation tends to depend on an individual's emotions toward an illness or disease. Individuals are more likely to be vaccine-hesitant if they have a high perceived susceptibility to COVID-19 (Limbu et al., 2022), which was indicated through Black Americans' concerns about COVID-19 but a susceptibility to the beliefs in healthcare systems. Interview question 2 focused on the HBM's second construct, perceived severity, which focused on an individual's feelings surrounding the intensity of contracting an illness or disease. As LaMorte (2022) stated, an individual's feelings of severity will cause an individual to consider the medical and social consequences when evaluating the severity of a situation or circumstance. Padamasee et al. (2022) highlighted that COVID-19 vaccine hesitancy has decreased more rapidly among Black individuals than among White individuals since December 2020 due to the belief that vaccines were necessary to protect themselves and their communities.

Interview question 3 focused on the HBM's third construct, *perceived benefits,* which focused on an individual's perceptions of available resources to reduce the threat of disease or illness. Perceived susceptibility was used as a consideration and evaluation tool to weigh health action's benefits. For example, an individual thinking about the likelihood of contracting the COVID-19 virus will take action dependent on low or high

perceived susceptibility to the virus. Padamasee et al. (2022) noted that Black Americans increased receiving the COVID-19 vaccine as it lowered the chances of morbidity rates. Interview question 4 focused on the HBM's fourth construct, *perceived barriers*, exploring an individual's feelings to the obstacles in being able to perform a recommended health action. In this construct, a cost and benefit analysis weighed the effectiveness of the actions against the perceptions of the cost, risk, unpleasantness, time, and inconvenience. An example is an individual assessing the overall cost and access to health resources to prevent illness and maintain health. Thier et al. (2023) found that developing culturally tailored interventions for Black Americans that build confidence in COVID-19 vaccines, highlight collective responsibility, and attend to Black Americans' information sources was key to boosting Black Americans' COVID-19 vaccine acceptance.

Interview questions 5 and 6 focused on the HBM's fifth construct, *cues to action*, the activation of health behavior through external events that prompts a desire to make a health change. A cue to action encourages an individual to move from wanting to make a health change to making the change. For example, in a study by Tsai et al. (2021), nursing students discussed how the media influenced more preventative measures toward COVID-19 based on global concerns of transmission and high mortality rates. The media was an external cue that triggered nursing students toward healthy behavior action in dealing with COVID-19 as the media was influencing Black Americans to receive the COVID-19 vaccine. Interview questions 7 and 8 focused on HBM's sixth construct, *self-efficacy,* a person's belief in their ability to make a health-related change. This construct

explored how it directly relates to whether a person will perform the desired behavior (LaMorte, 2022). During COVID-19, research by Huang and Gerend (2024) found that higher self-efficacy among African Americans led to an increased chance of receiving the COVID-19 vaccine.

The trustworthiness of medical systems was the focus of questions 9 and 10 in answering the research question. An example of questions 9 and 10 centered around asking participants about their health beliefs surrounding the healthcare system before and after COVID-19. In a study by Jindal et al. (2023) the importance of measuring structural racism from an individual and structural standpoint was emphasized to understand what components are necessary to develop trustworthy healthcare institutions to influence COVID-19 vaccine receipt, shape and improve individual perceptions and behavior of Black and Latinx communities to increase positive health outcomes such as vaccine receipt.

Prompts were used as needed to help participants clarify their responses. This qualitative approach was designed to elicit responses to help understand the phenomenon of interest. The research question was: What are the experiences of trust-related health beliefs in medical systems for Black Americans since COVID-19?

Procedures for Pilot Study Road Test

To test the design and literacy of the questions for potential participants, the interview guide was tested by recruiting 2 mock participants: a family member, such as my spouse or sister, friends, and a doctoral classmate. The family member and doctoral classmate were asked to participate in the study before the proposal and IRB approval. I

scheduled a meeting with the mock participants to test if the questions were easily understood without ambiguity. The purpose was to ensure the interview questions were feasible; if not, revisions would be made. Upon completion of testing the questions, the mock participants received a verbal thank you and would not be part of the study once the proposal and IRB approval were received. Once the IRB approval number was received, it was placed in the completed dissertation.

Procedures for Data Collection, Recruitment, and Participation

Participants were obtained through snowball sampling. Recruitment occurred through email flyers or posters presented to the Walden participant pool, community centers, and social media such as Facebook, LinkedIn, Research&Me, Black hair salons, and barbershops. If unable to obtain 6 participants with the first recruitment, the flyers were reposted to new social media venues. Participants were identified by meeting the inclusion criteria of 18 years of age and older, identified as a Black American, have or had interactions with the healthcare system since COVID-19, and have a minimum of a high school diploma or GED. Once identified, participants were contacted via email and telephone. Exclusion from participating in the study was based on individuals not identifying as Black Americans, not meeting the minimum age requirement, having not had or having interactions with the healthcare system since COVID-19, and not possessing a minimum of a high school diploma or GED. Before scheduling a Zoom interview, selected participants were provided an informed consent form, an opportunity to ask questions, a privacy and confidentiality statement regarding the information collected, and the participants have the right to change their mind about participating in

the study. Once participants agreed to participate, a Zoom link with the scheduled date and time was emailed. Data was collected through semistructured interviews lasting about 60 minutes. Since I was the sole researcher, I collected the data. Participants were interviewed through Zoom, allowing for video and audio recordings of all interviews. Once interviews were completed, participants were debriefed and given a 1-800-crisis hotline number if the participant experienced emotional distress. The transcript was sent via email a week after the interview to the participant after being reviewed for accuracy and revisions. Participants had a week to review the transcript. The participant confirmed if the transcript is accurate or inaccurate at the end of the week timeframe through email. If there were inaccuracies, revisions were made in a week and the final revision of the transcript was sent to the participant for a final review.

Data Analysis Plan

I was responsible for data collection for this study, including interviewing, transcription, and data analysis. Software was not utilized for data analysis. The seven steps of IPA were used to describe the analysis process—immersing in the original data, exploratory noting, constructing experiential statements, connections across experiential statements, naming the personal experiential themes, consolidating and organizing in a table, continuing individual analysis, and working with personal experiential themes (PETS) to develop group experiential themes across cases (Smith et al. (2022). *Step 1* involved immersing myself in the original data. As Smith et al. (2022) state, this stage will ensure that the participant will be focused on analysis. This was achieved through the interview transcript by reading and re-reading the data provided through the participant' s

interviews such as exploring participants experiences and specific beliefs. *Step 2* focused on exploratory noting, which was the content and language that highlighted anything of interest in the transcript. This was done by reviewing the transcript and identifying how the participant talked and their perception of the phenomenon. Smith et al. (2022) stated that there are no rules and requirements about what is commented on and that steps 1 and 2 will merge. This step helped to develop more interpretative notetaking to understand how and why the participants responded in the way they do by exploring the participant's perceptions of the phenomenon.

Moving to *Step 3*, constructing personal experiential themes, involved consolidating and forming thoughts. In constructing experiential statements, managing the data changes as the researcher simultaneously attempts to reduce the volume of detail while maintaining the complexity (Smith et al., 2022). Personal experiential themes tend to stem from exploratory notes and specific parts of the original interview transcript. To achieve this, I reflected upon the participant's words and thoughts related to their trust-related health beliefs conveyed during the interview to produce a concise summary of what is seen as significant in the participant's transcript notes. *Step 4* involved searching for connections across experiential statements, which involved mapping out how statements were connected. This step provided a structure for pointing out the most interesting and essential aspects of the participant's interview transcript (Smith et al., 2022). To achieve this, I maintained a copy of the annotated transcript with the exploratory notes and experiential statements to search for connections, and by treating each statement with equal importance to create a horizontal pattern that highlighted the

potential interconnections between each of the interviewee's statements. *Step 5* was naming the personal experiential themes (PETs), consolidating them, and organizing them in a table. Clusters of experiential statements were provided a title to describe the characteristics; this helped to form a pattern to develop a table or figure of all the themes formed from the experiential themes from the interview transcripts. The narrative organization was used to provide theoretical leverage as it reflected the thematic structure and highlighted any important temporal processes identified with the participant's experiences. Functional analysis also sufficed, as this involved interpreting the participant's words regarding particular sense-making or presentational strategies (Smith et al., 2022). This was achieved by using color coding to identify any related statements or words from participant interviews surrounding trust-related health beliefs. *Step 6* focused on continuing the individual analysis of other cases—meaning participants interviews. This step referred to analyzing each participant's transcript, treating each case as unique, and not generalizing ideas from the first transcript. As Smith et al. (2022) noted, it is easy to be influenced by the information you already have. I analyzed each participant's interview to ensure the process was complete by using steps 1-5 as outlined for the first case. Then, I proceeded to complete the process for each transcript to analyze if there were any distinct differences in trust-related health beliefs in the medical systems. The importance of this skill in IPA was that it allowed for new analytic entities to emerge for each participant's interview (Smith et al., 2022). *Step 7* involved working with personal experiential themes to develop group experiential themes across cases. The goal of this stage was to seek patterns of similarity and differences across the personal

experiential themes (PETs) from the previous step to create a set of Group Experiential Themes (GETs) (Smith et al., 2022). This occurred by scanning each table of the PETs and reviewing for any similarities and differences in trust-related health belief themes.

Discrepant cases remained as the participant's experiences and viewpoints were essential to understanding the phenomenon. Experiences that differ from the expected outcome will be explained to strengthen the research. As Smith and Osborn (2003) noted all viewpoints of the participants are essential for a richer analysis and to do greater justice to the totality of the person. Participant's interview transcripts all rendered meaning to answer the research question by analyzing personal experiences surrounding trust-related health beliefs among Black Americans. According to Antin et al. (2015), differing viewpoints within participants' narratives are essential for transforming ambiguity into meaning and understanding the phenomenon.

Issues of Trustworthiness

There are four critical criteria in qualitative research to ensure the quality of the research: credibility, transferability, dependability, and confirmability (Ahmed, 2024). *Credibility* was achieved through extended involvement, persistent observation, and triangulation; *transferability* was achieved through comprehensive and detailed explanations; *dependability* was achieved through rigorous documentation and the creation of an audit trail; and confirmability was achieved through peer debriefing, member checking, and reflexive journaling (Ahmed).

