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Exploring Cultural Experiences of African American Recipients of Healthcare

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This is to certify that the doctoral dissertation by

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Abstract

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Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
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Abstract

Culturally competent care is widely accepted as a strategy to address healthcare disparities based on the perceptions of the individual provider, yet this approach lacks the voice of the African American (AA) communities intended to benefit from the strategy. Individuals in AA communities have been shown to suffer higher incidence of disease, disproportionately poorer health outcomes, and inequitable healthcare treatment. Framed by Leininger’s culture care theory, the purpose of this interpretive phenomenological study was to explore the lived cultural experiences of AA recipients of care when interacting with the healthcare system in an effort to contribute evidence to improve the health of the AA community. For this qualitative study, seven AA participants, at least 18 years of age, were recruited to participate in semistructured interviews. Manual coding and thematic analysis revealed five major themes: (a) communication, (b) medical mistrust, (c) access to healthcare, (d) satisfaction with healthcare experience, and (e) dissatisfaction with healthcare experience. Thirteen subthemes were identified that supported the major themes. The results of this study provide a better understanding of the lived cultural experiences of the AA recipients of healthcare based on the shared perceptions of previous encounters. These findings have the potential to contribute to positive social change by providing better understanding of the experiences of members of a vulnerable population negatively impacted by healthcare disparities in an effort to support the development of initiatives to reduce these disparities. Future studies may use the identified themes as the basis for participatory research to develop system-level strategies that result in meaningful improvements to the healthcare experiences of AAs.

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Dedication

I dedicate my work to my parents, Beth and Steven Hairfield. Thank you for giving me the space to find my own way, the encouragement to keep moving forward, and the support to see it through.

Acknowledgments

I would like to thank my committee chair, Dr. Maria Ojeda, for her guidance and support during this process. I would also like to thank Dr. Carolyn Sipes, my committee member, and Dr. Janice Long, my university research reviewer, for their contributions to my success. I would also like to thank Dr. Cynthia Fletcher for her encouragement and guidance.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Introduction

Healthcare is delivered globally in culturally diverse societies. Shifting global demographics and increased cultural diversity challenge healthcare systems and healthcare professionals with providing safe, high-quality care to all recipients. Diversity within and across patient populations necessitates reducing disparities that diminish the quality of care to specific groups (Foronda et al., 2016; Wrenn et al., 2017). National healthcare quality goals require organizations and individual providers to address barriers to ensuring equity in access to and delivery of quality care to all healthcare recipients (Agency for Healthcare Research and Quality [AHRQ], 2015; Cuevas et al., 2016; Horvat et al., 2014; U.S. Department of Health and Human Services, n.d.).

In 2017, there were 41.4 million African Americans (AAs) living in the United States, with 58% living in the southern region (Office of Minority Health [OMH], 2019). Estimated life expectancy at birth was 3.5 years shorter for these citizens than their White counterparts (Arias & Xu, 2017). A deeper understanding of the lived experience of AA recipients of care may guide researchers and healthcare providers as they strive to improve the provision of culturally competent care to AA recipients. The lived experience of the AA community has been described in segments defined by specific healthcare needs or medical diagnoses but not through the lens of the community as a whole (Patton, 2017; Shen et al., 2018; Wren et al., 2017). In this study, I explored the healthcare experience as described by AA care recipients as it relates to the culture of the participant and the larger community. The data presented may contribute to the evidence that guides governmental agencies and healthcare organizations in efforts to eliminate healthcare disparities. Implications for potential positive social change include the contribution of the AA recipient of care to guide the development of initiatives and programs aiming to improve the health of the community. In Chapter 1, I introduce the background, purpose of the study, research question, theoretical framework, nature of the study, and significance.

Background

Ensuring equity of healthcare services and reduction of disparities in vulnerable populations is evident in the healthcare goals of improved patient outcomes and community health (AHRQ, 2015). Current research has linked culturally competent healthcare to improved patient outcomes, provider–recipient communication, and medication plan adherence as well as increased participation in healthy behaviors (Cuffee et al., 2013; Williamson et al., 2019). Evidence-based, culturally competent care is commonly aligned with initiatives to improve outcomes and reduce healthcare disparities for underserved populations (American Association of Colleges of Nursing [AACN], 2008; Beard et al., 2015; Health Research & Educational Trust, 2013). One tactic employed by stakeholders and organizations that aligns with this goal is the cultural competence of healthcare providers in patient encounters. A challenge associated with outcomes of efforts to deliver culturally competent care is the lack of understanding of the patients' perceptions (Health Research & Educational Trust ,2013; Kersey-Matusiak, 2013). Current literature supports the importance of the role of the recipient of care in the quality of healthcare provided, yet the voice of the AA patient/family is missing from the conversation.

Outcome measures of provider education and initiatives implemented to improve the delivery of culturally competent care primarily rely on the care provider's self-assessed competence (Benkert et al., 2009; Loftin et al., 2013; Truong et al., 2014). As a result, these outcome data may be unintentionally influenced by the individual provider's level of cultural awareness, beliefs, and biases. Researchers and key stakeholders must consider this challenge in the design and implementation of strategies and programs developed to improve the delivery of culturally competent care to the AA community (Truong et al., 2014). In addition to the focus on the individual, research has supported the necessity of implementing and evaluating initiatives at organizational and systems levels (Ollapally & Bhatnagar, 2009; Purnell et al., 2011; Truong et al., 2014). Despite support for the arguments that congruence of singular cultural characteristics does not equate to cultural similarity, the recipient is generally categorized by shared diversity characteristics of race, ethnicity, age, and/or disability in the context of culturally competent care (Michael, 2016). Experts have responded that person-centered care requires an assessment of the recipients' self-identified cultural values (McGinnis et al., 2010; Ollapally & Bhatnagar, 2009; Wrenn et al., 2017).

While culturally competent performance has been identified and widely cited as a critical component of quality healthcare, the value recipients of care place on culturally competent care is lacking from the conversation (Wren et al., 2017). Meleis (1996) advocated for culture in the context of professional nursing to be considered a multifactorial set of characteristics that influence the individual experience of the care recipient. Butler et al. (2019) cited that the nursing team (i.e., registered nurses, nursing assistants, and nurse managers) were present 86% of the time patients were actively receiving care. The nursing profession is the only healthcare discipline based on the tenet of caring whose members are ethically bound to incorporate the art of caring into the practice delivered (American Nurses Association [ANA], 2015). By virtue of duration and frequency of patient–nurse encounters, the discipline has the responsibility of addressing the quality of provider–recipient encounters and understanding the patient perceptions of care delivered by the interprofessional team. Improving the cultural experience for recipients of care and reducing cultural and racial disparities in the communities served is an area of care provision at the core of nursing practice (AACN, 2008; Leininger, 2006).

Self-identified cultural values identified by AA recipients of care are needed to deliver person-centered care to this population. Wrenn et al. (2017) found that AA care recipients valued bidirectional communication and being respected when contributing to the conversation. Better understanding of the cultural experiences of AA recipients of care may guide the design of programs or development of policies to improve the delivery of culturally competent care to the AA population. This study has the potential to identify factors that may contribute to reducing healthcare disparities for this community. Insight from research related to AA care recipients’ perceptions is necessary to provide a comprehensive definition of the concept and alignment of education and initiatives to improve the delivery and measurement of outcomes related to the provision of culturally competent care to this population (Cuevas et al., 2017; Horton & Irwin, 2018).

Problem Statement

Increased diversity in and across populations is attributed to the globalization of the workforce, increased immigration, and changing social norms that influence the demographic composite of global communities (Bleijenbergh et al., 2010; Horvat et al., 2014). Cultural competence is one strategy employed to address disparities related to increasingly diverse populations of healthcare recipients. The cultural competence of care providers is largely focused on improving the provider–recipient encounter or educating the provider on specific cultural aspects of cultural groups likely to be encountered in the clinical setting (Campinha-Bacote et al., 2005, Truong et al., 2014). This focused, or targeted, provider education is viewed as an impractical and misaligned strategy by experts proposing a shift from a group-centric focus to an individualized focus supported by deliberate assessment and communication with the recipient of care (Jirwe et al., 2009; Kersey-Matusiak, 2013; Markova & Broome, 2007).

Traditionally, the cultural competence of care has been driven by the race of the recipient. From this point of view, specific risks have been identified among different racially defined populations (Benkert et al., 2009; Bonar, 2019; Shen et al., 2018). Race has also been a variable in research driving strategies to improve the healthcare outcomes of identified at-risk populations (Cuevas et al., 2017; Shen et al., 2018; Truong et al., 2014). The AA community suffers higher incidence rates and disproportionately poorer outcomes related to diseases (Friedman et al., 2019; Patton, 2017). Concerns of inequitable treatment and pain management practices are common themes among AA care recipients (Bazargan et al., 2020; Booker, 2016). These barriers to equitable quality care are exacerbated by medical mistrust and perceived provider bias (Cuevas et al., 2017; Shen et al. 2018). AA populations in the United States are vulnerable to disparities related to quality of and access to care, including perceived discrimination, medical mistrust, and challenges in the provider–recipient relationship (Abramson et al., 2016; Cuevas et al., 2016; Powell et al., 2019). Addressing this gap in the literature, a more thorough understanding of recipients' perceptions of the provider–recipient encounter may provide practitioners and researchers with data to develop programs and policies that have the potential to improve outcomes and reduce disparities.

Purpose of the Study

The purpose of this interpretive phenomenological qualitative study was to explore the lived cultural experiences of AA recipients of healthcare in order to gain a better understanding of the healthcare experience through the patient lens. The results of this study may support efforts to reduce disparities in access to and quality of medical care for AA citizens in the southeastern United States. Experts have suggested that regional or local demographics should guide how communities address healthcare disparities (Bleijenbergh et al., 2010; Campinha-Bacote et al., 2005; Flowers, 2004). The AA population has been identified as vulnerable to inequities that include educational, socioeconomic, and health disparities, including access (Patton, 2017). The value of broad and inconsistent characteristics and factors associated with the delivery of culturally competent and individualized care is not well understood from the perspectives of the recipients of care (Cuevas et al., 2017; Horton & Irwin, 2018; Wrenn at al., 2017). The future direction of initiatives to improve the delivery of culturally competent care in the AA population must be guided by an understanding of the factors related to the provider–recipient encounter and relationship that are most valued by AA recipients of care and those intimately invested in their outcomes.

Research Question

The research question that guided this study was: What is the lived cultural experience of AA recipients of care when interacting with the healthcare system?

