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Perceptions and Beliefs of African American Men and Women 30 years and Older About the Health Care System in the United States

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Abstract

Perceptions and Beliefs of African American Men and Women 30 years and Older About the Health Care System in the United States

by

Jacqueline Chadwick McNair

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

This qualitative study described perceptions and beliefs of African American men and women ages 30 and over regarding their experiences with the health care system in the United States. The health belief model was the theory that drove this research, and it was grounded in the concept of cultural competency. The study used grounded theory methodology as well as phenomenology to describe the lived experiences of the participants and ethnography to describe the cultural characteristics of African American men and women ages 30 and over as related to their perceptions and beliefs about health care in the United States. The participants were purposefully selected from a women's group (19), a men's group (17), and a church group (38) for data collection. Selected questions from the Patient Satisfaction Questionnaire 18 and interviews of selected participants (3) were used to collect data. Data analysis consisted of organizing and arranging the raw data into categories by the research questions: (1) Do African Americans ages 30 and over perceive the health care system in the United States as biased and negative? (2) Do African Americans ages 30 and over believe the health care system in the United States as biased and negative? The themes that emerged from this study were distrust, lack of respect, lack of empathy, lack of communication and confidence, and racial bias. A theme that emerged from this study, not found in previous research or literature, was the high cost of medicine. This study supports social change by revealing that there is a need for policy changes among health administrators and practitioners to help mitigate disparities in medical care so all patients have equal and quality health care in the United States.

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Dedication

I would like to dedicate this dissertation to Dr. J. Winona Taylor, College of Education, Bowie State University, Bowie, Maryland – my confidant, my sorority sister, and my best friend who through her prayers and guidance inspired me to reach this pinnacle goal. Dr. Taylor has been a strong beacon in my life for many years and has never wavered in her assistance and commitment to help me complete this arduous task. Many times I was ready to give up, but Dr. Taylor was right there pushing and giving words of encouragement.

I would also like to dedicate this dissertation to my mother, the late Dr. Marie Patterson Tann, who prayed countless hours for me in this quest, who provided financial assistance when necessary and who has and will always be a solid anchor in my life and an excellent role model. Even though she is not here with me in body, she is with me in spirit to walk the awesome journey with me.

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Chapter 1

Introduction

In the United States, health care has been and continues to be a privately owned and operated institution, and for the majority of African Americans, it has been an almost impossible institution from which to receive adequate care. This qualitative research looked at the perceptions and beliefs of African American men and women 30 years of age and older about health care in the United States.

Health disparities are more prevalent among African Americans than any other ethnic/racial group in the United States. With African Americans accounting for about 13% of the population, it is imperative that research be conducted to ascertain the reasons for this ethnic population's high rate of health disparities. This study provided potential solutions that would decrease health disparities among African Americans and assist health care providers with the tools necessary to provide better health care to African Americans. In this chapter I present the problem statement, purpose of the study, research questions, theoretical and conceptual framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance.

Background of the Study

Health care for African Americans can be traced back to the days of slavery (Kennedy, Mathis & Woods, 2007). As slaves, African Americans were not provided health care by physicians or nurses and relied heavily on the use of remedies brought from the motherland, Africa, for healing and cures (Kennedy et al., 2007). These

remedies sustained African Americans for many decades. Even though African Americans now have more access to health care than ever before in the United States, health disparities exist for this ethnic group, and although these disparities exist in other ethnic groups, documentation of the increase in these disparities among African Americans have been recorded over the course of history (Kennedy et al., 2007). As this research looked at the perceptions and beliefs of men and women 30 years of age and older about health care in the United States, the related literature addressed these perceptions and beliefs with regard to barriers, racism, culture, trust/mistrust, and other factors.

Armstrong, Ravenell, McMurphy, and Putt (2007) provided information about the racial/ethnic differences in physician distrust in the United States, which has been identified as a contributor of African American health disparities. Bagchi, Schone, Higgins, Granger, Casscells, and Croghan (2009) provided additional information about racial and ethnic health disparities in the United States that support the need to understand the perceptions and beliefs of African Americans about health care and health care systems in the United States. Jupka, Weaver, Sanders-Thompson, Caito, and Kreuter (2008) focused on African American experiences with health care systems in the United States. Rickles, Dominguez, and Amaro (2010) identified race-based discrimination as a barrier to quality health care access and a contributing factor to health disparities. Shavers, Fagan, Jones, Klein, Boyington, Moten and Rorie (2012) conducted

a review of the literature on the effects of interpersonal and institutional racism and discrimination in health care systems on the health care of minority patients.

Many studies have been conducted and documented on the poor health outcomes of African Americans that reflect a long history of deprivation and barriers to health care (Brandon, Isaac, & LaVeist, 2005; Collins, Tenney & Hughes, 2002; Dreeben, 2001). However, few studies have been conducted on the perceptions and beliefs of African American men and women 30 years of age and older regarding health care in the United States. This study addressed the gap that exists in the research literature in understanding African American beliefs about why health disparities continue to exist among them.

According to the Centers for Disease Control and Prevention (2011), African Americans make up approximately 13.6% of the total population in the United States. Life expectancy, death rates, infant mortality, and other measures of health status and risk conditions and behaviors are attributed to health disparities among African American's (Centers for Disease Control and Prevention, 2011). In order to address and reduce these health disparities for African Americans, understanding the perceptions and beliefs of African American men and women 30 years of age and older about health care in the United States is important for health care professionals.

Problem Statement

Incidences of morbidity and mortality among African Americans for illnesses such as cancer, diabetes, coronary heart disease, and other illnesses are greater than any other ethnic group in this country (Jupka et al., 2008). Jupka et al. (2008) reported that

one of the contributing factors for this gap is the inequality of health care practices and poor patient and provider communication between African American patients and health care professionals. Another factor that may contribute to this gap is physician distrust (Armstrong et al., 2007, p. 1283). Shavers et al. (2012) contended that another reason for this gap is the poorer care minorities receive once they enter the hospital.

Purpose of the Study

Although studies have been conducted that looked at racial/ethnic discrimination with regard to receipt of health care, physician distrust, and personal experiences of African Americans with the health care system, few studies have looked at the perceptions and beliefs of African Americans 30 years of age and older regarding the health care system in the United States. In order to narrow the health disparity gap among African Americans and other ethnic groups, research needed to be conducted on how African Americans perceive health care and what they believe about the health care system in the United States. Therefore, the purpose of this qualitative study was to describe the perceptions and beliefs of African American men and women 30 years of age and older about the health care system in the United States.

Research Questions

The following research questions drove this study.

RQ1: Do African Americans ages 30 and over perceive the health care system in the United States as biased and negative?

RQ2: Do African Americans ages 30 and over believe the health care system in the United States is biased and negative?

Theoretical Framework for the Study

The theoretical framework for this study was the health belief model (HBM). In 1995, Glanz and Rimer defined the HBM as an intrapersonal theory that "addresses a person's perception of the threat of a health problem and the accompanying appraisal of a recommended behavior for preventing or managing the problem" (Cottrell, Girvan and McKenzie, 2012, p. 369). The HBM is used to understand the massive failure of people in accepting disease preventives or screening tests for the early detection of disease (Edberg, 2010). In addition, the HBM consists of four dimensions: perceived susceptibility, perceived severity, perceived benefit, and perceived barriers (Edberg, 2010, pp. 57-58).

Conceptual Framework

The concept that grounded this study was cultural competency. The concept of cultural competency describes the beliefs and perceptions of African American men and women ages 30 and over about the health care system in the United States (Cross, Bazron, Dennis, & Isaacs, 1989). It considers a person's cultural awareness, knowledge, attitudes, and skills with regard to the culture of individuals and not just the ethnicity of individuals (Cross et al., 1989). Cultural competency connects serious policy problems to major racial and ethnic disparities in health care and presents multiple approaches that can be implemented to address these problems (Betancourt, Green, Carrillo & Ananeh-

Firempong, 2003). The concept related to the research questions in that cultural competency considers the beliefs and perceptions of men and women and this study addressed the beliefs and perceptions of African Americans ages 30 and older about the health care system in the United States. A more detailed description of this concept appears in Chapter 2.

Nature of the Study

The nature of this study was qualitative in focus. Grounded theory was the qualitative approach used in this research. According to Creswell (2003), grounded theory attempts to derive a general, abstract theory of a process, action, or interaction grounded in the views of participants in a study. For this research study I used interviews and surveys to gather data of the perceptions and beliefs of African Americans ages 30 and over about the health care system in the United States.

Definitions

The terms below were used throughout this study and were applicable only to this study. These definitions of these terms were obtained from the free dictionary website. The free dictionary is a collection of dictionaries by subject (2014) Retrieved February 21, 2014 from www.thefreedictionary.com.

Beliefs: In this study, beliefs are defined as feelings of trust in the worth or ability of the health care system of the United States by African Americans ages 30 and over (Belief, 2014)

Health care: For this study, health care is defined as the prevention, treatment, and management of illness through the services offered by the medical and allied health professions as it relates to African American men and women ages 30 and above (Health care, 2014)

Perceptions: Perceptions are defined as the way African Americans ages 30 and older think about or understand the health care system in the United States for this study (Perception, 2014)

Assumptions

I assumed that participants, African American men and women ages 30 and older, were truthful and accurate in their responses to the surveys and interviews with regard to their perceptions and beliefs of the health care system in the United States. These assumptions were necessary given the age range of the study participants, where some may not wish to respond or be interviewed.

Scope and Delimitations

The morbidity and mortality rate, the inequality of health care practices and poor patient and provider communication, and physician mistrust are among the disparities experienced by African Americans from the health care system in the United States, and these are the specific aspects of the research problem explored in this study. The focus of this study was on the beliefs and perceptions of African American men and women ages 30 and over toward health care in the United States as related to these aspects. The

population participants of this study were African American men and women ages 30 and over. This study did not look at other ethnic groups, children, teenagers, or young adults.

Limitations

This study was limited to African American participants ages 30 and older, and therefore the findings of this study cannot be generalized to African American men and women under age the age of 30 or other ethnic groups of any age. This study was also limited to the truthfulness of participant responses, interviewer bias, participant bias, and objectivity of the researcher.

Significance

Health disparities are more prevalent among African Americans than any other ethnic group (Bagchi et al., 2009). In order to narrow the gap, health care professionals and the health care system needed to know what African Americans think of their practices. This study was significant in that it explored the perceptions and beliefs of African American men and women ages 30 and older about health care and the health care system in the United States. The findings of this research have the potential to bring awareness to health care professionals regarding the perceptions and beliefs of African Americans regarding health disparities and hopefully narrow the gap in health disparity among African Americans and other ethnic populations.

Summary

This chapter introduced the study that was researched. Described in this chapter was the problem to be researched, the purpose of the study, the theory and concept that

drove the study, and the methodology that was used. The chapter outlined the questions that were answered, the assumptions, limitations, and definitions addressed in the study. Chapter 2 discusses the related literature that supported this study.

Chapter 2: Literature Review

Introduction

African Americans' illnesses such as cancer, diabetes, coronary heart disease, and other conditions are greater than any other ethnic group in this country (Jupka et al., 2008). Jupka et al. (2008) reported that one of the contributing factors for this gap was the inequality of health care practices and poor patient and provider communication between African American patients and health care professionals. Physician distrust has been cited as another reason for this gap in the poor health care minorities receive once they enter the hospital (Armstrong et al., 2007; Shavers et al., 2012).

Although studies have been conducted that look at racial/ethnic discrimination with regard to receipt of health care and physican distrust and at personal experiences of African Americans with the health care system, few studies have looked at the perceptions and beliefs of African Americans 30 years of age and older regarding the health care system in the United States. The problem addressed in this qualitative research was to review how African American men and women perceive and what they believe about health disparities and the health care system in the United States. The purpose of this qualitative study was to understand the perceptions and beliefs of African American men and women ages 30 and older about the health care system in the United States.

In this study, the following issues are addressed: (a) problems of racial/ethnic differences in physician distrust in the United States, (b) the perceptions and beliefs of African Americans about health care and the health care system in the United States, (c) African Americans' experiences with the health care system in the United States; (d) race-based discrimination as a barrier to quality health care access, and (e) the effects that interpersonal and institutional racism and discrimination in the health care system have on the health care of minority patients. These issues are addressed in the current literature in this chapter, which establishes the relevance of this research problem.

The chapter is divided into six main sections. Section 1 discusses the literature search strategy used to gather relevant literature and research about the problem being studied. Section 2 discusses the health beliefs model, the theoretical foundation that drove this research study. Section 3 identifies concepts that arose from the literature reviewed for this study. Section 4 provides the current literature that addressed the problem and purpose of this research study. It is divided into four subsections that include (a) a history of health care systems in the United States, (b) a historical background of the Tuskegee Incident/Experiment, (c) health disparities among African American males and females (ages 30 and older), and (d) perception and beliefs of this age group about the health care system in the United States. The summary is the final section of this chapter.

Literature Research Strategy

The sources used for this literature search were: EBSCO database, Walden University Library, Nursing & Allied Health, ProQuest, Literature Resource Center, CINAHL, Health Source Plus, and Gale Virtual Reference Library. Journals used for this research included but are not limited to: *American Journal of Public Health, Journal of the American Medical Association, Journal of Cultural Diversity, Journal of the National Medical Association, Journal of Nursing Education, Journal of Health Disparities Research and Practice, Journal of Health and Social Behavior,* and *the Journal of Theory Construction and Testing*. The search terms used in all databases were: *African Americans, perceptions and beliefs of African Americans, health care and African Americans, the Tuskegee Experiments, physician distrust and African Americans, health care systems in the United States, racism and culture barriers, barriers in health care among African Americans, health disparities and African Americans,* and *cultural competence in healthcare.*

Theoretical Foundation

Health Belief Model

The theoretical framework for this study was the HBM. In 1995, Glanz and Rimer defined the HBM as an intrapersonal theory that "addresses a person's perception of the threat of a health problem and the accompanying appraisal of a recommended behavior for preventing or managing the problem" (Cottrell et al., 2012 p. 45). The HBM was used to aid in understanding the massive failure of people in accepting disease

preventives or screening tests for the early detection of disease (Edberg, 2010). The HBM consisted of four dimensions: perceived susceptibility, perceived severity, perceived benefit, and perceived barriers (Edberg, 2010).

The HBM was developed in the early 1950s by social psychologists Hochbaum, Kegeles, Leventhal, and Rosenstock as a psychosocial formulation to explain health-related behavior at the individual decision-making level (as cited in Mikhail, 1981). Although the HBM has been adapted to explore a variety of health behaviors, the originators of the HBM sought to determine (a) why some people used health services and others did not, (b) reasons for the high rate of noncompliance with health and medical care recommendations, (c) factors that interfered with people following health care recommendations, and (d) changing health-related behavior (Mikhail, 1981).

In studies conducted using the HBM, researchers have sought to provide direction and guidance for practice and research, in addition to attempting to change health beliefs toward appropriate health behaviors. The model is used also in uniting unrelated findings from previous investigations, providing clearer ideas, and demonstrating relationships among variables. The HBM serves as a catalyst for new questions to be asked and for the development of new theories or new aspects of the HBM.

Researchers using the HBM seek to explore the health related behavior of individuals and answer questions of why individuals behave as they do toward health related issues and factors. The HBM can be viewed as a catalyst for expansion and further development to include other concepts of perception to explain individual health

behaviors at the individual decision-making level. The HBM is also a theory based on individual assumptions. If I assume or perceive that my health provider is not trustworthy, then my health behavior will be reflected. Because the intent behind using the HBM is to address individual health behaviors and hopefully change that behavior, I used the HBM model in the current study in relation to the perceptions and beliefs of African American men and women ages 30 and older about the health care system in the United States with regard to perceived barriers (physician distrust, personal experiences, discrimination, and racism) and perceived susceptibility (opinion of the health care system in America only and not health conditions). The research questions of this study were developed based upon the existing theory by seeking to add another vein in which to describe or define individual health behavior or the lack thereof.