Credibility

To ensure the credibility of my study, the IPA method was adopted. IPA is a qualitative approach that allows the researcher to capture the participants' experiences. The choice of IPA focused on recruiting participants with lived experiences connected to the phenomena while illustrating the importance of scientific research principles. The approach focused on the detailed lived experiences of individuals and their attempts to make sense of the experience (Alase, 2017). This suggested that these experiences can best be explored through examining the meanings people place upon them (Shinebourne, 2011). To address credibility, I maintained reflexive journaling through a journal of notes highlighting any issues of biases. Reflexivity was linked to the researcher's ability to communicate nuanced and ethical decisions with the complex work of generating real-world data that reflect the messiness of participants' experiences and social practices (Olmos-Vega et al., 2022). Additionally, ensuring that interview questions do not lead participants to respond in a particular way, and doing member checks to ensure what is communicated on the transcript is the participant's own words and provides the opportunity to revise information if needed. Utilizing IPA was appropriate for investigating the lived experiences of Black Americans' trust-related health beliefs with medical systems since COVID-19.

Transferability

Exploring the experiences of Black Americans' health beliefs with the trustworthiness of medical systems helped with generalized findings of understanding the experiences and perceptions surrounding COVID-19. As noted in the research

surrounding this topic, many Black Americans have experienced historical health barriers through discrimination, racism, and inequitable access to health care from medical systems. Participants may also have different experiences depending on if they are in rural or urban areas regarding trust-related health beliefs with medical systems. My study explored the lived experiences of Black Americans through their trust-related health beliefs, which generated significant findings to improve how the health and medical systems interact with the Black community. As Merriam and Tisdale (2016) note, transferability involves taking the findings of one study and applying them to other situations. These findings helped to generate strategies more conducive to producing improved future health outcomes for Black Americans on both a local and national level.

Dependability

My study focused on collecting data from semistructured interviews. Interviews were recorded through Zoom. Transcripts were printed and reviewed by participants for response accuracy. I completed an audit trail of each transcript's descriptive, linguistic, and conceptual experiential notes. I supported my findings with specific participant quotes and interpretative commentary (Smith & Nizza, 2022). The results were used to connect to current literature and how the outcomes would affect social change.

Confirmability

I demonstrated confirmability in my study through respondent validation. Respondent validation is a form of ruling out the possibility of misinterpreting the meaning of what participants are saying and an essential way of identifying biases and misunderstandings of what will be observed (Merriam & Tisdale, 2016). I studied all

interview transcripts for accuracy without bias. This helped maintain neutrality and to be conscious of personal beliefs surrounding the phenomenon of interest. Additionally, this process took the preliminary analysis of the participants to ensure the researcher's interpretations were accurate, and if not, adjustments to better capture their perspectives were made. As the sole researcher, I also used adequate engagement with data collection to ensure the data and emerging findings were saturated. Merriam and Tisdale (2016) note that part of this fringes around the researcher's integrity to purposely seek data that shows variation in the understanding of the phenomenon.

Ethical Procedures

Ethical research involves perspectives of subject protection and conducting research based on ethical standards to ensure positive social change**.** The ethical principles that guide scientific research are based on the assurance of human freedom and dignity (Taquette et al., 2022). Every scientific research conducted with human beings must have a clear and relevant justification. This study highlighted the importance of the research through clear communication with the participants. Participants must be freely and properly informed about the research and provide consent. Participants were provided with an electronic informed consent form with detailed information about the study and their participation role, specifics that participation is voluntary, they may withdraw at any time, and there are no negative consequences if they decided to withdraw. Informed consent forms were sent to selected participants, and participation confirmation was required before the participant could proceed with the interview. The

risks, benefits, consequences, and the participant's agreement to participate must be given without being coerced or convinced (Taquette et al., 2022).

The confidentiality of participants must be respected and protected. The goal of IPA research was to explore human experience in depth so that sensitive topics would be involved. As the researcher, I was aware of and empathized with the process. Upon completion of the interviews, I followed up with each participant to ensure they were comfortable with the outcome and were not experiencing any emotional distress. IRB guidelines, as outlined by Walden University for doctoral research, were followed. Consent forms with information highlighting the study were provided to inform participants that the process was entirely voluntary and that they had the right to withdraw from the study at any time. All demographic information was removed to protect participants' identities and ensure confidentiality and privacy. Participants were identified by a random two-digit number assigned during the interview to maintain privacy and confidentiality and remove any identifying information.

Approval from Walden University was sought by receiving approval from the review board. Research data was stored in a password-protected personal computer and maintained for five years as required by the Walden University IRB office. After five years, all data will be destroyed following the required five-year retention requirement.

Summary

Chapter 3 discussed the purpose of the present study, which was to explore an IPA of trust-related health beliefs in medical systems among Black Americans since COVID-19. The research methodology for this study was an IPA. IPA is a qualitative

design that seeks to understand people's lived experiences and how they make sense of those experiences (Smith & Nizza, 2022). This methodology captured and interpreted the experiences of Black American's trust-related health beliefs with medical systems since COVID-19. The primary data collection method of qualitative research was interviewing. This IPA study used semistructured interviews to engage Black Americans in discussing how their trust-related health beliefs with medical systems have been since COVID-19. Each interview transcript was transcribed and carefully reviewed for data analysis.

Through observational notes and developing an authentic rapport, I captured the participants' unique experiences to ensure objectivity and reduce biases during the interview and analytical processes. IPA was a participant-oriented approach that allowed the researcher to develop rapport with participants (Alase, 2017). The goal was to create an authentic rapport that enabled interviewees to explore their perspectives, with the result being comprehensive and detailed data. The study findings are presented in the next section, Chapter 4. In following qualitative design protocols, participant responses to questions are reported. Each interview will be discussed in detail and connected to the research question. Additionally, the implications of the findings on social change are presented.

Chapter 4: Results

Introduction

The academic community had a narrow scope in understanding trust-related health beliefs with medical systems among Black Americans since COVID-19. To contribute to the literature, I compiled a study to explore the trust-related health beliefs in medical systems among Black Americans since COVID-19. Using IPA, I explored Black Americans' experiences of medical trustworthiness and unique health-related experiences through the Rosenstock (1974) HBM. This study addressed the health beliefs and trustworthiness in medical systems among Black Americans since COVID-19. The research question addressed was the following: What are the experiences of trust-related health beliefs in medical systems for Black Americans since COVID-19? In this chapter, I discuss the setting and the shared personal experiences of the participants' lives during the study's timeframe. Chapter 4 also addresses the data collection and analysis process, the level of trustworthiness of medical systems, and the study results. The chapter ends with a summary and a transition to Chapter 5.

Setting

The interviews were conducted virtually on Zoom using video, audio, and transcript platforms. The virtual platform provided an opportunity to include participants from various regions in the United States. The interviews were conducted in the privacy of my home in a quiet room with the door closed, free of distractions. To my knowledge, no circumstances during the interviews affected the interpretation of the study results. Each participant was informed that the process might take up to 60 minutes. Most of the

interviews were completed within 30–45 minutes, depending on the length of the participant's responses.

Demographics

The participants consisted of six adults who identified as Black Americans. There were three males and three females. Two participants were recruited through the snowball method but did not have a direct relationship. The remaining four participants were from the Walden Student Pool and social media, specifically LinkedIn. Further identifying characteristics were that the participants were 18 years of age and older and were having or had interactions with medical systems since COVID-19. All interviewees could speak, read, and understand English. The participants all resided in the Southwest, Southeast, and Midwest regions of the United States. The breakdown of areas the participants resided in is provided in Table 1.

Table 1

Region Breakdown

Southeast	Southwest	Midwest
1	3	2

Data Collection

I received Walden University IRB approval (11-14-24-1059800) to conduct research on November 13, 2024. Data collection occurred over a 3-week period during December 2024. Data collection started with a recruitment flyer posted through the Walden participant pool, community centers, and social media, specifically LinkedIn and

Instagram. Data collection was completed with the goal of six participants deemed appropriate for the study. Saturation was reached with the six participants as the themes and patterns expressed in the responses were repeated throughout the interviews, resulting in no new insights needing to be collected further. In December 2024, the participants were selected and interviewed. Upon acknowledgment of interest in the study, participants were sent a copy of the informed consent form to review and sign.

The six participants consented to video-recorded interviews conducted through Zoom. Once the participants provided informed consent by email and interviews were scheduled, a Zoom link was sent to their email addresses. The participants clicked on the link to join the Zoom interview at their scheduled time. Before the interview started, each participant was reminded of the voluntary nature of their participation and their right to refuse to answer any questions or to withdraw from the study at any time. The participants were also informed that the interview would be recorded with the Zoom platform, and permission was requested from each participant to start recording. When the recording started, I asked each participant questions from the interview guide until the interview was completed. At the end of each interview, I asked participants to provide any additional information or feedback. Once the interviews were completed, the recording ended. Variations in data collection did not deviate from the plan in Chapter 3. No unusual circumstances were encountered during the interviews except for minor technical issues with sound and internet connections on the participant's end.

Data Analysis

The inductive process for the IPA analysis comprised the following steps, which began with the interviews conducted through a Zoom platform. The Zoom platform provided audio, transcription, and video for each interview participant. Copies of the transcripts were emailed to each participant to verify and check for accurate experiences communicated during the interview. All participants responded with no objections or corrections. I manually analyzed each transcript based on the recommendations outlined by Smith et al. (2022) and the IPA process for the data analysis (Smith et al., 2022).

Participants each had their physical folders labeled Participant 11, Participant 12, and so forth. Each folder contained a printout of the participant's interview transcript, the interview video, and typed notes regarding the consent and scheduling for each participant. I analyzed each transcript several times to familiarize myself with each participant's unique experiences.

Step 1 involved immersing myself in the original data by reading and rereading the data provided through the participant's interviews. This step was intended to ensure that each participant was at the center of my analysis. I appreciated the unique experiences developed in each interview. My research journal also noted significant observations for each transcript (Smith et al., 2022).