Theoretical Framework

The framework for this study was based on Leininger's (2002) theory of culture care diversity and universality. Presented on and published in 1963, the culture care theory has been referred to as the theory of transcultural care, theory of culture care diversity and universality, transcultural nursing theory, the sunrise model, and culture care theory (Betancourt, 2016; Leininger, 2002, 2007; Leininger & McFarland, 2006). For this project, I refer to the theory in all iterations as the culture care theory. According to Leininger, this theory frames the discipline of transcultural care that began in the 1940s in response to an emerging social awareness of deficits in the care of diverse populations (HCR Home Care, 2012a, 2012b; Leininger & McFarland, 2006).

Leininger (2001) proposed that care is a central tenet and unifying focus of nursing. The most comprehensive and holistic approaches to understanding the act of caring incorporate the culture of the care recipient (Leininger, 2001). Thus, culturally competent care can only be provided when there is understanding and consideration of the preferences, values, and beliefs of the individuals, families, and communities served (Leininger, 2001).

The culture care theory is grounded in anthropology and nursing and was designed to provide a theory to guide the exploration of culture as a variable in the provision of nursing care (Leininger, 2007; HCR Home Care, 2012b). This model was also designed to frame the research of other healthcare-related professions (Leininger, 2001). In addition to the theory, Leininger (2002) also developed the method of ethnonursing to guide research on culture as a component of the delivery and receipt of healthcare. The goal of this project was to provide a comprehensive understanding of AA care recipients' preferences and beliefs related to culturally competent care based on their experiences in healthcare. The culture care theory aligns with the goal of this project and supports the importance of AA care recipients' experiential perspectives as shared in the problem statement.

Nature of the Study

In this study, I employed a qualitative interpretive phenomenological methodology (see van Manen, 2016, 2017). Phenomenology as a philosophy is focused on questioning, while phenomenological approaches or methods focus on understanding the lived experience of a phenomenon or concept (Heinonen, 2015). Phenomenological approaches are described as descriptive or interpretive. Descriptive phenomenology is based on the work of Husserl and is focused on the description of lived experiences (Heinonen, 2015). Descriptive phenomenological research aims to accomplish this goal through the description of the lived experience, while interpretive phenomenology extends to include the interpretation of respective lived experiences (van Manen, 2007). The interpretive, or hermeneutic, approach builds on the description to include interpretation of a lived experience.

I selected interpretive, or hermeneutic, phenomenology as the research design because it aligns with the exploration of individuals' lived experiences with the aim of developing a better understanding of the phenomenon of culturally competent care (see van Manen, 2016, 2017). Hermeneutic phenomenology supports my aim to better understand cultural beliefs, ideas, and practices on an individual level. The interpretive approach supports the interpretation of described individual experiences to contribute to a more holistic understanding of the culture studied (see van Manen, 2017). Based on evidence from current literature that supports the lack of understanding of recipient perspectives and experiences in healthcare, this design guided the exploration of, and allowed for a deeper understanding of, the concept of cultural competence as shared by recipients of care. Ethnonursing, developed by Leininger (2001) to guide scientific inquiry of nursing specific phenomenon, was used to explore culture as a holistic combination of the beliefs, values, and experiences of the AA population (see McFarland et al., 2012).

Data for this study were collected through interviews with a sample of AA residents in the southeastern United States. Participants were recruited in the community through flyers posted in publicly accessible places. The inclusion criteria required that participants were at least 18 years old, identified as AA, and had previously interacted with healthcare. I interviewed consented participants using the interview protocol outlined in Appendix A.

All interviews were audio recorded; participants were encouraged to secure a private area to participate in the interview and were assigned a participant identification number to ensure confidentiality. The goal of the interviews was to collect the participants' accounts of their lived cultural experiences. Participant accounts were coded to identify themes and then interpreted using Leininger's Sunrise Enabler as a guide. The Sunrise Enabler is a tool designed to guide researchers seeking to understand the cultural factors that influence the perceptions of care recipients in the provider–recipient interaction (Leininger, 2002). Data saturation was applied to ensure the thoroughness of my study. Leininger (2004) described saturation as the point that data becomes redundant and no new themes are identified. Once saturation was reached, no new interviews were conducted.

Definitions

In this section, I define key concepts and terms used in the study that may have multiple meanings. All definitions are supported by professional literature.

Culture: A shared set of values, beliefs, and behaviors acquired by social interaction with members of respective cultures (Jirwe et al., 2009; Meleis, 1996).

Cultural competence: Possessing knowledge and skills and applying them to the patient–provider interaction to effectively care for diverse individuals (Alizadeh & Chavan, 2016; Loftin et al., 2013).

Hermeneutic phenomenology: A phenomenological methodology that aims to describe and interpret the lived experience (Wilson, 2013; van Manen, 2016).

Medical mistrust: The absence of trust in healthcare as a system, organization, and/or individual (Powell et al., 2019).

Perceived racism: Also referred to as *perceived discrimination*; the belief of any individual that they, or another individual or group, are treated in an inequitable way based on race. Perceived racism or discrimination in healthcare focuses on the experience of an individual or group interacting with the healthcare system and individual healthcare professionals (Abramson et al., 2015; Cuevas et al., 2016; Powell et al., 2019).

Race: A social construct that prescribes the categorization of individuals based on visible, superficial differences that are not rooted in biology (DiAngelo, 2018).

Racism: The self-sustaining, systemic imbalance of power and oppression of minority groups based on race (DiAngelo, 2018; Powell et al., 2019).

Recipient of care: An individual, and family or chosen support system, interactive with or receiving care (Foronda, 2020; Leininger, 2001 & 2006).

Assumptions

Assumptions are ideas presumed to be true as they relate to a research study (van Manen, 2016). One assumption I made was that the information provided by AA care recipients would provide a deeper understanding of their healthcare needs. I also assumed that participants would share their experiences openly during the interview and that I would be able to capture their perceptions and experiences based on the accounts shared during my interpretive phenomenological study. Another assumption made was that the healthcare experiences shared by participants would adequately describe the phenomenon under study.

Scope and Delimitations

The scope of this study was the collection and thematic analysis of the lived experiences of AA participants related to culture. Meleis (1996) proposed that culture should be defined beyond race and ethnicity as a holistic set of attributes that sets the foundation for the individual perspective. As patient populations increase in diversity, the sharing of recipients' experiences is a vital component in efforts to ensure equity in the care delivered (Beard et al., 2015; Cuevas et al. 2017; Leininger, 2001). Leininger's (2006) culture care theory guided this study and the understanding that the information provided by participants would be of value and should be solicited and explored. The culture care theory prescribes that understanding a patient's ideas, beliefs, and situation is essential to providing care that fits the individual recipient of care (Leininger, 2001; Leininger & McFarland, 2006).

This study was limited to interested adult participants (at least 18 years of age) who identified as AA. Cultures considered but excluded from this study included Caucasian or European American, Latino/Latina, and Asian. I focused on one culture in this study to increase the impact of the outcomes for a prevalent vulnerable population in the community. Participants in this study were a part of the same local community, so their experiences may not describe the experiences of AA people in other communities. The study may, however, be easily replicated to empower researchers in other communities to gain a better understanding of the experiences of vulnerable populations in their geographic areas.

Limitations

I am a novice researcher; however, I was guided by the expertise of my research committee. In this study, I recruited one ethnic group and the information received may differ across ethnic groups (see Campinha-Bacote et al., 2005). Diversity within racially and ethnically defined populations may be based on region or community (Bleijenbergh et al., 2010). This may limit the transferability of my study findings.

Potential limitations of this study included the recruitment of participants. Recruiting AA participants may have posed a challenge related to medical system and provider mistrust. The fact that I identify as a different ethnicity than the study population may also have contributed to mistrust. These factors may have contributed to a population less receptive to participating in a research study and may have posed a challenge to recruitment of enough participants to reach saturation (Benkert et al., 2009; Williams et al., 2014). I recruited participants for this study from the community whose experience I aim to better understand. During my initial contact with participants, I allowed time to build rapport and focus on facilitating open communication (see Shen et al., 2018).

Significance

The current practice of assessing the cultural competence of healthcare providers is based on their self-assessment of their own ability; this limits the providers' understanding of the care delivered from the perspective of the recipient (Loftin et al., 2013; Truong et al., 2014). Systems of discrimination and oppression are adaptive and sustainable, supporting the need to assess cultural competence through the lens of the recipient of care and not the system that provides the care (DiAngelo, 2018). Efforts to increase a care provider's understanding of caring that fits the recipient's beliefs, values, and experiences contribute to the conversation in current healthcare research that aims to close disparity gaps for vulnerable populations based on cultural variables and to improve the provision of patient-centered, culturally respectful care. This study has the potential to contribute research to support increased understanding of the lived experience of AA recipients of care in the modern U.S. healthcare system as it relates to the understanding of and provision of culturally competent care.

More specifically, the results of this study have the potential for positive social change for healthcare professionals and recipients of care. Better understanding of AA care recipients' perceptions and lived experiences has the potential to guide healthcare professionals to develop patient-centered, culturally respectful care programs and policies to improve provider–recipient encounters. Ultimately, the results have the potential to improve provider–recipient communication; build better relationships at the point of care; and benefit recipients of care through increased provider–recipient collaboration, increased recipient engagement in healthcare, and improved health outcomes (Cuevas et al., 2017; Horton & Irwin, 2017; Leininger, 2002; Shen et al., 2018).

Summary

In Chapter 1, I introduced the purpose of the study in the context of the current body of scholarly evidence. Addressing the challenges associated with access to and quality of care in increasingly diverse societies is the responsibility of healthcare organizations and practitioners. In this chapter, I described the theoretical framework of the culture care theory as well as the qualitative interpretive phenomenological nature of the study. Assumptions, scope, and limitations of the study were also outlined. In Chapter 2, I will describe the literature search strategy details, provide a detailed overview of the theoretical framework guiding this study, and present the literature review related to key variables.

Chapter 2: Literature Review

Increasing globalization challenges healthcare systems with providing care to more diverse populations. Race and ethnicity have been cited as key variables in driving solutions to improve and identifying healthcare disparities in vulnerable populations. Culturally competent care is one method that healthcare organizations employ to reduce disparities in access to and delivery of healthcare to the community (Cuevas et al., 2016; Loftin et al., 2013). Culturally competent care traditionally has been evaluated from the perspective of the provider. The evaluation focuses on the extent to which the provider is believed to be culturally competent. Absent from the conversation are care recipients' lived experiences and their perceptions of the cultural competence of the patient–provider interaction. The purpose of this interpretive phenomenological qualitative study was to explore the lived cultural experiences of AA recipients of healthcare. In this chapter, I describe the literature search strategy and provide a detailed overview of the theoretical framework that guided this study and an in-depth literature review framed by key concepts.

