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Affirming Expectations: African American Men's Perceptions Of Trust In Physicians

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AFFIRMING EXPECTATIONS: AFRICAN AMERICAN MEN'S PERCEPTIONS OF TRUST IN PHYSICIANS

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DEDICATION

This work is dedicated to the memory of Sonya Young, NaKiesha Brown, and other family members and loved ones who have transitioned to the Light…Thank you ancestors and all of the nameless faces who have fought and continue to fight for a greater Humanity. I am because of you all.

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CHAPTER 1

INTRODUCTION

Trust is the foundation of the doctor-patient relationship (Murray, 2015; Mechanic, 1996). It promotes healing and medical efficacy. Patient trust in physicians exists when doctors act in their patients' best interests (Hall, Dugan, Zheng, & Mishra, 2001). Dimensions of interpersonal trust include fidelity, compassion, competence, honesty, dependability, and confidentiality. Moreover, trust consists of patients' expected behaviors of physicians, which may vary depending on the particular experience or medical interaction that patients receive from doctors. Patient trust in physicians is normally implicitly anticipated rather than explicitly articulated and discussed (Skirbekk, Middelthon, Hjortdahl, & Finset, 2011; Thom, Hall, & Pawlson, 2004). In order to establish trust, both patients and physicians need to convey their expectations during medical encounters. Patients who trust their physicians are less likely to feel detached, manipulated, and dehumanized when receiving medical care (Branch, 2014; Bosk, 2008).

This study examined how African American[1] men conceptualize (define) trust in physicians and it explored factors that influence trust. Historically, African Americans have had relatively little reason to trust medical organizations and other institutions. For example, during slavery, slaves were denied access to formal health care. Slave cadavers and in some cases slaves were used in medical experiments that many times approximated torture (Bankole, 1998). Also, between 1929-1977, thousands of poor Black and other women of color were involuntarily sterilized after childbirth or a routine medical procedure as part of the United States government's eugenics movement (English, 2004). Moreover, The Tuskegee Syphilis Study,

[1] The terms African American and Black are used interchangeably throughout this dissertation.

which ran from the 1930's into the 1970's was a grossly unethical and racist study where 399 Black men were researched by the United States Public Health Service and were denied access to treatment for syphilis, even after penicillin was scientifically proven to cure the disease in 1947 (Boulware et al., 2003; Armstrong, 2007; Guffey & Yang, 2012). The African American men were never informed that they had syphilis; they instead were told that they had "bad blood." Furthermore, recent studies reveal that clinicians' implicit (unconscious) racial biases may negatively impact how health care providers diagnose and treat racial minority groups because implicit biases manifest into how physicians treat and care for their patients (Stone & Moskowitz, 2011). Implicit racial biases may also contribute to Blacks' mistrust and greater skepticism in doctors and other health professionals than Whites.

Such distrust may have implications for the relatively poor health outcomes of African Americans. Compared to Whites, African Americans experience poorer quality of health care in treatment of cardiovascular disease, referral rates for clinical exams, mental health assessment services, pain management, and suffer disproportionately from treatable and preventable illnesses, such as asthma, diabetes, and heart disease (Williams, 2012; Stone & Moskowitz, 2011; Phelan, Link, & Tehranifar, 2010; Sabin, Nosek, Greenwald, & Rivara, 2009; Musa, Harris, Silverman, & Thomas, 2009). Blacks have higher rates of morbidity and mortality than their White counterparts for most indicators of physical health. Also, there is quite a bit of evidence that experiences with racial prejudice that Blacks and other marginalized groups experience are correlated with their reported lower levels of medical mistrust (Armstrong, 2007; Dovidio et al., 2008). Historically (and contemporarily), African Americans are less likely than Whites to trust clinicians and the medical community because of the history of discrimination, clinical racism, unethical medical practices, and exploitation by the health care system

(Williams, 2012; Simonds et al., 2013; King, 2003; Murray, 2015). David Williams (2012) argues that institutional policies and implicit biases that stem from racial stereotypes impact health disparities. He contends that structural inequalities, such as residential segregation contribute to concentrations of poverty and violence in communities. Moreover, these neighborhoods that African Americans disproportionately live in make it very difficult for Blacks to escape poverty and live mentally and physically healthy lives.

Despite the important work done on race and health, there is still much to learn about the role that trust plays in the health behaviors and attitudes of Black men. Most research on patient trust in physicians is on Caucasian patients or it compares White-Black trust levels. Furthermore, the vast majority of studies that examine African Americans' views of trust are quantitative (Jacobs et al., 2006). More *qualitative* research of how physicians behave and communicate with patients is needed to improve our understanding about Black men's views of trust in medical relationships. The qualitative approach provides a rich, in-depth, holistic understanding and description of people's experiences of trust or mistrust (Timmermans, 2013; Creswell, 2013; Branch, 2014; Andersen & Taylor, 2008). This research approach gives greater voice to participants' medical experiences. The narratives allowed me to examine the nuances in attitudes when describing medical encounters. Conducting qualitative research of patient trust in physicians may examine patients' (and physicians') implicit and explicit attitudes in discordant medical conditions. Such studies may also provide interventions to reduce in-group-out-group biases (Penner et al., 2009; Dovidio et al., 2008). Also, such research can increase health care providers' sensitivity in how they interact with their patients from all racial/ethnic backgrounds.

Furthermore, conducting a qualitative study that investigates Black males' perceptions of interpersonal trust in physicians is needed to gain a deeper understanding of the underlying

issues, attitudes, and experiences that Black men have in medical encounters (Timmermans, 2013). This exploration may encourage physicians and other health care professionals to interact and communicate differently and more effectively with Black male patients, which may reduce health disparities and increase medical compliance (Jacobs et al., 2006). This study adds to the knowledge and understanding of Black males' perceptions of trust in physicians and its implications may combat health care disparities and improve overall health among all individuals (Penner et al., 2009). The research questions subsumed in this study were:

1. What factors influence trust in physicians?
2. In what ways does trust in physicians influence medical compliance?
3. How does doctor-patient interaction impact trust in physicians?

Symbolic Interactionist Theory elucidates the existence of patient trust (and distrust) in physicians and increases our understanding of the communication problems/rapport that may persist among Black patients and medical professionals. Since patient trust in physicians is subjective and socially constructed, it necessitates examinations of social interaction that occurs between individuals (Weitz, 2012). Symbolic interactionism is a major theoretical perspective that emphasizes creating subjective meaning through the process of social interaction and human behavior. Symbolic interactionism takes on the idea that when individuals engage and communicate, they adjust to the actions of others. Thus, when people interact, their gestures, tones, and body language (both verbal and non-verbal) represent symbolic objects (Calhoun et al., 2012b). During human interaction, individuals do not respond to others' direct actions or words. Instead, they respond to their *interpretations* of these symbols, which create meaning in their everyday lives. Symbolic interactionism may explain trust in physicians specifically, within the context of doctor-patient interaction and communication (Cockerham, 2012; Andersen

& Taylor, 2008). Referring to W.I Thomas's definition of the situation, African American patients may experience an unpleasant doctor-patient encounter due their perceptions and interpretations of physicians' behaviors and verbal and non-verbal communication. For instance, if a physician lacks eye-contact, makes uneasy facial expressions, or displays social distance, Black patients (and other patients of color) may view that negatively and as disengaging, which influences mistrust (Dovidio et al., 2008).

Nevertheless, micro-level interactions do not solely explain the existence of patient trust (and mistrust) in physicians. Social location (e.g., SES, positionality) impacts the nuances in African Americans' perceptions of interpersonal and institutional racism, as well as medical mistrust (King, 2003). Moreover, Blacks' distrust of doctors may have its basis in structural factors (e.g., public policies, White public opinion, corporate interests that require Black labor for their prisons) that are not present in the individual interactions between doctors and patients. That is, clinicians may not be overtly racist or condescending to their Black patients, but the fact that Blacks are disproportionately poor and uneducated likely contributes to Blacks not seeing the doctor for preventative purposes and going to the doctor when they have emergencies (Jacobs et al., 2006; Boulware, 2003). Furthermore, coupled with being financially unable to follow through with doctor's recommendations, Blacks of low SES are also less prepared for the conversations they have with their physicians and are more likely to suffer from health illiteracy, such as not fully understanding what they must do to comply with physicians' recommendations. African Americans of low SES are also more likely to feel intimidated during their encounters and interactions with health care professionals. Such experiences could contribute to Blacks' feelings of physicians talking down to them. Thus, structural factors play a role in how Black

patients interpret the interaction with and perception of their health care providers (Boulware et al., 2003).

Furthermore, there is evidence that structural factors impact African Americans' attitudes of medical trust (Dovidio et al., 2008). For instance, Blacks are more likely than Whites not to receive preventative treatment and less invasive procedures that could have been caught earlier. This may lead Blacks to perceive that doctors do not heal, but they only give bad news and engage in invasive procedures, such as amputations. This could be a cause of mistrust. Also, the basis of Blacks not having as quality health insurance as Caucasians is rooted in White racism and imperialist white supremacist capitalist patriarchy (Williams, 2012 & hooks, 2004). Moreover, much of Whites' opposition to social welfare programs such as universal health care is rooted in racism, i.e., not wanting the government to help "lazy" and "undeserving Blacks." African Americans who are cognizant of the history of medical abuse, clinical racism, and exploitation of Blacks by the United States health care system will be more likely to distrust the system of health care, which increases mistrust in physicians (Williams, 2012; Boulware et al., 2003; Guffey & Yang, 2012).

CHAPTER 2

LITERATURE REVIEW

Empirical evidence has demonstrated that interpersonal trust in physicians is a complex, multidimensional construct that can reliably be measured and is distinct from related concepts such as satisfaction (Hall et al., 2001; Jacobs et al., 2006; Mechanic, 1996). There is also a substantial amount of studies on patient-physician trust. Measuring trust between patients and physicians can explore micro-level and broad system-wide failings of individual communication challenges because it enables both patients and physicians to examine their participation in how they potentially may reinforce and perpetuate communication breakdowns (Mechanic, 1996; Penner et al., 2009).