Step 2 focused on exploratory noting, with highlighting anything of interest or value within the transcript. I reviewed the transcript and identified how the participants talked and their perceptions of the phenomenon. I highlighted key concepts expressed by each participant's transcript to familiarize myself with the experiences for developing

exploratory notes. Focusing on the participants and the language used, I made notes that helped identify significant aspects of emotions, behaviors, and processes. In this step, I aimed to identify and gather aspects that mattered to the participants. Finally, conceptual comments from personal reflections and experiences were combined to understand the emergence of the participant's lived experiences (Smith et al., 2022).

Step 3 focused on the analysis of constructing personal experiential statements (Smith et al., 2022). I consolidated my thoughts by reviewing the exploratory notes from Step 2. During the interview, I reflected upon the participant's words and thoughts connected to their health beliefs and experiences to develop a clear summary of what was seen as significant in each participant's transcript. The focus was on capturing what was essential to the participants by reflecting on their words and interpreting the phenomenon. This helped to provide a stronger platform for the phenomenon.

Step 4 involved searching for connections across personal experiential statements (Smith et al., 2022). This involved mapping out how statements were connected from the participant's interview transcripts. The transcripts were reread to evaluate the relevance of personal experiential themes developed in Step 3. I maintained a copy of the transcripts with the exploratory notes and experiential statements for connections. Each statement was treated with equal importance to create a pattern highlighting the interconnections between each of the interviewee's statements. This step aimed to provide a structure for pointing out the most interesting and essential aspects of the participant's interview transcript (Smith et al., 2022).

Step 5 involved naming the personal experiential themes (PETs) and consolidating and organizing them into a table (Smith et al., 2022). In this step, a Microsoft Word document was used to track themes and personal experiential statements. The experiential themes helped to form a pattern to organize and develop a table from the interview transcripts. The statements were aligned with the interview questions to reflect the thematic structure and highlight the important temporal processes connected with the participant's experiences. The table consisted of four columns: group experiential themes (GET), personal experiential themes (PET), HBM constructs, and trustworthiness of medical systems. Each group experiential theme had a row within the table to track specific aspects of each major concept in the study.

Step 6 of the data analysis process involved continuing the individual analysis of the participant's interviews. I analyzed each transcript by repeating Steps 1–5 outlined in the first case. I analyzed differences in trust-related health beliefs in the medical systems. This focused on allowing new analytic entities to emerge for each participant’s interview (Smith et al., 2022). The last step involved working on personal experiential themes to develop group experiential themes across cases. The last step focused on working with personal experiential themes to develop group experiential themes.

Step 7 involved finding similarities and differences across the personal experiential themes noted in the previous steps (Smith et al., 2022). I reviewed each transcript and the themes and concepts table again to compare themes across participants. Several similar patterns of experience were found among the participants. During the process, 12 group experiential themes and 52 personal experiential themes were noted to

include one probing question. The breakdown of acronyms used in Table 3 on themes and clusters is explained in Table 2. The number of group and personal experiential themes were highlighted to capture the unique experiences of each participant during the process.

Table 2

Legend for Acronyms in Table 3

Word phrase(s)	Acronym
Personal experiential statements	PES
Personal experiential themes	PET
Group experiential themes	GET
Health belief model	HBM
Participant pseudonyms	P1 through P6

Note. This table shows the acronyms used for the words in the results.

Table 3

Results of Group Experiential Themes (GET) and Personal Experiential Themes (PET) With the Health Belief Model (HBM) & Trustworthiness of Medical Systems

Group experiential themes (GET)	Personal experiential themes (PET)	Health belief model (HBM) constructs	Trustworthiness of medical system
GET 1: Contracting COVID-19	PET 1: Initially did not feel at risk (P14, 16) PET 2: Felt more at risk with more COVID-19 information (P14, 16) PET 3: Felt more likely to contract/susceptible (P11, 12, 13, 15, 16)	Construct 1: Perceived susceptibility	Not applicable
GET 2: The influence of COVID-19 on health beliefs	PET 1: Like the flu (P11, P16) PET 2: Preventive measures (P12, 13, 14) PET 3: Holistic measures (P12, 14) PET 4: Healthy/would not have an effect (P15)	Construct 2: Perceived severity	Not applicable
GET 3: Accessibility of COVID-19 health resources and information	PET 1: Did not feel additional information would help (P16) PET 2: Health resource availability was present (P11, 12, 14) PET 3: Had to seek information (P13) PET 4: Health information was not readily available (P15)	Construct 3: Perceived benefits	Not applicable

Group experiential themes (GET)	Personal experiential themes (PET)	Health belief model (HBM) constructs	Trustworthiness of medical system
	PET 5: Did not know if people of color were affected (P14)		
GET 4: COVID-19 vaccine accessibility	PET 1: Vaccine was easily accessible (P11,14, 16) PET 2: Vaccine was not easily accessible (P12, 13, 15)	Construct 3: Perceived benefits	Not applicable
GET 5: Health information precautions	PET 1: Avoided crowds (P13, 15, 16) PET 2: Wore masks/gloves (P11, 12, 13, 15) PET 3: Sanitizer (P12, 13, 15) PET 4: Wiped everything down (P12, 13, 14, 15) PET 5: Received vaccine/maintained vaccine (P12, 13, 14, 15, 16) PET 6: Changed/washed clothes (P12) PET 7: Stayed informed about COVID-19 health information (P11, 12, 13, 14, 15, 16) PET 8: Naturopathic approach (P12, 14)	Construct 5: Cues to Action	Not applicable
GET 6: Barriers/Challenges to behavior change	During COVID-19 PET 1: Standing six feet apart (P13, 16) PET 2: COVID-19 being called a hoax and not taken seriously (P12, 13, 14) PET 3: Racism against Black individuals (P13, 15)	Construct 4: Perceived barriers	Not applicable

Group experiential themes (GET)	Personal experiential themes (PET)	Health belief model (HBM) constructs	Trustworthiness of medical system
	PET 4: Health misinformation (P12, 13, 15) PET 5: Health mistreatment of Black individuals (P13) PET 6: Delay of care (P12) PET 7: Wearing masks/gloves/sanitizer (P11, 13, 14, 16) Since COVID-19 PET 1: Maintained COVID-19 vaccine shots (P12, 15, 16) PET 2: Staying aware of health information (P12, 14, 15) PET 3: Adapting/adjusting to the environment (P13, 15) PET 4: Politics role awareness (P11, 13) PET 5: Maintained wearing masks, washing hands, and using sanitizer as needed (P11,13, 14)		
GET 7: COVID-19 precautions	PET 1: Still taking the same precautions (P12, 14, 15) PET 2: Lessened precautions (P13, 14, 15) PET 3: No longer taking precautions (P11, 16)	Construct 5: Cues to action	Not applicable
GET 8: COVID-19 precaution reasons	PET 1: Health research information (P13) PET 2: Abiding by precautions as needed (P13) PET 3: Personal beliefs (P14, 15 16)	Construct 5: Cues to action	Not applicable

Group experiential themes (GET)	Personal experiential themes (PET)	Health belief model (HBM) constructs	Trustworthiness of medical system
	PET 4: New COVID-19 virus strain development (P13) PET 5: Self-awareness (P13) PET 6: Protecting others (P12, 16)		
GET 9: Safety strategies since COVID-19	PET 1: Yes (P11,12, 13, 14, 15, 16)	Construct 6: Self-efficacy	Not applicable
GET 10: View/Outlook change since COVID-19	PET 1: Yes (P11, 12, 13, 14, 15, 16) PET 2: Behavioral (P11, 13, 14, 16) PET 3: Physical (P12, 13, 14, 15) PET 4: Emotional (P11, 12, 13, 14)	Construct 6: Self-efficacy	Not applicable
GET 11: Level of trust	PET 1: Some trust (P11, 13, 14, 15) PET 2: Complete trust (P12, 16)	Not applicable	Applicable
GET 12: Medical systems' handling of COVID-19	PET 1: Poor (P12, 13, 14, 15, 16) PET 2: Skepticism (P11)	Not applicable	Applicable

Note. This table provides a breakdown of the group and associated personal experiential themes. Additionally, the table demonstrates the group experiential themes connected to the HBM constructs as applicable and the themes connected to trustworthiness as applicable in the last column.

Evidence of Trustworthiness

Four critical criteria were used in qualitative research to ensure the quality of the research: credibility, transferability, dependability, and confirmability (Ahmed, 2024). *Credibility* was achieved through extended involvement, persistent observation, and triangulation; *transferability* was achieved through comprehensive and detailed explanations; *dependability* was achieved through rigorous documentation and the creation of an audit trail; and *confirmability* was achieved through peer debriefing, member checking, and reflexive journaling (Ahmed).

Credibility

To ensure the credibility of my study, the IPA method was adopted. The choice of IPA focused on recruiting participants with lived experiences connected to the phenomena while illustrating the importance of scientific research principles. The approach focused on the detailed lived experiences of individuals and their attempts to make sense of the experience (Alase, 2017). To address credibility, I maintained reflexive journaling through a journal of notes highlighting any issues of biases. Reflexivity is linked to the researcher's ability to communicate nuanced and ethical decisions with the complex work of generating real-world data that reflects the messiness of participants' experiences and social practices (Olmos-Vega et al., 2022). Additionally, I ensured that interview questions did not lead participants to respond in a particular way, and I did member checks to ensure what was communicated on the transcript was the participant's own words and provided the opportunity to revise information if needed.

Transferability

Exploring the experiences of Black Americans' health beliefs with the trustworthiness of medical systems helped with generalized findings of understanding the experiences and perceptions surrounding COVID-19. As noted in the research surrounding this topic, many Black Americans have experienced historical health barriers through discrimination, racism, and inequitable access to health care from medical systems. Participants may also have different experiences depending on if they are in rural or urban areas regarding trust-related health beliefs with medical systems. My study explored the lived experiences of Black Americans through their trust-related health beliefs that generated significant findings to improve how the health and medical systems interact with the Black community. As Merriam and Tisdale (2016) note, transferability involves taking the findings of one study and applying them to other situations, such as generating strategies more conducive for improved health outcomes for Black Americans on both a local and national level.

Dependability

My study focused on collecting data from semistructured interviews. Interviews were recorded through Zoom. Transcripts were printed and reviewed by participants for response accuracy. I completed an audit trail of each transcript's descriptive, linguistic, and conceptual experiential notes. I supported my findings with specific participant quotes and interpretative commentary (Smith & Nizza, 2022). The results were used to connect to current literature and how outcomes will affect social change.