Literature Search Strategy

Databases searched included Worldcat, Medline, Google Scholar, and Embase as well as in Walden University and Medical University of South Carolina multidatabase searches. The keywords searched were *African American, culture, cultural competence, patient, provider, perspective, communication, racial, race,* and *concordance*. Searches resulted in 91 relevant articles. After I reviewed the articles, giving priority to those published since 2016, the remaining 37 articles were included in the literature review. In addition to the literature references, I reviewed two interviews with Leininger that increased my understanding of culture care theory (HCR Home Care, 2012a, 2012b).

Theoretical Foundation

The culture care theory by Leininger served as the foundation and framework for this study (2001 & 2006). This theory was developed over the course of Madeleine Leininger's career exploring universality and diversity of populations starting in the 1960s. As a home health nurse in rural Alabama, Leininger shared her experiences with culturally competent care in the AA community. In a videotaped interview, Leininger also described the challenges faced while advocating for AA patients in the rural community she served and collaborating with other healthcare professionals to align the care provided with the needs of the individual.

Theoretical assumptions of the culture care theory focus on care as a central tenet of nursing. Leininger (2006) posited that care was an essential variable in the act of healing and that to deliver quality care, providers must understand the world view of the care recipient. The culture care theory proposes that there are many variables attributed to culture and identifies which of those are universal across cultural populations and which are unique to specific populations. An understanding of the culture and experiences of AA recipients of care may contribute to improvements in the care outcomes for this population.

The culture care theory is prevalent in literature aimed at understanding the worldview of recipients of healthcare. Foronda (2020) developed the theory of cultural humility in part based on Leininger's culture care theory. Fluid conceptual definitions of the cultural humility theory were based on Leininger's proposition that application of knowledge be applied with flexibility in practice (Foronda, 2020). Flexibility in application of theory enables a care provider to tailor care to the recipient relevant to the recipient's current worldview (Foronda, 2020; Leininger, 2006). Chiatti (2019) explored culture care beliefs of Ethiopian immigrants using the culture care theory to support the importance of focusing on the healthcare beliefs and practice of the care recipient. Leininger's four phases of data analysis guided the collection, analysis, interpretation, and synthesis of the data. Exploring cultural factors that influence care of Dominican migrants, Sabon Sensor (2018) applied culture care theory, citing the importance of emic versus etic variables in aiming to address healthcare disparities. Culture care theory prescribes that culturally appropriate care addresses variables that originate with the culture (emic) and outside the culture, which are considered etic (Leininger, 2001). Although not a phenomenological study, individual accounts provided the data for the identification of themes aiming to describe the individual experience through a broader cultural lens. The outcomes of the study provide implications for practice based on the perceptions of the care recipients, such as increased interpreter presence and improved patient–nurse interactions.

The culture care theory aligned with my goals and the aim of the study. As described by Leininger (2001), the goal of culture care theory is to provide culturally congruent care that fits the recipient. Leininger's contributions to nursing related to culture and experience of the care recipient guided the purpose of this study: to understand the worldview of AA care recipients through their experiences in interacting with and/or avoiding contact with the healthcare system, organizations, or individual providers.

Phenomenology as a philosophy of questioning and as a method of description and interpretation of firsthand accounts of lived experiences also framed my study. Descriptive phenomenology, as described by Husserl, evolved into interpretive phenomenology with the work of Heidegger. Interpretive phenomenological research involves bracketing and reduction to ensure a researcher's bias does not influence the thematic analysis (Heinonen, 2015). Bracketing is a researcher's reflection on their own beliefs and ideas, whereas reduction is a process of ensuring the original source is accurately portrayed (Heinonen, 2015). Van Manen (2016) described the thematic analysis and deduction of themes as two parts of the process of phenomenological reflection. Hermeneutic phenomenology aligns with the aim of my study to better understand the cultural experience of AA recipients of care. Using Leininger's work on culture guided the alignment of themes identified with a validated framework of culture.

Literature Review Related to Key Variables and/or Concepts

Diversity

The term *diversity* indicates the presence of a difference or differences among individuals who form a group (Foronda, 2020). Michael (2016) challenged that while diversity was about differences, the term also referred to the shared characteristics that include individuals in other groups. Diversity, attributed in part to globalization, challenges healthcare organizations with providing equitable care for populations of patients that are more diverse (Alizadeh & Chavan, 2016; Ollapally & Bhatnagar, 2009).

Increased diversity among patient populations contributes to healthcare disparities along racial and cultural lines (Shen et al., 2017; Wrenn et al., 2017). Steel et al. (2018) cited that the concept of diversity can be applied within groups or across groups and described three interrelated concepts of diversity in science; these include egalitarian, representative, and normic. The concept of egalitarian diversity prescribes that all individuals are equal and have equal opportunity. Representative diversity focuses on differences between members of two equal populations, e.g., male and female. The concept of normic diversity, which defined diverse individuals as those that differ from the norm, best guides this study (Steel et al., 2018). Normic diversity is commonly aligned with social or racial identities. This concept of diversity explains the division between group comparisons, the creation of subgroups when exploring differences within groups, and stereotypes (Bleijenbergh at al., 2010; Steel et al., 2018).

Culture

Culture is defined by some experts as a multidimensional composite of ethnic, racial, and socially obtained traits shared by a population or group (Foronda, 2020; Kersey-Matusiak, 2013; Meleis, 1996;). Culture as a concept is divisive in research literature that presents challenges to consensus as to what variables or traits should define a cultural group and which of those are relevant to all individuals or cultures (Centers for Disease Control and Prevention, 2016; HCR Home Care, 2012; Michael, 2016). In the 1950s, Leininger began exploring the question of how to define the culture of nursing care recipients and understand what culture means to them (HCA Home Care, 2012). Her work led to the development of the discipline of transcultural care, in which she aimed to understand how to better provide equitable care to diverse populations. Broad concepts of culture that understate the individual experience contribute to oversimplification of culture (Campinha-Bacote, 2005; Jirwe et al., 2009; Trittin & Schoeneborn, 2017). Focusing on the individual is important when determining culture: self-identified cultural affiliation is the necessary identifying trait when the goal is to provide person–centered care (Leininger, 2007; Markova & Broome, 2007; Michael, 2016). The concept of culture as it relates to the individual supports the need to understand what culture means to and how it shapes the health of the individual.

Healthcare Disparity

Disparities in healthcare are caused by moments in care recipients' interactions with the systems, organizations, or individual healthcare professionals that lead to failure to provide equitable access to and quality of services provided (Kersey-Matusiak, 2013; Cuevas et al., 2016). These disparities are commonly classified and identified in groups defined by racial, ethnic, cultural, or sexual similarities (Cuevas et al., 2016; Friedman, et al., 2019; Shen et al., 2017). Perceived or actual discrimination, medical mistrust and/or ineffective communication may negatively impact individuals' compliance with treatment regimens, which can further contribute to health disparities (Cuevas et al., 2016; Hammond, 2010; Powell et al., 2019). Two main strategies employed to address disparities focus on the provider's ability to provide culturally competent care to diverse populations and goals to ensure the diversity of that workforce matches that of the population (Shen et al., 2018; McGinnis et al., 2010; Zangaro et al., 2018).

Cultural Competence of Workforce

Cultural competence is a strategy employed by healthcare to improve the delivery of care to diverse groups of individuals and reduce healthcare disparities (Alizadeh & Chavan, 2016; Cuevas et al., 2016; Meleis, 1996). Evaluation of efforts to prepare the workforce for interaction with increasingly diverse populations of healthcare recipients rely largely on the self-assessed competence of the provider. Experts recommend efforts that aim to improve the patient–provider encounter, including increased provider awareness of personal biases and cultural beliefs; increased provider responsiveness to patient cultural needs, and trust building (Cuevas et al., 2016; Truong et al., 2014; Meleis, 1996).

Culturally and Racially Congruent Workforce

Building a culturally congruent workforce that mirrors the community is a frequently cited strategy in workforce management and healthcare (Beard et al., 2015; Williams et al., 2014;). This strategy aims to reduce mistrust, in healthcare systems and healthcare providers, by racial and ethnic minority groups. In the United States, the largest of these vulnerable groups include Latinos/Latinas and African Americans. The outcomes of efforts to improve cultural and racial congruence of the patients and providers relies on the patients' belief that racial concordance equates to better care (Cuevas et al., 2016). Experts cite benefits of increased workforce diversity, including increased patient trust, improved patient–provider communication, and greater healthcare access in underserved communities (Bonar, 2019, Benkert et al., 2009; Williams et al., 2014). The perception of the care recipient is necessary to fully understand the impact of racial and cultural concordance.

African American Care Recipients

AA care recipients face challenges when interacting with the healthcare system, organizations, and providers including perceived discrimination, medical mistrust, and poor communication (Abramson et al, 2015; Cuevas et al., 2016; Cuffee et al., 2013;). Social and lifestyle determinants also impact the quality of and access to care received by AAs. Cuevas et al. (2016) proposed that barriers related to the patient–provider interaction were interrelated and that improvement in one area may lead to improvements in another.

The experience of AA care recipients' experience has been described in specific populations defined by diagnosis, age, sex, or specific barrier to access or quality of care. Booker (2016) explored AA patients' perceptions of pain management concluding that alternative pain management modalities may improve pain management practices. Bazargan et al. (2020) focused on the inequity of pain management in underserved older AA patients citing economic burden and comorbidities as barriers to care. AA recipients of care also experience disparities when they encounter healthcare providers including perceived discrimination, medical mistrust, and poor communication (Cuevas et al., 2016). Diversity of individuals within the AA community also presents barriers to healthcare. Lower quality healthcare for AA's who identify as lesbian, gay, or bisexual has been attributed to culture citing a lack of social support (Friedman et al., 2019). The outcomes of these studies illustrate the impact that a deeper understanding of the AA healthcare experience may have on efforts to reduce disparities. An understanding of the AA patient’s individual lived experience may guide policies and strategies to improve the quality of care for the entire population.

Summary and Conclusions

Diversity within and across populations challenges healthcare with ensuring equitable care for all. Cultural competence and the cultural composition of the healthcare workforce are two leading strategies employed to address equity in access to and quality of care. AA care recipients are the second largest minority group in the U. S. yet suffer disproportionate barriers to accessing and receiving quality healthcare than their white counterparts. As a profession based on caring, nurses are obligated to address disparities in care. My study aimed to provide insight into the lived experience of AA patients that may contribute to the professional conversation on how to improve the health of this population. Chapter 3 will describe the rationale for how this qualitative phenomenological study supports the identified gap. Chapter 3 will outline the plans for participant recruitment, data collection methods, and a data analysis plan.