Trusting patients are more likely to disclose sensitive information and adhere to treatment recommendations, which increase good health outcomes (Simonds, Goins, Krantz, & Garroutte, 2013). Patient trust is also associated with the use of preventative services, such as health screenings and routine check-ups (Cuffee et al., 2013; Guffey & Yang, 2012; Blackstock, Addison, Brennan, & Alao, 2012). Furthermore, trust increases both patients' and physicians' desires to share roles in patient decision-making (Chawla & Arora, 2013; Peek, Gorawara-Bhat, Quinn, Odoms-Young, Wilson, & Chin, 2013). After all, many patients want their voices to be heard, valued, and involved in regard to what happens to *their* minds and bodies. However, Anderson and Dedrick (1990) argue that having extreme trust in physicians may prevent patients from acting autonomously and making important health decisions on their own. Moreover, Mechanic (1996) states, "to trust excessively is to endanger oneself" (p. 175). Although challenging, he urges patients to find a balance between trust and distrust, especially under clinical uncertainty. Davies and Rundall (2000) argue that therapeutic relationships can

potentially become damaged if patients trust physicians unquestioningly. Similarly, Thom and colleagues (2004) note that some patients' trust in physicians can be associated with poorer health care because patients may be less likely to question physicians' treatment and inappropriate medical advice.

However, a considerable amount of research has revealed the positive impact of patient trust in physicians. Thom et al. (2004) argue that trust can reduce the costs associated with physicians' recommendations because it may prevent patients from having unnecessary referrals and diagnostic testing. Moreover, examining trust and different components of health care delivery may improve the health care quality that one receives because it enables physicians and health organizations to recognize that stereotyping and implicit biases contribute to how clinicians diagnose and treat patients (Sabin et al., 2009; Schnittker, 2004; Sabin, Rivara, & Greenwald, 2008; van Ryn & Fu, 2003; van Ryn & Burke, 2000). Also, validated measures of medical trust can help inform public policy and balance market forces by increasing trust as a dimension of health care quality. Since trust is often implicitly and explicitly used in clinics, health care plans, and marketing hospitals, measures of trust could implement changes in the ways of how health care quality is delivered in health organizations (Thom et al., 2004). For instance, surveys that access patient trust in physicians can be used to evaluate how provider and payer organizations monitor and provide incentives to improve physicians and organizations' behaviors to promote patient trust (Thom et al., 2004).

Nonetheless, managed care, breaches of confidentiality, medical fraud and abuse, and highly publicized medical errors contribute to the decline of trust. Unethical medical practices, racism, and discrimination also contribute to the erosion of medical trust (King 2003; Platonova et al., 2008; Hall et al., 2001; Mechanic, 1996; Davies & Rundall, 2000; Thom, Hall, & Pawlson,

2004; Mechanic & McAlpine, 2010; Guffey & Yang, 2012; Stepanikova, 2012). Moreover, empirical evidence suggests that negative medical experiences, poor physician-patient communication, and the recognition of health care disparities increase medical distrust. Hall et al. (2001) define distrust as patients "having anxious or pessimistic views of motivation and expected results" (p. 618).

As Betancourt (2003) and others point out, it is *necessary* that the United States (and the world) continue to increase public health initiatives that improve overall health for people of color and health care disparities in general (Betancourt, 2003; King, 2003; Mechanic & McAlphine, 2010). Furthermore, approximately 75% of all medical interactions for African American patients in the United States involve non-Black health care providers (Penner et al., 2013). King (2003) argues that increasing cultural competence in physician training, providing translators, and increasing clinicians of color are not enough to reduce racial discrimination. A change in physicians' and health care organizations' underlying implicit attitudes may encourage them to act responsively and attentively to marginalized groups. Hence, King argues that a change in consciousness, "at all points of entry to the health care system is imperative if we are to reduce health disparities" (p. 367).

Studies on factors that increase patient trust in physicians have received substantial research attention. Mechanic and Meyer (2000) interviewed 90 breast cancer, chronic Lyme disease, and patients who battled mental illness (30 from each group) in New Jersey. Patients were asked questions about trust concerning their interactions with physicians, medical institutions, and health care plans. The questions focused on competence, agency/fiduciary responsibility, control, disclosure, and confidentiality. The results of the study indicated that patients viewed trust as an iterative process and they challenged their physicians' knowledge.

Compassion and technical competence emerged as the most common themes concerning of trust. However, patients were less concerned with disclosure and confidentiality because they expected and anticipated physicians to be honest (Mechanic & Meyer, 2000). Similar to the results of Mechanic and Meyer's research, Jacobs and colleagues (2006) found that technical competence, compassion, dependability, and good communication skills were the most important qualities of trust among African Americans.

Patient-Health Professional Communication

Ethnic minority patients have less positive perceptions of physicians than White patients (Doescher, Saver, Franks, & Fiscella, 2000; LaVeist, Nickerson, & Bowie, 2000). Fiscella et al. (2004) note that patient-centered care is positively associated with trust. A physician who is patient-centered is one who is attentive, honors patients' voices, encourages narratives, and does not rush or interrupt patients (Skirbekk et al., 2011). Other characteristics of patient-centeredness involve physicians expressing concerns for patients' worries, including patients in medical decisions, and providing patients with information about medication and treatment recommendations, including follow-up instructions (Aragon, Flack, Holland, Richardson, & Clements, 2006). However, Blacks are less likely than Whites to receive patient-centered care. African Americans also report feeling rushed or interrupted by their physician more than their White counterparts (Penner et al., 2013). The concept of patient-centeredness may help explain why Blacks report lower levels of trust physicians than Whites.

Moreover, Hammond (2010) argues that social constructionist ideologies of masculinity may be associated to men's health behaviors and mistrust. Traditional notions of Black manliness include strength, self-reliance, control, confidence, and restrictive emotions. African American men are more likely to receive *physician*-centered care, rather than patient-centered

care (Penner et al., 2013). Physician-centered care focuses more on the physician than the patient. *Physician*-centered care increases mistrust among African American men because some Black men may view this particular type of interaction as a form of disrespect because it limits their agency and control during decision-making processes (Hammond, 2010; Peek et al., 2013).

According to Hall et al. (2001), physician behavior and personality are the strongest predictors of patient trust in physicians. Moreover, Fiscella et al. (2004) investigated if trust was related to patient-centered behavior of primary care physicians. They also found that physician verbal behavior was the most salient factor that influenced patient trust in physicians. Furthermore, several studies consistently indicate that patient trust is strongly correlated to physicians' interpersonal skills and communication styles. More qualitative explorations of how physicians behave and communicate with patients are needed to enhance our understanding about Black men's perceptions of trust in medical relationships. Such research can increase health care providers' sensitivity in how they interact with their patients from all racial/ethnic backgrounds (Penner et al., 2013).

The existing literature on patient-physician communication reveals that patient trust in physicians influences the decision-making process (Trachtenberg, Dugan, & Hall, 2005). Patients may take on autonomous, passive, and/or shared decision-making (SDM) during medical interactions. Thom, Hall, and Pawlson (2004) found that open communication increased patients' perceptions of feeling respected, which improves patients' confidence to be autonomous in decision-making processes. However, patients who trust their doctors are more likely to engage in SDM. Peek and colleagues' (2013) study of African American patients with diabetes reveal that the relationship between trust and SDM is bidirectional in nature. Patients who understood their disease process (learned from patient education) also increased SDM.

However, physicians are less likely to provide Black patients with information about their health, including the benefits and limitations of different treatment options (Dovidio et al., 2008; Peek et al, 2013). This health inequity could contribute to why African American patients are less likely to understand the disease process and share decisions with doctors (Peek et al, 2013). This also may suggest that structural racist forces play a role in reinforcing and perpetuating health illiteracy for Blacks. Furthermore, the results of the study indicated that physician-patient racial concordance, implicit biases, honesty, cultural competency, and patients' ability to tell their stories influenced SDM and trust in doctors (Peek et al., 2013; Doescher et al., 2000).

Correspondingly, Chawla and Arora (2013) found that the majority of cancer patients (61.0%) preferred shared control in decision-making with their physicians, compared to 22-25% of patients who preferred to leave the medical decisions up to their doctors. The authors highlight that patients who allowed physicians to control their medical decisions reported higher levels of trust in their doctors compared to other physicians (Chawla & Arora, 2013). This study supports research that indicates that patients who prefer to a passive role in decision-making may have high levels of trust in their physicians. Moreover, patients who preferred autonomous decision-making were less trusting of physicians. Chawla and Arora argue that "physicians need to tailor their communication behavior to encourage participation and trust among all patients" (p. 592).

Medical Compliance

Numerous studies demonstrate that patients who trust their physicians are more likely to comply with medications and treatment recommendations. However, studies on the association of trust and medication adherence have primarily been on Whites and Black men (Abel & Efird, 2013). Research on the correlation of trust to medication adherence that focuses primarily on

Black women is scant. Nonetheless, O'Malley, Sheppard, Schwartz, and Mandelblatt (2004) found that trust among low-income African American women was associated with recommended preventative services.

HIV/AIDS disproportionately affects African Americans and other disadvantaged groups (Saha, Jacobs, Moore, & Beach, 2010). Blacks account for almost half of all new HIV infections in the United States each year (44%) (Centers for Disease Control and Prevention, 2014). Highly active antiretroviral therapy (HAART), which was approved by the Food and Drug Administration in 1995 has reduced HIV mortality because it decreases viral replications and the development of drug resistance. However, the access to HAART and other HIV treatment is not evenly distributed, particularly along the cleavages of race and SES. Vervoort, Borleffs, Hoepelman, and Grypdonck (2007) reviewed qualitative studies from 1996-2005 on adherence to antiretroviral therapy. They indicate that socioeconomic factors and patient-related factors influence HIV medication adherence. Vervoort et al. also describe that therapy-related factors[2] and condition-related factors (stigma, discrimination, emotional and psychological distress) impact adherence to HAART. They also found that trust in providers and in the health care system motivated adherence to HIV medication (Vervoort, Borleffs, Hoepelman, & Grypdonck, 2007). Patients reported that characteristics that increased trust in clinicians included respecting patients, having great communication skills, and taking the time to listen to patients' stories about how they cope with this stigmatized disease. Saha et al. (2010) also found that enhancing trust in providers may help reduce disparities in HIV adherence.