Confirmability

In the study, I demonstrated confirmability through respondent validation. Respondent validation is a form of ruling out the possibility of misinterpreting the meaning of what participants are saying and an essential way of identifying biases and misunderstandings of what will be observed (Merriam & Tisdale, 2016). I studied all interview transcripts for accuracy without bias. This helped to maintain neutrality and be conscious of personal beliefs surrounding the phenomenon of interest. Additionally, I did the preliminary analysis of the participants to ensure that my interpretations as the researcher were accurate, and if not, I made adjustments to better capture the participant's perspectives. As the sole researcher, I also used adequate engagement with data collection to ensure the data and emerging findings were saturated.

Results

This study aimed to explore the lived experiences of trust-related health beliefs in medical systems for Black Americans since COVID-19. Through semistructured interviews, I explored the gap in medical systems, trust-related health beliefs, and the experiences and perceptions of Black Americans with COVID-19. Discrepant cases remained as the participant's experiences and viewpoints were essential to understanding the phenomenon. One experience was slightly different from the interviews. P11’s experiences were essential to provide a richer analysis of viewpoints with health beliefs and trust in the medical systems to strengthen the research outcomes. As Smith and Osborn (2003) noted, all participants' viewpoints are essential for a richer analysis and for doing greater justice to the person's totality. Participant's interview transcripts all

render meaning to answer the research question by analyzing personal experiences surrounding trust-related health beliefs among Black Americans. The interviews consisted of a ten-question guide. As a result of the data analysis, 12 group experiential themes were created, as identified below in Table 4.

Table 4

Group Experiential Themes (GET)

RQ	GET
What are the experiences of trust-related health beliefs in medical systems for Black Americans since COVID-19?	GET 1: Contracting COVID-19 GET 2: The Influence of COVID-19 on health beliefs GET 3: Accessibility of COVID-19 health resources and information GET 4: COVID-19 vaccine accessibility GET 5: Health information precautions GET 6: Barriers/Challenges to behavior change GET 7: COVID-19 precautions GET 8: COVID-19 precaution reasons GET 9: Safety strategies since COVID-19 GET 10: View/Outlook change since COVID-19 GET 11: Level of Trust GET 12: Medical systems handling of COVID-19

GET 1: Contracting COVID-19

Group experiential theme 1 comprised three personal experiential themes on the HBM construct, perceived susceptibility. The PETs consisted of initially not feeling at

risk (PET 1), feeling more at risk with more COVID-19 information (PET 2), and being more likely to contract or be susceptible (PET 3). The participants expressed a mixture of responses with low and high perceived susceptibility. Participant 14 stated, “Well, I will say that initially, I did not feel at risk. I felt that because I had maintained a healthy lifestyle and I had not contracted common viruses or the flu and such, I did not feel that I was at risk.” Participant 16 acknowledged feeling the same, “When I initially heard of COVID-19, I thought it was more similar to a cold at first.” Their responses indicated a low susceptibility with not feeling at risk of contracting COVID-19. However, as more information about the COVID-19 virus was provided, participants 14 and 16 started feeling at risk, which indicated a high level of susceptibility. P14 stated, “As time passed and it [COVID-19] started affecting people close to me or that I was aware of and more prominent people, then I became concerned.” P16 expressed the same sentiments, “And then, as time went on, I started hearing from the media about people dying because of COVID-19, it became more serious to me.”

Participants 11, 12, 13, 15, and 16 immediately felt more likely to contract or be susceptible to COVID-19 as the responses expressed, which indicated high susceptibility. P11 stated, “Yes, I thought I was pretty susceptible to it as I was dealing with a heart condition,” while P12 stated, “I am not sure if it is because of my background, but I did not take it lightly and felt more likely to contract it [COVID-19].” Participant 13 mentioned, “Yes, so speaking from personal experience as it relates to COVID-19, I felt that I was at a higher risk.” P15 expressed, “I thought I was more likely to contract it, and how do I protect myself against a germ that does not differentiate between races?” P16

felt more at risk because they were older, and their immune system was not as strong. Even though some participants were initially not concerned or felt less susceptible to contracting COVID-19, participants collectively felt susceptible to contracting COVID-19 on a low and high level of susceptibility, particularly as more health information was divulged surrounding the virus and its impact on the Black community.

GET 2: The Influence of COVID-19 on Health Beliefs

Group experiential theme 2 comprised four personal experiential themes on the HBM construct 2, perceived severity. The PETs consisted of thinking the virus was like the flu (PET 1), preventative measures (PET 2), holistic measures (PET 3), and the belief that being in a good state of health, the virus would not affect their health (PET 4). The severity of COVID-19 highlighted the intensity levels of participant's experiences. Participants 11 and 16 felt the COVID-19 virus was more like the flu. P11 recalled it seeming like the flu. “For me, it was almost like a flu. I had symptoms, headaches, and various flu-like symptoms for about three days. I was pretty much in bed, tired on the fourth morning, soaking wet, but my fever had broken.” P16 experienced the same thought. “It seemed more like the flu, and I thought I would be okay until I started to see a lot of minority folks, especially Black people, were getting sick at a rapid pace.”

Participants 12, 13, and 14 took more preventative measures with their health beliefs on how the COVID-19 virus would affect them. P12 said, “My health beliefs are normally preventative. I am more of a preventative type of person.” P13 stated, “I listened to Dr. Fauci about the respiratory effects and systems. I was aware of some things and stayed away from people.” P14 concurred, “I wore a mask and kept

disinfectant around me. I limited my exposure outside of my house, especially in knowing how it [COVID-19] affected marginalized communities, primarily Black, African Americans."

In addition to preventative measures, participants 12 and 14 had holistic approaches as part of their health beliefs with COVID-19. P12 stated, "I am more on the holistic side. This is where the African American Black side comes out. If I were told to take more medication, I would not take it. I increased my vitamin C, ginger, and turmeric, which I would do." P14 said, "I am more of a natural kind of holistic believer. I think there is a combination of both preventative measures and holistic."

P15 was in the minority on the initial severity, believing the COVID-19 virus would not affect their health. This feeling was derived from the participant generally being in good health.

> If I contracted it [COVID-19], I did not think I would be worse off; my body would probably be able to handle it quite well; I was not really worried. Most people that were getting it [COVID-19] or had died had some predetermined condition, so I felt I would get well if I did get it because I did not have predetermined conditions.

GET 3: Accessibility of COVID-19 Health Resources and Information

Group experiential theme 3 comprised five personal experiential themes on the HBM construct 3, perceived benefits. The PETs consisted of those who did not feel additional information would help (PET 1), health resource availability was present (PET 2), had to seek information (PET 3), health information was not readily available (PET

4), and did not know if people of color were affected (PET 5). The perception of available health resources to reduce the risks of the situation was somewhat similar yet unique for participants. P16 felt that additional health information would not help mitigate COVID-19, “Well, as far as trying to mitigate the possibility of contracting the virus, I did not feel like there was any additional information being provided that would prevent anyone from contracting the virus.” Additionally, P16 stated, “It just seemed like a hit and miss because several people could be in a household, and one person would get it [COVID-19], and it would affect them more severely than someone else.”

Participants 11, 12, and 14 felt that health resources and information were readily available. P11 expressed that their employer and physician during that time were providing health information on COVID-19, especially with the participant's medical heart condition. P12 worked in the healthcare field and received information and resources as they became available. “With me being in the medical field, I was receiving information quickly. The organization I was working for was already sending out resources, but I know people were not receiving much information outside this area, especially certain populations.” P14 was also in the healthcare field and received information and resources quickly, “Fortunately, I was privileged to receive information and resources that were more focused on risk factors associated with age, along with having early access to the vaccine.”

Participants 13 and 15 felt they had to either seek health information or that the health information was not readily available, which caused them to engage in behavior or actions to access the information. P13 stated, “I felt like I had to go and seek help. No

one was reaching out to encourage getting information or the vaccine, especially when it came to me as a minority." P13 added, "I feel like you had to jump through hoops to get information when it should have been provided all along. As a veteran, I had to call and ask to receive the COVID-19 vaccine." P15 expressed that the health information and resources were not readily available. "When it [COVID-19 vaccine] came out, I did not feel the information was available to everyone. Priority was more toward those who could afford it, but access to the vaccine became better later."

One participant indicated not knowing if Black Americans were affected by the accessibility of COVID-19 health resources and information. P14 expressed,

> I was not necessarily privileged to whether people of color were affected, but I did take note that a lot of people of color who did not have access to medical care would be at a greater risk because they could not afford the vaccine or get to the clinic or hospital or have a provider.

GET 4: COVID-19 Vaccine Accessibility

Group experiential theme 4 comprised two personal experiential themes on HBM construct 3, perceived benefits. The PETs consisted of the vaccine being easily accessible (PET 1) and not easily accessible (PET 2). Participants 11, 14, and 16 felt that receiving the COVID-19 vaccine was readily accessible. Participant 11 communicated unusual circumstances surrounding the accessibility to the vaccine, which the participant did not receive due to a medical heart condition and high immunity levels to COVID-19 after contracting it before the vaccine was offered. Participant 11 noted, "I had COVID-19 before the vaccine was available, and my immune system had built a high immunity to

COVID-19. Basically, it was off the charts according to my doctor and hospital after being tested." Additionally, P11 was highly encouraged by their employer at the time to receive the vaccine despite the information about his immune system. With the participant's condition as being at risk, the vaccine would be readily available but considering the circumstances of the medical situation, accessibility of the vaccine was unique.

Participants 14 and 16 expressed different responses from P11. P14 stated, "Yes, especially for individuals with risk factors." P16 felt the vaccine was readily accessible and acknowledged their situation was geared more favorably than most individuals, "Yes, but in my situation, based on past history of being in the military and having consistent medical coverage, I had more access to the vaccine than other individuals without health and insurance coverage." P16 added, "I think initially the vaccine was not available as it should have been early on to many Black people, especially in certain Midwest regions."