Chapter 3: Research Method

The purpose of this qualitative interpretive phenomenological study was to explore the lived cultural experiences of AA recipients of healthcare. In this chapter, I describe the research design and provide rationale to support a phenomenological qualitative research study. My role as the researcher and proposed strategies for participant selection, collection methods, study procedures, and coding of collected data are outlined. Validity, reliability, and ethical procedures applicable to this study are also addressed.

Research Design and Rationale

A qualitative interpretive phenomenological design was used to answer the following research question: What are the lived cultural experiences of AA recipients of care when interacting with the healthcare system? The qualitative tradition facilitates sharing of participants' experiences without the constraints of predefined instruments (Creswell & Creswell, 2018). Interpretive phenomenology provides an approach to understand the world as uniquely experienced by the participant, not necessarily as others experience the world. Hermeneutic phenomenology as described by van Manen (2016) incorporates the description of Husserl and the interpretive approach described by Heidegger. Phenomenological approaches, in aiming to determine the essential components of the human experience, become an act of caring (van Manen, 1997). The concept of caring is essential to the theoretical framework and purpose of this study as well as nursing as a discipline.

Quantitative approaches were not considered for this study. To better understand the experiences of the study population in their own voice, the qualitative tradition better supported the purpose of the study. The objective nature of quantitative research designs and methods does not facilitate an understanding of individual experiences (Creswell & Creswell, 2018). Mixed-methods research was considered for the ability to draw from both objective and subjective data but expands beyond the goals of a phenomenological study. Anticipated complexity of design and limited experience of the researcher were also exclusion factors for a mixed-methods approach.

My goal in this study was to explore the lived cultural experience as described by AA adults when interacting with the healthcare system. The healthcare recipients' perceptions of care provided is necessary to guide the conversation on developing strategies to reduce racially driven health disparities. The data generated by this study describe the individual experiences of AA healthcare recipients.

Role of the Researcher

Creswell and Creswell (2018) described the researcher as a data collection instrument in qualitative research. Qualitative researchers serve not only as the primary researcher, but also as data collector and analyzer. In qualitative research, the active role of the researcher is collecting, transcribing verbatim recorded interviews, and deriving themes. These activities may present challenges related to my values, biases, and beliefs (Rubin & Rubin, 2012). To increase my awareness of any bias, I completed the Implicit Association Test (IAT) for race to improve self-awareness.

As the primary researcher, I designed the study and ensured consensus among my committee and obtained IRB approval. As the data collector, I conducted and recorded all the semistructured telephone interviews with participants. After data collection, I was responsible for the transcription, organization, and thematic analysis. Thematic analysis continued until the point of saturation was reached and no more interviews were conducted.

There were no identified relationships between the participants and me, as they were recruited from the community. Familiarity with participants was not exclusionary, but personal friends and their immediate families were excluded. Participants were not recruited from my work environment and no related conflicts or ethical issues were identified.

Underrepresentation of AA individuals in research was used as justification for the use of incentives to encourage participation. Potential barriers to participation included lack of trust, communication, and logistical issues (Luebbert & Perez, 2016; Radecki Breitkopf et al., 2018). Radecki Breitkopf et al. (2018) proposed that increasing the number of AAs represented in research studies may reduce healthcare disparities related to race. Financial incentive has been cited as a strategy that may increase research participation among AAs, addressing the barriers to participation of time commitment and general inconvenience (Luebbert & Perez, 2016).

Methodology

The qualitative tradition guided the research design and the collection, analyzation, and interpretation of data. The interpretive phenomenological qualitative approach is focused on gaining deeper understanding of individuals' lived experiences. Greater understanding is the desired outcome of a researcher's collection of personal accounts followed by structured analysis and interpretation (van Manen, 2007).

Prior to the interview phase of my study, I completed the IAT for race to improve self-awareness (Project Implicit, 2011). This increased my self-awareness of my race-related bias. Data were collected using open-ended semistructured questions in recorded interviews. While conducting the interviews, I used reflexive journaling to record my thoughts and reactions to the participants' descriptions of their experiences. After interview completion, I transcribed the interviews verbatim. Transcripts were coded following a coding protocol (see Appendix D). The coding protocol involved review and comparison of transcripts and journal entries while reflecting on my own experience to ensure the interpretation of the participants' experiences was based on their shared account and not influenced by personal bias. Van Manen (2007) described this process as *phenomenological reflection*. Following the reflection process, themes derived were examined using Leininger's (2007) culture care theory.

Participant Selection Logic

The population that participated in and was intended to benefit from this study was the local AA community in the southeastern region of the United States. A convenience sample of adult AA individuals was recruited from residents within that region using recruitment flyers posted in publicly accessible locations. Inclusion criteria were: (a) self-identification as AA, (b) at least 18 years of age, and (c) experience interacting with the healthcare system. My friends and their immediate families were excluded from the sample. Eligibility was verified through a screening questionnaire administered when individuals contacted me to learn more about the study. Confidentiality was maintained through the use of participant identification numbers.

Convenience sampling, or opportunistic sampling, is described as a nonprobability sampling method suitable for situations in which recruitment may be difficult and sample variation does not influence the phenomenon of interest (Holloway, 2017). Qualitative sampling should focus on identifying individuals who can articulate or describe the phenomenon being explored (Holloway, 2017). In similar studies, researchers have sampled as many as 15 participants (Chiatti, 2019; Sobon Sensor, 2019;). Creswell and Creswell (2018) suggested three to 10 participants for interpretive phenomenological studies, although the number can be increased if necessary (Holloway, 2017). My goal was to recruit and interview 15 participants. I interviewed until data saturation was reached. Saturation is defined as the point in collecting and coding qualitative data when there are no new themes being revealed (see Creswell & Creswell, 2018). Saturation ensures the study produces thorough results and promotes trustworthiness in validating the sample size (Creswell & Creswell, 2018; Rubin & Rubin, 2012).

Instrumentation

Qualitative interviewing is a method that allows researchers to gain new understanding of a concept providing the opportunity to explore the nuances related to the specific population being studied (Rubin & Rubin, 2012). The main research question was: What are the lived cultural experiences of AA recipients of care when interacting with the healthcare system? I used an interview guide that included seven open-ended, nonleading, probing questions asked of participants in one-on-one virtual interviews. Interviews were scheduled for 1 hour to elicit answers to the main research question (Appendix A). Questions were developed after reviewing the literature to explore the lived cultural experience of participants when interacting with healthcare.

Procedures for Recruitment, Participation, and Data Collection

After obtaining Walden University Institutional Review Board (IRB), approval number 02-19-21-0744031, I began to recruit participants for the study. Recruitment was facilitated through a flyer distributed to AA members of the local community (see Appendix B). The flyer included my email address and telephone number and directed potential participants to contact me if interested in hearing more about the study.

Participation

I screened individuals who contacted me to verify their eligibility using a screening questionnaire (see Appendix C). There were no interested individuals who did not meet the inclusion criteria for the study. I contacted individuals who met the inclusion criteria, described the purpose of the study and expectations of participants, and informed them they would receive an honorarium for participating. In addition, I reinforced that participation was voluntary, they could stop participating at any time without penalty, and their names and other identifying information would be kept private. I emailed the consent form to those who continued to be interested in the study after our initial meeting. Interested individuals agreeing to participate in the study responded to the consent email with the phrase “I consent” and emails were retained to be included in the study documents.

Data Collection

As the primary researcher, I collected all data through recorded semistructured telephone interviews following the interview protocol (see Appendix A). Following verification of consent via email, I scheduled a date and time that was convenient to the participant for a telephone interview. I encouraged individuals to secure a private place for the interview where the conversation would not be overheard. Upon consent, participants were assigned a participant identification number that was used during data analysis and reporting to maintain confidentiality. The interview consisted of seven guiding questions. Creswell and Creswell (2018) recommended an interview consist of eight to 10 content questions. Probing questions were asked when more information or a more detailed explanation was needed (Creswell & Creswell, 2018). The anticipated duration of each interview was 60 to 90 minutes. The first few minutes of each telephone interview were spent answering any additional questions the participant may have had and clarifying the intent of the interview. Interviews were conducted via telephone and recorded on a handheld digital recorder. I journaled during the interview. The follow-up procedure included a typed mailed letter to all participants thanking them for their participation and a $25 Amazon gift card. Upon completion of the study a two-page summary of the findings was emailed to all participants.

Data Analysis Plan

The data collected were the shared experiences of participants describing their interactions with healthcare professionals. Audio recordings of interviews were be reviewed for the purpose of transcription, coding, and phenomenological reflection. Researcher journal entries were also be included in the data to be analyzed. Digitally recorded interviews were self-transcribed by replaying interviews and typing the contents verbatim in an electronic document. All experiences collected were processed and included in the thematic analysis.

Coding was done manually. Rubin and Rubin (2012) suggested that the manual coding process provides the opportunity to focus on deeper meaning of events and examples and outline a process to guide researchers. The coding process included reviewing transcripts to identify words or phrases that capture the meaning of the content, identifying codes and themes. Following the coding of data, I performed a thematic analysis to interpret and derive themes and subthemes from the collected data. Coding, thematic analysis, and synthesis was guided by the coding protocol (see Appendix D).

Issues of Trustworthiness

Trustworthiness in qualitative research is guided by researcher developed procedures and protocols that ensure the reader can be confident in the validity of the findings (Connelly, 2016; Leininger & McFarland, 2006). Holloway and Gavin (2017) illustrated the complexity of this process and criteria in qualitative research validating the absence of a consistent and commonly recognized definition or application of validity. Experts in the tradition of qualitative research agree on the necessity of reliability but maintain that these criteria are not directly associated with their quantitative counterparts (Graneheim et al., 2017; Holloway & Gavin, 2017). Areas addressed to ensure trustworthiness in qualitative research include credibility, transferability, dependability, and confirmability.