Conceptual Framework

In addition to the HBM theory, in this study I utilized the concept of cultural competency (Cross et al., 1989) as a frame for which to describe the beliefs and perceptions of African American men and women ages 30 and older about the health care system in the United States. The concept of cultural competency considers a person's cultural awareness, knowledge, attitudes, and skills with regard to the culture of individuals and not just the ethnicity of individuals. Cultural competence is a set of behaviors, attitudes, and policies that come together in a system, agency, or among professionals to enable work in cross-cultural situations. Culture is those human behaviors that include language, thoughts, communications, actions, customs, beliefs,

values, and institutions of racial, ethnic, religious, or social groups. Competence is functioning effectively as an individual and an organization within the context of those cultural beliefs, behaviors, and needs presented by consumers and their communities (Cross et al., 1989).

Research studies in cultural competency as related to health have been around for a little over 10 years. In 2000, Brach and Fraserirector conducted a review of the literature on cultural competency and found that major racial and ethnic disparities in health presented serious policy problems and that multiple approaches needed to be implemented to address these problems. They believed that the implementation of cultural competency techniques in the delivery of health care services could aid in reducing disparities among ethnic groups. Research found that cultural competence has moved from a marginal to a mainstream policy issue and as a strategy for improving health disparities (Betancourt et al., 2003).

Wallace, Weiner, Pekmezaris, Almendral, Cosiquien, Auebach and Wolf-Klein (2007) advocated for further research and cultural sensitivity training to improve physician awareness of racial differences among patients. This study described the beliefs and perceptions of African Americans about health care systems in the United States.

Historical Overview of Health Care Systems in the United States

Health care in the United States has been and continues to be mainly a private institution, although it receives financing from the government (Shi and Singh, 2013,

p.53). Historically, the practice of medicine in the United States began as more of a domestic venture than a professional one. Medical procedures that were used in the early Colonial days were rather primitive, especially because medical education was not grounded in science but was considered more of a trade. During that time there were only a handful of hospitals, no health insurance, and health care was delivered in a free market (Shi & Singh, 2013, pp. 55-56). Shi & Singh (2013, pp. 55-56) summarized health care in preindustrial America as (a) primitive; (b) competitive among tradesmen, because any tradesman could practice medicine; (c) a free market delivery system; (d) having few hospitals and only in large cities, where sanitation was poor and staff were unskilled; and (e) medical training and education was received through individual apprenticeship under a practicing physician instead of through university education. For African Americans, however, health care in the United States was either limited or nonexistent.

As far back as slavery, African Americans have received poor to no health care. The health of slaves was left to the discretion of their owners, who may or may not have had hospitals on the plantation and these hospitals were staffed by African American women knowledgeable in illnesses and healing or received minimum care from the European doctor contracted by the plantation owner (Fauci, 2001). African Americans were also used for experiments during this time period, especially African American women for gynecological surgical techniques as well as general anesthesia. Because these African Americans were slaves, their consent was not needed to conduct these

experiments. Experiments conducted on slaves also included inoculating slaves with the smallpox virus to see if the vaccine worked; pouring boiling water on the spinal column as a treatment for typhoid pneumonia; and placing them in open pit ovens to see if certain medicines enabled the withstanding of excessive temperatures. African American slave bodies were also used for cadaver research by European doctors (Fauci, 2001).

The Emancipation of 1865 brought about passage of the Freedman Bureau legislation, which operated 90 health care facilities for African Americans throughout the South. These facilities continued to provide health care for African Americans until the bill expired, and with its' expiration, southern health institutions refused care for African Americans in the early 20th century (2014). Retrieved January 20, 2014, from http://www.racetimeplace.com. Black hospitals emerged around the early 1900s and lasted through the 1930s and still the inequalities existed. Most of the black hospitals were in the south and there was one black hospital for every 100,000 black patients compared to the white hospitals of 1 for every 19,000 patients and services for blacks were minimal in comparison to whites (2014). Retrieved January 21, 2014 from http://www.racetimeplace.com.

The New Deal under Theodore Roosevelt's administration and the ending of World War II brought about some changes in health care which included African American, but still not to the degree with which whites received health care. The onset of integration in the 1960s closed many black hospitals and by 1988, 71 black hospitals were closed, merged, consolidated, or converted (2014). Retrieved January 24, 2014 from

http://www.racetimeplace.com. Even with the passing of the Civil Rights Act of 1964 which brought about changes, African Americans are still plagued by racism, discrimination and prejudice from the health care system (Fauci, 2001).

Several historical factors have shaped the health care delivery system in the United States as we know it today (Shi & Singh, 2013). Historical factors such as cultural beliefs and values, social changes, technological advances, economic constraints, and political opportunism have shaped the United States health care delivery (Shi & Singh, 2013). These historical factors explain why the United States have been very hesitant in establishing national health insurance and why health care in the United States is mainly a private industry, but substantial funding from the government is used to help the poor, elderly and the disabled receive health care services (Shi & Singh, 2013). On March 23, 2010, President Barack Obama signed The Patient Protection and Affordable Care Act of 2010 (Goodson, 2010; Weinick & Hasnain-Wynia, 2011). Weinick and Hasnain-Wynia, (2011, p. 1837) state "Despite persistent evidence of continued racial and ethnic disparities in health care, little explicit attention has been paid to how quality improvement activities might affect disparities." The Act focuses on several aspects, but one of the main focuses is everyone must have minimal health insurance coverage known as individual mandate (Goodson, 2010).

Barriers to Health Care Systems

Health care and health care systems have progressed since the days of doctor home visits, but for African Americans and other minorities health care systems change

has been slow to non-existent. African Americans and other minorities are still challenged with barriers when it comes to health care in the United States (Blanchard & Lurie, 2004). These barriers may include racism, discrimination, prejudice, stereotyping, physician or health care workers distrust, attitudes, opinions and perceptions, and personal experiences (Jupka, et al., 2008; Bankert & Peters, 2005).

In a study conducted by Blanchard and Lurie (2004) minority patients stated that they felt they were being treated with disrespect and were looked down upon because of their race or the language spoken. The data for their study was taken from the Commonwealth Fund 2001 Health Care Quality Survey conducted between April 30 and November 5, 2001 (Blanchard & Lurie, 2004). The researchers found that "Perceptions of disrespect or of receiving unfair treatment within the patient-provider relationship are prevalent, particularly among racial/ethnic minorities. Such negative perceptions influence health care utilization and may contribute to existing health disparities" (Blanchard and Lurie, 2004, p. 721). Disrespect and being treated unfairly may contribute to the negative outcomes viewed by minorities, especially African Americans, as it relates to their health and health care systems (Blanchard & Lurie, 2004).

Shavers et al. (2012) examined current literature surrounding racial and ethnic discrimination in health care. In their study entitled "The State of Research on Racial/Ethnic Discrimination in the Receipt of Health Care," interpersonal and institutional racism and discrimination in the health care setting was examined. They reviewed 58 articles related to health care received by racial/ethnic patients from health

care settings for a period of three years, 2008 to 2011. The 58 articles were obtained from PsychNet, PubMed, and Scopus databases. Shavers et al. (2012) found that perceptions of discrimination and provider bias were topics more frequently examined in health care settings. They also found few studies were conducted on the prevalence of racial/ethnic discrimination and little to none on interpersonal and institutional racism (Shavers et al., 2012).

Another factor that contributes to African American's perception of health care systems is physician distrust (Armstrong et al., 2007). Armstrong et al., (2007) in their study "Racial/Ethnic Differences in Physician Distrust in the United States," analyzed data from a 1998-1999 Community Tracking Study of health and health care. The study analyzed, had surveyed over 32,000 households in about 60 communities across the United States. Armstrong et al. (2007) found that physician distrust was higher among African American and Hispanic populations than the white populations.

African American Experiences with Health Care Systems

African American perceptions of health care systems stem from inequalities, past and present discriminations, and personal experiences throughout the United States (Randall, 2009). According to Collins et al. (2002) numerous studies have been conducted that document the relatively poor treatment of African Americans and report negative health care experiences. In the Commonwealth Fund 2001 Health Care Quality survey conducted by Princeton Survey Research Associates from April to November, Collins et al. (2002) found that 23% of African Americans reported poor communication

with their physician; 14% felt their doctors looked down upon them; 15% felt they could receive better care if their doctor was a different race; and 16% felt they were disrespected.

African American women reported overt and covert prejudicial experiences resulting in inadequate care or outright prejudicial actions by medical providers and that this poor treatment is believed by these women because they are African American and in many instances poor (Benkert & Peters, 2005). In their research, Benkert and Peters (2005) interviewed 20 African American women, ranging in ages 18 to 65, to ascertain how they coped with health care prejudice. The researchers found that the African American women felt fear, hate, anger, powerless and caution towards health care providers; believed the health care provider scolded them like children; that they received inadequate or conflicting information; and had their needs ignored and/or contradicted. They felt as though they were taken for granted. The researchers found that the women used strategies such as getting angry, walking away, being assertive, and learning to unlearn or cope with the prejudice experienced by the medical providers (Benkert and Peters, 2005).

Jupka et al., (2008) conducted focus groups of 79 African American men and women ages 40 and older to determine their experiences and interactions with health care providers and the health care system. The participants cited trust, attitudes, opinions, personal experiences with health care, history, and discrimination as reasons for their apathy toward health care systems and health care providers. The participants in their

study felt from a historical perspective that they were guinea pigs and were not informed that test or studies were being conducted on them (Jupka et al., 2008).

The Tuskegee Study conducted between 1932 and 1972 deceived and bribed approximately 600 African American men into cooperating with research examining the progression of syphilis without treatment, even when a cure had become available (Gamble, 1997). The Tuskegee Syphilis Study, which began in 1932 and lasted until 1972 conducted experiments on 399 African American men from Macon County, Alabama (Gamble, 1997). The study began in 1932 when the United States government promised 399 African American men free treatment for Bad Blood, which was the euphemism for syphilis (Walker, 2009, p. 5). Syphilis was epidemic in Macon County, Alabama, where all of the participants originated. These men were described as poor and uneducated and became unknowing participants in a government sanctioned medication investigation (Walker, 2009, p. 5). African Americans also felt that because of the Tuskegee Study, they only would go to the doctor if something hurts.

From a personal perspective, the participants felt that the doctors did not know what they were talking about because examinations were not given; the doctor was incompetent; incorrect medicine was administered; and doctors were experimenting on them (Jupka et al., 2008). The participants felt discriminated by the medical providers because of an assumption of the lack of insurance or Medicaid and the length of time they must wait for medical assistance or treatment in hospitals. They reported feeling as if

"white people" get the better care. Overall, the researchers found that the participants did not have complete trust in health care providers (Jupka et al., 2008).

Racism, Culture and Health Care Systems

Martin Luther King, Jr., once stated "Of all forms of inequality, injustice in health is the most shocking and the most inhuman" (Byrd & Clayton, 1992, p. 189). Research supports that Black Americans have and still experience poor health in the United States compared to other ethnic groups and whites since slavery (Byrd & Clayton, 1992).

Johnson, Saha, Arbelaez, Beach, and Cooper (2004) state racial and ethnic disparities in health care access and quality have been extensively documented in studies. These documented studies have shown that minority populations have less access to care, use fewer health care resources, and are less satisfied with the care they receive than the majority white population (Saha, Komaromy, Koepsell, & Bindman, 1999). Communication between minority patients and white health care provider's maybe partly the case of racial inequalities in health care in the United States (Saha, Komaromy, Koespell, & Bindman, 1999).

Disproportionately affected by poor health care in the United State are racial and ethnic minorities (Sorkin, Ngo-Metzger, & De Alba, 2010). These groups report "differences in access to care, receipt of needed medical care, and receipt of life-saving technologies may be the result of system-level factors or maybe due to individual physician behavior" (Sorkin, Ngo-Metzger, & De Alba, 2010, p. 390).

African Americans feel that they are less likely to receive adequate health care because of their race than any other ethnic group. African Americans perceived that they would receive better care if they were of a different race (Johnson et al., 2004). Chen, Fryer, George, Phillips, Robert, Wilson, and Pathman (2005) further states that racial differences have been documented in access to care, receipt of needed medical care, preventive services, and life-saving technologies. African Americans feel that physicians of their own race treat them better than physicians of other races or ethnic background. Kennedy et al. (2007) summarized a book written by Professor James entitled "Bad Blood." In it, the author states that "bad blood" identifies African Americans' distrust of the health care system and that the Tuskegee study has become a blue print of distrust of mistreatment for African Americans by the medical community. Professor Jones' book further states that the Tuskegee study was a "metaphor of deceit, conspiracy, malpractice, and neglect, if not out-right genocide."

African Americans continue to distrust the health care system even though great strides in medicine have been made (Kennedy et al., 2007). African Americans have experienced something that no other ethnic group has experienced – slavery, racism and segregation. These three elements have not only caused African Americans to develop different perceptions and beliefs of mistrust of the health care system, but also a different belief of the health care system as a whole (Kennedy et al., 2007).

"The history of African Americans and the traditional health care system can be traced back to the times of slavery" (Kennedy et al., 2007, p. 57). As slaves, many

African Americans were not afforded the opportunity to see any physicians or nurses, so they relied heavily on their care in using the many remedies they brought with them from Africa (Kennedy et al., 2007). These remedies sustained African Americans for many decades. Even though African Americans now have access to health care in the United States, there are many disparities that still exist for them (Kennedy et al., 2007). These disparities that exist for African Americans also exist for other minorities. However, disparities for African Americans have well been documented over the course of history (Kennedy et al., 2007). "Many African American feel that the actual act of receiving health care is very often a degrading and humiliating experience (Kennedy et al., 2007, p. 57)." "Often times African Americans are viewed as beneath White Americans by White health care providers, to include communication or poor quality of care. Also, unintentional insults by the providers may include some form of gestures or comments that may be demeaning; i.e., the actual tone of the voice used when speaking to a client" (Kennedy et al., 2007, p. 57). Kennedy et al. (2007) further states that health care providers may have trouble relating to African American clients and the clients may sense the uneasiness contributing to their distrust. Cultural competency on the part of the health care provider has been one of the most dynamic factors relating to mistrust of the health care system by African Americans. African Americans feel it is the lack of cultural competency and cultural sensitivity on the part of health care providers that breeds mistrust of the health care system.

Historical Background: The Tuskegee Incident

Mistrust of the medical care system in the United States can be attributed to a number of factors such as limited access to medical care and mistreatment or discourteous treatment by medical personnel and health care professions (Brandon, Isaac, & LaVeist, 2005). Although other reasons have been cited for this mistrust, the one that may have had the most significant impact on African American mistrust more than any other was the Tuskegee Study. The Tuskegee Study was conducted by the United States Public Health Service and lasted for 40 years (Brandon, Isaac, & LaVeist, 2005).

During the four decades the Tuskegee experiment existed, the 399 participants were observed, intentionally deceived, and deliberately denied treatment for syphilis, even when penicillin became the standard treatment in the 1940s (Brandon, Isaac, and LaVeist, 2005, p.951). Walker (2009) states that according to Jones (1992) by the time the experiment ended in 1978, 28 of the 399 participants had died from syphilis and another 100 had died from complications related to the disease. Forty of the wives had been infected with the disease and 19 children had been born with congenital syphilis (Walker, 2009). As Walker (2009) states, " the Tuskegee Experiment symbolizes the medical misconduct and blatant disregard for human rights that take place in the name of science" (p. 5).

In 1997, 25 years after the study ended, President William Clinton issued a formal apology for the wrongs committed by the U. S. government in the Tuskegee Study (Gamble, 1997; Walker, 2009; Reverby, 2009). Even with the apology, the shadow of

Tuskegee continues to haunt African Americans and may play a role in the distrust and mistrust of medical care and the medical profession in the United States as well as low participation in clinical trial studies (Gamble, 1997; Brandon, Isaac, & LaVeist, 2005; Katz, Jean-Charles, Green, Kressin, Claudio, Wang…Outlaw, 2008).