Participants 12, 13, and 15 did not feel the vaccine was easily accessible for various reasons, indicating their perceptions of the availability of COVID-19 vaccines. P12 expressed, "As far as the availability of the vaccine, no, there were limitations for the general population. The vaccine was available for certain people, such as the elderly with comorbidities, healthcare workers, or those who heard through word of mouth where they could get the vaccine." P13 felt, "No one was reaching out to say go get the vaccine, especially when it can to minorities, but I can only speak for myself. I feel like you had to jump through hoops to receive the COVID-19 vaccine." P15 explained, "The vaccine was only accessible for certain individuals, those who could afford it, so I did not even

attempt to access it when it first came out because it was a challenge. I waited until it became available for everyone later."

GET 5: Health Information Precautions

Group experiential theme 5 comprised eight personal experiential themes on HBM construct 5, cues to action. The PETs consisted of avoiding crowds (PET 1), wearing masks/gloves (PET 2), using sanitizer (PET 3), wiping down everything (PET 4), receiving/maintaining vaccines (PET 5), changing/washing clothes (PET 6), staying informed about COVID-19 information (PET 7), and using a naturopathic approach (PET 8). Participants' activation of behavior was prompted by the health information provided during COVID-19 to take certain precautions.

Participants 13, 15, and 16 avoided crowds as a precaution. P13 expressed that they did social distancing and voluntarily quarantined, which involved not going out or going to gyms or restaurants. Participants 15 and 16 responded similarly to avoiding crowds as much as possible. P16 stated, "I just avoided crowds. When traveling, I preferred taking my personal vehicle rather than flying. I limited myself to others and was mainly with immediate family members."

Participants 11, 12, 13, and 15 emphasized that they wore masks, gloves, or both for slightly different reasons. P11 said, "I took the necessary precautions and wore a mask, especially if it was required to enter a place of business." P12 stated, "I wore masks, sprayed down the car with Lysol, and wore white clothing because it could be bleached." P13 stated, "First and foremost, getting vaccinated, wearing a mask, listening

to Dr. Fauci." Participant 15 agreed that wearing a mask was a precaution, "I would wear my mask to protect myself outside of the house."

When it came to sanitizing and wiping everything down, most participants indicated these processes' necessity as precautions against COVID-19. Participants 12, 13, 14, and 15 responded differently based on their experiences. P12 stated, "I always made sure to have a basket with sanitizer, and I would wipe down everything and change my clothes when I would get home." P13, "I would use sanitizer, wipe everything down, social distance, and voluntary quarantine myself." P14 stated, "I kept everything extra clean by wiping down everything at home, in my car, and washing my hands." P15 added, "The mask and sanitizer wiped down everything I could. At the gas stations, I would put on gloves."

GET 6: Barriers/Challenges to Behavior Change

Group experiential theme 6 comprised eight personal experiential themes on HBM construct 4, perceived barriers during COVID-19, and five personal experiential themes since COVID-19. The PETs during COVID-19 consisted of standing six feet apart (PET 1), COVID-19 being called a hoax and not taken seriously (PET 2), racism against Black individuals (PET 3), health misinformation (PET 4), health mistreatment of Black individuals (PET 5), delay of care (PET 6), wearing masks/gloves/sanitizer (PET 7).

A few participants felt challenges or barriers to behavior change resulted from one of the procedures of maintaining social distancing by staying six feet apart. Participants 13 and 16 expressed similar thoughts. P13 stated, "Yes, challenges of six feet apart or the

mask mandates were actions that made it hard to keep COVID-19 under control or reduce the likelihood of it spreading." P16 shared the same sentiment with a slightly different response, "Some of the barriers were surrounding the protocols of having to wear a mask, standing six feet apart, touching things and not sanitizing, or washing your hands." A few participants felt that with COVID-19 being called a hoax, individuals did not take the virus seriously. P12 confirmed that "the barriers originally came from other people's beliefs of thinking the virus was not real despite the information showing it was real and affecting individuals on different levels." P13 conveyed the same thoughts, "Some of the challenges came from people calling it a hoax. Some prominent figures called it a hoax, spreading so much disinformation." Some individuals during COVID-19 displayed a nonchalant attitude toward the seriousness of the virus, which was a noted obstacle toward behavior change. P14 expressed:

> The mindset of many individuals was somewhat cavalier, putting people at a greater risk of contracting the virus. Some individuals would not socially distance, would not wear masks, and intentionally cough in people's faces. It seemed to be mostly individuals that did not look like me and were not respecting the guidance provided by the health department.

Other barriers or challenges during COVID-19, as noted by the participants, involved racism against Black individuals, along with health misinformation and health mistreatment of Black individuals. In exploring the racism during COVID-19, P13 stated, "People were saying that if you had melanin, you would be fine and could not get COVID-19, and that Black Americans had tougher skin, and it would not affect us." P15

emphasized that racism and health misinformation created challenges with behavior change, “There was a saying in my country that we do not die from germs that others in the U.S. believed about us. Much of the misinformation distorted the reality of the situation.”

Delay of care, wearing masks and gloves, and using sanitizer were also noticeable challenges or barriers to health behavior change during COVID-19. P12 felt the delay of care derived from individual's beliefs, mainly regarding bloodwork:

> People were refusing to draw the blood of patients. I had to draw the blood of my patients. Administrators did not want to report positive COVID results to the CDC, so initially, the results were thrown out. This delayed treatment, and as a result, the COVID-9 virus spread on a whole hospital wing.

Individuals not choosing to wear masks, gloves, or sanitizer was challenging, as Participants 11, 13, 14, and 16 illustrated. P11 expressed that the COVID-19 protocols of wearing a mask and standing six feet apart were tiresome for most, including themselves. The protocols made it a challenge for individuals to change their behavior as P13 re-iterated:

> With the protocols and health misinformation, people could not see facts and would listen to the most salacious or the most threatening things about COVID-19 but would refuse to wear a mask, wash their hands, or sanitize because they felt the government was trying to control them.

P14 emphasized “the cavalier behavior of many in the community with individuals that did not look like me, were against wearing masks and would intentionally

do things that were devoid of the health department recommendations for safety against COVID-19." P16 stated, "On a personal level wearing a mask was challenging as it seemed to restrict my breathing." Additionally, P16 expressed, "On a communication level, when someone had a mask on because of some hearing loss, it was hard for me to hear what someone else was communicating," making it difficult for them to adhere to changing their behavior while understanding they did need to follow the CDC recommendations regarding COVID-19.

Since COVID-19, the PETs were comprised of maintaining COVID-19 vaccine shots (PET 1), staying aware of health information (PET 2), adapting/adjusting to the environment (PET 3), political role awareness (PET 4), maintaining wearing masks, washing hands, and using sanitizer as needed (PET 5). Maintaining COVID-19 vaccine shots was seen as a challenge toward behavior change, as expressed by three participants: P12, 15, and 16. P12 stated, "Maintaining vaccine shots, your symptoms are less severe; the research is there, especially with there being so many strains out there. Some people think it is a stigma, not realizing it is better to have the protection." P15 felt "the vaccine was a precaution. It was prevented for a reason: to protect us and show effectiveness against the virus. Seeing family members affected, some dying from COVID-19, along with seeing friends become sick, the vaccine was necessary, along with the mandates." P15 further expressed, "Seeing people react negatively to the mandates and the vaccine caused some people to follow suit, making it difficult for people's behavior to change positively." P16 shared the same sentiments and expressed that "having all the shots has protected me from the virus, so I do not let others nonprotection behavior bother me and

just try to carry on with my life knowing people are going to choose what they want to. I must protect myself and my family by doing what I can."

Staying aware of health information was another barrier to behavior change, as communicated by participants 12, 14, and 15. P12 stated:

> There is pushback when you talk about how it is with information. Whenever I wanted to discuss anything related to COVID-19, especially with prevention, there was always pushback with information. Even now, some information is not readily given, like with new treatments or strains.

P14 discussed that since the mandates have been lifted, individuals feel precautions are no longer necessary for COVID-19. "The community mentality has caused many people to behave like the virus never existed. There are no longer wipes or anything like that as before. It has all been removed. There are no longer free kits or vaccine shots." P15 said, "My behavior has not changed; I still do what keeps us safe. However, I noticed many people around me, especially after the political back and forth, abandoned what kept them and others safe."

Adapting or adjusting to the environment has been a change most participants expressed. P13 stated:

> I feel I have been affected in different ways that have changed my behavior in society. When you look at the country today, it is divided. People listen to others and not health professionals. People are like this whole thing was a lie, the government is taking away my rights, my freedom. Like some really thought COVID-19 was a hoax, and people are still saying it today.

P13 added, “I seek out information to stay educated. I still listen to health professionals, so I have had to adapt to the fact that people will be people, and I have to make sure I protect myself.” P15 expressed, “Precautions were there for a reason. I still keep those precautions, so I did not adjust much from the height of COVID. I still use hand sanitizer, wiping everything down, but not as much. I still wear a mask when I am out in crowded situations because I don’t trust what other people are doing.”

Politics played a role in behavior change as some participants felt more awareness surfaced with how politics affected health behavior with medical systems. P11 thought politics played a big role in providing health information and how doctors interacted with patients. P11 recalled:

> My employer at the time required everybody to take the vaccine or get a medical or religious exemption. With my condition of having immunity to the COVID-19 virus and being recommended not to receive the shot because of the side effects it would cause me, I went to my physician to get a medical exemption. The hospital my physician worked for would not allow medical exemptions to be written.

P11 added, “I was approved not to take the shot, and so I begin to think, are these medical decisions or political decisions?”

With PET 5, half of the participants expressed they maintained wearing masks, washing hands, and using sanitizer to a certain degree. P11 stated, “I wore a mask as needed during COVID-19, but otherwise, I don’t really follow any COVID protocols now. I don’t wear a mask, stand six feet apart, or any of that anymore.” P13 expressed:

> The challenges of social distancing and mask mandates were hard to keep under control during COVID, and since COVID in looking at the country today, I still try to stay educated on what is happening health-wise and listening to medical professionals, but it is a challenge when others still choose to listen to misinformation.

P15 stated, “everything has been removed, wipes, test kits, and COVID-19 is not as publicized as it was. The wearing of masks is pretty much gone, with a few exceptions. Many people, especially in my community, have resorted to pre-COVID behavior of not washing hands, wiping things down, etc.”