Credibility refers to the extent to which the reader can trust in the processes, protocols, and outcomes of a research study (Amankwaa, 2016; Connelly, 2016). To ensure credibility in qualitative cultural studies it is important to sample individuals who have a holistic experience of the culture (Rubin & Rubin, 2012). Belonging to a culturally defined group of people indicates some level of knowledge about the practices, beliefs, and values of the community but does not guarantee credibility in qualitative research. Strategies to ensure credibility for this study include transparency, the inclusion of all data collected, and recruitment of adult participants. Interview recordings and notes were saved and available for review. Exclusion of participants less than 18 years of age may yield more personal experiences for individuals to draw from. As this project was completed under the guidance of a committee, the peer review process supports the credibility of my project and the outcomes produced. Dodgson (2019) proposed that qualitative research is contextual, and that this context must be described by the researcher to support the credibility of a study. I used reflective journaling during interviews to ensure the descriptions and interpretation of accounts are objective and not influences by my beliefs.

Transferability refers to how generalizable the outcomes of a study are in the sampled population or other populations (Connelly, 2016; Holloway & Gavin, 2017).

Korstjens and Moser (2017) described transferability in qualitative research as the reader’s perceived applicability of the research to other populations or environments, citing thick description as a strategy (Amankwaa, 2016). Thick description that includes detailed information about participants, protocols, and processes were applied to my study as a method of ensuring transferability. Detailed descriptions of the project ensure that the study can be replicated by other researchers with other populations. Amankwaa (2016) suggested availability of records, including my journal notes, for review by the reader if requested as a strategy for ensuring transferability. My records will be maintained for 5 years and available for review if requested.

Dependability in the qualitative investigation of culture refers to the accountability of the data. The qualitative equivalent of generalizability, dependability is ensured through accountability of data collection and record keeping (Holloway & Gavin, 2017; Leininger, 2006). To ensure the data generated are reliable, records for this study were be maintained and password protected electronically. Peer-review is also a recommended method of ensuring the dependability of qualitative research (Rubin & Rubin, 2012). As a Walden University student, working with my committee strengthened the dependability of the study. During the data analysis process, the support of my committee also supported the confirmability, reliability, and credibility of the study. This study aimed to understand the lived cultural experience of the AA community. The protocols and design of this study can be replicated by other researchers in sample groups defined by the similar or different cultural characteristics. This supports the reliability of the study (Creswell & Creswell, 2018).

Confirmability refers to the perceived objectivity of the researcher (Kallio et al., 2016). Reflexivity is the process a researcher employs to reflect on personal values, beliefs, and experiences and the impact these biases may have on the interpretation of data. Identification of researcher bias is the initial step in reflexivity (Creswell & Creswell, 2018). The IAT for race was developed by Harvard University to increase awareness of subconscious bias related to race (Project Implicit, 2011). For this study, I assessed my bias using this tool prior to interviewing and synthesizing the data. Biases identified were addressed through awareness of the researcher and reflection on the results of the assessment taken online. Amankwaa (2016) suggested using multiple researchers in analyzing and reviewing data, which I accomplished through the collaboration with my committee.

Ethical Procedures

Participants for this study were recruited following review and approval by the Walden University IRB (Walden University, 2020). I obtained informed consent prior to any data collection. I also verified with each participant that they agreed to participate verbally at the beginning of the recorded telephone interview session. Data were not anonymous but are confidential. Confidentiality was ensured by the assignment of a participant identification number at the telephone screening interview. Transcribed and coded data did not include any participant identifiers and data were reported in themes identified from combined data from all participant accounts. All electronic data was stored on a password protected external hard drive to protect the identity of participants. At the conclusion of the data collection phase, I converted any paper records to be stored as electronic files and stored them on the same storage device. I have destroyed all paper records that were converted. I alone have the password for the storage device. Data will be maintained for 5 years after the completion of the study and the portable storage device will be destroyed at that time.

Summary

This qualitative research study used a phenomenological approach to explore the lived cultural experience of AA recipients of care. Phenomenology is a framework for researchers to understand an experience from the unique perspective of another individual. The goal of this study was to explore the lived experience as described by AA adults when interacting with healthcare system. The role of the researcher was described and justification for the use of incentives was provided based on literature specific to the AA community. The methodology proposed was outlined in detail and included: participant selection, instrumentation, data collection procedures, and a plan for data analysis. Participants were recruited in the community and selected using convenience sampling. Semistructured interview questions and protocol are outline in the appendices. Data analysis was guided by the process outlined by Rubin and Rubin (2012). Concepts related to the validity and trustworthiness of the proposed study were defined and addressed in addition to ethical considerations and procedures.

Chapter 4: Results

The purpose of this interpretive phenomenological qualitative study was to explore the lived cultural experiences of AA recipients of healthcare. The research question that guided this study was: What are the lived cultural experiences of AA recipients of care when interacting with the healthcare system? Results from this study provide insight into the lived experiences of AA recipients of healthcare when interacting with the healthcare system. In this chapter, I present the results of this study, descriptions of the setting, demographics of participants, data collection and analysis processes, trustworthiness, and results.

Setting

In March 2020, the community where the study was conducted was impacted by the COVID-19 pandemic, and the community was in emergency mode. Local healthcare organizations were in emergency operations, operating rooms were closed, and large scale COVID-19 testing sites were established across the state. At this time, I was working with my chair on final approval of my data collection plan, which was changed to accommodate for the new social landscape and the COVID-19 era. My original plan was to partner with area churches and host focus groups to gather accounts of lived experiences of local AA recipients of healthcare. With churches closed due to the pandemic, my data collection plan was changed to individual interviews conducted by telephone. At the time of recruitment, the local community was in the middle of vaccination efforts.

Demographics

Relevant participant demographics related to this study were limited to identifying as AA, being at least 18 years of age, and having had interactions with healthcare delivery. The goal of this study was to document and explore the lived cultural experiences of adult African Americans. Participants were not asked to identify age, sex, gender, orientation, specific age, etc.

Data Collection

Semistructured interviews were conducted and recorded with seven individuals who consented to participate. All data were collected via telephone interviews with individual participants. The average interview length was 29 minutes with interviews ranging from 20 minutes to 45 minutes. Data were recorded on a handheld digital recording device. I manually transcribed each interview immediately following the interview. Flyers were posted across the community to recruit participants. Initially, my flyer only included my Walden email address, which was updated with IRB approval to include my cell phone number after an early lack of response by email.

An unusual circumstance encountered in data collection was the global COVID-19 pandemic. One of the questions asked of the participants was to describe their most recent healthcare experience. Five of the seven participants interviewed described an experience related to COVID-19.

Data Analysis

Data analysis followed a coding protocol (see Appendix D). Analysis began in the manual transcription phase. I listened to the interviews multiple times to ensure accurate manual transcription, which provided valuable time to reflect on the data collected. I listened to interviews until I was confident in the accuracy of the transcription. Coding was initiated by reviewing a printed copy of each transcript and identifying events, concepts, key points, themes, subthemes and examples while reviewing my interview notes using principles of thematic analysis. I created a table to aggregate key points from the initial coding process and organized by question. Five major themes emerged in the data analysis: (a) communication, (b) medical mistrust, (c) access to healthcare, (d) satisfaction with healthcare experience, and (e) dissatisfaction with healthcare experience. Direct quotes from participants were used to support the data. There were no discrepant cases.

Evidence of Trustworthiness

The confidence of the reader in the study outcomes are supported by a researcher's adherence to prescribed protocols and procedures (Connelly, 2016; Leininger & McFarland, 2006). The trustworthiness of this study is supported by my adherence to study protocols and procedures as approved by the Walden IRB and my committee. Implementation and adjustments to strategies are described here as they relate to the credibility, transferability, dependability, and confirmability.

Credibility was maintained through the inclusion of all data collected in the coding process and journaling during the interview process. The selection criteria requiring that participants be at least 18 years of age and identify as AA further supported the credibility of this study aiming to recruit participants with a holistic experience as AA recipients of healthcare (Rubin & Rubin, 2012). There were no adjustments, and planned strategies to ensure credibility included transparency of data, inclusion of all data collected, recruitment of adult participants, and contextual definitions of the themes identified.

Transferability, or the applicability of study outcomes to other populations and environments, was maintained through the use of thick descriptions (Holloway & Gavin, 2017). Detailed description of the study information and data at all stages, including information about process and protocols, supports the transferability of the study as well as transparency of researcher notes and records. There were no adjustments and planned strategies to ensure transferability that included maintenance of records for 5 years and detailed descriptions of protocols and processes.

Dependability was maintained in this study through the electronic storage of records and data that will be available for review for 5 years. The oversight of my committee supported efforts to ensure dependability of this study. There were no adjustments, and planned strategies to ensure dependability included electronic maintenance of study files and committee support.

Confirmability of this study was supported through the application of reflexivity. Creswell and Creswell (2018) supported the effectiveness of reflexivity in identifying and addressing researcher bias through awareness and reflection. There were no adjustments, and planned strategies to ensure confirmability included completion of the IAT and application of the reflexibility process (Project Implicit, 2011).

Results

Five major themes and 13 subthemes were identified through manual transcription and coding of recorded interviews as outlined in the coding protocol (see Appendix D). The five major themes were: (a) communication, (b) medical mistrust, (c) access to healthcare, (d) satisfaction with healthcare experience, and (e) dissatisfaction with healthcare experience (see Figure 1). Subthemes were identified related to each of the themes (see Table 1).