Health Disparities

Factors Contributing to Health Disparities

In the United States today, health care has improved greatly for most, but for ethnic minorities the prevalence of health disparities seem to be increasing instead of decreasing. The first commitment to eliminate health disparities was presented as a Presidential Initiative in 1998 (Copeland, 2005). Copeland (2005) describes what needs to be done to eliminate health disparities and cites several factors as contributors of health disparities. These factors include lack of access to health care; barriers to care; increased risk of disability and disease resulting from occupational exposure; biological, socioeconomic, ethnic, and family factors; cultural values and education; social relationships between majority and minority population groups; autonomous institutions within ethnic minority group populations; and culturally insensitive health care systems, which she believes are rooted in inequitable health care systems.

Chernew, Gibson, Yu-Isenberg, Sokol, Rosen, and Fendrick (2008) found that cost sharing (price sensitivity), income, and socioeconomic status may account for the rise in health disparities among ethnic minorities. Their research found that patients in low-income housing areas were unable to keep up with the rising costs of medical

(medicine) co-payments and adversely affected the patient's health and thus increased the disparities (Chernew, et al., 2008). They believe that there is a strong relationship between socioeconomic status and adherence to medicine.

Other factors that have been mentioned in the literature are access to curative and preventive health care, disproportionate exposure to risk factors such as stress, poor nutrition, and low educational attainment (Baffour & Chonody, 2009 as reported by Lu & Halfon in 2003). McFayden (2009) believes that the key factors influencing health disparities are racism and discrimination and that they contribute to the late and misdiagnosis of African Americans. These late and misdiagnoses also contribute to the scope and accuracy of treatment towards African Americans (McFayden, 2009). Factors influencing and impacting health disparities among ethnic minorities, especially African Americans, are many, and although income and socioeconomic status are high on the list of factors, the key and most consistent factors are racism, discrimination, bias, and prejudice.

Race/Ethnicity/Discrimination and Health Disparities

Disparities in the treatment and health status of minorities (African American, Latino and Native Americans) have plagued the health profession for centuries and continue to plague the United States even in the 21st century (Geiger & Borchelt, 2003). In March 2002 the Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in health care reported "that the quality of care received by racial and ethnic minorities in this country is lower than that provided to the majority

population" (Nelson, 2003, p. 1377). Although the report does not provide any evidence of overt prejudicial attitudes among health care professionals, discriminatory attitudes and behaviors are still reflected in society within the United States (Nelson, 2003). The study was commissioned by Congress and their findings indicate that persistent racial and ethnic discrimination is evident in many sectors of American life and many sources contribute to racial and ethnic disparities in health care. The committee concluded that although progress has been made in reducing disparities, much still needs to be done before "treatment is equal under the law" (Nelson, 2003, p. 1380).

In *The Meaning of Race in Health Care and Research–Part I the Impact of History,* Tashiro (2005) stated that the social structure and system of relations in the United States have evolved around race since the days of slavery. The role and rights of individuals were defined by one's position in the racial hierarchy, which led to the conquest of Native Americans and especially the role of black slavery in history and economic development of the United States (p. 209). The racial inferiority of blacks was the justification for slavery and as Stephen Steinberg states "it is facile to think that blacks were enslaved because they were defined as inferior; it would be closer to the truth to say that they were defined as inferior so that they might be enslaved" (Tashiro, 2005 as stated by Steinberg, 1981). The stigma that has been attached to African Americans from a historical perspective as racial and ethnic disparities continue to exist. In a research study conducted by Tashiro (2005) racial and ethnic disparities were found to exist in the treatment of pediatric appendicitis and cardiac care for minority children. Her study also

found that white children with long bone fractures receive 2.3 times more pain medication than black children with the same injuries. Her research shows that race and unconscious biases by health care providers play a role in the medical treatment received by African Americans. She believes that health care providers should maintain an awareness of race, its history, what it is or is not and should examine their own assumptions to determine whether they are based on evidence or a reflection of stereotypes (Tashiro, 2005, p. 209).

The research no matter the author continues to report that racial/ethnic bias, prejudice and stereotyping persists even today and play a significant role in health disparities among minority patients, especially African Americans and health care treatment received. Infant mortality is higher now than it was in 1950 (Williams, Neighbors, & Jackson, 2008). As many researchers have stated changes must be implemented if we want to eliminate racial/ethnic health disparities and to do that, we must understand race, culture, stereotype, and our own prejudices and misconceptions about those who are different (Nelson, 2003; Tashiro, 2005; Bediako and Griffin, 2007; Clark, 2009; Aronson, Burgess, Phelan, and Juarez, 2013). Lillie-Blanton, Maleque, and Miller (2008) believe that although the challenges of creating equitable health care for all American may be enormous, but not insurmountable. Unless the President and Congress recognize that elimination of these disparities is crucial and make it a priority on the political and policy agenda, the implications can impact who we are as a nation today and in the future (Lillie-Blanton, Maleque, & Miller, 2008).

Education and Health Disparities

In the African American community, the Black Church has always played an important role in the life of its members and the community. Historically, the Black Church has been the primary focus for social, cultural, political and religious gatherings. It is the site of worship, teaching and learning, refuge in troubled times, artistic and leadership development, and a cultural and health center (Isaac, Rowland, & Blackwell, 2007). Education has always been an agenda item for the Black Church and as a result many Black Churches, especially in the south, were targeted and set on fire by the Ku Klux Klan to stop their educational endeavors. African Americans acquired skills, knowledge and values through the educational programs offered by the Black Church (Issac et al., 2007). Today Black Churches promote healthy lifestyles and some employ health practitioners and have health education programs or ministries for their parishioners and the community. As stated by Isaac, Rowland and Blackwell (2007) the Black Church can serve as an advocate for eradicating health disparities among African Americans through their efforts in showing how important health education and health promotion are important to the African American community and challenging the "norms and standards of the larger society to create an equal health care system."

Perceptions and Beliefs of African Americans and Health Care Systems

Health care in the United States has improved greatly over the last decades. Health Disparities among African Americans as compared to that of Caucasian Americans and other ethnic group still exist (Rickles et al., 2010). These disparities in

health care and access to health care continue to persist and in many cases have increased over the years (Rickles et al., 2010). The morbidity and mortality rate for African Americans is much higher than that of Caucasian Americans. This higher rate in morbidity and mortality has led to less access to health care services and in some cases lower quality of health care (Rickles et al., 2010).

Malat and Van Ryn (2005) interviewed African American adults who preferred health care providers among their own race to assess the extent to which perceptions of racial discrimination was associated with these preferences. The research suggests that while knowledge of unfair treatment historically and perceptions of current racial inequity do not affect preferences, personal experiences of unfair treatment may have a significant effect on African American patient preferences regarding health care providers. The findings of this study suggest that the focus of research should be on individual experiences instead of historical mistreatment and current inequities in medical treatment (Malat & Van Ryn, 2005).

Medical Distrust/Trust

Mistrust among African Americans toward the medical profession and the health care system in the United States can be traced as far back as slavery (Hammond, 2010). As Hammond (2010) reports from other researchers, mistrust among African Americans of health care organizations is linked to incidents of medical malice, which includes “the Tuskegee Study of Untreated Syphilis in the Negro Male” between 1932 and 1972 and remains the primary source of mistrust for African Americans (p. 87). Hammond (2010)

conducted a study of 216 African American men mostly from barbershops to determine what factors were associated with medical mistrust. His study looked at background factors of age, masculine role identity/socialization factors, recent health care experiences, recent socio-environmental experiences (such as discrimination), and health care system outcome experiences (such as perceived racism in health care). The findings from this study proved that perceived racism in health care to be the most powerful factor associated with medical mistrust and age, masculine role identity, recent patient-physician interaction, and discrimination experiences as having a direct association with mistrust. Although age had a direct correlation to mistrust, it was found the older the African American male, the more mistrust was exhibited (Hammond, 2010).

Shea, Micco, Dean, McMurphy, Schwartz, and Armstrong (2008) revised a health care system distrust scale and conducted a three phase study of 404 minority individuals to discover whether medical mistrust was multi-dimensional. Their findings suggest that the primary domains of distrust among minority patients were values and competence. Rose, Peters, Shea, and Armstrong (2004) using an earlier version of the health care system distrust scale found that distrust of the health care system was higher among African Americans than whites and their trust in personal physicians was inversely correlated. Armstrong et al. (2007) also found that the levels of distrust were higher among African Americans than whites. The areas of distrust for African Americans are medical research, the health care system, and health care providers. The authors believe this distrust is attributed to “current and historical evidence of inequitable treatment of

Blacks by the health care system as well as racial differences in patient-provider communication, insurance coverage, and physical characteristics" (Armstrong et al., 2007).

LaVeist, Nickerson, and Bowie (2000) found that African American cardiac patients displayed a higher level of distrust of the medical care system than whites. The author's state that African American cardiac patients reported mistrust across all measures and perceived more racism and were less satisfied with the care received. The authors agree with Gamble (1997) that African American medical mistrust stems from centuries of racial discrimination and maltreatment. Boulware, Cooper, Ratner, LaVeist, and Powe (2003) validates the findings of other researchers in that African American mistrust of the health care system and the medical profession stem from history. They report that historically African Americans have been victims of interpersonal and institutional racial discrimination and are less likely to trust physicians than their white counterpart.

According to Pearson and Raeke (2000) trust is one of the key factors of patient-physician relationships and with the rapid changes in health care system mistrust in physicians appears to increase. The authors state that many theories have evolved about trust and the medical field but measures have not been taken to change these perceptions and very little data has been collected. In 2001, Hall, Dugan, Zheng and Mishra examined trust in physicians and medical institution by defining trust, determining whether trust could be measured and asking if trust mattered. In their research, the authors concluded that definitions and distinctions of trust should be clearly articulated;

use an empirical approach in the study of trust that will lead to the shaping of normative theory and public policy. Finally, LaVeist, Isaac, and Williams (2009) found that mistrust of the health care system, especially for African Americans, contributes to delay in care seeking, complicates the care process and patient outcomes worsen. Medical mistrust causes patients to seek care later than earlier increasing the cost of treatment and may be an explanation for the disparities among racial/ethnic minorities.

Summary

This chapter reviewed previous literature and research conducted about the perceptions and beliefs of African Americans about the health care system in the United States. The literature reviewed discussed the history of health care in the United States, the historical background of the Tuskegee Experiment, health disparities among African Americans and perceptions and beliefs of African Americans as related to trust and distrust of health care in the United States. Chapter 3 described the methodology used to conduct this qualitative study.

Chapter 3: Methodology

The purpose of this qualitative study was to describe the perceptions and beliefs of African American men and women ages 30 and older about the health care system in the United States. In this chapter I discuss the methodology that was used for this research divided into 10 sections. Section 1 restates the research questions. Section 2 discusses the central concepts of the study. Section 3 discusses the research design that the study used. Section 4 discusses the role of the researcher. Section 5 discusses the population and participants of the study, which consisted only of persons 30 years and older. Section 6 discusses the data collection instrument. Section 7 discusses the data collection procedures. Section 8 discusses the data analysis plan. Section 9 discusses the reliability and validity of the instrument and the study. Section 10 discusses the ethical procedures used in the study. The chapter concludes with a summary.

Research Questions

The following research questions drove this study:

RQ1: Do African Americans ages 30 and over perceive the health care system in the United States as biased and negative?

RQ2: Do African Americans ages 30 and over believe the health care system in the United States is biased and negative?

Central Concepts

This qualitative study used a systematic approach to describe perceptions and beliefs of African American men and women ages 30 and over about the health care

system in the United States. The goals of this qualitative research study were to gain insight into and explore the depth, richness, and complexity inherent in the phenomenon of the perceptions and beliefs of African American men and women about health care systems in the United States.

Research Design

The study was qualitative in nature and used the grounded theory methodology. According to Creswell (2014) and as stated by Charmaz (2006) and Corbin and Strauss (2007), grounded theory is used to derive a general or abstract theory of a process, action, or interaction grounded in the views of participants in a study. Grounded theory research design involves multiple data collection procedures, and as such, this research study used a combination of phenomenology, ethnography, and interview approaches. I used phenomenology to describe the lived experiences of the participants and their perceptions and beliefs about health care in the United States. I used ethnography to describe the cultural characteristics of African American men and women ages 30 and older as related to their perceptions and beliefs about health care in the United States.

Role of the Researcher

According to Creswell (2014), the role of the researcher is to collect data through examining documents, observing behavior of participants, or interviewing participants. Creswell (2012) also recommends that the researcher include past experiences with the research problem in order to help the reader understand the connection between the researcher and the study (p.188). To that end, my role in this study was to collect data

using surveys and interviews. I ensured that data collection protocols were properly followed.

Population and Participants

The participants in this study were African American men and women 30 years and older. This study collected data from a women's group, a men's group, and a church group, where only those members of each group 30 years and older were used for data collection. The number of participants for each group varied, depending on the numbers ranging in age 30 years and older. Because the participants in this study were African American men and women, participation was solely based on age. The study was conducted at three different sites.

Instrumentation

This study used the (PSQ-18, Appendix A) to collect data from each participant group. The PSQ-18 is a shortened version of the PSQ that was originally developed by Ware, Snyder and Wright in 1976 and consisted of 80 questions. The PSQ-18 retains characteristics of the full 80 item questionnaire, but only has 18 questions and is produced by Rand Health (Retrieved from www.rand.org/health/surveys). I selected questions from the PSQ-18 (Appendix A) that related to the study and modified the questions to make them open-ended in order to obtain written thoughts of the participants, especially those who did not wish to verbally participate.

Data Collection Procedures

I conducted data collection for this study by purposefully selecting the participants and the three sites that were used. The participants from each site were African American men and women ages 30 years and older. One site consisted of a men's group. Another site consisted of a women only social group that met monthly in a public library, and the last site consisted of a church adult group consisting of both men and women who met weekly at the church site. Participant numbers at each site varied depending on the age of the participants.

I developed an interview protocol and interview questions (Appendix C). In order to capture the responses of the participants accurately, I taped interview sessions with the permission of the participant using a Sony digital recorder.

Participants were given an open-ended survey for the purpose of capturing their private thoughts. These open-ended survey questions were modified from the PSQ-18. Finally, at least one individual from each group volunteered to participate in the interview. I asked six interview questions of the interviewees. By using multiple data collection procedures, the data was saturated. Saturation is an idea that stems from grounded theory and occurs when the categories or themes no longer reveal new insights or properties (Charmaz, 2006). Prior to data collection, I obtained Walden University Institutional Review Board (IRB) approval (#03-07-16-0117639) and participants' permission to conduct the research. Once IRB approval was given, data was collected. This included three 60-minute open-ended sessions for the survey groups and three 1

hour one-on-one interview sessions with the three interviewees. Each informed consent form and survey question were matched to a unique participant number so that I could differentiate the data from each participant to maintain data integrity.

Data Analysis Plan

The data analysis plan consisted of organizing and arranging the raw data into categories. The categories were organized according to survey and interview questions. Data collected from the open-ended surveys assisted me with research question number 1 (Do African Americans ages 30 and over perceive the health care system in the United States as biased and negative?). Research question number 2 (Do African Americans ages 30 and over believe the health care system in the United States is biased and negative?) obtained data from the interviews. Data collected for the interviews connected both research questions. I reviewed all data to determine a general sense of the information collected and reflected upon the overall meaning of the information and ideas from the participants.

After permission had been granted to tape the interviews and the interviews were conducted, I transcribed interview data from the recordings and formatted them into a usable form. This allowed me to hear the data repeatedly while it was being transcribed into text data, become familiar with the data and the common themes that emerged. I coded all data, organized it into categories or themes, and labeled it based on information that emerged from the participants. Coding the data segmented it into descriptions and broad themes. Coding, according to Creswell (2012), is a process to make sense out of

text data by dividing it into text or image segments, labelling the segments with codes, examining codes for overlaps and redundancy, and collapsing the codes into broad themes (p. 243). In other words, I used an inductive process that narrowed the data into a few themes. Discrepant cases in the data were not used in the data analysis and a rationale was given.