Similar to having high rates of HIV, African Americans also disproportionately suffer from hypertension (HTN). The prevalence of HTN for Black men in the United States is 45.7%

[2] Therapy-related factors that impact HIV medication adherence are the number of antiretroviral pills, the amount of daily doses, the side-effects related to HAART, the consequences of skipping doses, as well as the food prescriptions that need to be accounted for when taking HAART.

and 43.0% for Black women, compared with 33.9% for White men and 31.3% White women (Cuffee et al., 2013). Abel and Efird's (2013) study exclusively on Black women found that African American women with hypertension who trusted their health care providers were more likely to adhere to their medications. The authors argue that "…it is important that health care providers and Blacks with HTN find ways to transcend the effects of history, restore trust in the health care system, and form collaborative relationships to foster optimal health care" (p. 5). Moreover, Cufee et al. (2013) found that trust mediated 39% of the association between discrimination and medication adherence among inner-city African Americans with hypertension.

The United States has one of the most scientifically and technologically sophisticated health care systems in the world, where complex advances in diagnosis, treatment, and intervention of illnesses have been developed (Penner, Albrecht, Coleman & Norton, 2007). However, many individuals struggle to pay for medications and medical treatment due to expensive health care costs. Piette and colleagues (2005) investigated how diabetic patients' trust in physicians may mediate the influence of economic constraints for cost-related problems of adherence. Their study showed that patients with diabetes who indicated low levels of trust in physicians were significantly more at higher risk for medication non-adherence in response to the costs of medications. In other words, low income people that trusted their physicians were more likely to adhere to medication use than low income people that did not trust their doctors (Piette et al., 2005). Similarly, Bauer et al. (2014) found that low levels of trust and a lack of shared-decision making increased non-adherence among diabetic patients. Moreover, Polinski and colleagues' (2014) research that explored barriers to primary medication compliance

suggests that doctor-patient trust, shared decision-making support, full disclosure of side effects, and cost sensitivity may increase primary adherence for antihypertensive medications.

Race and Trust

Research consistently indicates that race has a profound impact on medical trust. Along these lines, Boulware et al. (2003) found that African Americans were less trusting than Whites toward the three realms of health care delivery (doctors, hospitals, and health insurers). Overall, 71% of the respondents in their study trusted their physicians, 70% of the participants trusted hospitals, and only 28% trusted their health insurance (Boulware et al., 2003). Nonetheless, African Americans were more likely than Whites to report concern about confidentiality and fear of potentially being harmed from medical experiments. This study also reveals that the differences between both races "may reflect divergent cultural experiences that affect the domains of both interpersonal and institutional trust" (p. 362). Interpersonal trust is trust that stems from peoples' direct personal experiences with clinicians, and institutional trust refers to people's impressions of professional organizations (Boulware et al., 2003; Dovidio et al., 2008; Mechanic, 1996). Boulware and colleagues' (2003) findings support published research that African Americans' reports of mistrust and patient-physician concordance (or adherence) that relate to their perceptions of quality of care may be linked to interpersonal race-based discrimination by health care providers (Johnson, Roter, Powe, & Cooper, 2004; Boulware et al., 2003).

There have been a number of studies that have investigated the consequences of medical mistrust among Blacks. However, there has been a dearth of *qualitative* research that has examined how the legacy of racism and discrimination influences African Americans' views of trustworthiness of physicians. Jacobs et al. (2006) recruited 32 Black women and 34 Black men

from a public hospital clinic and a community advocacy organization in Chicago to explore their views of trust in physicians. The participants were put into 9 focus groups of four people. The patients reported that perceptions of physicians' greed, racism, and beliefs of experimentation in routine medical visits increased mistrust (Jacobs et al., 2006). A disturbing finding that the authors concluded is that patients from all focus groups *expected* discrimination by physicians, which can lead to distrust and avoidance of care. Jacobs and colleagues argue that these expectations of racial discrimination may contribute to health care disparities. The authors do not blame African Americans for health care disparities, however they…"highlight the fact that even when discrimination is not a conscious or unconscious intent expectations likely have an impact and need to be addressed" (p. 645). Jacobs et al.'s study contributes to trust research because it identifies factors that influence trust (and mistrust) specifically in African Americans.

Many empirical studies indicate that people of color are less trusting of the medical system than Whites. Armstrong et al. (2007) argue that in spite of the theoretical justifications for studying the variations among races in medical trust, little research has examined the racial/ethnic and geographic differences in distrust in doctors in the United States. In fact, the authors indicate that many prior studies only focus on one metropolitan area and do not explore the racial variations across different areas. For their study, Armstrong et al. explored if fidelity-based trust (the belief that physicians will care for their patient's welfare) among different racial/ethnic groups will vary across the United States. The authors' quantitative study analyzed data from the Community Tracking Study, which took place from 1998-1999. The sample was comprised of 32,047 Black, White, and Hispanic respondents from 48 United States metropolitan areas (Armstrong et al., 2007). However, the study was only limited to people who had a doctor or who had seen a physician within the past year. The dependent variable was fidelity-based

trust. This construct was measured by using 4 items relating to how patients feel their doctors will refer them to medical care and services. Socio-demographic variables were self-reported and the categories for age, education, and insurer type were created.

Armstrong and colleagues' study yielded interesting results. Blacks and Hispanics reported lower levels of trust than their White counterparts. Women reported lower levels of trust than men, and Whites who were health insured indicated higher trust scores than Whites without insurance (Armstrong et al., 2007). Furthermore, in many cities the relationship between race/ethnicity and trust varied by social class and education. The authors note that even after controlling for individual characteristics, there were significant underlying geographic variations in trust in doctors among Whites. In addition to Blacks' and Hispanics' higher mean levels of trust in physicians compared to Whites, Armstrong and colleagues speculate that social, physical, and contextual characteristics of the locations may influence the geographic differences in racial variations in doctor mistrust. For example, regardless of peoples' lived experiences, individuals living in neighborhoods or communities that are inflicted with crime or poverty are more likely to distrust many social and health care aspects (Williams, 2012). Lastly, this article highlights that determinants of physician trust are complex and they vary across different racial/ethnic groups throughout different geographic spaces.

Interwoven systems of power and inequality and individuals' social and geographic locations are not the only factors that influence mistrust in physicians. As previously mentioned, clinicians' implicit or unconscious racial biases also impact patient trust and health care disparities because implicit attitudes may negatively influence how health care providers diagnose and treat African Americans and other disadvantaged patients (Stepanikova, 2012; Dovidio et al., 2008; Green, Carney, Pallin, Ngo, Raymond, Lezzoni, and Banaji, 2007).

Implicit attitudes are beliefs displayed through non-verbal behaviors, such as limited eye contact, body language, subtle avoidance, and other subtle behaviors that convey dislike and unease in the presence of minority patients (Stepanikova, 2012; Quillian, 2006; Dovidio et al., 2008; Sabin, Nosek, Greenwald, & Rivara 2009). Researchers suggest that unconscious racial biases are held by everyone because it is how the brain operates in the context of a culture including stereotypical representations (Quillian, 2006; Kawakami, Phills, Steele, & Dovidio, 2007). Social psychological studies have revealed the subtle influences that stereotypes can have on doctors' judgments and perceptions, which then are manifested in behaviors that affect medical care.

Dovidio et al. (2008) present a review of literature and emphasize that most research on interracial interactions suggest that African Americans have less medical trust than Whites, which can adversely influence medical interactions, particularly, the doctor-patient relationship. Dovidio et al. introduce the concept of *aversive racism*, which is a form of subtle racism where individuals *consciously* promote racial equality and do not view themselves as prejudiced, however they *unconsciously* express negative racial attitudes (Dovidio et al., 2008). The authors express that understanding implicit attitudes during racial interaction is crucial because it reveals the ways in which people act, think, and behave during interracial interaction. Aversive racism can create bias, which often leads to discrimination (Dovidio et al., 2008).

Dovidio and colleagues state that subtle biases impact treatment delivery and medical interactions and it influences medical mistrust among Blacks and other people of color. They explain that research indicates that Whites receive more information from doctors and offered greater opportunity in the decision-making process than Blacks (Dovidio et al., 2008). Also, within the doctor/patient dyad, Whites are significantly more likely to be referred for further

testing, and doctors view Black as less intelligent, more likely to abuse drugs, and less likely to comply with medical recommendations compared to White patients based on previous studies that have examined the consequences of racial bias in health care.

Dovidio et al.'s research has many implications. Examining subtle or implicit biases may serve as an intervention for racial bias and mistrust. The authors propose physicians to apply the Common Group Identity Model, which makes people aware of social categorizations and it enhances rapport between the doctor and the patient, which allows them both to recognize their racial/ethnic differences (Dovidio et al., 2008). This works by individuals consciously changing the focus from in-group (we) and out-group (they), to a more inclusive identity can gain control over in-group favoritism and encourage reduction in bias. Dovidio et al. also emphasize that understanding the complexity of interaction interactions promotes trust and medical efficacy.

Penner et al. (2013) conducted a study to ascertain if intervention based on the Common In-Group Identity Model reduces implicit biases to increase trust in physicians. 14 non-Black physicians and 72 disadvantaged African American patients at a family medicine residency clinic were placed into two groups: the community identity treatment group or a control group (which received standard health information). Then both patients and physicians met for scheduled appointments. Intervention occurred before engaging and 4 and 16 weeks after the intervention. The results of the study showed that the patient trust in physicians were significantly greater in the intervention group compared to the control group (Penner et al., 2013). Interventions such as the Common In-Group Identity Model may increase patient trust and mitigate providers' implicit racial biases among patients of color.

Westergaard et al. (2013) examined the racial differences in trust in health care regarding HIV conspiracy beliefs and vaccine research participation. The study indicated that HIV positive

Black and Mexican Americans reported higher levels of HIV conspiracy beliefs compared to Whites (59% and 58.6% versus 38.9%, P<0.001). In contrast, these two racial/ethnic groups reported that they were *more* willing to participate in vaccine research more than their White counterparts. Westergaard and colleagues argue that despite their suspicions of government conspiracies, African and Mexican Americans' willingness to participate in vaccine research more than Whites may be based on their motivation of potentially receiving beneficial HIV vaccine trial (Westergaard, Beach, Saha, & Jacob, 2013).

Racial/Ethnic and Cultural Identity, Patient-Physician Concordance, and Trust

As previously noted, the majority of Black patients' interactions with physicians are racially discordant (Penner et al., 2013). Moreover, a growing body of literature suggests that racial concordance between patients and providers positively impacts medical trust. Racial concordance occurs when patients and physicians are of the same race (Dovidio et al., 2008; Street, O'Malley, Cooper, & Haidet, 2008). Furthermore, research indicates that African Americans view race concordance in their providers positively primarily due to patients' beliefs that providers share similar cultural values (Guffey & Yang, 2012; Dovidio et al., 2008). These perceptions encourage Blacks to share their medical histories and sensitive information with their physicians.