Figure 1

Major Themes

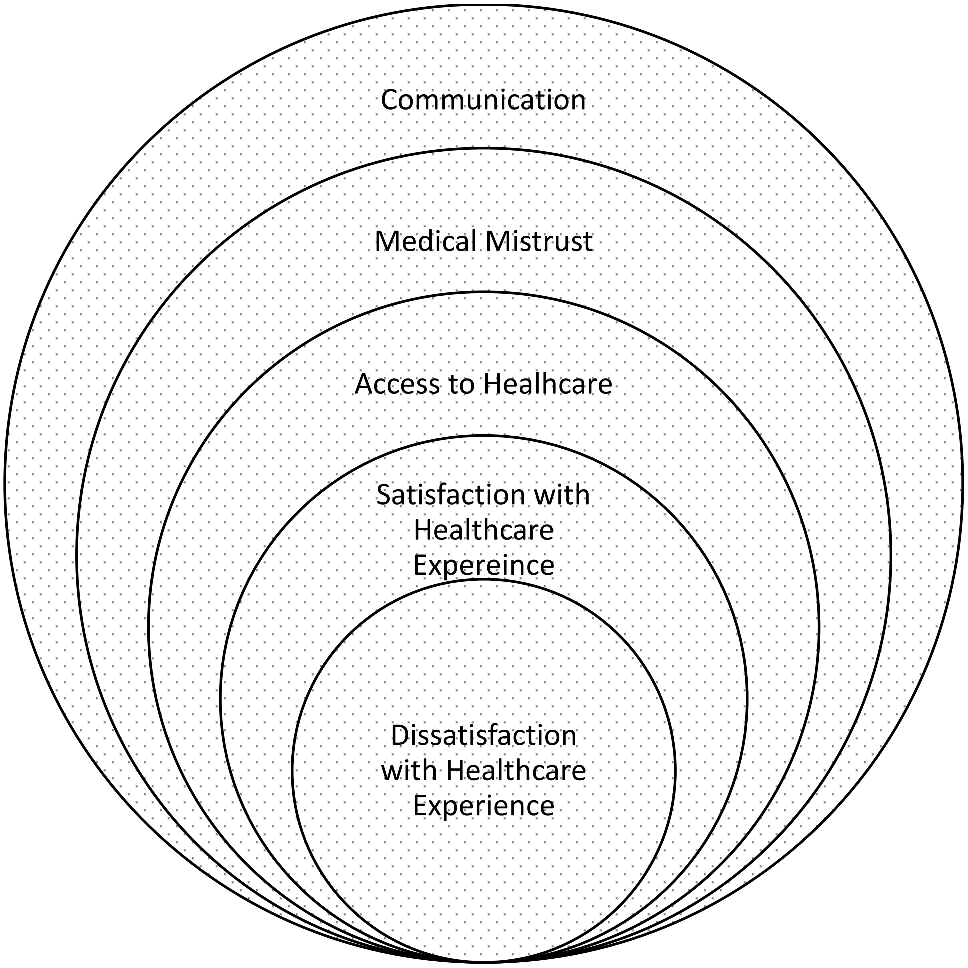

Table 1

Major Themes and Associated Subthemes

Major themes	Subthemes
Theme 1: Communication	Importance of active listening Importance of eye contact Importance of honesty Importance of respect
Theme 2: Medical mistrust	Medical mistrust related to healthcare system Medical mistrust related to healthcare professionals
Theme 3: Access to healthcare	Lack of access to healthcare Limited access to healthcare Accessible healthcare
Theme 4: Satisfaction with healthcare experience	Communication with healthcare professionals Relationship with healthcare provider
Theme 5: Dissatisfaction with healthcare experience	Communication with healthcare professionals Dissatisfaction with reception staff

Theme 1: Communication

A major theme identified in this data involved communication. In the context of these findings, communication is defined as an exchange of verbal and nonverbal information between two or more individuals as experienced and perceived by each party. Communication emerged as a theme across all seven interview questions and was reflected heavily in the responses for Question 6: What is most important to you as a patient? Communication, a key factor in patient satisfaction with healthcare, leads to a positive experience when the provider demonstrates active listening, maintains eye contact, explains the findings of examinations and subsequent treatment in a way patients can understand, demonstrates a caring concern for the patient, takes the time needed to talk with the patient, and treats the patient with the same respect as other patients.

Subthemes that emerged included (a) importance of active listening, (b) importance of eye contact, and (c) importance of honesty. Communication was a factor influencing satisfaction and/or dissatisfaction related to the healthcare encounter as well as a facilitator of patient comfort and engagement. Participant 5 cited communication's impact on comfort and perceived caring, stating, "Oh, it made me feel very relaxed and comfortable, almost like a home type environment. Like you know when someone really cares about you." Communication facilitating patient comfort was prevalent in the interview with Participant 4:

> It definitely put ME at ease. It was very nice just to know that the person who I was interacting with and was going to stick something in me was not trying to rush through the experience was not trying to rush through this.

The importance of active listening and eye contact was evident in examples of communication with providers shared by participants. When asked about communication with a physician, Participant 1 stated, "She talked to me... not like, like a physician. She sat down and crossed her leg like she was talking to one of her girlfriends." Participant 5 expressed the importance of knowing the provider is actively listening stating:

> The fact that if I am talking that the doctor is actually looking at me directly, of course doctor write notes. But doctors looking at me back and forth as I am talking, and actually responding as we're having a conversation or as I'm explaining my situation.

The importance of honest communication was a bidirectional concept. Participants described understanding the importance of honest communication to and from healthcare professionals to provide the best patient outcome. For example, when asked if a negative experience in communication with a physician would impact their willingness to be forthcoming with information in the future, Participant 5 stated,

> No, because the point is this physician has to have all of the information to make a true assessment. If they're going to, if the physician is going to do his or her job, the physician must have all of the information.

Theme 2: Medical Mistrust

Another theme that emerged from the data was medical mistrust, which was prevalent across questions and participants. Medical mistrust in the context of these findings is defined as a lack of confidence in the beneficence, equity, and quality of the care delivered by the healthcare system and/or individual healthcare professional. Mistrust occurs when providers do not work to make patients comfortable in the healthcare setting, stereotype patients or make assumptions about them, appear to be insensitive to the impact of high costs of healthcare, fail to demonstrate a caring concern, take too little time to talk with the patient, or fail to provide adequate information. Medical mistrust was related to the healthcare system as well as mistrust related to healthcare providers/ professionals.

Participant 3 stated, "They need to be focused more on, um, just getting that person comfortable with actually coming to the doctor, knowing that… it's so much that, because African Americans are not comfortable doctors… For some apparent reason."

This statement highlights the opportunity for the healthcare system and individual healthcare professionals to include addressing medical mistrust in strategies to improve the health of the AA community.

Mistrust related to the healthcare system revolved around the perception/belief that unfounded stereotypes are applied to AA patients. Participant 7 cited pain tolerance of AA women as a commonly applied and inaccurate stereotype in healthcare and stated, “We tend to think that black women can take a lot of pain and it’s not that we can, we just do.”

Other variables influencing distrust in the system were related to necessity of prescribed interventions related to cost as well as effectiveness and communication of risk when surgical interventions are prescribed. Participant 4 described systemic medical mistrust among AA patients, stating, “A lot of people, especially AA people, both male and female, don’t trust the system because they feel like all it’s doing is trying to suck you dry.”

Mistrust related to the individual healthcare professional related to perceived dishonesty in communication. Participant 7 described a situation where her medical situation was made clearer at a later visit by another provider on review of the chart. This experience compounded already existing and recurrent medical mistrust. They stated that it was “another situation where I, I feel like he was spoon feeding me information and not giving me everything that I needed to know.” Participant 3 shared and example that supports the generational influence of medical mistrust stating,

> Because my mom would tell you this first thing when it came down to her… she has diabetes. She wanted to stay on, um, just taking a diabetes pill. The same doctor I had issues with my dad, did not fill my mom's prescription or her pills… But then sent her out to have the insulin… So, the needle insulin. So, my mom thinking this is an experiment. She's thinking that the clinics are experimenting for the drugs that's passing through. So, this is this is, this is her mind frame. So, I think what doctors need to be more aware of it.

Even this example of medical mistrust highlights the opportunity to employ more effective communication with patients related to the plan of care, medications prescribed, and medical interventions with the aim of reducing medical mistrust in the AA community. There were also examples shared of how communication and choice of provider served to increase the patient's trust in the provider. Comforted by communication with the provider in the shared example, Participant 1 stated,

> We signed all the paperwork. We knew that there was a possibility that certain things could happen. Uhm, but he's having the surgery and the doctor was very, very specific as to. Uhm, just making us feel good then he's gonna be OK. He's gonna come out of this. Uh… You know not to worry. Uh, but we, you know we did a lot of research on him as well to make sure that he was the right fit for this type of surgery.

Not all examples of medical mistrust shared by the participants were clearly delineated between mistrust of the system of mistrust of the individual provider. Question 4 was intended to explore the participants understanding of culturally competent care and revealed mistrust of the concept intended to improve care to diverse populations of people. Four of the seven participants interviewed asserted that the expectation should not be culturally competent care, but the same care for all patients. Participant 5 stated,

> The statement would offend me slightly. And my reason for that is the care should be the same, in terms of each, I know that each patient has different needs like from a healthcare perspective, but the care should be the same" when asked what culturally competent care meant to them.

In addition to the lack of trust in the concept of culturally competent care, some participants were distrustful of the provider and the organization's ability to operationalize the culturally competent care as intended. Participant 7 responded, "I mean it… in theory, it's great. But it's, it's kind of like, who's gonna check that this is happening? What are the checks? Um, what what are the standards?"

Theme 3: Access to Healthcare

Access to healthcare also emerged as a theme in this data. Access to healthcare in the context of these findings is defined as the ability to obtain healthcare services for preventative care and treatment as desired. A lack of access to healthcare was described in two ways depending on the participant. Some examples of healthcare access related to a blatant lack of access by geography, mainly rural communities. Participant 1 stated,

> Okay, I think one of the issues for me, even though I don't live in the rural areas of [redacted]. But I really feel that there are a lot of people that live out in the rural areas who lack getting a really good evaluation from a doctor.

Although not a member of the rural community, they expressed concern for the AA community at large. The participant shared that access in rural areas were an opportunity for local healthcare organizations in improve the health of the AA community and stated,

> I wish that someplace like maybe [name of organization redacted] or [name of organization redacted] to take a… have a bus to go out there to treat the people. Because I think that they're missing out on a lot. In the Black community, we have a lot of health issues. We have high blood pressure, we have a tendency for stroke, sugar diabetes, and the list. The list goes on. So, I think a lot of people out in the rural areas don't get the kind of healthcare that they should.

Other examples were related to access to basic healthcare but limited with no choice of provider or facility. Participant 6 expressed limited access to healthcare with little choice stating, "there's very few… there's a few doctors around that offer primary care."

Lack of access was not the only example with some participants expressing satisfaction with their access to healthcare while citing insurance and employment as the variables facilitating it. Adding income as a variable in access to healthcare, Participant 1 stated

> Now, as far as I'm concerned, because I am employed and I'm working and I have healthcare coverage, It's easy for me to get to a doctor, or call a doctor when I when I'm in need. That's the difference.

The same participant highlighted the impact of income on healthcare in the rural AA community stating,

> To me, it seems like the… the income, like this is a low-income clinic that's out in the community. They lack every… I've had, um, doctors has been there that have really stepped it up when it comes down to my parents' health, um, but recently I haven't had that, but I take it… I'm thinking like maybe it's because they're on Medicaid, maybe because they are at this clinic.

Positive relationships between patient and provider were also described as a factor in access to healthcare. Participant 5 cited the length of the relationship with their primary care provider as a variable in improved access to care "It makes a huge difference. I can go any time I can go as a walk in. I do not even have to make an appointment if an emergency arises."