GET 7: COVID-19 Precautions

Group experiential theme 7 comprised three personal experiential themes on HBM construct 5, cues to action. The PETs consisted of still taking the same precautions (PET 1), lessened precautions (PET 2), or no longer taking precautions (PET 3). There were some overlaps with PET 1 and PET 2. Participants 13, 14, and 15 used the same precautions since COVID-19 but lessened precautions simultaneously. P13 expressed, “This present day, I do not wear a mask. However, if recommended, I will always follow the rules of wearing a mask, social distancing, and wiping things down with Clorox.” P14 stated, “From a behavioral standpoint, my behaviors have lessened in public, but nothing has changed at home. I do not do anything different.” P14 added, “I carry alcohol-based wipes that were designed to reduce the COVID virus by 99%; I do not wear the mask but keep one on me, in my car, and in my bag.” P15, “Yes and no. I still use my hand

sanitizer but do not wipe everything down as I used to. I will, on occasion, wipe down my home or office. I will put on my mask on occasion when out."

Participant 12 expressed that they had taken the same precautions since COVID-19, whereas Participants 11 and 16 no longer took precautions. P11 stated, "I would say no, I am not taking precautions. I was not taking precautions unless I was forced to. I never did get the shot or any boosters." P16 stated, "No, I have had about four or five shots, and I figured if it is going to get me, it will get me."

GET 8: COVID-19 Precaution Reasons

Group experiential theme 8 comprised six personal experiential themes on HBM construct 5, cues to action. The PETs consisted of health research information (PET 1), abiding by precautions as needed (PET 2), personal beliefs (PET 3), new COVID-19 virus strain development (PET 4), self-awareness (PET 5), and protecting others (PET 6). Participants experienced external prompts with COVID-19 and medical systems that led to certain precautions. Participant 13 expressed this regarding health research information as a reason they abided by precautions. P13 stated:

> There is always a new strain that continues to develop, so I listen to the news, read on what is happening as it relates to the virus. At the same time, I am self-aware and still abide by the precautions needed for cleaning, the spread of the virus, and the development of new strains. I just want to be cautious.

Personal beliefs and protecting others were cited as reasons for precaution among several participants: P14, 15, and 16. P14 stated, "I would say these precautions have more to do with my beliefs and the appropriateness of the circumstances. It is better safe

than sorry. It is about taking responsibility because we cannot always depend on having available medical care and access to it." Additionally, P14 noted, "I make informed decisions based on what the research states, my personal beliefs regarding my health conditions." P15 stated, "Because it is the right thing to do to keep myself from contracting any type of thing of sickness and based on my personal beliefs of doing what is right." P16 followed these reasons, "I do not want to be exposed to COVID because if I am exposed, that means my family is exposed. I am more concerned for my family, wife, and grandchildren." P16's response also aligned with wanting to protect others. P12 shared the sentiments of protecting others, "I want to protect others. I do things not just to protect myself but to protect others."

Participant 13 reasons centered around the possibility of new COVID-17 strains and self-awareness. P13 expressed, "There is always a new strain that can develop, and staying self-aware through being precautious is going to be good. Even though the social distancing is over and the mask mandates, it is fundamental to remain cautious."

GET 9: Safety Strategies Since COVID-19

Group experiential theme 9 comprised one personal experiential theme on HBM construct 6, self-efficacy. The PET consisted of stating yes (PET 1). All the participants have incorporated safety strategies since COVID-19 in varied ways. P11 stated a simple yes, whereas P12 relayed, "Yes, the strategies did help keep me safe. I did not pick up any flu, cold, upper respiratory, nothing." P13, "Yes, I think the strategies have worked. I have not gotten COVID. I think being mindful of the pandemic just four years ago has helped a lot. I listened to the advice from health professionals and those who researched

the virus daily." P14 responded slightly differently, "I feel assured the strategies worked. There was so much misinformation put out there, but with a combination of what we heard and felt, I feel my measures were effective." P15 shared, "Yes, the strategies mostly did, though I did get COVID only once; the symptoms were not major; it was like a week of coughing. I contribute that to the safety strategies I had in place." P16 aligned with the participant's responses, "I believe that practicing the methods of trying to be safe, the strategies I had prevented any spread within the family or friends."

GET 10: View/Outlook Since COVID-19

Group experiential theme 10 comprised four personal experiential themes on HBM construct 6, self-efficacy. The PETs consisted of yes (PET 1), behavioral (PET 2), physical (PET 3), and emotional (PET 4). All the participants expressed their views or outlooks that have changed since COVID-19 from either a behavioral, physical, emotional, or a combination of two or three criteria. P11 and P13 emphasized behavioral and emotional changes, with P13 expressing physical changes. P11 stated:

> I do not feel the behavioral or emotional changes were a direct result of COVID-19. I already felt what I needed to do, but my changes were more associated with my attitude toward the medical system and how they took advantage of people.

P13 responded, "It was a behavioral, emotional, and physical combination. Like not wearing a mask anymore or social distancing felt like all three." P14 shared a similar yet slightly different response, "Yes, I think it is a combination of all three. I use teas to help with my respiratory system. I do more steaming with my home cleansing. I have upgraded my Neti pot. I am more aware."

P12 discussed having emotional and physical changes, whereas P15 solely expressed physical changes. P12 stated:

> For me, it was more physical. I try to get vitamin C to boost my immune system. The emotional changes are more like whatever, do you if that works for you. I find I am more focused on myself. Is it selfish? Yes, but it gives you time to reflect and appreciate myself more.

P15 confirmed only physical changes without further clarification.

GET 11: Level of Trust With Medical systems

Group experiential theme 11 comprised two personal experiential themes on trust, with HBM not applicable. The PETs consisted of some trust (PET 1) and complete trust (PET 2). Trustworthiness in medical systems was explored through the participants' experiences, with each participant sharing unique thoughts. Participants 11, 13, 14, and 16 felt poor trust in medical systems for varied reasons. P11 stated, “I trust the medical system in general, but I am more cautious because of COVID-19, especially with the pharmaceutical industry making more money. It did make me somewhat skeptical, but I am not anti-medical establishment.” P13 expressed:

> It has definitely went down. I am extra cautious with how the medical professionals speak to me. I had an experience during COVID-19 where I was made to feel like an inconvenience. Not receiving information, so the trust has been broken.

P14 and P15 both expressed concerns about trusting the medical systems since COVID-19. P14 stated, “Yes, I certainly have concerns and must be honest. I think the

pandemic raised or highlighted some issues that healthcare practitioners are challenged with." P14 elaborated further:

> Even the knowledge disseminated to healthcare practitioners from a political agenda raised concerns on how this influenced care delivery. Since COVID, I am concerned about the controls in place and how this might impact the doctor's ability to practice. I am concerned about the quality of care since COVID.

P15 shared that, "After hearing all the stories of what happened since COVID-19 and what people have experienced, I always put a second thought on what the doctor tells me to do. I am more cautious."

A few participants had complete trust in medical systems based on their experiences. P12 responded, "As a healthcare practitioner, my patients trust me, so I must trust someone. I trust the medical systems because whatever the resources are, I will do my best to get information out there for my patients." P12 elaborated further after questioning whether the level of trust is strong, "I am strong on what I have experienced in the company I worked for. The company ensured that even when vaccines and medication could not get to the patient, they would use every resource to get the treatment." P16 shared some of the same sentiments:

> I trust the medical process since COVID-19. The shots that were recommended to me for protection reinforced my trust in the medical system. I have not been ill from COVID and no one in my household has been ill, so I do trust in the process.

Additionally, P16 stated, "I think the medical systems made great progress with the developments of the treatment for COVID."

GET 12: Medical Systems' Handling of COVID-19

Group experiential theme 12 comprised two personal experiential themes on the medical systems, with HBM not applicable. The PETs consisted of Poor (PET 1) and skepticism (PET 2). Many of the participants felt that the handling of COVID-19 in the medical system for Black Americans was poor and responded with their perspectives. P12 stated, "I think anything that comes to Black Americans was put to the wayside, even with treatments. It was not fair. The information was not there. Many of the resources available to African Americans were limited, but the resources are there." P12 added:

> Of course, the blame will be on African Americans not listening, but there must be effort to speak to a person and explain it on their level. Our African American or Black people generally lack insurance and would be lacking in getting the vaccine.

P12 elaborated, "The medical systems have African Americans at the bottom of the totem pole. If you found a Black person getting the vaccine, I guarantee they were insured, but what about the ones who were not." P13 conveyed:

> I think health access and information was handled poorly from my experience. I do not want to speak for anyone else, but I was not being reached out to about COVID-19 shots. I had to look for this information. I feel that applies to many aspect for minorities, especially African Americans.

P13 added, "You feel like an inconvenience. I feel like the medical systems would have been beating down my door to give me a COVID-19 shot if I was not a person of color. The medical system would have made sure I had all the information and

medication needed." P15 shared sentiments about discrimination with the Black community and medical systems:

> We know there was much discrimination against the Black community in general. One thing stood out for me. It was the story of another African American who was experiencing labor pains. She was asking for a pain reliever, and one of the nurses told her to stop being a drama queen, that she could handle pain because she is Black.

A few participants, P14, expressed opportunities for information to be divulged in African American communities, but it was not. "There were missed opportunities to disseminate more information and respond with more research regarding the availability of access to care. This could have raised an opportunity to lean in more into African Americans and people of color in general." P14 added, "We have missed opportunities in history where things have come up demonstrating the disparities within these communities, and yet there is just not a robust effort to disseminate across education, healthcare, housing, etc." P16 felt, "Information was slow. Many people of color were being lost. If you do not care for one group of people, it will eventually spread to everybody." P16 added, "Efforts did start to pick up, but I think some people were hesitant, fearful of the vaccine." Skepticism was shown with P11:

> The healthcare has not changed in terms of African Americans and how they have been treated. There was skepticism with everything happening, such as wearing a mask, saying you will not get COVID, taking the shot, and you will not get COVID. It became ridiculous.

P11 elaborated, “The system has not necessarily changed, but I think people’s attitude towards what the system says and does has changed, making people more cautious, perhaps skeptical, especially in looking at the history with African Americans.”