Similarly, Earl et al. (2013) found that institutional trust and perceived cultural similarity were significantly correlated to trust in providers among African Americans. The study's findings also support previous research that indicates that Blacks' lack of institutional trust is more than an interpersonal issue (Earl et al., 2013; Boulware et al., 2003). Rather it is beliefs and fears about the medical community as a whole. Furthermore, Black patients' attitudes about

provider racial discordance suggests that providers' interactions and communication style are important for reducing trust because African American patients may perceive that the physicians are detached due to the lack of cultural similarities.

To the point, Peters, Benkert, Templin, and Cassidy-Bushrow's (2013) study revealed that African American pregnant women's trust in their providers was not influenced by provider type (physician or midwife), but was related to perceived racism and clinicians' ethnic identity (Peters, Benkert, Templin, & Cassidy-Bushrow, 2013). Correspondingly, Simonds and colleagues (2013) found that 95% of American Indian patients reported trusting their physicians. However, only 46% reported trusting their health care institution. This study may suggest that providers' medical exchanges with American Indian patients who strongly identify with their cultural heritage can pose unique challenges because verbal and non-verbal communication during medical interaction may mean something completely different for non-native cultures. Simonds et al. urge researchers to investigate how minority subpopulations' complex cultural identities influence patient trust (Simonds et al., 2013).

CHAPTER 3

RESEARCH METHODOLOGY

The goal of this study was to examine how African American men conceptualize trust in physicians and it explored factors that influence trust. The qualitative approach is best suited to investigate Black men's perceptions of medical trust because it explores the subjective nature of medical interaction that occurs between patients and physicians. According to Creswell (1994), "A qualitative study is defined as an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting" (p. 1-2). Qualitative inquiry enables researchers to explore the *process of how and why* social situations occur and it investigates determinants of human behavior. Qualitative research generally takes on the inductive model of science which moves from specific observations, the discovery of patterns, the formulation of hypotheses, and lastly to broader generalizations and theories (Creswell 2014; Babbie, 2012).

Moreover, the qualitative approach is rich in detail and allows the researcher to study the nuances in attitudes that Black men have within medical encounters (Creswell, 2014). In doing so, it seeks to give greater voice to respondents' medical experiences. Moreover, qualitative research of how physicians behave and communicate with patients is needed to improve our understanding about Black men's views of trust in medical relationships. This exploration may raise consciousness and encourage physicians and other health care professionals to interact and communicate differently and more effectively with Black male patients, which may reduce health disparities and increase medical compliance (Penner et al., 2013; Dovidio et al., 2008).

Furthermore, conducting qualitative research of patient trust in physicians may examine patients' (and physicians') implicit and explicit attitudes in discordant medical conditions (Dovidio et al., 2008; Jacobs et al., 2006). This qualitative study is needed to gain a deeper understanding of the underlying issues, attitudes, and experiences that Black men have in medical realms. Three research questions guided this study:

1. What factors influence trust in physicians?
2. In what ways does trust in physicians influence medical compliance?
3. How does doctor-patient interaction impact trust in physicians?

Ethical Considerations

This study took place after the approval from Wayne State University's Institutional Review Board (IRB). Furthermore, informed consent, voluntary participation, confidentiality, and no harm to participants are important ethically linked concepts when studying human subjects. These concepts were highlighted in the research consent form. For this research, all participants read the research information document that explained the goals of the researcher's study and the potential risks involved. It described the length of the study and stated that there were minimal risks (emotional, psychological, and/or physical) to the participant. However, in the case that a participant *was* harmed during any part of the research process, the research information document listed the services that would help to resolve the harm, such as offering the participants referrals to treatment or counseling (Creswell, 2014). Moreover, under no circumstances were participants coerced or pressured to take part of the study. The research information sheet stated that participants had the right to drop out during any time or part of the study without fear of retaliation, harassment, humiliation, embarrassment, or job loss. The

consent form also explained that the study would rely upon pseudonyms and change other identifying characteristics to maintain respondent confidentiality.

Sample: This study relied upon purposive and snowball sampling. Purposive sampling is where participants are recruited based on particular characteristics of a population that are relevant to a researcher's study (Creswell, 2014). The participants were 20 African American men ages 18 and older who had received some form of medical treatment at a health care facility in the past 12 months. Snowball sampling is when existing participants refer or recruit future respondents (Creswell, 2014). Participants were asked to identify other potential subjects. This sampling technique is especially useful when it is difficult finding participants for particular types of research. Furthermore, since trust literature demonstrates that social location impacts individuals' views of medical trust, Black men's experiences and perceptions of patient trust in physicians from different SES groups were compared (King 2003; Jacobs et al., 2006). Participants were recruited from Wayne State University, clinics, community organizations, and barbershops in inner city Detroit, the Detroit metropolitan area, Lansing, East Lansing, and Grand Rapids, MI (King, 2003; Williams, 2012). In seeking this purposive sample, I posted flyers advertising the study and offered $10 as an incentive to participate. The participants were recruited from January 11, 2015 to March 03, 2015.

Data Collection: I conducted one-on-one, open-ended, in-depth, semi-structured interviews that explored patients' trust in physicians. Semi-structured interviews allowed both the subjects and the researcher to have control in the study. It also helped to reduce interviewees from getting off of the topic (Creswell, 2014). I asked the participants 20 questions and the interviews lasted approximately 25-55 minutes. Questions: Respondents were asked to define what *trust in doctors meant to them* and they described qualities/characteristics that increased

and decreased trust (or distrust). I also asked participants about their experiences that led them to trust a physician and situations that have caused them to establish or lose trust. Respondents were encouraged to ask if they needed clarification or elaboration on a question. Also, I observed, took notes, and recorded respondents' mood and non-verbal communication. Each interview was auto-recorded and tapes were transcribed verbatim by the researcher. Participants also completed a brief demographic survey prior to their interviews.

Data Analysis: Transcripts were imported into the qualitative data analysis software, ATLAS.ti for organizing and coding the qualitative data. ATLAS.ti was very helpful in assisting with open coding because it enabled the researcher to mark a passage to create and assign codes (ATLAS.ti, 2014). The program also helped with coding management because after placing each code under a category, the researcher was able to describe the connections between the categories. These categories and connections were the result of the study, which is useful for both selective and axial coding. ATLAS.ti also allowed the researcher to merge codes and streamline the code lists, which removes unnecessary synonyms and improves the quality of the terminology (ATLAS.ti, 2014). Moreover, salient themes emerged from the interviews. Transcripts were coded using grounded theory. Developed by Glaser and Strauss (1967), grounded theory is derived from data that analyzes the patterns, themes, and common categories discovered in observational data (Strauss & Corbin, 1998). The categories for my research included: 1) Caring, 2) Communicating clearly and completely, 3) Honesty/respect for patient, 4) Providing appropriate and effective treatment, 5) Thoroughness in evaluation, 6) Partner-building, 7) Understanding the patient's individual experience, 8) Technical Competence, 9) Time, 10) Being personable, and 11) Feeling a sense of security.

I used *open coding*, which labels and categorizes observations through a close examination of data (Strauss & Corbin, 1998). Open coding primarily focuses on text to define concepts and categories. Strauss and Corbin state that…"during open coding, data are broken down into discrete parts, closely examined, and compared for similarities and differences" (p. 102). This exploration may lead to new discoveries and assumptions. I also read and re-read the data and labeled the responses, identifying definitions of when each theme occurred, descriptions of how to know when each theme occured, and using both positive and negative aspects of patient trust in a physician helped to reduce confusion when looking for themes (Saldaña, 2013; Babbie, 2012).

Next, I used *axial coding* to identify the primary concepts of the study and to make connections amongst the categories and subcategories (Babbie, 2012). This involved exploring the context, conditions, and outcomes that influence trust or distrust (Creswell, 2014). Lastly, I used *selective coding*. Selective coding is "the integration of concepts around a core category and the filling in of categories in need of further development and refinement" (Stauss & Corbin, 1998, p. 236-237). Selective coding builds on open and axial coding by systematically relating and validating the relationships of categories and by confirming and disconfirming the relationships of the categories.

To ensure accuracy, validity, and credibility of the data, three other researchers reviewed the same data to clarify any discrepancies in coding and to verify reliability. I used member checking, which followed up with the respondents with my findings to confirm or modify my discoveries (Harper & Cole, 2012). Interviewees also received a copy of the transcripts for respondent validation. I also memoed during the entire research process. Memoing is recording reflective notes that I will make to myself during the research process of what I am learning.

The notes reflected concepts, categories, and relationships about categories. Memos also contributed to the credibility of the qualitative research process (Creswell, 2014; Babbie 2012).

CHAPTER 4

RESULTS: FACTORS THAT INFLUENCE TRUST

The African American men's varied and nuanced medical experiences illuminate multidimensional aspects of interpersonal trust in physicians including, fidelity, compassion, competence, honesty, dependability, and confidentiality. Their rich narratives also delineate how *time* and navigating various spaces (e.g., geographical region and social location) influence trust. The focus of this chapter is the discussion of participants' views of the factors that influence trust in physicians. Some of the responses included, caring, technical competence, thoroughness in evaluation, providing appropriate treatment, good communication, partnership building, being personable, and feeling a sense of security.

Views of How Being a Black Male Impact Medical Treatment

More than half of the participants (N=13) indicated having neutral thoughts or they *did not* believe that being a Black male impacted how their physician treated them. However, Xavier a 25 year-old man, and Julius, a 46 year-old man and father of two, believed that being a Black male *positively* influenced their medical treatment. With having family histories of diabetes and high blood pressure, both men appreciated being informed of health risks and trends that disproportionately affect Black men. They indicated that being an African American man potentially increased receiving more thorough and comprehensive health assessments, such as their physicians taking extra precautions and measures during routine health screenings and exams. Xavier explained,

> Um, and you know, one time one person [doctor] pointed it out, we look for these certain things because they are a part of, you know, your family tradition…It's possible that you may run into some glaucoma issues and things like that. So, I think as an African American male there are certain procedures and certain steps doctors take—extra [ones] to focus on.