Theme 4: Satisfaction With Healthcare Experience

Satisfaction with the healthcare experience was another theme to emerge from the data. Satisfaction with the healthcare experience in the context of this study is defined as a positive perception of the healthcare encounter from the perspective of the patient. Satisfactory experiences were described citing long-standing, respectful relationships between the patient and provider and welcoming care environments. One participant stated the following about their experience related to communication with nursing staff. "The nurses in my primary care doctor's office. I love them all. They are so good. They're professional. We joke a lot. You know when I come in, we, we have fun before I actually see my doctor."

Participant 5 described similar satisfaction with their primary care provider while clarifying that the experience was not likely the norm for AA recipients of care. They stated,

> Um Yes now I'm going to be honest. A lot of my experience will deal with them. Physicians and nurses have dealt with for over 20-30 years. So my experience is going to be may be quite different than some other African Americans experiences have been with the healthcare profession.

Theme 5: Dissatisfaction With Healthcare Experience

The theme of dissatisfaction related to healthcare experience related. Multiple participants described a perceived lack of caring on the part the reception staff. The setting of these encounters was inconsistent spanning emergency rooms ambulatory clinics community clinics and primary care offices. Participant 6 recalled an experience stating,

> Going back to the receptionists. I was visibly upset, and I felt like they just didn't care because they didn't ask. I felt insignificant I felt like they just didn't care. They saw me standing there crying hyperventilating and talking to myself but still just didn't ask.

Participant 4 shared a similar experience related to caring of the reception staff stating,

> But, like it just… I can feel from the nurses and the front desk people that this has started… like that constant rolling emotional state… that people waiting are in. It started to take its toll. And for some of those, for some of those people waiting out

> they really just became indifferent to it all. And that’s very much reflected on how they treated people when they come in. It’s very much all business.

Summary

The themes that emerged from the data serve to inform the research question: What is the lived cultural experience of AA recipients of care when interacting with the healthcare system? Communication, a prevalent theme in the lived experience of AA recipients of healthcare, was described by participants as the level of satisfaction with the healthcare experience or encounter as well as the level of patient comfort and trust in the system and the provider. Medical mistrust on a systemic level and at the level of the individual provider was prevalent in the shared experiences of study participants. Examples of trust in healthcare shared by participants present the opportunity to improve the lived experience of AA patients through improved communication. Access to healthcare was another theme that was prevalent in the descriptions shared by participants described as a total lack of access to care and healthcare services, a lack of choice or provider or facility, or ready access to healthcare of choice. Access to and choice of provider facilitated better experiences across participants. The satisfaction with the healthcare experience or encounter was another prevalent theme. Satisfactory experiences were shared through descriptions of positive, respectful communication, while dissatisfaction was expressed where communication with the healthcare provider was not positive.

In this chapter I described the data collection and analysis process. Setting, participants, data collection, and results were presented as well as evidence of trustworthiness. Chapter 5 will present the conclusion of my study and recommendations for further research.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this interpretive phenomenological qualitative study was to explore the lived cultural experiences of AA recipients of healthcare. This study was conducted to address a gap in the peer-reviewed literature regarding the lived experiences and perspectives of the AA population. The results of this study have the potential to provide insights that may inform the development of protocols, programs, or policies that reduce disparities and improve the quality of medical care for AA citizens. In this study, I identified five major themes related to the lived experiences of AA individuals when interacting with the healthcare system: (a) communication, (b) medical mistrust, (c) access to healthcare, (d) satisfaction with healthcare experience, and (e) dissatisfaction with healthcare experience (see Figure 1). In Chapter 5, I describe the interpretation of findings and limitations of the study and provide recommendations for further research and discuss potential implications for social change.

Interpretation of the Findings

Thematic analysis of the shared healthcare experiences of AA participants in this study revealed themes and subthemes largely consistent with current peer-reviewed literature. Cuevas et al. (2016) proposed that improving communication facilitates other improvements in the quality of healthcare encounters. In my study, some participants described communication as a barrier to satisfaction with healthcare encounters; others attributed positive communication to satisfactory experiences. This finding aligns with the assumption that communication is related to other barriers to quality patient–provider interactions.

Findings related to medical mistrust among AA recipients of care add to the current conversation highlighting the opportunities for healthcare, on a systemic and individual level, to implement strategies to build trust with the AA community. Medical mistrust and ineffective patient–provider communication have been shown to negatively impact patient outcomes and disproportionately impact the AA community (Cuevas et al., 2016; Powell et al., 2019). In response, healthcare systems have implemented a goal of providing culturally congruent care to improve the care of diverse communities. The findings of this study indicate a need to better understand the concept of medical mistrust as it is influenced by the goal of culturally congruent care. Participants in my study described mistrust of the concept of culturally congruent care as well as the ability of the healthcare system to implement and manage it.

The theme of access to healthcare revealed in this study expands on the current peer-reviewed narrative. Powell et al. (2019) suggested that preventive healthcare among AA men is impacted by the patient–provider encounter when racism is perceived and medical mistrust is experienced by the recipient of care. Additionally, medical mistrust may not be the singular or most prevalent barrier to healthcare use (Powell et al., 2019). The major theme of access to healthcare in this study supports this assertion as subthemes revealed that the AA community also faces barriers related to total access and access to choice of provider or facility. Participants who shared a positive experience in accessing healthcare services noted that their ability to access care was supported by employment and medical insurance and may not be shared by other AA individuals.

Both satisfaction with and dissatisfaction with healthcare experience as themes expand current peer-reviewed literature and support the importance of the patients' perceptions of the cultural congruence of care provided. Michael (2016) proposed that the concept of diversity in research be expanded to include similarities and differences across diverse populations of people. Participants of this study supported the importance of shared characteristics as they shared the expectation of equal care, not a racially guided approach to caring for diverse communities. These themes and subthemes also support the call for a deeper understanding of AA patients' lived experiences. Friedman et al. (2019) suggested that this understanding may guide healthcare policies and practices that aim to reduce disparities experienced by the AA community.

Leininger's (2006) culture care theory prescribes that, in order to provide culturally congruent nursing care, a competent nurse must understand the cultural influences on nursing care practices. Communication is a key component in the provision of nursing care. Leininger and McFarland (2006) highlighted the importance of active listening, defining it as a universal care construct. The findings of this study support the importance of communication as a facilitator of patient comfort and trust.

The findings of this study provide examples of medical mistrust related to the influence of economic, educational, political, and social factors as prescribed in Leininger's (2006) culture care theory. Participants expressed distrust in the cost of healthcare services provided and the perceived lack of honesty in provider communication related to risk involved with prescribed surgical interventions and medications. Perceived racism of the system and that of individual healthcare professionals was also communicated through the shared experiences of the participants.

Access to healthcare as a theme relates to Leininger's (2006) culture care theory, aligning with the theory's prescribed influences on culturally congruent care. Access was not only described to include a total lack of access to healthcare services influenced by economic, educational, and social factors, but also as a lack of choice. Participants who described unfavorable healthcare experiences still experience a lack of access to their preferred healthcare provider or facility influenced by social and economic factors including geographic location, employment, and insurance policy status.

The culture care theory prescribes that the worldview of the recipient of care and the cultural and social dimensions have the broadest influence on the patient experience (Leininger, 2001). In this context, the themes of satisfaction and dissatisfaction with the healthcare experience provide insight into the worldview of the recipient of care and present common themes from the lived experiences of AA individuals. Despite the importance of worldview's impact on the healthcare choices and behaviors of patients, families, and communities, lack of access and choice more closely align with other Leininger (2001) prescribed influencers: economic and social factors. Subthemes revealed factors that promoted satisfactory experiences, including communication and long-standing relationships with providers, and factors that negatively impacted the healthcare experience.

Limitations of the Study

Limitations to trustworthiness that arose during the execution of this study were identified in the planning stage and addressed. One limitation that was not able to be addressed was the regional nature of the findings. Bleijenbergh et al. (2010) posited that the transferability of studies on racial or ethnic populations may be limited by regional diversity of populations. According to population estimates published by the U.S. Census Bureau (2019), AA individuals account for 13.4% of the total population nationally. In South Carolina, where this study was conducted, the AA community contributes to 27.9% of the total population, which is twice the national percentage (U.S. Census Bureau, 2010). In addition to the size of the local AA community, transferability may also be limited by diversity within regional AA populations and local factors impacting those communities (Drevdahl et al., 2006; Steel et al., 2018).

Recommendations for Further Research

The aim of this phenomenological study was to better understand the lived experiences of AA individuals when interacting with the healthcare system. As healthcare continues to strive to provide culturally congruent care for diverse populations, more research needs to be done to better understand the perceptions of patients these initiatives aim to serve. Cultural competence is a self-reported competency of the provider but the perspective of the care recipient is missing from the conversation (Cuevas et al., 2016). The findings of this study highlight the need to explore ways to evaluate the effectiveness of strategies aimed at improving the healthcare experiences of AAs.

The necessity of exploring medical mistrust on a broader level was evident in the findings of this study. Current peer-reviewed literature supports the negative impact of medical mistrust on the provision of equitable, quality healthcare and the need to further explore the perception of the recipient of care (Cuevas et al., 2016; Shen et al., 2018; Williamson et al., 2019). The historical roots of medical mistrust among AA are deep, and its influence on the effectiveness of many patient–provider encounters may not be avoided. Thus, further research is needed to better understand the span of medical mistrust and identify specific strategies to address mistrust on a systemic level using population-based approaches.

Broad concepts of culture have been shown to contribute to the oversimplification of culture and the minimization of the individual experience (Cuevas et al., 2016; Trittin & Schoeneborn, 2017). There remains a lack of consensus in research literature related to a standard set of factors and variables that define a cultural group (Foronda, 2020; Meleis, 1996). In addition, current strategies including cultural competency are designed and evaluated through the lens of the healthcare professional, not the recipient of care (Alizadeh & Chaven, 2016; Cuevas et al., 2016). Further research into the lived experience of individuals and their perceptions of the care provided by healthcare is needed to inform strategies to improve the health and healthcare utilization of the larger AA community. The recommendation is that researchers engage in more participatory research methods that include members of the AA community and provide them with the opportunity to tell researchers that is important to them (International Collaboration for Participatory Health Research, n.d.). The outcomes of these recommended studies can help inform the development of programs and strategies that partner the researcher and the community they aim to support through their findings.

Implications

The themes identified in this phenomenological study align with the current conversation regarding the health and wellbeing of the AA community. The AA community faces challenges in the access to and utilization of healthcare services and is disproportionately affected by healthcare disparities. These barriers and disparities are compounded by perceived racism, medical mistrust, and breakdowns in patient/provider communication. As healthcare on a global scale develops and implements strategies aiming to improve the health of AA and other underrepresented ethic and racial minorities, it is critical that researchers and healthcare professionals engage and partner with patients and families to ensure that AA recipients of healthcare voices are present in the conversation. The findings presented in the form of themes and subthemes have the potential to add support to the importance of the perception of the recipient of care in efforts and the diversity across populations defined simply by race or ethnicity.