Validity and Reliability

The credibility of this research was assessed utilizing the following strategies: triangulation of data, member checking, and clarification of research bias. Triangulation was accomplished by collecting multiple sources of data (open-ended surveys and interviews). "Triangulation is the process of examining multiple sources of data and building a coherent justification for themes" (see Creswell, 2014, p. 201). I discuss researcher bias in the section “Researcher’s Role.” I used detailed descriptions to ensure external validity.

I utilized triangulation, multiple methods of data collection, and analysis to strengthen reliability and validity. I describe data collection and analysis procedures in detail to provide a picture of the methods used in this study.

Validation of the findings occurred throughout the steps of the data collection process. I checked for accuracy of the findings by employing a variety of procedures, triangulation, descriptions, and member checking to ensure qualitative validity. To ensure reliability, the process of data collection was consistent throughout. The validity of the research is based on the findings from my vantage point and that of the

participants. I documented each step of the data collection procedures to ensure reliability and checked the interview transcripts in order to assure mistakes were not made during the transcription. In addition, I compared codes with the data collected and memos written regarding their definitions.

Ethical Procedures

Because I respected the rights, needs, values, and desires of the participants in this study, each participant was given an informed consent form in order to participate in this study. I verbally and in writing explained the contents of the consent form to all participants. Participation in this study was voluntary, and names and personal information was not divulged as a result of participation. All data collected throughout the study was kept confidential. Each participant was assigned a participant number based on the research group. The groups were coded as PF, representing the female social group; PM, representing the men only group; and PC, representing the church group. Each participant of the groups was assigned a corresponding number to coincide with the informed consent. I explained the objectives and goals of this research to the participants both verbally and in writing. I provided an explanation of all data collection procedures and activities to the participants. Finally, I will maintain all data and consent forms for a period of 5 years in a locked combination safe. After 5 years, the data will be shredded.

Summary

In Chapter 3 I discussed the research design, role of the researcher, methodology, data analysis plan, issues of trust, and ethical procedures in relation to obtaining data for this research study. In Chapter 4 I discuss the findings of this qualitative research study.

Chapter 4: Findings

Introduction

Chapter 4 presents the findings of this study. The focus of this study was the health care system in the United States and how African American men and women ages 30 years and older viewed the health care system. The study used surveys and interviews. The purpose of this qualitative study was to describe the perceptions and beliefs of African American men and women ages 30 and older about the health care system in the United States. This chapter is organized into six sections: demographics, data collection, and data analysis, evidence of trustworthiness, results, and a summary of the chapter.

Research Questions

The research questions that guided this study were:

R1: Do African Americans ages 30 and over perceive the health care system in the United States as biased and negative?

R2: Do African Americans ages 30 and over believe the health care system in the United States as biased and negative?

Demographics

The participants of this qualitative study are represented in Tables D1 through D36. The tables represent the responses of the participants overall and by group for survey question 1 (SQ1) and SQ2. After meeting with each participant group, explaining the study, and answering questions, I disseminated a total of 120 surveys to the three participant groups. Each informed consent and survey questions had the same

corresponding numbers so that I could differentiate the data from each participant to maintain the integrity of the data. Of the 120 surveys, only 74 surveys were used based on the criteria: African American male or female in the age range of 30 and older. Although not represented in any of the tables, the participants also represented all socioeconomic and educational backgrounds. Tables 1, 2, 3, and 4 below display the age range, frequency and percentages of all participants in this study and response to SQ1, "My age is . . ." Table 5 represents the participant responses to SQ2, "My sex is . . ."

Table 1 represents the ages of all participants in this study, and as shown in the table, 16% of the total participants were in the age range of 50-54.

Table 1

Total Participants by Age

Age range	Frequency	Percent
30 – 34	3	4
35 – 39	5	7
40 – 44	8	11
45 – 49	9	12
50 – 54	12	16
55 – 59	8	11
60 – 64	5	7
65 – 69	7	9.5
70 – 74	4	5
75 – 79	6	8
80 – 84	7	9.5
Total participants	74	100

Table 2 represents ages of the female group participants in this study, and as shown in the table, 16% of the female group was in the age range of 45 to 49 and 50 to 54 respectively.

Table 2

Female Group by Age

Age range	Frequency	Percent
30 – 34	2	11
35 – 39	1	5
40 – 44	4	21
45 – 49	3	16
50 – 54	3	16
55 – 59	1	5
60 – 64	1	5
65 – 69	2	11
70 – 74	0	0
75 – 79	1	5
80 – 84	1	5
Total participants	19	100

Table 3 represents ages of the men's group participants and as shown in the table 18% of the male group was in the age range 50-54.

Table 3

Male Group by Age

Age range	Frequency	Percent
30 – 34	1	6
35 – 39	1	6
40 – 44	1	6
45 – 49	1	6
50 – 54	3	18
55 – 59	2	11
60 – 64	1	6
65 – 69	1	6
70 – 74	2	11
75 – 79	1	6
80 – 84	3	18
Total participants	17	100

Table 4 displays the ages of the church group participants and shows that 15% of participants in the church group were in the age range 50-54. The tables show that collectively, the participants (15.75% or 16%) in this study were in the 50-54 age groups.

Table 4

Church Group by Age

Age range	Frequency	Percent
30 – 34	0	0
35 – 39	3	8
40 – 44	3	8
45 – 49	5	13
50 – 54	6	15
55 – 59	5	13
60 – 64	3	8
65 – 69	4	11
70 – 74	2	5
75 – 79	4	11
80 – 84	3	8
Total participants	38	100

Table 5 displays the gender, frequency, and percentage of the total participants in this study and answers SQ2, sex. As represented in Table 5, 19 participants were male, representing 26% of the participants, and 55 participants were female, representing 74% of participants in this study.

Table 5

Participant Gender

Gender	Frequency	Percent
Male	19	26
Female	55	74
Total participants	74	100

Data Collection

A total of 120 surveys (Appendix B) were disseminated among the three groups (women, men, and church). Of the 120 surveys disseminated among the groups, only 74 surveys could be used based on the stated criteria. During the survey, I asked each participant to answer the questions and to be as truthful and accurate as possible in their responses. Each group completed the survey questions in 60 minutes. At the end of the survey, each group was thanked for their time and participation in this study and was told that the information provided would add to the body of knowledge about health care in the United States and hopefully aid in improving not only health care provider behaviors and attitudes, but health care in general.

Data Analysis

The following analysis represents Tables D1 through D36, found in Appendix D. SQ3 through SQ14 are answered in the analysis below.

SQ3 (Table D1 thru D3): “I have been under a physician’s care for . . .” In each group, the responses were mostly divided between numbers of years to specific illnesses. Each group had participants who did not respond to the question. Because the responses for SQ3 ranged from number of years to specific illnesses, I concluded that the wording of SQ3 may have been confusing to the participants and therefore the responses were not used.

SQ4 (Tables D4 thru D6): “Sometimes I question the diagnosis my doctor gives me because . . .” The range of responses were:

- not questioning;
- "not agreeing";
- "getting a second opinion";
- "too quick to decide about my health";
- "want only to medicate";
- "for a better understanding;" and
- "just don’t agree."

Although several participants failed to answer SQ4, the findings indicated the participants did not trust the diagnosis they were given.

SQ5 (D7 thru D9): “I believe the cost of my medical care is _____ because . . .” The responses to SQ5 for each group showed the majority of the participants believed the cost of medical care was too high. Few participants from each group felt the

cost of medical care was reasonable. Five participants did not response to the question, but the findings indicated the cost of health care was too expensive.

SQ6 (D10 thru D12): “Many times I believe the cost of my medicine is_____ and I am . . .” The responses to SQ6 were similar to those of SQ5. The majority of the participants in each group believed the cost of medicines were too expensive and too high. Only a few of the participants believed the cost was adequate, fair, or not expensive. Four participants did not respond to the question. The findings for survey question 6 indicated cost of medicine was a problem.

SQ7 (D13 thru D15): “When I need a medical specialist, I feel . . .” The responses to SQ7 showed a variety of opinions:

- “satisfied";
- "overwhelmed";
- "I feel because of my prison records physicians look down on me and are not willing to treat me; badly; frustrated";
- "helpless";
- "I feel they talk down to me and I am too stupid to understand what they are talking about";
- "I feel as if they are not listening to me, even when I describe my symptoms"; and
- "They are always in such a hurry to get you in and out.”

Four participants did not respond to the question. The findings from SQ7 indicated medical specialist lacked patience.

SQ8 (D16 thru D18): “When I am seen by doctors, other than my private physician (emergency room), I am treated . . .” The responses from SQ8 included:

- “with respect”;
- “great”;
- “respectful;”
- “I am treated with suspicion”;
- “I am treated like a nobody”;
- “I am treated too swiftly”;
- “I am treated with some respect";
- "but many times these health people look down on you because you are on medical assistance or social service”;
- "I am treated with some respect until they find out that I have been in prison and then the attitudes change.”

Although six participants did not respond to SQ8, the findings indicated a lack of respect from outside medical professionals.

SQ9 (D19 thru D21): “My private physician treats me . . .” The responses of question nine showed that the participants felt their private physician treated them well, “with respect,” or “good”; therefore, the findings indicated private physicians valued their patients.

SQ10 (D22 thru D24): “When I tell doctors how I feel, they . . .” There were varying responses for SQ10. The participants in each group felt that their doctors did not listen to them.

- “They do not listen. My previous physician did not and besides he was younger than I was and I did not trust anything he said”;
- “I feel that sometimes they look at me as though I don’t know what I am talking about”;
- “I feel they don’t seem to be listening to what I am saying”;
- “It is if they have tuned me out and what I say isn’t important";
- "I feel they assume it is prison related.”

Four participants of the women’s group felt their doctors did not listen:

- “they dismiss my symptoms”;
- “stared at me as if all I wanted was pain meds”;
- "my previous doctor tuned me out like a radio”;
- “often aren’t concerned about my outcomes";
- “assume they know my ailment”;
- “I wish they would listen”;
- “sometimes talk over me.”

Six participants did not respond to the question. The findings indicated a lack of empathy and listening skills from doctors.

SQ11 (D25 thru D27): “Many times I question the ability of the doctors who treat me because . . .” Responses included:

- “sometimes my office visit is too short”;
- “they guess and don’t ask questions”;
- “I don’t trust them”;
- “they don’t treat me with respect”;
- “they are not listening to what I am saying and since I see a different physician each time I go for treatment it makes me question their ability to treat me”;
- “I question the ability of the doctors who treated me because I am black.”

The findings from SQ11 showed that the participants lacked trust in their physicians and felt they were treated with a lack of disrespect and empathy.

SQ12 (D28 thru D30): “It bothers me when I cannot get an appointment immediately when I need medical care because . . .” The responses for SQ12 varied from “never been an issue” to “I don’t have a problem” to “I usually do get an appointment within a reasonable amount of time.” Ten participants did not respond to SQ12. The findings indicated the participants did not feel this question was a problem with their health care.

SQ13 (D31 thru D33): “The medical care I receive is . . .” The responses for question 13 showed that the participants felt they received “good,” “excellent,” and

"okay, but it could be better." The findings indicated that although medical care could be improved, the participants did not view this to be a serious problem.

SQ14 (D34 thru D36): "What is your honest opinion about health care in the United States?" The responses for SQ14 varied in opinion about the health care in the United States.

- "The health care system in the U.S. is poor. If you have money you get excellent care and if you are poor you get substandard care. And if you are "black" all they want to do is medicate you with drugs."
- "It sucks, especially in the VA hospitals."
- "I feel that health care in the United States is not good for people of color like myself. All they want to do, is to give you medications."
- "Okay, but could be a lot better."
- "For many, many people, it is not good, due to the greed of insurance companies."
- "Depends on your access and ability to pay."
- "The health care in the United States is very color blind."

Although the responses were varied the findings indicated participant's had negative feelings about health care in the United States. It appears the theme is mistrust and not caring.

The findings from the surveys resulted in the following themes: lack of respect, lack of trust, lack of communication, lack of confidence, and racial bias. The findings

from this study reflect similar findings of previous studies conducted by Armstrong et al. (2007); Jupka et al. (2008); Benkert and Peters, (2005); and Blanchard and Lurie, (2004). The themes that have emerged from this study are the same themes found nine years ago by Armstrong et al. (2007); Jupka et al. (2008), Benkert and Peters (2005), and Blanchard and Lurie (2004). A theme that emerged from this study, not found in previous research, was the high cost of medicine.

Interviews

The Interview Protocol and Questions (Appendix C) were explained to each participant. Each participant was informed by the researcher that their participation in this interview was voluntary and the information gathered would assist the researcher in completing this dissertation. All information collected was strictly confidential, no names were disclosed, or appeared in the dissertation. Each interview lasted 60 minutes. The interview sessions were taped using a Sony digital recorder with playback, pause and stop capabilities. The digital recorder allowed the researcher to transcribe each response to the questions with precision, clarity and accuracy. Once all interviews were completed and the responses were transcribed with all information being verified for accuracy and completeness, the digital recorder was locked in a combination safe for security.

Listed below are the transcribed responses of the interviewees for the six interview questions (IQ1 thru IQ6).

IQ1 was: “What is your overall opinion of health care in the United States and Maryland, Baltimore, in particular?” The question elicited the following responses.

Participant 31: All physicians want to do is give medicine. My girlfriend who is Caucasian and I suffer from high blood pressure, yet her doctor referred her to a Nutritionist, suggested she enroll in an exercise program and they created a plan for her to get off of the blood pressure medication. My doctor who is Caucasian just increased my medication and told me that my body needs to adjust to taking the higher dosage of the medication. He didn't suggest any intervention programs at all. Well that was my last time seeing him or taking any of his advice. The only good thing is that I have a good job with excellent insurance.

Participant 32: The health care in the United States is very color blind in my opinion. If you have insurance you are treated with some respect. However, if you don't you are just out of luck because the system doesn't give a damn. And if you go to the hospital the first thing they want to know is how they will be paid. For black people all they want to do is experiment on us with different types of medication. I don't trust any of these medical professionals to tell me the truth about my health. That is why I do research before I take any medications because all of those medications have some serious side effects. I was taking one medication for high blood pressure and my hair started to fall out. When I reported this side effect to my doctor, all he did was reduce the dosage. Well I stopped taking that medication and sought out another professional. My hair has started to grow back. My doctor at the time was so nonchalant about my hair loss. He didn't even refer me to a dermatologist. I knew he was not the physician for

me. How can you not care about your patients? Hair loss is a big deal to a woman and should be a concern of her doctor. My doctor now is African American. I purposely sought an African American doctor because I can relate and I trust what she is saying to me about my health. She's very pleasant and she spends time talking to me to find out what's going on with my health. She recommended that I join a senior exercising class which I did at the YMCA and I am happy to say that I am now down 25 pounds and she's removed me from one of my blood pressure medications. My other doctor who was Caucasian didn't suggest anything other than medication. I was just a number or shall I say a patient with a number and his staff was just like him, abrupt and rude.

Participant 97: I feel the health care system sucks. I had better treatment when I was in prison. Can you believe that, better treatment in prison? But since I've been released getting good treatment is a thing of the past. It seems my medical assistance care doesn't have good physicians attached to it or at least I haven't found one as of yet. Medical care in the United States is too expensive and I have one medication that costs $85.00 per prescription and when you have a minimum wage job this prescription is too expensive for me. Sometimes my mother and sister help me pay for my prescription.

Participants 31, 32, and 97 agree the health care system is bias and as participant 31 states, "colorblind." All agreed that more could be done about health care in the United States. They also agreed that if you have insurance, treatment was a little better.

IQ2 was: “What has been your experiences with health care (doctor or hospital visits)?” The question elicited the following responses.

Participant 31: My previous doctor didn’t seem to give me the respect that I felt was due me. He was always in a rush and never listening to what I was telling him about how I was feeling. He was only concerned with giving me medications. I often thought he was getting some kind of kickback from the pharmaceutical company for giving his patients certain medications. And I never could get an emergency appointment with him when I was feeling bad.