Like Xavier, Julius stated,

> The main thing is because I am an African American male, he's very, very concerned about, um…for me, blood pressure and diabetes, especially since [high] blood pressure runs in my family. I'm the only person in my family that doesn't have high blood pressure. Umm…so he wants to make sure that it stays that way. I'm also—you know, he's always on me about my weight because he does not want me to develop type II diabetes even though my blood work every year comes back that I'm okay. But he just wants me to reduce the risk factors and he's always telling me—you lost some weight, but you need to keep losing some more. You know, so he is concerned.

However, the five other participants (N=5) described their skepticism that physicians did *not* have racial biases (implicit or explicit) when treating them. Anwar, a 34 year-old man, recounted that although his primary care physician had not overtly said or did anything that he perceived as being racially biased, he often found himself ruminating about potentially being treated differently because of his gender and race. He described his experiences of being an African American male patient in the context of living in a highly racialized society. Anwar stated that health care disparities are manifestations of systematic biases and racial discrimination.

> As much I try to be objective, many times, I *cannot* be. Especially knowing how the medical community stereotypes people of color…and *that* affects treatment and their health outcomes...Just look at the health disparities right now. It's *Blacks* that have it the worst! I do wonder if having Black skin influences how doctors treat me. So yes, I am sensitive as to how I think my doctor views me *because I have to be*! *They* [clinicians] may not care about me, but *I* care about me. And I have to protect my health and my life!

Similar to Anwar, Larry, a 54 year-old man with a history of having two strokes, high blood pressure, and gout, stated that although *his* Caucasian physician was friendly, several other clinicians in the medical facility were condescending and had "snobby" attitudes. He believed that African Americans have unique medical experiences because of their race. Larry indicated

feeling that many of the medical staff only talked to him out of obligation; because it was their job. He noted that, "We as Black people have to go through that."

Furthermore, some participants believed that their doctors initially had preconceived notions about African American males as being unintelligent, inarticulate, and that their medical care needed to be policed. Quincy, a 34 year-old man who was recovering from a blood clot surgery, stated,

> …The feelings that I have in seeing the different physicians is that…they sometimes have the perception of Black men as not being as intelligent or not being as…connected to their own medical care. Like often times I feel like the statements that they make are sort of very general and like, oh—almost as if you're not concerned yourself about what's happening to you—[so] I need to be concerned about [his health] because I'm your doctor. So I think *that* feeling, like an example I would say is like, a recent time [that] I went to the doctor she mentioned something about, making sure I make it to my appointments. And my response was, *wait*, [laughing] I've never missed a doctor's appointment okay. And if it is the case that you might be *careless* in scheduling appointments, that's on you. But I know that you didn't give me an appointment. So I feel like often times there's a perception of we're [African American men] not as concerned [about our health] and that someone needs to be concerned for us. And I've gotten that on more than one occasion…

Rashad, a 33 year-old man and doctoral student, indicated that various physicians over the years seemed shocked that he was educated and able to communicate eloquently and in ways in which doctors were not expecting. He explained that during a recent routine check-up, the types of questions that he asked seemed to intimidate his physicians because they acted flustered and did not know quite how to answer his questions. Furthermore, some participants indicated that the assumptions of Black men as being unintelligent were somewhat debunked when the participants began communicating and interacting with their physicians in ways that were not "stereotypically Black." For instance, Jamal, a 24-year old man and pre-med student, believed that his race and cultural background impacted how his physician initially treated him. He

explained that irrespective how many cultural diversity courses physicians take, he still felt that doctors still had racial biases. He stated, "When my doctor sees me he's like okay, you do have some sense of education, so maybe you don't smoke all of the time [or] drink all [of] the time."

Like Jamal and Rashad, Dwight, a 65 year-old man and the eldest participant in the study, explained that being a Black male affected how his physicians treated him on a broader scale. He conveyed the view that doctors initially stereotype Black men on appearance, such as how they are dressed. However, he explained that, "that can be adjusted and amended based on your personality and your relationship with your care giver."

The aforementioned narratives are couched in terms of systematic oppression and domination, such as participants discussing the stereotyping and racial discrimination that African Americans (and other people of color) navigate daily, and even in medical settings. Moreover, some of the interviewees stated that physicians *treating* them differently because of the farcical and caricatured portrayals (stereotypes) of Black men, influenced mistrust in physicians. Other interviewees highlighted how racial/cultural patient-physician concordance facilitated trust and mitigated the judgments of being a Black and male body in dominantly White medical spaces. As previously noted, racial concordance occurs when patients and physicians are of the same race (Dovidio et al., 2008).

Gerren, a 28 year-old man, indicated that being an African American male made it a bit more difficult when it came to finding a doctor that can relate to him. He stated that he had only had one doctor who was Black and he was a well-known specialist, with whom he formed a great relationship. He stated that every other doctor he previously had were Asian Indian or White. His most current physician was Latino. Gerren explained, "I think most of them [non-Black physicians] go by statistics, so it's harder for them to relate on a personal level." Another

participant, Malcolm, a 34 year-old man, revealed that he preferred his physician being African American because he experienced a sense of connectedness or relatability. He expressed that having the same racial and cultural identity of his physician helped to build trust "because it's a feeling as though he's been there, done that—even though we're not the same person I can relate to him and he can relate to me."

Factors that Influence Trust in Physicians

Several salient themes for factors that influenced trust in physicians emerged from the interviews. The categories for my research included: 1) Caring, 2) Communicating clearly and completely, 3) Honesty/respect for patient, 4) Providing appropriate and effective treatment, 5) Thoroughness in evaluation, 6) Partner-building, 7) Understanding the patient's individual experience, 8) Technical Competence, 9) Time, 10) Being personable, and 11) Feeling a sense of security. Other qualities that increased trust were kindness, compassion, physicians listening to patients and asking them questions about their health, and maintaining confidentiality. Moreover, the men in this study explained that trust in physicians consisted of physicians giving high quality, effective care, and doctors doing everything in their power to help and not exploiting patients in the process.

Two men in the study (N=2) indicated that building trust necessitates physicians treating the *whole* person, not just a body or symptoms. Hence, viewing health *holistically* increased trust. For Lorenzo, a 29 year-old man, trust in a physician encompassed his physician taking into account his mental, spiritual, and physical well-being. He stated that physicians need to consider the potential causes of the ailment, such as the dynamics surrounding patients' symptoms and not just a blanket solution for the symptoms. Thus, Lorenzo believed that physicians could only truly devise an appropriate health plan based on listening to patients' full, personal stories.

Correspondingly, Anwar noted that he did not want his physician to treat him like a symptom or an illness, but rather like a human being who exhibited symptoms or an illness. He stated that during doctor's visits, physicians should also inquire about patients' mental health. Anwar explained that, "Since some physical ailments are manifestations of people's psychological states, doctors need to assess their patients' state of minds and hearts, not just their bodies. Now that is true healing."

The men in this study were asked to describe *what trust meant to them* and what qualities increased trust in their doctors. In addition to providing responses to the previously mentioned categories of trust above, powerful themes of feeling *comfortable* and *unafraid* with their physicians resonated throughout some of the men's narratives. Khalil, a 33 year-old man and father of two, stated that "trust to me means that my doctor will make me feel comfortable and will provide me with a sense of security with all of my medical needs." Similarly, Marcel, a 44 year-old man and father of three, stated that,

> I guess trust would be that you feel comfortable…having dialogue between—what's going on with your body and not feeling afraid to ask the doctor additional questions or ask for additional things, additional tests whatever, maybe [be]cause you don't feel right, you know. Having that trust to being able to call him and say hey, "I don't feel good, can you do x, y, and z."

28 year-old Gerren also emphasized the importance of feeling comfortable and being able to disclose sensitive information to his physician without feeling *judged* or *stigmatized*. He stated that, "Trust is a very important factor. [It is] feeling comfortable with them [doctors] enough to tell [doctors] everything without feeling ashamed." Furthermore, when describing the qualities that increased trust in physicians, Gerren revealed that physicians who were personable increased his comfort level, which influenced trust. He explained,

> Being able to connect with them [doctors] on a personal level and not just for medical reasons. I need to be able to feel comfortable with them and they need to be a people person. It's harder for me to be open to someone who is unapproachable and preachy. I have to feel that I can tell that person anything without the judgment factor.

A few of the men (N=3) defined trust in their doctors primarily as being *confident* in physicians' technical competence (possessing the tools and knowledge to provide appropriate care) (Penner et al., 2009). Andre, a 30 year-old man, stated that trust for him meant, "Being confident that doctors are knowledgeable and will not do anything that will harm my health." Dorian, a 32 year-old man with a history of pre-hypertension, and 65 year-old Dwight, also emphasized the importance of being confident in their physicians' technical competence.

> Trust in a doctor to me means that the patient has complete faith and reliability in what the doctor is saying, performing, prescribing, diagnosing, etc. Total trust in the doctor means 100% confidence in the doctor's abilities to perform their job accurately and professionally.

> That I'm confident that they did their homework about whatever might ail me. I like be confident that things are prescribed, correct medication, proper dosage. Ah, and that just goes back to the bedside manner also. You know. If I get the impression that you really *value* me, you know or have certain biases then again, I'm never going to be comfortable or feel like with communicating because of those barriers, those barricades. I'd just like to be confident that he knows what he's doing. And that's basically by his history and the relationship with other people that know that have probably have been to him….Their incidents, over prescribing…

Medical Abuse, Trust, and Survivorship

Perhaps the most poignant narrative captured in this study is that of Reginald, a 52 year-old man and father of two. However, *resilience* and faith resonated throughout his story and life. Since 2010, Reginald had several hospitalizations and dozens of doctor's appointments due to having heart disease, kidney failure, and high blood pressure. At the time of his interview, he

was currently on dialysis (three days a week) and on the kidney transplant list. Most recently, a cardiologist had prematurely told him that an aneurysm that was dangerously located on his lung was cancer, *without even* doing a biopsy. Reginald was scheduled to have the biopsy the week following his interview.

Reginald discussed in great detail his medical history, which included having a heart attack, a few cardiac catheterizations, and several stents placements for blocked arteries. In addition to dealing with poor health, Reginald encountered several brazenly harsh, detached physicians who lacked compassion. He recounted staying a week in the hospital due an infection. During that particular in-patient visit, a physician told Reginald's wife, "Your husband's got 24 hours, if the antibiotics don't work, he's a goner." Reginald discussed how painful and traumatizing hearing those words did to his mind and body.