The findings of this study also present recommendations for practice related to culturally competent care as a strategy to address disparities impacting the health of the AA community. Described as impractical by some experts who are calling for a shift to cultural humility, cultural competence is not a one size fits all solution and is shown to oversimplify culture and proliferate stereotypes about the patients intended to benefit from the strategy (Kersey-Matusiak, 2013; Markova & Broome, 2007). Furthermore, culturally competent care through the lens of the patient or family may not align with the intent of the concept and may perpetuate medical mistrust. Consensus was evident that the participants of this study favored the idea of equitable care for all, not racially driven care for the AA community. The themes revealed through the stories and experiences shared by the participants of this study are evidence that positive social change can be achieved by thoughtfully designing new approaches to education and training programs aimed at developing cultural competence among student nurses, practicing nurses, and other providers. Thus, the knowledge gained in this study may be applied in the healthcare setting to improve the comfort, engagement, and the ability to address the needs of each individual patient rather than that of a larger community defined by a single characteristic: race.

Conclusion

In completing this study, I explored the lived experience of AA recipients of healthcare through the thematic analysis of stories shared in recorded telephone interviews. The findings of this study support the need for action on the part of the healthcare system aiming to improve the health of the AA community. The shared experiences of the participants in this study support the importance of communication, medical mistrust, and access to healthcare as they impact and influence the AA patient/family healthcare experience and frame opportunities to address healthcare disparities in the AA population.

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Appendix A: Interview Protocol

Date of Interview:

Start Time:

End Time:

Participant Identification Number:

Date Informed Consent Obtained via Email:

Introduction to Interview Session:

Hello, [participant name]. Thank you for participating in this research study. This research aims to better understand the African American experience when interacting with the healthcare system, which includes individual healthcare professionals and organizations. I will be asking you a series of interview questions that are asking about your personal experiences during your interactions with healthcare system. There are no right or wrong answers. Please provide as much detail as you are comfortable sharing. If you feel uncomfortable at any time and wish to stop the interview, please let me know.

Interview Questions:

Main Research Question: What is the lived cultural experience of African American recipients of care when interacting with the healthcare system?

Interview Question	**Probing Questions**
Describe your most recent experience receiving healthcare.	What do you remember about the waiting room? What do you remember about the people you encountered? How did ____ make you feel?

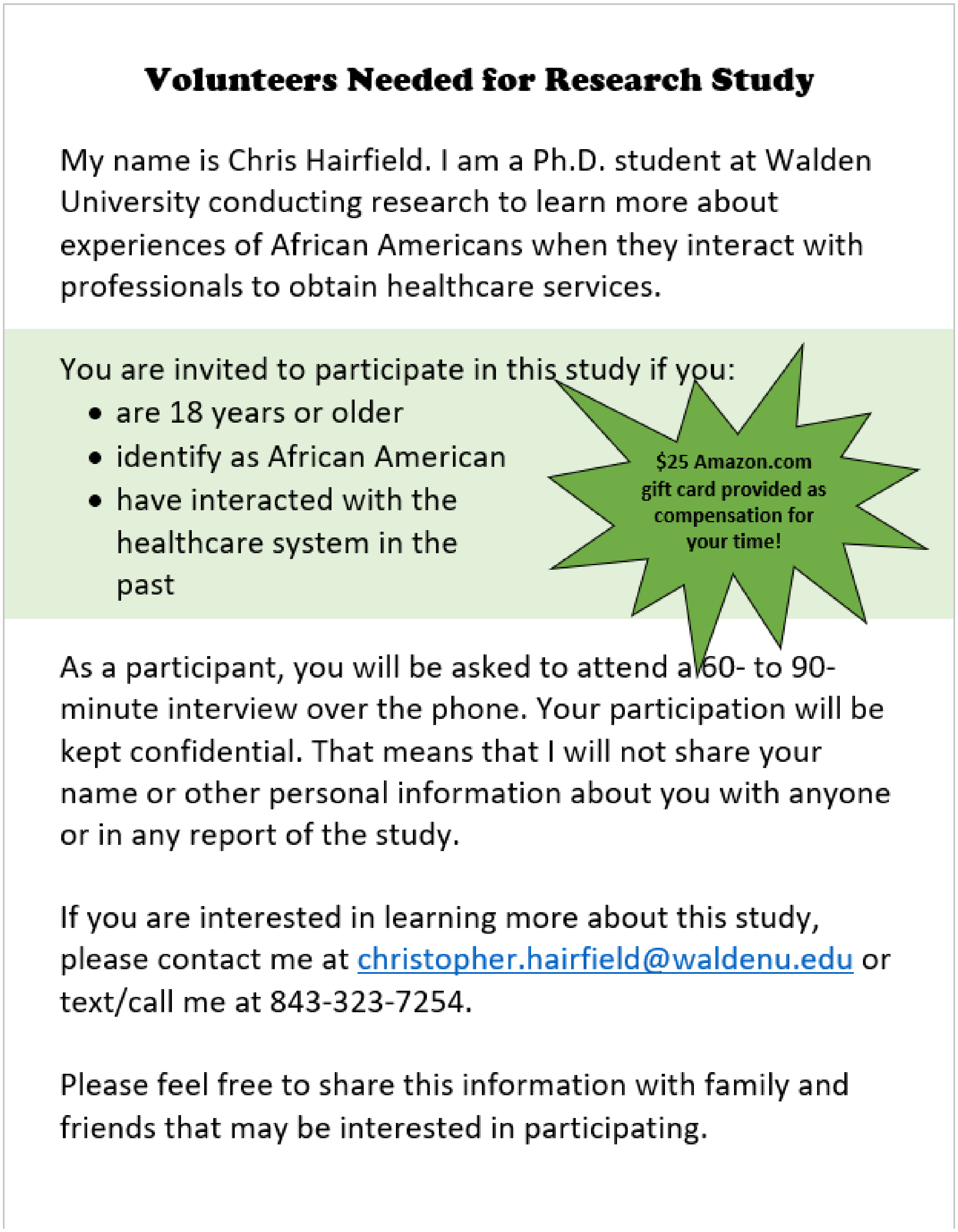
	Tell me more about ____ (Creswell & Creswell, 2018). What do you mean by ____ (Creswell & Creswell, 2018)?
Describe a specific experience that involved communication with a nurse	How did the encounter make you feel? Do you believe that the nurse understood what you were concerned about? How did ____ make you feel? Tell me more about ____ (Creswell & Creswell, 2018). What do you mean by ____ (Creswell & Creswell, 2018)?
Describe a specific experience that involved communication with a doctor.	How did the encounter make you feel? Do you remember anything specific about the communication style of the doctor? Do you believe the doctor understood what you were concerned about? How did ____ make you feel? Tell me more about ____ (Creswell & Creswell, 2018). What do you mean by ____ (Creswell & Creswell, 2018)?
Describe your experiences as a visitor or family member in a hospital or doctor's office.	How did ____ make you feel? Tell me more about ____ (Creswell & Creswell, 2018). What do you mean by ____ (Creswell & Creswell, 2018)?
What does the term culturally competent care mean to you?	Tell me more about ____ (Creswell & Creswell, 2018).

	What do you mean by ____ (Creswell & Creswell, 2018)?
What is most important to you as a patient?	Tell me more about ____ (Creswell & Creswell, 2018). What do you mean by ____ (Creswell & Creswell, 2018)?
Is there anything you would like to share about your personal experiences interacting with healthcare providers or the healthcare systems?	Tell me more about ____ (Creswell & Creswell, 2018). What do you mean by ____ (Creswell & Creswell, 2018)?

Closing Statement:

Thank you very much for participating in my research study. I will mail you a letter thanking you for your participation. The letter will include a $25 Amazon.com gift card to compensate you for your time. At the conclusion of the study, I will mail all participants a typed 2-page summary of my findings. Please reach out to me if you have any questions.

Appendix B: Recruitment Flyer



Volunteers Needed for Research Study

My name is Chris Hairfield. I am a Ph.D. student at Walden University conducting research to learn more about experiences of African Americans when they interact with professionals to obtain healthcare services.

You are invited to participate in this study if you:

- are 18 years or older
- identify as African American
- have interacted with the healthcare system in the past

$25 Amazon.com gift card provided as compensation for your time!

As a participant, you will be asked to attend a 60- to 90-minute interview over the phone. Your participation will be kept confidential. That means that I will not share your name or other personal information about you with anyone or in any report of the study.

If you are interested in learning more about this study, please contact me at christopher.hairfield@waldenu.edu or text/call me at 843-323-7254.

Please feel free to share this information with family and friends that may be interested in participating.

Appendix C: Screening Questionnaire

Date:

Participant Email:

Hello. My name is Chris Hairfield, and I am a doctoral student at Walden University. I appreciate your interest in participating in my study about the lived healthcare experience of African Americans. My study aims to improve the understanding of challenges faced by African American participants when they encounter the healthcare system. The following questions are used to ensure you qualify to participate in the study.

Do you identify as an African American?	YES	NO
Are you at least 18 years of age?	YES	NO
Have you ever interacted with the local healthcare system?	YES	NO
Do you have access to a computer, mobile device, or telephone?	YES	NO
Are you willing to share your healthcare experiences in a virtual interview?	YES	NO
Are you willing to be video recorded during your interview?	YES	NO

Thank you for responding to these questions.

Appendix D: Coding Protocol

This coding protocol outlines the steps described by Rubin and Rubin (2012) in *Qualitative Data: The Art of Hearing Data*. The steps listed will be followed in the coding, analysis, and synthesis of data collected.

Coding

1. Identify and label events, topical markers, quotes, examples, concepts, and themes.
2. Review all data identified.
3. Start coding themes and concepts related to the research and interview questions.
4. Identify these and concepts emphasized by participants.
5. Review quotes to identify additional themes emphasized by participants.
6. Review quotes to identify additional themes emphasized by participants.
7. Assign a code or label to each concept or theme that will be used in coding the data.
8. Define codes to ensure consistency.
9. Review transcripts for sections that correspond to identified codes.
10. Compile excerpts associated with labels into a single Excel file.

Thematic Analysis

1. Sort and summarize the codes.
2. Combined codes into themes.

Synthesis

Determine the meaning of analyzed data.