Participant 32: The physician I had (White) was very condescending. He never listened to what I had to say. He just read what was in my chart and when I asked him questions he dismissed me as if I was a child. Even though I am 65 years old, doesn’t make me stupid. I am very capable of understanding the English language when it is explained to me, especially about my health. He gave me the impression that what I stated did not matter because he was the doctor.

Participant 97: As I have stated before in the survey, I received better health care treatment when I was in prison. The prison doctor always treated me with respect and he listen to me when I describe my symptoms. On the outside of prison things are certainly different. I had to find a doctor who would take my medical assistance care and when I found one I had to take three buses to get to his office. I only went to this doctor when I felt like I was dying because that was the only way I could put up with his disrespect.

Participants (31, 32, and 97) found a lack of respect and empathy from the health care system.

IQ3 was: “How do you feel when you are to visit the doctor’s office or hospital and when you leave?” The question elicited the following responses.

> Participant 31: I truly hated going to my previous doctor’s office. His staff mimicked his behavior of abruptness and rudeness. The receptionist was very unfriendly when you entered the office, never smiling. She looked like she was constipated all the time. I never felt comfortable visiting his office and never really wanted to go back. When I asked questions, he didn’t take the time to answer my questions. I really felt very frustrated with him. When I complained to my husband how I was treated, he said I should seek another doctor, which I finally did. I don’t see how this man keeps any patients of color. He made me feel like he was doing me a favor just to talk to me and I did not like that feeling at all.
>
> Participant 32: I remember visiting my doctor’s office once and waiting 45 minutes in the examining room waiting for him to see me. After about an hour, I inquired as to when would the doctor becoming in to see me. I was then told by the nurse that the doctor had not arrived. At no time was I even told the doctor had not arrived nor was I asked if I wanted to reschedule my appointment. I was furious and I left. My time is just as valuable as my doctors and for his office to treat his patient this way was inexcusable. I changed doctors after that incident.

> Participant 97: I feel that because I have a prison record I am treated differently as a patient in my doctor's office. It is bad enough that I have to find doctors who will take my medical assistance card, but to suffer the humiliation of going to his office and have his staff stare at me as if I have a signed painted on me that said jail bird. I see the nurses or the assistants taking other patient's blood pressure, but when it comes to me only the doctor takes my pressure. If I feel bad and need to see a doctor, I just go to the emergency room at the hospital near my house. I know they will treat me and give me respect.

Participant (31, 32, and 97) found a lack of respect, empathy and caring.

IQ4 was: "How would you describe the treatment you have received when vising the doctor or hospital?" The question elicited the following responses.

> Participant 31: My previous physician was not very responsive to my needs. Every time I visited his office, I always felt as if I never received any treatment. This man seemed tone deaf when I told him my symptoms and how the medication made me feel. All he kept saying was that he would adjust my medication and it was a process to find the right medication that my body would tolerate. I remember that he changed my blood pressure medication four times in one month and the medication was expensive even with my copay. I felt like I was on an assembly line. He made me feel like I was an old black woman he didn't have time to treat. Prescribing different medications was all he was good

for. I really don't know how he graduated from medical school. Maybe the requirements were not has strict as they are now.

Participant 32: I called my doctor's office once when I had a terrible cold for an appointment. The receptionist stated the nurse would call me back. When I called it was 8:30 a.m. on a Monday morning and the nurse did not call me back until the next day late in the afternoon. The nurse stated to me that the doctor could not see me until Friday. I told her it was an emergency and I was having difficulty breathing, but she continued to say that he could not see me until Friday of that week. That night I got sicker and my breathing was difficult. I was rushed to the emergency room and was diagnosed with pneumonia. Pneumonia, can you believe that. You have to take your health in your own hands these days because these health professionals don't really care and I do believe it was because I was black and I was on Medicare.

Participant 97: I don't like going to my doctor's office. I just have not had any successful treatment with him. I would just rather go to the emergency room and wait for several hours before I visit his office. As I have stated before and will keep on saying it, I received better medical treatment and respect when I was in prison.

Participant (31, 32, and 97) found a lack of respect, lack of communication, lack of caring and empathy from the health care system.

IQ5 was: “Please think back to a time when you felt uncomfortable during a visit to your doctor or hospital and can you describe how you felt?” The question elicited the following responses.

Participant 31: I went to see my doctor because I was having problems with my diabetes medication. I told him how I was feeling on this medication and he said to me, all you do is complain, you have to give the medicine a chance to work. Can you believe a doctor would say that to a patient? Instead he could have said, ‘I need to adjust your medication or try a new medication.’ Instead I was chastised like a child. I told him that he was disrespectful, and I would not be talked to in that manner. He apologized, but I never felt comfortable with him again and changed doctors later to someone who was respectful of me.

Participant 32: I went to the emergency room once for having difficulty breathing after a bee sting. I was badgered by an admission clerk as to how was I going to pay the bill for emergency services. I could hardly breathe, let alone talk and this individual was trying to collect money. The doctor finally asked her to leave and come back later when I was able to talk without shortness of breath. I was utterly shock at this type of treatment of me as a patient. I realize that hospitals are businesses, but really where is the human dignity in how you are treated as a patient.

Participant 97: Because of my prison record, I feel the doctor’s that have treated me look down on me because of my prison record. It is truly a shame to admit

that I received better treatment and respect when I was in prison by the medical profession.

Participant (31, 32, and 97) found a lack of respect, lack of communication, lack of caring and empathy from the health care system.

IQ6 was: “Is there anything else you would like to tell me about your experiences with health care?” The question elicited the following responses.

Participant 31: Doctors need to listen to their patients especially people of color. In my opinion the health care system seems to treat people of color one way and the non-people of color better. My previous experience with the health care system was not very good. I became a health advocate for myself, meaning I changed doctors who were more attentive to my health needs and those who listened to me when I talked about my symptoms. My previous doctor made me feel stupid as if I could not understand what he was talking about. He never had the time to really sit down with me and create a plan of treatment, that why I changed doctors.

Participant 32: My opinion of the health care system in the United States is that it is very color blind. If you have insurance, you are treated with some type of respect. However, if you don’t you receive less than adequate treatment especially if you are on some type of medical assistance. I don’t trust any medical professional to tell me the truth from my past experiences. All they want to do is medicate blacks without doing any interventions. The white doctors I have had in

> the past have not given me the best treatment and I was brushed aside as if they could not have been bothered. This is how I was treated.
>
> Participant 97: I have not had any great success with the health care system in the United States outside of prison. I know that I sound like a broken record, but I received better health care treatment in prison. The cost of medications is too high. Sometimes I have to decide on paying my rent or buying my medication and I will forego my medication some months to pay my rent if my mother or sister cannot help me in a particular month.

Participant (31, 32, and 97) found a lack of respect, lack of communication, high cost of medication, and empathy from the health care system.

The following themes emerged from the interviews: lack of trust, lack of communication, lack of empathy (patience), respect, racial bias and high cost of medicine.

Evidence of Trustworthiness

The participant's in this study were African American men and women 30 years and over. This study collected data from a woman's group, a men's group and a church group where only those members of each group 30 years and older were used for data collection. The number of participants for each group varied, depending on the number ranging in age 30 years and over. Since the participants in this study were African Americans men and women, participation was solely based on age. The study was conducted at three different sites.

The study utilized the Patient Satisfaction Questionnaire 18 (Appendix A) to collect data from to each participant group. The PSQ-18 is shortened version of the PSQ that was originally developed by Ware, Snyder and Wright in 1976 and consisted of 80 questions. The PSQ-18 retains characteristics of the full 80 item questionnaire, but only has 18 questions and is produced by Rand Health. The research selected questions from PSQ-18 (Appendix A) that related to the study and modified the questions to make them open-ended in order to obtain written thoughts of the participants, especially those who did not wish to verbally participate (Retrieved from www.rand.org/health/surveys).

Data collection for this study was conducted by purposefully selecting the participants and the three sites that were used. One site consisted of a male group. Another site consisted of a female only social group that meets monthly in a public library and the last site consisted of a church adult group consisting of both men and women, who met weekly at the church site. The open-ended survey was given to each group at their respective sites. Surveys were identified by letter and number i.e. C for church group, M for men group; and W for women group. Participants were given 60 minutes to complete the survey. Participants who needed more time to complete the survey were granted additional time. The surveys were collected and place in envelops identifying each group. Once the data was analyzed from each of the three survey groups, they were placed back in the sealed envelopes marked "women's group, men’s group and church group" and locked in the combination safe for security.

An interview protocol and interview questions were developed (Appendix C). In order to capture the responses of the participants accurately, interview sessions were taped with the permission of the participants using a Sony digital recorder. Participants were asked open-ended questions for the purpose of capturing their private thoughts. These open-ended survey questions were modified from the PSQ-18 Questionnaire.

Six interview questions were asked of the interviewees. In using multiple data collection, the data was saturated. Saturation is an idea that stems from grounded theory and occurs when the categories or themes no longer reveal new insights or properties (Charmaz, 2006). Prior to any data collection, the researcher obtained IRB approval (#03-07-16-0117639) from Walden University and participants' permission to conduct the research. Once IRB approval was given, data was collected. At least one individual from each group volunteered to participate in the interview. The interview questions were given to each interviewee in written format for them to read along while the researcher asked each question. The taping of each interview sessions was done accurately and meticulously using a Sony digital recorder. This included three 60 minute one-on-one interview sessions with the three interviewees. The interviews from each interviewee were transcribed by the researcher from the Sony digital recorder.

Interview data was transcribed from the digital tape recorder by the researcher, as long as permission was granted to tape the interviews, and formatted into usable form to allow the researcher to hear the data repeatedly while it was being transcribed into text data. This allowed the researcher to become familiar with the data and the common

themes that emerged. All data was coded and organized into categories or themes and labeled in terms based on information that emerged from the participants. Coding the data segmented and labeled in terms based on information that emerged from the participants. Coding the data segmented and labeled the text data in forming descriptions and broad themes that existed in the data. Coding, according to Creswell (2012), is a process to make sense out of text data; divide it into text or image segments, label the segments with codes, and examine codes for overlaps, redundancy, and to collapse the codes into broad themes (p. 243). In order words an inductive process that narrows the data into a few themes was present. Discrepant cases in the data were not used in the data analysis and a rationale was given.

The credibility of this research was assessed utilizing the following strategies: triangulation of data, member checking, and clarification of research bias. Triangulation was accomplished by collecting multiple sources of data using (open-ended surveys and interviews). "Triangulation, is the process of examining multiple sources of data and building a coherent justification for themes" (see Creswell, 2014, p. 201).

This study was limited to African American participants, ages 30 and over and therefore the findings of this study cannot be generalized to African American men and women under the age of 30 and other ethnic groups of any age. This study was also limited to the truthfulness of participant responses, interviewer bias, participant bias, and objectivity of the researcher. The data retrieved and analyzed from this study can only be

applicable to the participants in this study. This study focused on African American men and women ages 30 and over and relied on their perceptions and beliefs.

Results

The findings from the surveys resulted in the following themes: lack of respect, lack of trust, lack of communication, lack of confidence, and racial bias. The findings from the interviews resulted in the following themes: lack of trust, lack of communication, lack of empathy (patience), lack of respect, racial bias and high cost of medicine. The themes that were more prominent from this research are lack of trust, respect, communication and racial bias. The findings from this study reflect similar findings of previous studies conducted by Armstrong et al. (2007), Jupka et al. (2008), Benkert & Peters (2005), and Blanchard & Lurie (2004). The themes that have emerged from this study are the same themes found 9 years ago by Armstrong et al. (2007), Jupka et al. (2008), Benkert and Peters (2005), and Blanchard and Lurie (2004). A theme that emerged from this study, not found in previous research studies, was the high cost of medicine. Participants in the survey found that the cost of medicine was too high and they had to give up certain living conditions in order to pay for their medications. The findings from the interviews resulted in the following themes: lack of trust, lack of communication, empathy (patience), respect, racial bias and high cost of medicine.

Summary

Chapter 4 discussed the findings of the study, the demographics, data collection, data analysis and evidence of trustworthiness for this research study. Chapter 5 discussed the findings of this qualitative research study.

Chapter 5

Introduction

The focus of this qualitative study was how African American men and women ages 30 years and over viewed the health care system in the United States. The study used surveys and interviews. The purpose of this qualitative study was to describe the perceptions and beliefs of African American men and women ages 30 and older about the health care system in the United States. This study was conducted based on personal attitudes, beliefs and perceptions of my mother, who had some very poor interactions with the health care system during her lifetime. She often stated that she "never trusted what her physicians said and all they wanted to do was just medicate." She felt they never really listened to her in her communications with them. She often talked about how the white (male) physicians dismissed what she said about her symptoms and only when she took matters in her own hands in getting female physicians (black and white) did she begin to have a somewhat better view of the health care system in the United States.

African Americans continue to distrust the health care system even though great strides in medicine have been made (Kennedy et al., 2007). African Americans had experienced something that no other ethnic group has experienced: slavery, racism, and segregation. These three elements have caused African Americans to develop different perceptions and beliefs of mistrust of the health care system (Kennedy et al., 2007). The key findings of lack of respect, lack of trust, lack of communication, lack of confidence, lack of empathy (patience), and racial bias were evident from the participants' responses

in both the surveys and interviews, and although the high cost of medical costs emerged strongly from the interviews as an important issue, it was subtle in the participant answers from the surveys.

Interpretation of Findings

The findings from this study confirm findings of previous studies conducted by Armstrong et al. (2007), Jupka et al. (2008), Benkert and Peters (2005), Blanchard and Lurie, (2004) and Shavers et al. (2012). Previous studies conducted by Armstrong et al. (2007) and Shavers et al. (2012), initially found African Americans distrust of the medical profession, and 14 years later, distrust in the medical profession by African Americans was still a key finding. Illnesses such as cancer, diabetes, coronary heart disease, and other conditions are greater among African Americans than any other ethnic group of this country (Jupka et al., 2008), in part as a result inequality of health care practices and poor patient and provider communication between African American patients and health care professionals, which was also a finding of this study.

Although studies have been conducted that look at racial/ethnic discrimination with regard to receipt of health care and physician distrust and personal experiences of African Americans with the health care system, few studies have looked at the perceptions and beliefs of African Americans 30 years of age and older regarding the health care system in the United States. The findings from this study also took into account culture as well as race; the findings stemmed from the concept of cultural

competency and the HBM and addressed the participants' perception of health care as a threat to their well-being.

Limitations of the Study

This study was limited to African American participants ages 30 and over, and therefore the findings of this study cannot be generalized to African American men and women under the age of 30 and other ethnic groups of any age. This study was also limited to the truthfulness of participant responses, interviewer bias, participant bias, and objectivity of the researcher.

Recommendations

While the findings from this study confirmed findings from studies conducted 9 to 15 years ago, further research should be conducted in the health care system. I recommended that this study be replicated to look at the perceptions of women regarding health care in the United States. This research should also be replicated to obtain the perceptions of physicians regarding health care. Because cultural competency was the concept used in this study, a recommendation for further study would be to look at cultural training in health care in the United States. Studies should also be conducted regarding parental perceptions of health care of children.

Implications

This qualitative study revealed that further training by health care professionals is needed in cultural sensitivity awareness and interpersonal communication with

minorities, especially African Americans. The study further revealed that although many strides have been made in the improvement of health care for people of color, especially African Americans, changes in practice and policy need to be made in order for patients of all ethnic, racial, cultural, and social economic backgrounds receive the best quality medical care. This study also revealed that the cost of health care is high and therefore policy changes need to be looked at by those who control the health care system in the United States.