Moreover, Reginald also experienced medical abuse and neglect both in semi-conscious and conscious states. During one ICU in-patient stay for having blocked arteries, Reginald described that against his wishes a nurse continuously kept putting a granulated dye-type solution in his IV. Reginald explained how muted his voice felt during the entire ordeal. He stated, "And when the night nurses come in, they don't take into consideration what the patient says, you know. This bedside manner stuff goes out [of] the window." Unfortunately, the solution caused Reginald to begin having breathing problems and his stomach to become enlarged. After pleading with nurse to no avail, Reginald asked to use the nurse's cell phone to call his wife and cardiologist to save his life. Reginald described the atrocious events.

> So finally he wouldn't listen to me—I asked him, "May I use your cell phone?" You know what he said? [The nurse said], "We don't have phones!" I said, "Are you bull—everybody got a cell phone—everybody's doing this [Reginald making gestures like he's using dialing/texting on a cell phone]. So then I said ah, He says, "Well, who do you want to call?" I said, "Well, I want to call the doctor." He says, "Oh no, we can't call the doctor. You don't want to piss him off." I

> said, "Look, that guy [doctor] told me I could call him anytime I get ready to." So then I sat there and all of the sudden get—I start to have problems breathing [be]cause I'm sitting there—[and] my stomach is getting so big. I said, "Hey, bring me a phone, somebody's phone." I said, "I want to call my wife and let her know you know, what condition I am in because I can't breathe now." He brings the phone and me and my wife got into a little argument because she was thinking I was being combative. But I was saying, "Look [wife's name]! They're putting this stuff in and I caught him—and I told him don't give me no more of this medicine and I caught him—because now you know I can kind a see. And I said, "[Nurse's name], don't put no more stuff in my IV!" And it was granulated type stuff. They put some of that stuff in my stomach, man. Finally, I said, "Look [Reginald's wife's name]!" I need somebody to come up here and check on me because I don't know what's gon' go on." You know. And ah, finally the nurse called [his cardiologist]. In the meantime my wife and my daughter—my daughter was pissed at that point. [She said] "We [are] going to get Dad!" [Laugh] You know? And they came up there and they looked at my stomach and [the cardiologist] walked in and he says, "Oh my God! You are a little swollen up here…" So he took something—he took a long tube and stuck it in my nose and rammed it all the way down my gut. He says, "It's gonna hurt a little bit!" At that point, I didn't really…And he [cardiologist] did a back flow of some or something and [to] liquefy it a little bit more. And then sucked it back out. My stomach went wrrrrrh, all the way down [Laughs].

Reginald's negative medical experience represents medical trauma and the abuse of power among the clinician-patient dyad. In spite of Reginald's incessant pleading with the nurse to discontinue administering the toxic medication and to prevent him from aspirating, Reginald's voice was ignored. Reginald was clearly vulnerable and exhibited a sense of loss of control in a space that was supposed to treat and heal him. It is not surprising that Reginald's appalling medical experience increased mistrust in physicians.

Furthermore, interweaved throughout Reginald's narrative was how he navigated White racism and ignorance from unsympathetic clinicians and fellow employees. Reginald worked for over 25 years as an electronics technician and was the *first* Black technician to be hired at popular department store in the late 1980s. During his tenure as an employee, he recalled facetiously telling his eight-month pregnant wife not to give birth to their son, for fear of losing

his first "decent job." He stated that at his previous employment he did not have any breaks, no lunch periods, and he was working for minimum wage, if not less. However, Reginald described that some of his White colleagues "joked" about how he and his wife were the only Blacks at an employee dinner. They would say, "Oh, it's awfully dark at the end of the table." Similar to many of the African American men's experiences noted above, racism and discrimination were added stressors to Reginald's poor health.

When describing what trust meant to him, Reginald emphasized that *sensitivity* facilitated trusting physicians. He bluntly reiterated what *insensitivity* does to patients' emotional and physical well-being.

> I think trust in a doctor is being able to deliver your diagnostics with sensitivity. You know, but be truthful. Um, I had a doctor tell me when my mom passed away you know and she had Alzheimer's…he [his doctor] gave me a hard knock. The doctor says, "You know, she's going to die?" It threw me off. Because I'm here in [the] emergency [room]—[I told the doctors to] get her back stable and don't tell me no shit like that! But there's a way to approach a person. You can't come and say well hell, you're going to be dead in—like the one guy [doctor], you know. I wanted to turn him in. I said, "How could this dude you know—?" And he probably thought I couldn't hear him or something cause I was still in that unconscious state, but I could blink my eyes and shit. You know. You would think he would know how…And to tell somebody like that, you know it messes somebody up, shit!

Summary of Major Factors that Increased Trust in Physicians

Participants suggested that honesty, respect, kindness, and compassion increased trust in physicians. Great communication, technical competency, providing effective and appropriate care, and giving pertinent information also enhanced trust. Additionally, racial/cultural patient-physician concordance facilitated trust and mitigated the judgments of the African American

men in medical contexts. Nevertheless, throughout their narratives, the interviewees explained that racial (and gender) biases, stereotyping, and condescension caused distrust.

Other Factors that Increase Trust in Physicians

In addition to physicians having compassion and sensitivity, the concept of *time*, in particular *quality* time was a seminal factor that increased trust in physicians. The respondents discussed that thoroughness in evaluation required the physician to spend quality time with them as patients. Ervin, a 47 year-old man who has had type 1 diabetes for 30 years, asserted that he would have switched physicians if he felt that his physician of over 25 years rushed through his appointments. He stated, "I never felt like he was just saying something to get me out of the office." Ervin indicated that the longevity of his patient-doctor relationship influenced trust in his physician. *Time* was also an important quality of trust for DaSean, a 29 year-old man, and Lamont, a 56 year-old father of five. Both men emphasized that they did not want physicians to merely give them prescriptions in hopes of placating their health problems. Instead, they expected physicians to spend time providing them with as much information as possible and asking them comprehensive questions about their health conditions. When describing what trust meant to him, DaSean discussed the importance of *time.*

> Uh, that they're [doctors] not taking any short cuts. Um…that they're just not going through the motions. And basically just doing a thorough examination or a thorough job on you know, looking at any precautions instead of just saying oh, "It's just this and be on your way." Or [saying] I'll just give you this prescription and so forth. I think it's just important just to cover all your bases. Um, yeah because I want to walk out of the doctor's office feeling like, like I haven't been a, shorted on time and all that type of stuff.

Similarly, Lamont stated,

> I think I can trust a doctor that can spend a little time with me. [A physician] that will not just come in and—and I've seen situations where doctors come in and before you finish telling them what's wrong, they start writing prescriptions or

> solving the problem. So, spending a little time with me, asking me questions…You know, I just think that—being a little personal. I think that really lends itself to trusting a doctor.

Participants' Views of Trusting Physicians

The majority of the men in this study indicated that they trusted their physicians (N=15). Trusting patients were more likely to disclose sensitive information, which increases good health outcomes (Dovidio et al., 2008). Honesty, integrity, being approachable and down-to-earth, and being *heard* were characteristics that increased trust. Participants who trusted their physicians also indicated feeling *that they mattered and that their lives had value*. 56 year-old Larry, who was on five different medications for various health conditions, described how getting a routine flu shot turned into being hospitalized, which probably saved his life. He explained,

> Like a month ago, I went to the doctor just to get a damn flu shot…They [clinicians] took my blood pressure…It was so high, den they work on me at the doctor's office for me a while and couldn't get it down and she [his doctor] called the ambulance and took me to [the local hospital]. You know, she said, "I'm not taking no chances." So I said, "Whachu you wanna do?" She said I don't trust you going home like this [in dangerous conditions]. So…Yeah, she gone tell me what's what.

However, of the 20 participants in the study, five of them (N=5) suggested either being unsure if they trusted their doctor, that they *somewhat* trusted their physicians, or that they *did not* trust their doctor. Four of the interviewees who indicated feelings of mistrust concerned technical competency of their physicians. To reiterate, fundamentally, trust takes on the notion of physicians acting in their patients' best interests (Hall et al., 2001). Anwar explained that for many years he trusted his physician. However, the trust had eroded over the years due to negative medical encounters, such as Anwar experiencing his physicians' ego, pride, and arrogance. Moreover, Anwar had a food allergy that his physician did not have the tools and

medial knowledge to diagnose or treat. When Anwar asked to be referred to a specialist, his doctor was reluctant to refer him to one. His physician seemed offended that Anwar would even question his physician's expertise. His physician seemed too proud to admit that he could not diagnose or treat Anwar. Moreover, Anwar's mistrust was also bolstered by his physician's increased apathy during office visits, detached, impersonal demeanor, and his perceptions that his doctor was out for profit (greed), as opposed to being passionate about healing and connecting interpersonally with patients.

Unfortunately, the mistrust did not end with his primary care physician. Anwar discussed that on one occasion a substitute physician at his medical specialty office questioned his medical condition as if he did not believe his symptomology. Anwar stated that the doctor said, "If I'm convinced by your story I may prescribe you this particular medication or do further testing." I asked Anwar how that made him feel. Anwar recounted feeling frustrated, angry, and deeply pained by how the physician questioned his medical experiences and framed them as being untrustworthy and *not credible*. Anwar was not the only participant who had perceptions of physicians not trusting *their* voices and medical experiences. DaSean discussed something quite similar when asked if he trusted his physician. He stated,

> Um. Actually the last one [doctor] I seen, I feel like she kind a, didn't trust what I was saying as far as just my aliments I had and a—yeah so right now I know [laughs]. [PROBE: *Could you elaborate on that?*] I had issues with like a couple of my fingers. [They] might be like out of place and they've been like that for over a year now. And I wanted—she just said, just try putting some ice on it and all [of] that type of stuff. And um, see how it goes. And I'm like—I told her that I've iced it before and then like this now for however long---It's the difference between a jammed finger and a sprung finger. Like the joint might actually be you know, sticking out of place. So um, that was the issue just—I think she just didn't believe me or whatever the case may be as far as things that was wrong. So…

The above two participants elucidated how dehumanizing it was walking into medical facilities in need of help, articulating their medical conditions, but physicians *not believing them*. Furthermore, when asked if he trusted his doctor, Dorian, another participant replied, "For the most part I do trust my current doctor, however I do feel like my trust could be slightly greater." Dorian had been having trouble consuming 2500 calories that were necessary for him. He explained that although his physician was trying to get to the root of the problem, the physicians' delivery, as well as his facial expressions and body posture seemed as though he just did not care as much as he hoped his physician would. After probing, Dorian indicated that he was among one of this doctor's last patients and he may have been tired.