Summary

The research question was: What are the experiences of trust-related health beliefs in medical systems for Black Americans since COVID-19? I uncovered 12 group experiential themes with 52 personal experiential themes. The group experiential themes consisted of: GET 1, contracting COVID-19, with three PETs; GET 2, the influence of COVID-19 on health beliefs, with four PETs; GET 3, accessibility of COVID-19 health resources and information, with five PETs; GET 4, COVID-19 vaccine accessibility, with two PETs; GET 5, health information precautions, with eight PETs; GET 6, barriers/challenges to behavior change, with seven PETS during COVID-19 and five PETs since COVID-19; GET 7, COVID-19 precautions, with three PETs; GET 8, COVID-19 precaution reasons, with six PETs; GET 9, safety strategies since COVID-19, with one PET; GET 10, view/outlook change since COVID-19, with four PETs; GET 11, level of trust, with two PETs; GET 12, medical systems handling of COVID-19, with two PETs. The group experiential themes were developed from the interview questions and participant's feedback on the study topic.

Based on the in-depth analysis and review of the participant’s experiences, I found that individuals shared some similar health beliefs and levels of trustworthiness with medical systems. While there were some noted differences in experiences, the

overall scope of the study results highlighted that the health beliefs of Black Americans showed levels of challenges in trust with medical systems since COVID-19.

In Chapter 5, I discussed my interpretation of the findings, the limitations of the study, and further recommendations. I also discussed the future implications of positive social change, concluding thoughts on capturing key components based on the study's results.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative IPA study focused on an IPA of trust-related health beliefs in medical systems among Black Americans since COVID-19. I used the IPA approach to implement an in-depth, rich exploration of individuals' lived experiences. The study was conducted to explore the trust-related health beliefs since COVID-19. Based on the in-depth analysis of interviews conducted with the participants, 12 group experiential themes (GETs) with 52 personal experiential themes (PETs) were discovered to address the research question. The 12 group experiential themes were contracting COVID-19, the influence of COVID-19 on health beliefs, accessibility of COVID-19 health resources and information, COVID-19 vaccine accessibility, health information precautions, barriers/challenges to behavior change, COVID-19 precautions, COVID-19 precaution reasons, safety strategies since COVID-19, view/outlook change since COVID-19, level of trust, and medical systems' handling of COVID-19.

Interpretation of the Findings

In exploring the trust-related health beliefs of Black Americans with medical systems since COVID-19, the aspects of the HBM and trustworthiness of medical systems led to some similarities and differences in experiences. The findings focused on the six HBM constructs and trust levels with medical systems associated with the group and personal experiential themes.

Health Belief Model

The conceptual framework for this study was the Rosenstock (1974) HBM that was initially developed in the 1950s and proposed by social psychologists Godfrey Hochbaum, Irwin Rosenstock, and Rosenstock and Kirscht (Ghorbani-Dehbalaei et al., 2021). The model is based on the theory that people's willingness to change their health behavior primarily derives from their health perceptions and beliefs. Use of the HBM involves reviewing the beliefs and perceptions of individuals to understand what influences health-related behavior and actions.

Using the model, I explored how health beliefs in a medical environment have influenced the maintenance and change of health-related behaviors since COVID-19. The HBM was used as a framework for guiding health behavior interventions and preventions (Rosenstock, 2000) using the six constructs—perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy. The HBM produced 10 group experiential themes (GETs) and 48 personal experiential themes in the study findings aligned with the trust-related health beliefs: GET 1 (Contracting COVID-19, GET 2 (Influence of COVID-19 on health beliefs), GET 3 (Accessibility of COVID-19 health resources and information), GET 4 (COVID-19 vaccine accessibility), GET 5 (Health information precautions), GET 6 (Barriers/challenges to behavior change), GET 7 (COVID-19 precautions), GET 8 (COVID-19 precaution reasons), GET 9 (Safety strategies since COVID-19), and GET 10 (View/outlook change since COVID-19).

GET 1: Contracting COVID-19

The results of Construct 1, perceived susceptibility with contracting COVID-19, confirmed that if individuals felt more at risk of contracting the COVID-19 virus, there was a high perceived susceptibility to engage in health-promoting behaviors but with hesitation. Individuals with low perceived susceptibility may deny the gravity of the situation and continue to engage in unhealthy behavior. In contrast, individuals with a high perceived susceptibility will attempt to reduce the risks (Rosenstock, 1974). Most participants, such as P14 and P16, initially had a high suspicion of receiving the COVID-19 vaccine, which meant susceptibility was low. However, as more health information was produced, their susceptibility became high, indicating a stronger inclination to receive the vaccine. As Limbu et al. (2022) noted that individuals are more likely to be vaccine-hesitant if they have a high perceived susceptibility to COVID-19 (Limbu et al., 2022), but when the susceptibility is low, there is less vaccine hesitancy. The results highlighted that all the participants had concerns about COVID-19 and mixed health beliefs with those of the healthcare systems; most were inclined to receive the vaccine to reduce the risks of acquiring the virus.

GET 2: The Influence of COVID-19 on Health Beliefs

COVID-19 influenced participants in myriad ways depending on Construct 2, perceived severity beliefs. This theme highlighted the participant's feelings surrounding the intensity of contracting COVID-19. As Hita et al. (2022) indicated, the severity of contracting COVID-19 would ideally encourage individuals to receive the vaccine. Several participants, particularly P12, P13, and P14, approached the severity of COVID-

19 by using preventative and holistic measures depending on the health information received. The severity of the situation influenced the intensity of their approach toward COVID-19. In contrast, two participants, P11 and P16, had less intensity of the negative effects in thinking the virus was like the flu, with only one participant, P15, feeling their good health made it less likely for COVID-19 to affect them negatively. The mixed results alluded to the interpretation that COVID-19 did influence how the virus may impact the participant's health beliefs.

GET 3 and GET 4: Accessibility of COVID-19 Health Resources and Vaccine Accessibility

In exploring the results with Construct 3, perceived benefits and the accessibility of COVID-19 health resources, information, and vaccine accessibility, the participant's perceptions of available resources to reduce the threat of disease or illness indicated that there were mixed feelings. The participants all believed on varied levels that access to health resources, information, and the vaccine would have been beneficial and effective in preventing the severity and susceptibility of COVID-19. As outlined by Rosenstock (1974), if an individual feels their health belief behavior will be beneficial and effective for prevention and reduction surrounding the severity and susceptibility of the disease, they will likely engage in behavior to reduce the seriousness or effectiveness of the action. The results neither confirmed nor denied that accessibility of health information and the vaccine were present. The study results indicated a split between the accessibility of health information and the easiness of receiving the vaccine to reduce the severity and susceptibility of COVID-19.

GET 5: Health Information Precautions

The results of health information precautions were associated with Construct 5, cues to action. Cues to action focused on activating health behavior through external events to prompt health changes. This area involved what cues encouraged the participants to move from wanting to make a health change to making the change surrounding the health information provided and the safety precautions taken to reduce contracting COVID-19. The participants took several cues to action, including but not limited to wearing masks, using sanitizer, receiving and maintaining the vaccine with naturopathic approaches, and staying informed about COVID-19 health information. As Rosenstock (1974) noted, the intensity of cues varies between individuals in prompting action. The interpretation of the results indicated that participants took varied actions to ensure their safety from COVID-19.

GET 6: Barriers/Challenges to Behavior Change

This theme focused on Construct 4, perceived barriers, the barriers/challenges that may have prevented behavior change in understanding the COVID-19 virus. Two areas were explored: during COVID-19 and since COVID-19. The interpreted results indicated that all the participants felt several aspects affected their behavior toward understanding the phenomenon during COVID-19, such as standing 6 ft apart, COVID-19 being called a hoax, racism against Black individuals, health mistreatment of Black individuals, health misinformation, the delay of care, wearing gloves and masks, and using sanitizer during the pandemic. Since COVID-19, maintaining COVID-19 vaccine shots, staying aware of health information, adapting to the environment, political role awareness, maintaining

wearing masks, washing hands, and using sanitizer as needed were identified as elements of behavior change. These aspects highlighted that much of the impact was the same with the addition of dealing with a political climate that harmed the health of the Black community.

GET 7 and GET 8: COVID-19 Precautions and Reasons

Precautions were measures aligned to construct five cues to action. These cues involved what prompted individuals to take action to mitigate contracting COVID-19. The results from my interpretation indicated that participants took many of the same precautions since the COVID-19 pandemic. Many of the reasons involved issues with trust in the medical systems and how health research information was being conveyed to the Black community. All the participants chose to abide by precautions as needed to protect themselves against new COVID-19 virus strands by practicing their personal health beliefs and having more self-awareness of how the virus would affect them and how the healthcare community viewed them as Black Americans.

GET 9: Safety Strategies Since COVID-19

The safety strategies were parallel to Construct 6, self-efficacy, which focused on an individual's ability to make health-related changes and the will to perform the desired behavior change to produce positive health outcomes. All the participants stated that their chosen strategies would continue to ensure safety or protection against COVID-19 since the pandemic. This indicates that participants had to take specific measures to ensure long-term safety against COVID-19, especially when the information from health resources was not forthcoming. Research by Huang and Gerend (2024) found that higher

self-efficacy among African Americans increased the chance of receiving and maintaining the COVID-19 vaccine. All the participants, except for one, P11, received the vaccine and boosters as a safety strategy. The participant did not receive the vaccine due to a medical heart condition and contracting COVID before the release of the vaccine, which caused an immune system resistance to contracting the COVID-19 virus again.

GET 10: View/Outlook Since COVID-19

This theme highlighted how the outlook/views of participants paralleled Construct 6, self-efficacy. This area explored whether the preventative measures used during the COVID-19 pandemic changed or remained the same. The results highlighted that all participants changed their views of the medical system based on the phenomenon's dynamics, involving political challenges, racism, discrimination, and access to health information and resources. Most were behavioral changes, which were more action-oriented, followed by physical, deemed as physiological changes, ending with emotional, reactionary views. My interpretation of this theme is that the participants felt it was essential to adapt to the new health environment since COVID-19, which meant their health beliefs had to change to accommodate and navigate the nuances of their experiences from the pandemic.

Trustworthiness

Throughout history, there have been systemic inequities that have led to inferior health care for Black individuals, which has created issues of trust. Trust has been expressed in medical researchers' competency in doing a great job from Black

Americans. However, there are still concerns about the potential for research misconduct and accountability (Funk, 2022). These concerns have stemmed from the less-than-optimal health care experienced by socially disadvantaged populations, as seen in Black communities. Studies have continued to demonstrate that Blacks exhibit less trust in the health care system for a variety of reasons that come from personal experiences with racism, knowledge of the history of racism in the health care system, and social and cultural distance between Black patients and White physicians (Musa et al., 2009). As shown in the study results, the issue of trust provided two GETs—level of trust and medical systems handling of COVID-19—and four PETs highlighting the mixed experiences from participants about their trustworthiness with medical systems.