Despite the gains that have been made in health care, the findings of this study have revealed that substantial differences in health care across race, gender, and socioeconomic status continue to exist. The findings indicate that inequalities continue to exist among members of certain ethnic and racial groups, especially African Americans. These inequalities are avoidable, unnecessary, and unjust and are a result of policies and practices that have created unequal distribution of money, power, and resources in communities based on race, class, and gender. The implications for change and social justice as a result of the findings from this study strongly encourages and promotes training of health care professionals in advocacy and diversity education to assure that everyone, regardless of race, gender, class, and place of origin has an opportunity to attain the highest level of health care in the United States.

Conclusion

This qualitative study described the perceptions and beliefs of African American men and women ages 30 and older about the health care system in the United States. The

study revealed that there are still perceptions of distrust of the health care system by African Americans. The findings from this research study show that African American perceptions of the health care system in the United States have not changed and the findings confirm previous research conducted by Armstrong et al. (2007), Jupka et al. (2008), Benkert and Peters (2005), Blanchard and Lurie (2004) and Shavers et al. (2012). The findings of this study have the potential to bring awareness to health care professionals regarding the perceptions and beliefs of African Americans regarding health disparities and hopefully narrow the gap in health disparity among African Americans and other ethnic populations.

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Appendix A: Patient Satisfaction Questionnaire 18

Patient Satisfaction Questionnaire

SHORT-FORM PATIENT SATISFACTION QUESTIONNAIRE (PSQ-18)

These next questions are about how you feel about the medical care you receive.

On the following pages are some things people say about medical care. Please read each one carefully, keeping in mind the medical care you are receiving now. (If you have not received care recently, think about what you would expect if you needed care today.) We are interested in your feelings, good and bad, about the medical care you have received.

How strongly do you AGREE or DISAGREE with any of the following statements?

(Circle One Number on Each Line)

Question	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1. Doctors are good about explaining the reason for medical tests……	1	2	3	4	5
2. I think my doctor's office has everything needed to provide complete medical care…….	1	2	3	4	5
3. The medical care I have been receiving is just about perfect……	1	2	3	4	5
4. Sometimes doctors make me wonder if their diagnosis is correct…….	1	2	3	4	5
5. I feel confident that I can get the medical care I need without being set back financially…….	1	2	3	4	5
6. When I go for medical care, they are careful to check everything when treating and examining me……..	1	2	3	4	5
7. I have to pay for more of my medical care than I can afford……..	1	2	3	4	5
8. I have easy access to the medical specialists I need…….	1	2	3	4	5
9. Where I get medical care, people have to wait too long for emergency treatment…….	1	2	3	4	5
10. Doctor's act too businesslike and impersonal toward me……	1	2	3	4	5
11. My doctors treat me in a very friendly and courteous manner……	1	2	3	4	5
12. Those who provide my medical care sometimes hurry too much when they treat me……	1	2	3	4	5

13. Doctors sometimes ignore what I tell them….	1	2	3	4	5
Question	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
14. I have some doubts about the ability of the doctors who treat me…..	1	2	3	4	5
15. Doctors usually spend plenty of time with me….	1	2	3	4	5
16. I find it hard to get an appointment for medical care right away…….	1	2	3	4	5
17. I am dissatisfied with some things about the medical care I receive……..	1	2	3	4	5
18. I am able to get medical care whenever I need it	1	2	3	4	5

Appendix B: Physician/Medicare Care Perception Survey

(From the PSQ 18 Questionnaire)

Instructions: Please complete the survey by answering the questions to the best of your ability. Please be as truthful and accurate as possible.

1. My age is _____
2. My sex is _____
3. I have been under a physician's care for _____
4. Sometimes I question the diagnosis my doctor gives me because _____
5. I believe the cost of my medical care is _____ because _____
6. Many times I believe the cost of my medicine is _____ and I am _____
7. When I need a medical specialist, I feel _____
8. When I am seen by doctors, other than my private physician (emergency room), I am treated _____
9. My private physician treats me _____
10. When I tell doctors how I feel, they _____
11. Many times I question the ability of the doctors who treat me because _____
12. It bothers me when I cannot get an appointment immediately when I need medical care because _____ _____
13. The medical care I receive is _____
14. What is your honest opinion about health care in the United States?

The questions 4 through 13 were adapted from questions 4, 5, 7, 8, 10, 11, 13, 14, 16, and 17 of the PSQ 18 Questionnaire.

Appendix C: Interview Protocol and Questions

Protocol

- Good morning/afternoon!
- Thank you for taking the time to meet with us. We will honor your time by making sure that we wrap up in the next 45 to 60 minutes.
- Does anyone mind if we tape record this for our records? We won't share the tapes with anyone else.
- My name is Jacqueline C. McNair and I am a doctoral student at Walden University. Your participation in this interview will assist me in completing my dissertation.
- All information I collect is confidential and your names will not be disclosed as participants in this interview nor appear in my dissertation. I hope this encourages you (if you need encouragement) to speak freely.
- Any questions before we begin?
- Please complete the informed consent form and return it to me before I begin**.**

Interview Questions

1. What is your overall opinion of health care in the United States and Maryland (Baltimore) in particular?
2. What has been your experiences' with health care (doctor or hospital visits)?
3. How do you feel when you have to visit the doctor's office or hospital and when you leave?
4. How would you describe the treatment you have received when visiting the doctor or hospital?
5. Please think back to a time when you felt uncomfortable during a visit to your doctor or hospital and can you describe how you felt?
6. Is there anything else you would like to tell me about your experiences with health care?

At the end of each interview: Thank you very much for your time. The information you have provided will help to add to the body of knowledge about health care in the United States and hopefully aid in improving health care provider behaviors and attitudes.

Appendix D: Tables

Table D1

Male Response to Question 3

Participant	Response
P5	45 yrs.
P19	Over thirty years.
P24	Blood pressure.
P30	Three months and prior to that I was on Social Service assistance.
P49	No response.
P51	Diabetes.
P53	General Care (High Blood Pressure).
P57	No response.
P65	20 + yrs.
P74	Over forty years.
P76	Multiple problems.
P77	High blood pressure and other problems.
P79	High blood Pressure.
P96	Only a month.
P97	Since December 2014.
P102	Couple of years.
P120	Several years.

Table D2

Church Group Response to Question 3

Participant	Response
P1	No response.
P2	Over 30 years.
P4	1 year.
P6	Several years.
P7	No response.
P8	10 years.
P9	No response.
P11	4 months.
P13	General health.
P14	Weight management.
P15	42 years.
P16	Breast Cancer and Multiple Sclerosis.
P17	21 years.
P29	6 months.
P32	3 years.
P42	No response.
P46	History and Physical and wellness.
P47	30 years.
P55	Since 1970.
P66	30 years.
P67	No response.
P68	Regular Check-ups.
P69	No response.
P70	30 years.
P80	High Blood Pressure and Cholesterol.
P81	Last 5 years.
P83	45 years.
P84	No response.
P86	All my adult life.
P91	Cervical Spondylosis.
P92	53 years.
P99	Heart Disease.
P100	Various ailments.
P104	All my life.
P105	No response.
P106	High Blood Pressure.
P107	No response.
P108	36 years.

Table D3

Women's Group Response to Question 3

Participant	Response
P3	Obesity.
P10	16 years.
P20	30 years.
P23	10 years.
P25	Diabetes.
P26	Nothing, no chronic conditions.
P27	1 year, 3 months.
P28	My entire adult life.
P3	With my new physician for about 3 years. Prior to that I changed physicians because he was not responsive to my needs.
P41	7 years.
P75	Regular checkups.
P82	No response.
P89	17 years.
P90	4 years.
P93	32 years.
P94	Stress.
P95	No response.
P101	No response.
P119	Asthma.

Table D4

Men's Group Response to Question 4

Participant	Response
P5	No response.
P19	"Sometimes I question the diagnosis my doctor gives me because"…if and when I do, I will see a different doctor to assure that the first doctor is correct in this diagnosis.
P24	I feel good.
P30	In going to the clinic, I never saw the same doctor which really "sucked".
P49	No response.
P51	No response.
P53	Never.
P57	I think they are guessing.
P65	No response
P74	The treatment isn't helping.
P76	Too much medication.
P77	It may mean seeing another doctor or a hospital stay.
P79	I was stressed when diagnosed.
P96	It seems he is only prescribing medicine and not listening to me when I tell him how I am feeling.
P102	It does not work.
P120	No response.

Table D5

Women's Group Response to Question 4

Participant	Response
P3	No response.
P10	He doesn't personally know me.
P20	Sometimes I question the diagnosis my doctor gives me because I sometimes think the diagnosis is made too quickly.
P23	Of the service received.
P25	No response.
P26	I believe there is more money in sickness than in cures.
P27	I don't trust them.
P28	No response.
P31	My former physician did not explain or did he feel he had to when asked about a course of treatment.
P41	I do not question.
P75	I don't agree with him.
P82	No response.
P89	Some of the medications and they are always asking about my mental health being stable.
P90	I still have pain.
P93	It always involves costly medication.
P94	Of my socio-economic status.
P95	They can't find the reason for my pain.
P101	I know something about health.
P119	No response.

Table D6

Church Group Response to Question 4

Participant	Response
P1	No response.
P2	No response.
P4	I do not question diagnosis. It correlates with my signs and symptoms.
P6	No response.
P7	The previous physician was not sure of my conditions.
P8	It's unclear.
P9	No response.
P11	No response.
P13	To ensure understanding.
P14	I want to better understand.
P15	I want to confirm and double check for accuracy.
P16	Some days I feel like I am completely healthy.
P17	No response.
P29	I feel all these medical people want to do is medicate black people.
P32	I feel she is too quick to reach a decision without tests.
P42	It's a feeling about the pain.
P46	Not sure where they care going with it.
P47	No response.
P55	I would like to know.
P66	I have not had a reason to question.
P67	No response.
P68	No response.
P69	I trust my doctor.
P70	No response.
P80	No response.
P81	Not accurate.
P83	No response.
P84	No response.
P86	I don't agree, get a second opinion.
P91	No response.
P92	No response.
P99	When he advises surgery.
P100	When I don't think it is right.
P104	No response.
P105	I have been trained to get second opinions.
P106	No response.
P107	I do extra self-research.
P108	I've never questioned my doctor's diagnosis.

Table D7

Men's Group Response to Question 5

Participant	Response
P5	Very reasonable because Retired Military – Tri-Care.
P19	High "because" some other countries provide free medical service.
P24	Good because low co-pay.
P30	Way too expensive because most of these doctors are learning and they are practicing on us. I never trusted what they said and when I questioned the treatment they did not have time to explain and when they did it was short.
P49	High because I think they over charge you.
P51	High because seemingly my insurance coverage is limited.
P53	Not sure.
P57	Too high because it's a money making business and not a care business.
P65	Too high.
P74	Inflated because it's more about the dollar than the care.
P76	Okay because I don't pay for it.
P77	Too high because I am on a fixed income.
P79	Too costly because cost of health care/medical care, shouldn't be high in America.
P96	Very expensive because in this country if you don't have money, you don't get treated. I lost my job several months ago and it was hard for me to find a physician who would take my medical assistance card.
P97	Expensive because I am on assistance and I can only stretch my money so far with having arthritis.
P102	High because of Insurance Companies.
P120	High because co-pays; office visits; medicine.

Table D8

Women's Group Response to Question 5

Participant	Response
P3	Appropriate because my employer subsidizes the cost.
P10	High.
P20	I believe the cost of my medical care is too expensive, and I constantly question the cost of medical care in this country because medical care in other developed countries cost less, and covers more health care services.
P23	Too high because the doctors see patients at a fast rate.
P25	Alright because I have good health coverage.
P26	Average because I'm single and although my employer pays the premiums, I know what it costs.
P27	Fair because my medical needs were major.
P28	Too expensive because doctors are looking for their payment from insurance companies and bill as much as possible to obtain higher revenue.
P31	Expensive because of treatment as a black female they only want to just medicate.
P41	Reasonable because I currently do not have insurance.
P75	Too expensive because the time spent with the doctor is less than an hour
P82	Adequate because I receive preventive care.
P89	$1,500 monthly – monthly visits and needed medications.
P90	Way too expensive because of the Republican Party.
P93	Decent because my company provides great insurance coverage.
P94	Affordable because of my insurance.
P95	Expensive because follow up visits are not included.
P101	High because many physicians charge by the hour.
P119	High because insurance companies make many decisions counter to the doctors' medical decisions based on money.

Table D9

Church Group Response to Question 5

Participant	Response
P1	No response.
P2	Fair because of the health care that I have purchased.
P4	Adequate because I have good insurance and do not focus on actual cost
P6	Within normal limits because I pay copays and I have medical insurance.
P7	Fair because my status has changed.
P8	Slightly overpriced because I have a low federal plan.
P9	Average because the nature of my issues are not abnormal
P11	Free because I work for Howard University.
P13	Expensive.
P14	No response.
P15	Average because it is obtained via state employee.
P16	Reasonable because I have federal government insurance.
P17	Minimal because of excellent health care coverage
P29	Too high because he never prescribes generic medicines or comes up with alternative treatment. I have begun to take my health in my own hands.
P32	Extremely too high because I am on a fixed income and sometimes I have to forgo my medication to pay a bill or buy food. My social security check only can be stretched so far.
P42	High because they send it to me.
P46	Reasonable because I have insurance.
P47	Too high because I am on a fixed income.
P55	High.
P66	Too high because my income doesn't match the cost.
P67	Fair because it's free and included with my job.
P68	Reasonable because insurance covers most of it.
P69	Sufficient because by copays are reasonable.
P70	Reasonable.
P80	No response.
P81	Too high.
P83	No response.
P84	Too high because I am on a fixed income.
P86	High.
P91	No response.
P92	Overpriced because of the services needed are not included (vision, dental).
P99	Expensive because I'm on a fixed income.
P100	High because I'm on a fixed income.
P104	Reasonable because I have insurance.
P105	High because of our complicated insurance system.
P106	Overpriced because the high cost of service this is not regulated by the industry.
P107	Reasonable because full medical access.
P108	No response.

Table D10

Men's Group Responses to Question 6

Participant	Response
P5	Covered.
P19	Very high because pharmaceutical companies are controlling the medical industry.
P24	Cheap and I am happy.
P30	Way too high and I am being used as a guinea pig because I sear the physicians are taking a kick back from those drug companies to push those drugs on us "black folks."
P49	No response.
P51	Extremely high and I am on a fixed income.
P53	No expense
P57	Too high and I am forced to buy it.
P65	Since I use generic brands, cost is okay.
P74	Overpriced and I am sure the price is based on whatever the market will bear.
P76	I don't pay for medicine.
P77	Too much and I am a senior citizen on a fixed income and medicine does not cover everything.
P79	Great and I am satisfied. I pay zero co-pay for medicine.
P96	Expensive and I am juggling bill just to pay for the medicine because my social security check only goes so far.
P97	Too expensive and I am just barely getting by with no full-time job.
P102	Too high and I am shocked as to why.
P120	High.

Table D11

Women's Group Response to Question 6

Participant	Response
P3	Too high and I am upset with paying prescription drug coverage.
P10	Fair.
P20	Many times I believe the cost of my medicine is overpriced, even the generic medicine. I am angry at Congress, government regulators, and the pharmaceutical companies, for not doing enough to keep prices down.
P23	Too high and I am living on an educator's salary.
P25	Fair and I am satisfied.
P26	Overpriced and I am shocked at the costs. My dermatologist saved me on prescriptions for face cream that cost $600.
P27	Too expensive.
P28	Expensive and I am always trying to determine my baseline needed for what I can cut out.
P31	Expensive and I am juggling between paying a bill my filing the prescriptions.
P41	Cheaper and I am satisfied with what I am paying.
P75	Too high and I am sometime not willing to get the needed medication because of the cost.
P82	Appropriate and I am comfortable with my affordable co-pay.
P89	Very expensive and I am very blessed to have insurance coverage so I can get my medication at a reasonable price.
P90	Way to high and I am not able to afford my medications/co-pays.
P93	A bit high priced and I am reluctant to fill certain prescriptions I don't think I need such as pain medication.
P94	Affordable and I am able to use my insurance to purchase the medicine.
P95	Reasonable.
P101	Too high and I am not sure of the side effects that it may cause.
P119	High and I am sure the cost is due to the greed of insurance companies.