For Xavier, trust in his physician was still being negotiated. He affirmed that he was skeptical of his physician's technical competence due to being given a medication that did not treat his skin condition. Hence, that caused him to question trust in his physician. Lastly, Quincy, a 34-year old man, stated that he currently trusted his physician, however, "with reservation." Moreover, he stated that, "If there's a scale from one to ten on trust, I'd give her about a seven." Quincy recalled being hospitalized some years ago due to a lupus protein being discovered in his blood that caused hyper coagulation (having the tendency toward blood clotting). When he informed his primary health care provider of his new diagnosis, she had no idea what hyper coagulation meant. Furthermore, during the same conversation, she informed Quincy that she was not a physician, but a physician assistant. Quincy stated that his primary health care provider should have informed him that she was a physician assistant when he signed up with her six months prior. He stated, "that made me feel like you're not being as transparent and honest with me." Hence, technical incompetency and his physician not disclosing that she was physician assistant, decreased trust in his primary health care provider.

Feeling Respected, Patients' Well-Being, and Trust

All but two of the participants in this study (N=18) revealed feeling respected by their physicians. Anwar and DaSean, the two participants whose physicians questioned the credibility of their medical experiences, attributed feeling disrespected due to their doctors becoming increasingly detached, apathetic, and desensitized. Anwar also stated that at his last doctor's appointment his physician was too busy looking at his computer. Those poor characteristics influenced their mistrust in physicians. DaSean reiterated that his physician questioning the credibility of his medical experience caused mistrust. He stated, "I'm not a 16 year old kid, you know. I'm almost 30 and I'm telling you—I know what's wrong with me!"

Furthermore, Anwar and DaSean were the only two patients who stated that their physicians *did not* care about their well-being. Moreover, factors that facilitated trust were doctors asking the men questions about their lifestyle, giving practical suggestions on how to improve their health, and informing them of new studies about their medical conditions. Ervin, a 46 year-old explained,

> Well, I detect in his—in some of his quiffs and in some of his instructions, and some of his counseling that he is serious about the matter—that he thinks there are things that I should do especially when I've done the wrong thing or I'm not doing quite the right thing. That he's serious about pointing me in the direction of doing better, doing the more positive thing. So I think he shows care in that. I've never had an occasion to feel like he was just collecting a check.

Quincy noted that his doctor cared about his well-being because she remembered what was said during his previous doctor's appointments. He affirmed that *remembering* garnered trust.

> I do feel that she does care about my well-being because when I talk to her, she must have read her files before or her notes before her previous session because she remembers what we talked about. You know, so that to me—remembering things about me helps me build trust in relationship with the doctor. [Be]cause

> when I go into sessions now with her, she like, "Oh because the last time we talked I think I remember we talked about this, and how has this been going?"

Participants described various medical experiences where trust in their physician were created, maintained, or breached. Xavier, a 25 year-old man, explained that trust in his physician was created due to his physician explaining his bloodwork. He recalled his doctor explaining each section of the laboratory document in a way that he could understand it. Xavier's physician also provided him with information to improve his results. For Larry, trust in his physician was maintained due to feeling cared for. He stated that trust was created, "When she told me [that] she loved me last year." He also explained that he would prolong making an appointment if he knew that he could not see his physician. For 65 year-old Dwight and the eldest participant, trust was maintained by his physician being personable.

Julius, a 46 year-old man and father of two, noted that maintaining trust in his physician was providing social and medical support at all times, especially during times of crises. He recounted his doctor supporting him during a very difficult time in his life.

> I was really depressed when I went through my divorce so he [his doctor] was really concerned about that and um when I called—Ah, when I was really in a depressed state, like practically suicidal, they [doctor's office] were like, *"but we don't have an appointment."* And I said ah, you don't understand, if I don't come in today I might not be here for an appointment. And then they immediately put me on hold and came back and told me, "How soon can you get here?" And he came in and saw me right away and prescribed medicine for me—antidepressants for me to make it through that. And I went back for a follow-up and also I went into therapy with my psychologist too---Umm, which we also have a great relationship. I've had the same psychologist for the last uh…14, 15 years. So yeah.

Dorian, a 33 year-old man described a time when trust in his physician was breached due to being given inappropriate and ineffective treatment. He recounted being put on a trial for a week with medication that unfortunately did not help him increase his appetite. After doing his own

research, Dorian discovered that the medication he was given had nothing to do with regulating his appetite. Dorian recalled that in that moment he questioned and doubted his physician, which influenced distrust.

Unfortunately, Anwar experienced a huge breach of confidentiality that caused him to lose trust in his physician. At a doctor's appointment, Anwar requested to get tested for STDs, including HIV. After the appointment ended his doctor said goodbye and walked out of the room as Anwar gathered his belongings. When Anwar arrived at the reception desk he noticed that his physician had placed his medical chart *directly* on top of the reception station where *everyone* could see it. And his *chart was open.* Although it was not there for long, his doctor's unethical behavior profoundly decreased trust in his physician. Anwar described how the experience made him feel.

> *Anybody* could have walked by and saw all of my information. *I was so furious and in shock!* I couldn't believe that he would do something so rude and inconsiderate! [It was] so disrespectful! *How could he do something so careless?* What doctor in their right mind would do that? I'm talking about what he did was what he should have learned in basic, maintaining confidentiality 101. That's a prerequisite to becoming a doctor. He clearly didn't give a damn about me as a person! If he saw that the receptionist was not there he should have placed it [medical chart] face down in her chair or on the desk! *He knows better!* [PROBE: *Why do you think he did that?*] I have no idea! I just don't think he cares anymore about me as his patient. [PROBE: *Did you address this issue with your doctor?*] I was going to at first but I didn't because the damage was already done. He showed himself. And as much as I tried to rationalize why he would do something so violating, like maybe he was rushing or just wasn't thinking, *that experience has stayed with me*. That changed everything! [PROBE: *What do you mean by that?*] What he did made me lose trust. [Be]cause if he did that, just imagine what else he has done or will continue to do to me and other patients!

There was a level of anger and equanimity that Anwar tried to restrain when recounting his doctor's overt breach of confidentiality. Violating his privacy and potentially revealing his identity or making it visible disappointed and infuriated Anwar. Medical charts reveal the

contents of a human being such as, their medical history. This pejorative medical experience changed the way he viewed his physician and it caused distrust. Anwar informed me that he was searching for a new primary care physician.

Summary

The men in this study discussed various factors that influenced trust in physicians. The majority of the participants (N=15) were trusting patients. However, five of the men (N=5) reported either being unsure if they trusted their doctor, that they *somewhat* trusted their physicians, or that they *did not* trust their doctor. Some of the responses that increased trust in physicians included, caring, technical competence, thoroughness in evaluation, providing appropriate treatment and information, good communication, partnership-building, being personable, and feeling a sense of security. Moreover, physicians taking *time* with patients and viewing patients' health holistically were important variables that increased trust. Respect, kindness, compassion, empathy, and maintaining confidentiality also enhanced trust in doctors. Participants who trusted their physicians also indicated that they felt like they *mattered, and that their lives had value*. Nonetheless, perceptions of implicit and explicit biases (e.g., stereotyping, policing their medical care, viewing the Black men as inarticulate and less intelligent than Whites, ect.), *feeling unheard*, apathy, condescension, and greed increased mistrust. Furthermore, based on this data, participants who trusted their physicians were more likely to feel unafraid and comfortable to share sensitive and pertinent information with medical professionals, which promote healing and good health outcomes.

CHAPTER 5

RESULTS: TRUST AND MEDICAL COMPLIANCE

The focus of this chapter is the discussion of participants' responses of how trust impacts medical compliance. The results of this study reveal that the majority of the men were trusting patients. Moreover, trust in physicians positively influenced medical adherence. In many cases it seems quite clear that the rapport the men had with their physicians enabled them to ask questions and in some case challenge their doctor's treatment recommendations during the decision-making process. But, they did so in a non-threatening manner that allowed for them and their doctors to have a conversation about their health. The men's excellent rapport with their physicians was due to their well-established relationship that had evolved over time from receiving medical care.

Furthermore, it appears that in most instances, participants' social location (race, gender, social economic status, ect.) positively impacted their medical care because I speculate that the men who may have been perceived as educated or a middle class professional, were therefore treated as such. I also feel that men's positionality or their situated knowledge that is located within his multiple identities allowed them to frame how they viewed their physicians' medical knowledge. Thus, this may have influenced the participants' medical assumptions and the knowledge they sought within the world.

As previously mentioned, although challenging, Mechanic (1996) urges patients to find a balance between trust and distrust, especially under clinical uncertainty. Similarly, Thom and colleagues (2004) note that some patients' trust in physicians can be associated with poorer health care because patients may be less likely to question physicians' treatment and inappropriate medical advice. The participants' social location and positionality may also play a

salient role in asking questions about medical terms and being comfortable in questioning or challenging their doctors in terms of the medicine prescribed. Inquiring about medications was how some of the men understand how drugs impact their body in relation to health and illness. Therefore, validating and questioning medical information and treatment acts like a counter narrative to the "doctors knows best" approach because it challenges the notion of potentially taking toxic medications. After all, Davies and Rundall (2000) argue that therapeutic relationships can potentially become damaged if patients trust physicians unquestioningly.

The majority of the men (N=15) in this study indicated following their doctor's treatment recommendations primarily due to trusting physicians' medical expertise and wanting to heal. When asked if he adhered to treatment recommendations, 33 year-old Khalil stated that, "Yes, because he practices medicine and I don't. So he'll know what's best for me medically." Like Khalil, Gerren, a 28 year-old man noted, "I've always followed my doctor's treatment recommendations because I could trust them and what I didn't know, they educated me on." Similarly, Xavier, a 25 year-old man empathically explained,

> Absolutely! Yeah…um, the assumption is that they are the expert[s] at that…ah…so I'm gonna tell you a part of the reason why. Part of the reason why is because I feel [that] a lot of people who don't...And I see that their issues and problems continue over periods of time. I've never had that problem and I think it's because I've also stuck to what they've [doctors have] given me and done what they told me to do. I can't remember a time not taking a dose of what have you. I can't remember a time not taking a tablet when I was told to take it. So I think it's almost a blind compliance to a certain extent but it's worked out well so, I haven't deviated.