GET 11 and 12: Level of Trust and Medical Systems' Handling of COVID-19

In exploring the level of trust and medical systems handling of COVID-19, most participants conveyed some trust (P11, P13, P14, and P15), with two participants, P12 and P16, responding that they trusted the medical system but had some reservations about how health information and resources were handled, which aligned with prior research literature. In following the literature, trust is conveyed by Black Americans in the medical system as doing their job; however, as seen during the COVID-19 pandemic, there were significant disparities seen in mortality rates, hospitalizations, and diagnoses among Black Americans (Andraska et al., 2021) as prior health racial atrocities generated a lack of trust toward information concerning the COVID-19 vaccine. This was confirmed in the study results as participants on one level trusted the medical systems to do what was required; however, due to misalignment of information, it was noted that

there were delays in sharing health information and resources regarding COVID-19 among minorities. Most participants felt the information was handled poorly, which may have contributed to the mixed feelings of trust. According to Harris et al. (2023), COVID-19 vaccine receptibility of the vaccine was low due to historical and contemporary experiences of systemic racism against the Black community, while structural barriers surrounding inaccessibility to vaccination sites and lack of accurate information from trusted community and public health officials solidified suspicion regarding medical institutions. The participants' experience confirmed these sentiments with regard to COVID-19 and the medical system.

Limitations of the Study

There were two limitations to the study. The first limitation involved the initial willingness of Black Americans to participate in the study. After study information was posted on varied social media platforms and at community centers, the interest was not immediate during the first week. However, providing more study information through small discussions helped increase participation and interest. Also, further discussing the time commitment, expectations, and projected outcome of the study provided participants with an understanding of the value of their contributions. When the first participant consented to an interview, genuine rapport was established, which led to their experience being shared with another individual. I quickly obtained the minimum number of participants outlined in the proposal as I established and invested in developing trust between the first participant and myself by being transparent with the study details,

assuring that withdrawal from the study could occur at any time if the participant felt uncomfortable. I established that questions could be asked at any point during the study.

The second limitation stemmed from researcher bias. My health beliefs and experiences with the medical systems since COVID-19 had levels of mistrust. I had to remember that my role as a qualitative researcher was to ensure that participants were treated fairly. I used the four established principles of Bourdeau (2000) to help guide research participants' treatment and prevent dual relationships. The first was to respect participants' autonomy by having flexibility in understanding the independence and needs of each participant. The second is nonmaleficence, meaning do no harm. The third is beneficence, which is striving to work for the benefit of the participants. Last is justice through the commitment to being equitable by distributing responsibilities and rewards between researcher and participant. A commitment to justice means that the researchers will not use the study to benefit themselves to the detriment of others, resulting in an imbalance of responsibility for the participant and reward for the researcher. These principles ensured that participants understood that the interviews were confidential, and that participation was voluntary, and that my biases did not interfere with the participant's responses.

Recommendations

Based on the study addressing the gap of exploring the trust-related issues surrounding Black Americans' health beliefs with medical systems since COVID-19, there are two recommendations to strengthen and improve for future research. This study was qualitative, with six participants. It would be beneficial to conduct a study with more

participants to determine if the experiences would have more variance or similar results. Though participants were received from varied sources, most were educated Black Americans with advanced college degrees. It would be interesting to study if differences in trust-related health beliefs would exist with nondegreed Black Americans, as well as possibly explore from a quantitative standpoint.

Another recommendation would be to conduct a follow-up research study on this group with a specific focus on the Black immunity myths and how the myths may contribute to challenges with trust in the healthcare community among Black Americans. As Williamson and Tarfa (2022) noted, trust in providers has been repeatedly established as a factor in various vaccination behaviors. Trust in providers fringes on the belief that an individual's needs and concerns will be met if the provider is competent and will do what is best for the patient.

Implications

The implications of this study provided an exploration of trust-related health beliefs, health historical racism, and medical systems in the context of COVID-19 to provide increased awareness and understanding toward educating the healthcare community on best practices for interacting with Black Americans to promote positive health outcomes for future pandemics. Furthermore, the research provided an essential platform for programs or organizations seeking to understand and engage Black Americans to help further educate the importance of vaccines and understand future health-related behaviors. These implications could initiate positive emotional and

psychological outcomes for the Black American population, healthcare providers, and the healthcare community.

Positive social change from this study would improve relationships with healthcare and medical systems through understanding the reasons behind trust-related health beliefs. This could lead to increased positive health outcomes, especially considering historical health inequities, structural racism, lack of access, and health information that has led to differential treatment toward the Black community.

Conclusions

African Americans have a long history of mistrust in the medical system, and this did not change with the health misinformation, structural racism, and discrimination that occurred with COVID-19. Much of these elements have stemmed from legacies of abuse, mistreatment, and historical atrocities, including unethical experiments on Black people. Examples have included the Tuskegee syphilis study, the gynecology malpractice of J Marion Sims on enslaved Black women, and the exploitation of Henrietta Lacks for cancer treatment (Scales et al., 2023), all of which violated the principles of research ethics. Throughout history, two enduring physiological myths, that Black people have a higher pain tolerance and weak lungs that could be strengthened through hard labor, have persisted and circulated within the medical community. This continued with Robert F Kennedy Jr. mimicking the same rhetoric during the 2025 Senate confirmation to lead the Department of Health and Human Services, when he claimed that Black people have a stronger immune system than white people and should receive vaccines on a different schedule (Holt, 2025) have influenced modern medical education and practice. The basis

of all these events stemmed from exploitation upheld by the idea that race is biological. In 2003, the Human Genome Project found that there is no genetic basis for race and that the term “race” is not biologically meaningful (National Human Genome Research Institute, 2020), meaning statements like Kennedy’s are not only outdated but also false. Research has continuously shown that many American physicians, medical students, and residents hold incorrect beliefs about biological differences between races, which contribute to racial bias and disparities in pain perception and treatment recommendations.

Health beliefs will continue to play a vital role in shaping an individual's perceptions of trust in medical systems. According to Thier et al. (2023), medical mistrust plays a significant role in understanding Black Americans’ COVID-19 vaccine attitudes, intentions, and behaviors. Home remedies among African Americans remain an avenue for managing their health, as demonstrated in the study results, instead of traditional medical approaches because of the mistrust of health and medical organizations. The research study revealed that there are still misconceptions about Black Americans and Black communities that have contributed to challenges experienced during and since COVID-19. Some trust issues created levels of caution with medical systems despite higher levels of education. Black Postgraduates, 78%, and college graduates, 76% stated less access to quality medical care as a significant reason for worse health outcomes in comparison to Blacks with some college experience at 68% and Blacks with a high school diploma or less at 51% (Funk, 2022). Most participants indicated less access to

health information and resources during and since COVID-19, based on their experiences.

The study provided an avenue to explore and understand the experiences of Black Americans and their trust-related health beliefs since COVID-19. The research will hopefully create a foundation to improve the relationships between Black Americans and the healthcare and medical systems. Additionally, improved positive health outcomes considering the historical inequities, structural racism, lack of access, and health information that have often led to differential treatment in the Black community would be lessened. Continued research in this area would be beneficial in understanding how Black Americans' unique experiences have influenced their health beliefs about medical systems since COVID-19.

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Appendix A: Interview Question Guide

The interview protocol question guide is based on the HBM constructs and the trustworthiness of medical systems. This will be an open-ended semistructured interview format, allowing for flexibility but following a predetermined thematic framework to have a sense of order. The interviews will be conducted on Zoom for 60 minutes.

Health Belief Model (HBM)

Question 1 (***Construct 1: Perceived Susceptibility***)

Option a: The COVID-19 virus started the pandemic of 2020 that affected minorities at higher mortality rates—particularly Black Americans. When you first heard about COVID-19, what were your thoughts on contracting the virus based on personal health beliefs and the information received from the media? Did you feel less or more likely to contract it?

Option b: When the COVID-19 pandemic began in 2020, what was your understanding of the COVID-19 virus? Did you feel you were at a higher risk or lower risk of contracting the virus based on personal health beliefs and health information from the media?

Question 2 (***Construct 2: Perceived Severity***)

Option a: As more information was provided on the COVID-19 virus and its negative effects on Black Americans, what were your health beliefs or thoughts on how the virus could affect you?

Option b: With the negative effects of the COVID-19 virus on Black Americans, what is/was the probability of changing your health behavior to reduce the consequences of contracting the virus?

Question 3 (Construct 3: Perceived Benefits)

Can you share your thoughts on the availability of health resources and information during the COVID-19 pandemic, such as the vaccine, in taking action against or mitigating contracting the COVID-19 virus?

Probing question: Do you feel the COVID-19 vaccine was easily accessible for minorities, specifically Black Americans?

Question 4 (Construct 4: Perceived Barriers)

Were there barriers/challenges that may have prevented behavior change with understanding the COVID-19 virus, such as the restrictions (6 feet apart, mask mandates, washing hands, etc.) and health information (transmission of the virus, incubation timeframe, etc.) provided during the pandemic? How did those barriers/challenges affect you?

Question 5 (Construct 5: Cues to Action)

Considering the health information provided during the COVID-19 pandemic, what precautions did you take to ensure your safety from contracting COVID-19?

Question 6 (Construct 5: Cues to Action)

Why did you choose these actions? Was it based on the information provided by healthcare resources, social media, or individuals?

Question 7 (Construct 6: Self-efficacy)

Did the strategies used to ensure safety against COVID-19 work? Why or why not?

Question 8 (Construct 6: Self-efficacy)

Did your outlook/view toward COVID-19 change after you put specific measures in place? Were those changes behavioral (action-oriented), physical (physiological), or emotional (reactionary)?

Trustworthiness of Medical Systems

Question 9

Can you discuss your level of trust in medical systems during the height of COVID-19 and since COVID-19?

Question 10

In dealing with the COVID-19 pandemic, what are your thoughts on how the medical systems handled health access and information with Black Americans?