Table D12

Church Group Response to Question 6

Participant	Response
P1	Not expensive.
P2	Expensive and I am not given a large quantity for the cost.
P4	Slightly high and I am now using discounts to bring the cost down lower and sometimes free.
P6	Too high and I am paying to obtain the meds I feel are effective.
P7	Okay.
P8	Slightly overpriced and I am dealing with it.
P9	No response.
P11	Reasonable.
P13	No response.
P14	Expensive and I am using multiple work benefits as well as out of pocket to pay.
P15	Fair and I am grateful to have insurance cover most costs.
P16	Affordable and I am able to afford it.
P17	Minimal and I am privilege to have an employer that offers excellent benefits.
P29	Too high and I am seeking alternative treatments for my high blood pressure.
P32	Too high and I am giving medicine that costs too much. Even the generic brand which is supposed to be cheaper is still high.
P42	High and I am grateful to get reasonable.
P46	Okay.
P47	Very costly and I am on a fixed income.
P55	Doing me good and I am grateful.
P66	Excessive.
P67	No response.
P68	Ridiculous.
P69	Sufficient.
P70	Reasonable and I am able to pay at this time.
P80	No response.
P81	Too high.
P83	High.
P84	Too high and I am constantly in doctor’s office.
P86	Too high.
P91	Adequate and I am satisfied.
P92	Overpriced and I am sometimes without some of them
P99	Too much and I am on a fixed income and Medicare does not cover everything.
P100	Too much and I am on Medicare and it does not cover a lot.
P104	Reasonable and I am insured.
P105	Relatively high and I am glad I have insurance to help.
P106	Expensive and I am using alternative medication sources.
P107	Too high and I am so grateful to having spouse’s medical plan
P108	More and I'm paying a lower price due to my insurance.

Table D13

Men's Group Response to Question 7

Participant	Response
P5	Satisfied
P19	I research, identify with the best doctor that I can find and make an appointment.
P24	Upset.
P30	I feel like just going to the emergency room.
P49	No response.
P51	Lost.
P53	Okay.
P57	No response.
P65	I feel that it's for my benefit.
P74	I feel the next step is surgery
P76	I feel I deserve it.
P77	I feel terrible and sad.
P79	I feel overwhelmed trying to find the right specialist.
P96	I feel very helpless. I just go to the emergency room.
P97	I feel because of my prison record that physicians look down on me and are not willing to treat me.
P102	Overwhelmed.
P120	I feel that an additional expense will occur.

Table D14

Women's Group Response to Question 7

Participant	Response
P3	Anxious.
P10	Many are available.
P20	I feel fortunate that I live in an area where such specialist are readily available and that I have adequate health to help cover the cost.
P23	Discouraged.
P25	Uninformed.
P26	Non-threatened.
P27	Confident I will get the treatment I need.
P28	Anxiety.
P31	I feel they do not take the time to listen to me and that's the reason I changed physicians.
P41	Anxious. I do not like doctors.
P75	That it is just another way of getting more money out of me.
P82	No response.
P89	Comfortable.
P90	No response.
P93	Uneasy. I've come to not like going to the doctors.
P94	That I don't want to go through the process of getting a referral.
P95	Free.
P101	Suspicious.
P119	Okay, but I also feel that we have more specialists to spread money around.

Table D15

Church Group Response to Question 7

Participant	Response
P1	Badly.
P2	It's more costly than needs to be.
P4	I feel that because of my insurance I can choose whom I like as a specialist.
P6	Frustrated.
P7	Overwhelmed.
P8	Okay.
P9	I feel I can call and make an appointment.
P11	I feel they know what they are doing.
P13	Confident I can find one.
P14	Confident I'm seeing a specialist.
P15	I feel I should view all of my options.
P16	Helpless.
P17	Comfortable.
P29	I feel they talk down to me and that I am too stupid to understand what they are talking about.
P32	I feel as if they are not listening to me describe my symptoms. They are always in such a hurry to get you in and out.
P42	I feel so bad.
P46	Okay.
P47	I feel I have gotten just what I need.
P55	Really bad.
P66	I feel it is necessary.
P67	I feel comfortable with recommendations made.
P68	It's okay.
P69	Confident in my doctor's choices.
P70	Privilege to be able to receive one and pay the co-pay.
P80	Sometimes it's not necessary.
P81	I feel it takes a lot of time to see one.
P83	Okay.
P84	I can ask for one and get him or her.
P86	Fine, no problem.
P91	Whatever I need is available to me.
P92	I feel that my primary sends to me to the appropriate specialist.
P99	Sick.
P100	More money.
P104	Confident in my primary physician's choice.
P105	I generally have access.
P106	I feel health is poor.
P107	Confident that I can find one timely.
P108	I feel at ease with my health care provider.

Table D16

Men's Group Response to Question 8

Participant	Response
P5	With respect.
P19	I demand to be treated well by any doctor that I see. Otherwise, I will go to another doctor.
P24	Fairly.
P30	I am treated with some respect, but often times I am not. I don't like the fact I am called by my first name instead of "Mr."
P49	I am treated okay.
P51	Fairly good.
P53	No response
P57	I am treated too swiftly.
P65	No response
P74	I am treated more as a subject than a person.
P76	I am treated with suspicion.
P77	I am treated like a no body.
P79	I am treated with dignity and respect.
P96	I am treated with some respect. But many times these health people look down on you because you are on medical assistant or social service.
P97	I am treated with some respect until they find out that I have been in prison and then the attitudes change.
P102	Okay.
P120	Fairly.

Table D17

Women's Group Response to Question 8

Participant	Response
P3	Like they are in a hurry.
P10	Great.
P20	When I am seen by doctors, other than my private physician (emergency room) I am treated with respect, but sometimes in haste, with a less than caring attitude.
P23	Respectfully.
P25	With respect.
P26	With respect because I demand it! I don't let them get away with not treating me in a respectful and courteous manner.
P27	Decent.
P28	Okay when they know I have good insurance.
P31	I am treated with respect but the interaction could be a little better.
P41	Like an uneducated individual.
P75	No response.
P82	With respect.
P89	I am treated well because I stay within my network that has my records.
P90	Okay.
P93	Well. I've never seen a physician that has treated me poorly.
P94	Respectfully.
P95	Professionally.
P101	No response.
P119	Okay, but this depends on the specific emergency room hospital. Some okay – some not.

Table D18

Church Group Response to Question 8

Participant	Response
P1	With respect.
P2	Fairly.
P4	Very well.
P6	With dignity and respect.
P7	Fairly.
P8	Fairly well.
P9	Good.
P11	I am treated like a drive by patient.
P13	No response.
P14	Sometimes distantly
P15	With respect.
P16	Fairly and with respect.
P17	With respect and care.
P29	I am treated most of the times with some respect, however, I have been in the emergency room and medical personnel were not respectful calling me by my first name
P32	I am treated with respect only because I demand to be treated with respect. Those physicians want to call me by my first name and I insist upon calling me "Mrs."
P42	I am treated good and comfortable.
P46	No response.
P47	Very well.
P55	Good.
P66	No response.
P67	Fairly.
P68	Good.
P69	No response.
P70	I am treated very well and like they are concerned about my issues.
P80	Good.
P81	Not enough physicians.
P83	No response.
P84	I am treated with care.
P86	Okay.
P91	I am treated competently.
P92	I am treated well because I am still within the network my primary doctor is in.
P99	Okay.
P100	Okay at times and at other times like someone from outer space.
P104	Fair.
P105	Generally with care
P106	Like a number and not a patient.
P107	I am treated well with need information.
P108	No response.

Table D19

Male Group Response to Question 9

Participant	Response
P5	With respect.
P19	My private physician treats me well. If not, I will see another doctor.
P24	Good.
P30	With respect because I have insurance now which I did not have several months ago.
P49	Okay, because I ask questions.
P51	Well.
P53	Well.
P57	Too swiftly.
P65	As often as needed.
P74	With a sincere interest in my health.
P76	Okay sometimes.
P77	Okay.
P79	With dignity and respect.
P96	I don't have a private physician. I see different people in a group practice. Never the same physician and they all ask the same question. Don't they read the notes from the previous physician and they never look at you when they talk to you which is very irritating to me. I have worked all my life and to be treated like this because I have medical assistance is disgusting. Obamacare hasn't made these attitudes any different.
P97	With respect.
P102	Very well and satisfactory.
P120	Fairly, answers questions.

Table D20

Women's Group Response to Question 9

Participant	Response
P3	Wonderfully, marvelous.
P10	Okay. Again, he doesn't know me personally.
P20	My private physician treats me with respect and concern for my health outcomes.
P23	Respectfully.
P25	Very well.
P26	Like family.
P27	My private physician treats me as if I'm ignorant.
P28	As a person – fine.
P31	With great respect because she takes the time to listen to me and gets to know me which is important to me.
P41	Very well.
P75	With respect.
P82	With respect and as an equal.
P89	Like a close friend and she is invested in my well-being.
P90	Okay.
P93	Okay. She is often reluctant to listen to my concerns. I am looking for a new physician.
P94	Respectfully.
P95	Well.
P101	Okay.
P119	Very well. Is knowledgeable, knows my medical history, interested and respectful.

Table D21

Church Group Responses to Question 9

Participant	Response
P1	Yearly.
P2	Good.
P4	Very well.
P6	Like an old friend.
P7	Great.
P8	Very well.
P9	Well.
P11	Honestly, with respect and is very thorough
P13	Very well.
P14	Like a family friend.
P15	With respect.
P16	Like family.
P17	With respect.
P29	My previous physician didn't listen when I told him about my symptom which was disrespectful to me.
P32	With respect now because I told her she was rude and too abrupt. She stated she didn't realize that was what she was doing.
P42	Good.
P46	Pretty good.
P47	With respect and care.
P55	Wonderful.
P66	No response.
P67	Very well.
P68	Quite well.
P69	Great and I trust her.
P70	Wonderful.
P80	With great care.
P81	Okay.
P83	Good.
P84	Good.
P86	Fine.
P91	Effectively for my long term health.
P92	Very well.
P99	Okay.
P100	Okay.
P104	Outstanding.
P105	Well. He is open an honest and a good listener.
P106	Very well and professionally.
P107	Exceptionally professionally.
P108	Very well.

Table D22

Men's Group Response to Question 10

Participant	Response
P5	Listen
P19	They treat me to the accurate description that I communicated to them in regards to that particular problem. If the problem continues I may see another doctor.
P24	They look into it.
P30	They do listen. My previous physician did not and besides he was younger than I was and I did not trust anything he said.
P49	Listen.
P51	Sometimes questioned.
P53	Continue to ask questions.
P57	No response.
P65	Listen.
P74	I feel they sometimes look at me as though I don't know what I am talking about.
P76	I feel thy act as though I don't know what I am talking about.
P77	I feel they just look at me as if I don't matter.
P79	They are compassionate.
P96	I feel they don't seem to be listening to what I am saying. It is if they have tuned me out and what I say isn't important.
P97	I feel they assume it is prison related.
P102	Ask further questions and run tests.
P120	I feel they try to eliminate the cause of the problem.

Table D23

Women's Group Response to Question 10

Participant	Response
P3	Acknowledge my concerns.
P10	Are supportive.
P20	When I tell doctors how I feel, they appear to listen, and to ask the appropriate questions. Sometimes, I feel that there are more questions that should be asked, and find that I must volunteer inform, which should have been inquired about.
P23	They dismiss symptoms.
P25	Listen and try to narrow down what is wrong.
P26	Listen for the most part, sometimes they've dismissed my concerns and I come right back.
P27	Stare at me as if I want pain meds.
P28	Listen – if it is my private physician. If not, unsure, different reactions
P31	My previous doctor tuned me out like a radio and always commented "well you're getting old" which is why I changed doctors.
P41	Test me for everything.
P75	Make more of it than is necessary.
P82	Listen and ask follow-up questions.
P89	Listen to me and try to find a solution.
P90	Refer me to other doctors.
P93	Often aren't as concerned about my outcomes as I am
P94	Seem genuinely concerned.
P95	Ask other questions.
P101	When I tell doctors how I feel, they better believe me.
P119	Listen and respond excellently. Follow-up with calls to my home.

Table D24

Church Group Response to Question 10

Participant	Response
P1	No response.
P2	Sometimes diagnose before tests or x-rays.
P4	Listen attentively and do not judge.
P6	Listen to me.
P7	No response.
P8	Concerned and compassionate.
P9	Probe for further information.
P11	Assume they know my ailment. I wish they would listen
P13	Listen and respond.
P14	Listen.
P15	Listen and provide possible solutions.
P16	Listen to me.
P17	Listen and ask questions.
P29	My previous physician didn't listen when I told him about my symptom which was very disrespectful to me.
P32	Listen to me because I make them listen. Because I am old doesn't make me stupid.
P42	Listen carefully.
P46	Sit – listen – when I am finish they speak.
P47	Listen.
P55	No response.
P66	Listen and advise accordingly.
P67	Respond and plan best course of action.
P68	Take whatever action required.
P69	Treat accordingly.
P70	Have questions as to how long, when, where and what brought it on.
P80	Know what I'm talking about.
P81	Try to evaluate the problem.
P83	No response.
P84	Sometimes talk over me.
P86	No response.
P91	Listen and thoroughly review treatment.
P92	Listen and follow-up.
P99	Believe me but are quick to run more tests.
P100	Want to start poking and jabbing me.
P104	Listen, diagnosis and respond.
P105	Will typically listen.
P106	Believe me most of the time.
P107	Listen carefully.
P108	No response.

Table D25

Men's Group Response to Question 11

Participant	Response
P5	Don't question.
P19	Not often because if I question the ability of the doctor, I seek out another doctor.
P24	I don't feel as bad as they say.
P30	No response.
P49	If it is not right, well I let him or her know.
P51	Sometimes my office visit is too short.
P53	Never.
P57	They guess and don't ask enough questions.
P65	No response.
P74	They have you fill out these long questionnaires.
P76	I don't trust them.
P77	They don't treat me with respect.
P79	I have no complaints.
P96	They are not listening to what I am saying and since I see a different physician each time I go for treatment it makes me question their ability to treat me.
P97	I question the ability of the doctors who treat me because I am "black".
P102	Not in my case with my doctor.
P120	I do not question their ability, on interactions of medicine.

Table D26

Women's Group Response to Question 11

Participant	Response
P3	They appear to be residents, learning.
P10	They are foreign and I cannot understand them.
P20	Many times I question the ability of the doctors who treat me because of the limited time that some doctors are able to allocate to treatment. However, I am confident in the care that I receive from my primary care physician.
P23	They seem less interested in treatment than in medicating.
P25	I don't.
P26	I don't. I wouldn't go to a doctor who I thought was not competent.
P27	Only my primary care physician.
P28	They rush to provide a prescription and send me out the door.
P31	My previous doctor always wanted to give me different medicines – he never offered any alternatives for treatment.
P41	No response.
P75	I feel that they are just using me as a test subject.
P82	No response.
P89	I do not have a reason to question. They have always helped me to feel better.
P90	No response.
P93	They seem very dismissive of presented concerns.
P94	Of being so patient oriented.
P95	They don't give me a diagnosis.
P101	I think they really don't know and they are guessing.
P119	No response.

Table D27

Church Group Responses to Question 11

Participant	Response
P1	No response.
P2	I feel rushed after such a long wait to be seen.
P4	The physicians that are charged with my care have shown professionalism and adequate knowledge in their field.
P6	No response.
P7	They may not know what they are doing.
P8	I may not understand the diagnosis.
P9	No response.
P11	They appear to be busy, distracted or ready to move to the next person.
P13	No response.
P14	They make assumptions about my condition.
P15	I want to make sure they have my best interest under consideration.
P16	No response.
P17	It seems they are tired and should consider retiring.
P29	I get the feeling because I am black the white physicians don't feel they have to explain any type of alternative treatments – just dole out prescriptions.
P32	They always want to medicate. All these doctors know is to give black people a whole lot of medicine because they don't think we are worth the effort of treating.
P42	They have the wisdom and knowledge.
P46	He now has a Nurse Practitioner.
P47	No response.
P55	I would want to let them know how I feel.
P66	No response.
P67	No response.
P68	No response.
P69	No response.
P70	Do not question my doctor's ability.
P80	No response.
P81	Sometime if I am not satisfied.
P83	No response.
P84	No response.
P86	No response.
P91	No response.
P92	I trust my doctor completely.
P99	They want to poke or probe all the time.
P100	I feel like they are using me for practice.
P104	No response.
P105	I know doctors are overwhelmed and busy and I like to get a second opinion.
P106	Exceptions to measuring standard health numbers based on ethnicity
P107	No response.
P108	Never questioned my doctors, they've always been very helpful and caring.

Table D28

Men's Group Responses to Question 12

Participant	Response
P5	Never been an issue.
P19	It depends on the seriousness of the problem. If I consider the problem to be serious and the doctor is delaying, I will identify another doctor the doctor that took his time seeing me when I was in great need. Most times I have already identified a doctor who will attend to my needs.
P24	No response.
P30	When I was at the clinic they rotated physicians and you could never get an appointment immediately. I just went to the emergency room instead and I was treated without having to wait two or three weeks. I could be dead by that time.
P49	I always get an appointment or medical care when I need it.
P51	If I go to the ER, the wait is quite long.
P53	Never.
P57	It doesn't bother me.
P65	I don't have this problem.
P74	The sooner I get help, the better the chance my medical problems will be resolved.
P76	I need to be seen right away and I get mad and upset, causing my problems to get worse.
P77	I am really sick.
P79	Of how much I pay in health care premiums and I feel my health is very important and requires immediate attention.
P96	I am not seeing the same physician and it make it hard having to answer the same questions over again. It makes me wonder if these people (physicians) can read with all that education.
P97	I feel it is because of my prison record. So I just go to the emergency room where they have to treat me.
P102	The doctors are always booked.
P120	No response.

Table D29

Women's Group Response to Question 12

Participant	Response
P3	When I need to see my physician, it is because I have a legitimate concern.
P10	I should be able to. The wait is too long.
P20	It bothers me when I cannot get an appointment immediately when I need medical care because this is an indication of the lack of providers available, and indicate a problem that is likely to be with us as the demands for health care increases in the future, and no viable affordable programs to increase the number of professional health care providers. It also bothers me that there is a scarcity of such providers in certain communities and in certain areas of the country.
P23	My time should matter depending on the ailment.
P25	I only call when it is necessary.
P26	I want to see the doctors who know me and have my medical records.
P27	When I do call, I am in need of help. I do not call all the time because of the doctor's behavior.
P28	My appointment is because I am experiencing a medical problem that may not be an emergency, but needs attention before it becomes an emergency.
P31	This was one of the reasons I left my previous doctor because when I was ill I could never get an emergency appointment.
P41	I feel like I am at a higher risk to become more ill.
P75	The wait could cause more problems.
P82	No response.
P89	It may take weeks to see my primary because she is a great doctor and always booked up.
P90	Dock has too many patients.
P93	I pay a great deal for insurance and having to wait up to 2 months to see my primary care doctor seems a bit ridiculous.
P94	Of my work schedule.
P95	No response.
P101	No response.
P119	I usually am seen right away when needed. Even weekends and after hours by my allergist.

Table D30

Church Group Responses to Question 12

Participant	Response
P1	I need medical attention immediately.
P2	I need medical care because the symptoms can worsen or be gone by the time I'm able to get an appointment.
P4	I usually do get an appointment within a reasonable amount of time.
P6	I am not one to complain and I only want to see the doctor if I need to.
P7	No response.
P8	The wait is too long.
P9	When I don't feel well I need to see a doctor and depending on the feeling I get worried.
P11	It is annoying. I often have immediate needs and I don't want to wait two to four weeks for an appointment.
P13	No response.
P14	It's usually so far in the future.
P15	I want to get immediate attention to prevent issues.
P16	I am always able to get an appointment immediately.
P17	Of my complex health issues, when illness arises, immediate attention must be given to prevent other complications.
P29	I left my previous physician because when I was sick, I could not get an emergency appointment and I had to deal with rude personnel in his office and his nurse was not better either.
P32	If I am sick, I need to see my doctor and I don't want some young receptionists to tell me I have to wait two weeks. I left my previous doctor for this very reason because you could never get an emergency appointment with him.
P42	No response.
P46	No response.
P47	I am proactive. I get my appointments and keep them and go on time.
P55	I want them to examine me right away.
P66	No response.
P67	No response.
P68	No response.
P69	I don't have that problem.
P70	I have not experience this as a problem.
P80	Because of the Doctor's schedule.
P81	No response.
P83	No response.
P84	The doctors are too busy and understaffed.
P86	If I can't get an appointment on week-ends then I just go to the emergency room.
P91	No response.
P92	Because of the nature of my ailments, they find a doctor to see me if my primary is not available.
P99	No response.
P100	Waiting causes me more problems. I could die waiting on them.
P104	N response.
P105	I want to have my issues addressed as soon as possible.
P106	I am sick to the point only medical care can address the illness.
P107	No response.
P108	No response.

Table D31

Male Group Response to Question 13

Participant	Response
P5	Good Quality.
P19	Excellent.
P24	Good.
P30	The medical care I received at the clinic was very poor. The physicians did not show any respect and the personnel was even worse just because I was on medical assistance.
P49	My medical care is okay when I received it.
P51	No response.
P53	Excellent.
P54	No response.
P65	Okay.
P74	Good because I have good insurance coverage.
P76	Marginal.
P77	Not the greatest.
P79	Excellent.
P96	Below standard. If I could see the same physician maybe I could establish a rapport with the physician and then maybe I would trust what they say.
P97	Okay, but it could be better.
P102	Good.
P120	Good – I have been with my cardiologist over 20 years.

Table D32

Women's Group Response to Question 13

Participant	Response
P3	Satisfactory.
P10	Good.
P20	Very Good.
P23	Sometimes rushed.
P25	Great.
P26	Very Good.
P27	Adequate for my primary doctor and very good for my specialist.
P28	Okay when I do my research first and ask questions.
P31	Great with my new physician. The treatment I received from my previous physician was not good at all.
P41	No response.
P75	Good.
P82	Adequate and meets my standards.
P89	Excellent.
P90	Okay.
P93	Adequate.
P94	Good.
P95	No response.
P101	Okay.
P119	Great.

Table D33

Church Group Responses to Question 13

Participant	Response
P1	Great.
P2	For the most part is fair.
P4	Very good.
P6	Okay.
P7	Fair.
P8	Great.
P9	Good.
P11	No response.
P13	Good.
P14	No response.
P15	Adequate.
P16	Phenomenal.
P17	Excellent.
P29	Was not great that's the reason I left. He spent maybe 10 minutes with me and I just did not like the way he talked to me as if I was a child.
P32	Much better now because I changed doctor's. I didn't like him or his staff. They were very condescending and just down right rude.
P42	Very Good.
P46	Good.
P47	Okay.
P55	Wonderful.
P66	Appropriate.
P67	Excellent.
P68	Good.
P69	Sufficient.
P70	Great.
P80	Good.
P81	Okay.
P83	Good.
P84	Good.
P86	No response.
P91	Competent and Effective.
P92	Adequate to meet my needs.
P99	Okay.
P100	Okay.
P104	Outstanding.
P105	Generally adequate.
P106	Adequate.
P107	Very Good.
P108	No response.

Table D34

Male Group Response to Question 14

Participant	Response
P5	Being ex-military my opinion might be bias. I have always had excellent care.
P19	It is great for the rich and middle class of people.
P24	Works very well for me.
P30	The health care system in the U.S. is poor. If you have money you get excellent care and if you are poor you get substandard care. And if you are "black" all they want to do is medicate you with drugs. No alternative treatments are suggested or given and the health care professionals don't have bedside manner to take the time to explain treatments to you even when you ask. I have taken my health in my own hands to that I don't have to deal with any health care professionals. I am totally disgusted with the health care system in the U.S.
P49	There can be some improvement.
P51	It has yet to reach in full potential.
P53	No response.
P57	It's a money making business and not a human care concern.
P65	No response.
P74	Good health care should be available to everyone, but if you are not rich or don't have good insurance and don't qualify for any of the specials program, you could have a short life.
P76	It sucks, especially in the VA hospitals.
P77	It should be overhauled.
P79	In my opinion, health care could be better in the United States. We should have better options, better trained medical professionals.
P96	I feel that health care in the United States is not good for people of color like myself. All they want to do is give medications. If you have money you receive the best of care, if you are on some type of assistance then you do not. Health care professionals do not have time for poor people like me. I have not had the best interaction with health care professionals, especially the white ones. I dread having to seek any type of medical intervention.
P97	It may be okay for people who have money and not people of color, however; I have not had any success since I was released from prison. I received better health care when I was in prison.
P102	Okay, but could be a lot better.
P120	My personal experiences have been good.

Table D35

Women's Group Responses to Question 14

Participant	Response
P3	Our health care system is broken. Medicine is a business and patients are collateral damage.
P10	I'm glad it's available.
P20	The health care system is too complicated. The system is controlled by health insurance carriers and by the pharmaceutical companies. It is a system that favors those who can pay, and discriminates against low income communities. Depending on where you live, access to physicians can be very difficult, as in rural and small town areas. There is no viable plan to provide educational assistance for medical school students and others preparing for careers in the health care area. Opposition to the one major step taken in the passage of the Affordable Care Act makes it highly probable that this country is far from providing universal health care for all its citizens.
P23	The quality of doctors has diminished over the years. They often treat symptoms rather than the cause.
P25	Too expensive.
P26	It's like all other systems it benefits the rich and disenfranchises the poor. It's incentivized by money instead of actual "health care." I believe it is such a huge money making economy, that it will never be changed because there's too much money to lose.
P27	There are health disparities with medical treatment for African Americans. They don't believe our health matters.
P28	Too much money on the middle persons – insurance and drug companies. Takes away from the doctor's ability to really take the necessary time with the patient.
P31	The health care system in the United States could be much better for people of color especially African Americans. All physicians want to do is give medicine. My girlfriend who is white and I suffer from high blood pressure, yet her physician suggested that she see a nutritionist, set up an exercise program and set a plan for her to get off of her high blood pressure medication. My physician on the other hand just increased my medication and told me that my body needs time to adjust to the medication. Well for me that was my last time seeing him or taking any of his advice. The only good thing is that I have a job with good insurance and I take my own health in my hands. But for some individuals especially people of color they are not related good in the health care system especially if they don't have any health insurance.
P41	Health care is questionable. Some providers do not actively listen to patients.
P75	It could be better.
P82	If you are not active in preventative care your options are slim for finding a provider that will provide the amount of care and mutual respect. Many people are not given an equal opportunity for optimal health care if they are not insured.
P89	If a person is not working or covered under a good insurance, there are always problems with getting appointments to be seen, getting medications at reasonable price. It is more about money rather than well-being of citizens.
P90	It "Sucks."
P93	It's really expensive and having to get insurance company approvals for procedures can cause a great deal of stress and confusion.
P94	If you have a job that offers health benefits, you are more likely to seek health care.
P95	No response.
P101	It could be better.
P119	For many, many people, it is not good, due to the greed of insurance companies. Also, it is very, very difficult to understand many foreign doctors' spoken accents.

Table D36

Church Group Response to Question 14

Participant	Response
P1	Great since Obama Care.
P2	Health care is not affordable for everyone.
P4	I believe I have access to quality care because I have good insurance. This is not the case for everyone. I do support Obamacare, yet realize that it needs re-evaluating to work more efficiently.
P6	Our health care system is broken. If you have money, you can get the best care. People of color are not treated well in the health care system.
P7	It should be free like France and other countries.
P8	Average.
P9	It is very costly but needed. It's the case of the haves and the have nots.
P11	The quality of health care is based upon economics and the insurance company protocols.
P13	Depends on your access and ability to pay.
P14	Way to expensive.
P15	Those without insurance may not have positive experiences.
P16	I believe it depends on who you are. I think it is unfair because health care is not affordable to all.
P17	Pharmaceutical companies are money driven and not really focused on the overall wellness of our citizens.
P29	Substandard care. Medical personnel feel it is a waste of time to discuss alternative treatments with people of color because they don't have money.
P32	The health care in the United States is very color blind. If you have insurance you are treated with some type of respect, however, if you don't you are just out of luck because the establishment doesn't give a damn. And if you go to the hospital, the first thing they want to know is how are they going to be paid and for Black people all they want to do is experiment on us with different types of medication. I don't trust any of these medical professionals to tell me the truth. This is why I do research before I take any of these medications because all of these medications have side effects. I was taking one medication and my hair started to fall out and when I reported it to my previous physician all he did was to reduce the dosage. Well I stopped taking that medication and my hair has started to grow back. He was so nonchalant about my hair loss; he didn't ever refer me to a dermatologist. I knew at that time he was not the doctor for me. How can you not care about your patients? When a woman loses her hair, that's a big deal and should be a concern of her physician. My physician now is African American. I purposely sought an African American physician because I can relate and they care relate to me. She's very pleasant and she spends time trying to find out what's going on with me. She recommended that I join a senior exercising class which I did at the YMCA and I am happy to say I am now down 25 pounds. Her goal is to get me off of the blood pressure medications. My other physician who was white didn't suggest anything other than medication. I was just a number or shall I say a patient with a number and his staff was just like him abrupt and rude.
P42	No response.
P46	Could be better.
P47	I am glad to live here.
P55	You have to stand up for your health.

(table continues)

Participant	Response
P66	I believe the biggest problem is cost.
P67	Great strides are being made to improve it for all persons. I am conflicted because everyone needs it but can't always afford it.
P68	I have no problem with it.
P69	I have had sufficient medical care all of my life.
P70	I truly believe that we are privilege and the care is consistent in treating the population.
P80	It's very high.
P81	Not like it used to be.
P83	Could be much better.
P84	Not enough Nurses; They are over worked.
P86	If you have insurance it's good; otherwise God bless you.
P91	The health care system should not be fee for service. It eliminates people without money or insurance. There should be a flat tax for universal health care for all citizens.
P92	I think it is over-priced; not conducive to the needs of elderly; many times seniors have to choose between eating and or medication.
P99	Needs help.
P100	It needs help.
P104	Thank God for Obamacare.
P105	I am concerned about the level of care for those whom have limited access economically.
P106	Health care in the United States is overpriced. All citizens should have adequate health care this is affordable.
P107	Good care.
P108	No response.

Appendix E: Rand Survey Permission Letter

Permissions Information

All of the surveys from RAND Health Care are public documents, available without charge.

Patient Satisfaction Questionnaire from RAND Health Care
The Patient Satisfaction Questionnaire (PSQ), consisting of 80 items, was originally developed by Willis H. Ware and his colleagues (Ware, Snyder, and Wright, 1976 a, b; see "Related Reading" below). A more recent version of the questionnaire is the PSQ-III, available below. The PSQ-III is a 50-item survey that taps global satisfaction with medical care as well as satisfaction with six aspects of care: technical quality, interpersonal manner, communication, financial aspects of care, time spent with doctor, and accessibility of care. A memo on scoring the PSQ-III is also available below. It provides background information, results of psychometric analyses, and scoring rules for measures constructed from the periodic satisfaction surveys.

The PSQ-18 is a short form version that retains many characteristics of its full-length counterpart. The PSQ sub-scales show acceptable internal consistency reliability. Furthermore, corresponding PSQ-18 and PSQ-III subscales are substantially correlate with one another. The PSQ-18 may be appropriate for use in situations where the need for brevity precludes administration of the full-length PSQ-III. The PSQ-18 takes approximately 3-4 minutes to complete.

PSQ-18 Documents
The Patient Satisfaction Questionnaire Short Form (PSQ-18) **1994**

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