However, 52 year-old Reginald, admitted regretting not following treatment recommendations in the past because non-compliance caused his kidney failure. Nonetheless, he currently and faithfully adhered to all medications. For Marcel, a 44 year-old man, medication or treatment adherence occurred due to multiple forces, such as having social and community support, in

addition to acknowledging that non-compliance could potentially be fatal. He expressed that some of his friends have passed away at young ages due to potentially preventable causes. When posed with the question whether he followed his physician's treatment recommendations he indicated,

> I try to [laughing]. You know, usually he'll recommend something and you know you go at it good for a couple of months and you kind of fall off the wayside. Until the next visit—when you got to get back on the horse, so. [PROBE: *So what motivates you to get back on track?*] Ah, probably more just you go in and talk to the doctor and they either say…you're doing well with what they prescribed or your slacking—they give you the what ifs—could happen. I also through my fraternity, one of the docs that's in the group has a Black men's health portion or agenda, so he always sits and talks about different issues and—You get it from the doctor, you get it from friends, so you kind of strap it up. And then also you know I'm getting to the point in age where I had a few friends just pass away [from] heart attacks. I had a real good friend last year die of a heart attack and never would have though he was—He wasn't overweight, but he was a stress bomb! So I do think that stress is that silent killer. So those things make you, more than anything—with the doc tells you and you have some real life events that kind of say, "Yes this really does happen" that kind of get you there.

Five (N=5) of the participants in this study admitted to not following their physician's treatment recommendations, but *not* due to medical distrust, but rather primarily due to irresponsibility, time constraints, and the fatigue of taking multiple medications. Dorian, a 33-year old man, admitted to not complying with his physician's treatment recommendation due to lacking self-discipline and his chaotic work schedule, which consisted of working overnights and extensive hours. Ervin, a 47 year-old man with diabetes, who passionately mentioned trusting his physician stated that he just simply fell short of taking his mediations.

Both Larry, a 54 year-old man, and 29 year-old DaSean, attributed their non-adherence to being "hard-headed" or stubborn. Moreover, Larry, who had multiple health issues, which included having two stokes, admitted that he often got tired of taking his medication. However, he explained how his doctor reprimanded and admonished him for not complying. Larry stated,

> "But Lord, don't you thank she [his doctor] don't know [about it]! She'll say, "I know you've been slippin!" I know you ['ve'] been slipping. [Laughing.] [She says], "You ain't doin' right!

Nevertheless, some of the men explained that even though they were trusting patients, they also did *their own* research on mediations and treatment recommendations. For Winston, a 57 year-old father of 4, following his doctor's treatment recommendations was contingent upon the particular type of medication or treatment. Winston stated that irrespective of doctors' instructions to take medications, he stressed that he would *not* take particular treatments that were toxic to his body. He also vehemently expressed not wanting to be potentially manipulated like a science project.

> Um, it depends. It depends on how bad, you know—what medication you are giving me. I always check all of the side-effects and everything else. And if it's not necessary to take that, *I don't care what the doctor say[s]*, if it's not necessary for me to take it, and I got all of these side-effects over here that's going to kill me [laughs], that's worse than what I have, then *no*! I'm not going to take it. I'm not going to do what they ask me to do. I just won't take it, you know.

Similar to Winston, 34 year-old Malcolm, admitted that he *did not* take his medication to reduce his cholesterol because he did not believe in taking statin drugs. Instead, to improve his health Malcolm exercised agency to be in control of his body by using natural-based products (as opposed to taking allopathic medicine), along with eating fiber-rich foods and exercising. He emphasized, "If the recommendation is to prescribe me a drug then I find a natural—or I do a healthy alternative."

All of the men in this study (N=20) illustrated that physicians provided them with information regarding medications or treatment recommendations. They were provided with pamphlets and encouraged to visit websites on certain medications. Physicians also explained the reasons *why* they prescribed certain treatment recommendations and informed them of the

potential risks and side-effects of medication and treatment. Doctors encouraged the men to ask questions about particular treatment recommendations and instructed them to call the doctor's office if they have any problems or questions about treatment. Participants also discussed negotiating treatment options, which gave them agency and power to make decisions about their bodies and lives. Moreover, *all* of the men revealed that trust and being provided with information regarding treatment recommendations facilitated medical compliance, which influenced trust. They found their physician's genuine concerns about how medication or treatment may affect them comforting. Furthermore, in many cases it seemed that the rapport the men had with their physicians enabled them to ask questions and in some cases, challenge their doctor's treatment recommendations. The men's excellent rapport with their physicians was due to their well-established relationship that has evolved over the years from receiving medical care.

Similarly, *following up* with physicians was facilitated by the good rapport and the meaningful relationships among the doctors and patients. Participants reported feeling cared for when doctor's offices called or e-mailed the men regarding follow-up care. Only 3 men out of the 20 participants indicated not following up with physicians. This was mainly attributed to being busy and not feeling like they had any immediate complications or health concerns to medication or treatment.

Trust and the Decision-Making Process

As previously mentioned, the existing literature on patient-physician communication reveals that patient trust in physicians influences the decision-making process (Trachtenberg, Dugan, & Hall, 2005). Patients may take on autonomous, passive, and/or shared decision-making (SDM) during medical interactions. Similar to previous studies, this study found that open communication increased patients' perceptions of feeling respected, which improved

patients' confidence to be autonomous in decision-making processes. However, patients who indicated trusting their doctors were more likely to engage in SDM.

15 of the 20 participants preferred shared-control in decision-making, compared to three of men who preferred to leave the medical decisions up to their doctors. The remaining two respondents took on passive roles in the decision-making process regarding medication or treatment recommendations. Moreover, participants who allowed physicians to control their medical decisions reported higher levels of trust in their doctors compared to other physicians. This study supports research that indicates that patients who prefer to a passive role in decision-making may have high levels of trust in their physicians (Chawla & Arora, 2013).

Out of the 15 men who reported being involved in the decision-making process regarding medication or treatment recommendations, all of them preferred *shared-control* decision making. They indicated communicating with physicians regarding the risks and potential side-effects of treatment. Furthermore, negotiating different treatment options was a salient theme that emerged from the narratives. Julius, a 46-year old man, recounted negotiating his anti-depressant medication with his doctor. At his last check-up, Julius's physician inquired if he still felt the need to continue taking his anti-depressant medication. Julius stated that he did, however, he talked about decreasing the dosage because he was feeling better than before, but he stated that he still needed it because he still was experiencing anxiety and depression. His doctor agreed to lower his prescription dosage, but informed him that he would continue giving him prescriptions as needed and as long as the medication did not affect his organs. Thus, Julius's well established relationship and rapport with his doctor, along with communication facilitated negotiating treatment in the decision-making process, which help to maintain trust.

Xavier, a 25 year-old man, described that when he initially met his physician he took on a passive role in the decision-making process regarding treatment. He stated, "He [his doctor] kind of just said this is what you need and we'll try this out." However, after building a rapport and a relationship with his physician, he felt more comfortable to share control in decision-making. For Dorian, a 33 year-old man, having a choice in treatment was very important to the decision making process. He stated,

> I generally am involved in the decision making process regarding medications [and] treatments mainly because I want the option[s] that's best suited for my health needs. My doctor has provided options for me, which in turn helps me to make the best informed decision for myself. I take upon myself to ask as many questions as I possibly can in order to get all the necessary advantages [and] disadvantages of meds and treatments.

However, 34 year-old Quincy, a doctoral student, took a more autonomous and active role in the decision-making process regarding treatment recommendations. For him, a bit of skepticism occurred throughout his very thoughtful process. He took time to consider how particular treatment could impact his body and mind. He fervidly replied,

> Oh yeah! That's—*you're not giving me any medication unless I say so, okay!* Anytime anything is recommended for me to take on an on-going basis *I* look up what the side-effects are. You can tell me what they are, you can print them in that little magazine, but I'm going to Google, I'm going to Yahoo answers, I'm going to the MD dot whatever, Web MD or whatever it's called! I'm going to look up the side-effects and get some reviews from people and I'm gonna call around to other doctors to find out…And I generally don't probably decide the day I'm in the office with my doctor, I generally say, well, *let me get back to you* on whether or not I want to do this one, or that one or whatever your [doctor] is recommending for me. Even with pain medication. When the doctor first told me about *that* [medication] —What I'm supposed to be taking, it's called Norco. I said, "*Wait a minute! Is it anything that's related to Vicodin?*" He was like, "Well *I think*!" I said, "*What do you mean, you think?*" Cause the last time I took Vicodin when I got my wisdom teeth taken out, I was literally hallucinating…Turns out that this [Norco] actually is a byproduct or something related to Vicodin. I said, "Okay." That was eight years ago. I'm gonna try it again—and I'm gonna make sure that I follow the directions. Maybe I didn't follow the directions last time. So, I will say yes. I'm very active in—because *I* decide what goes into my body. So that's—And I try to give off that vibe when I

> walk in there [doctor's offices]—You're not just going to impose anything on me about what I should be taking.

Both Ervin, a 47 year-old man, and Jamal, a 24 year-old man, noted that they *sometimes* were involved in the decision-making process. The men stated that being involved in the decision-making depended upon the severity of their medical conditions and the particular types of medications being prescribed. However, three participants, Gerren, Marcel, and DaSean revealed taking passive roles in the decision-making process primarily due to trusting their physician's treatment recommendations. Gerren and Marcel allowed their doctors to make decisions regarding medications because of trusting their medical expertise. DaSean's stated,

> Ah, I just pretty much just—whatever they tell me—I'm just allergic to one type of medication. So as long as they're [doctors] not giving me that I just take what they tell me to.

Summary

The results of this study indicate that trust in physicians positively influenced medical adherence. The majority of the men (N=15) in this study indicated following treatment recommendations. Moreover, trust in doctors, along with being provided information regarding medications or treatment recommendations facilitated medical compliance. Furthermore, medical compliance was also based on the rapport and the well-established relationships that the men had with their physicians. This enabled them to ask questions and in some cases challenge their doctor's treatment recommendations. Similarly, *following up* with physicians was facilitated by trust, good rapport, and the meaningful relationships among the doctors and patients. I believe that in most instances, participants' social location (race, gender, SES, ect.) and positionality impacted their medical care because men who were educated and were of

higher SES, were more skeptical of treatment recommendations and more likely to negotiate their treatment options. Also the majority of the participants (N=15) preferred shared-control in decision-making with their physicians. Inquiring about medications provided an understanding of how drugs impacted the men's bodies (and minds) in relation to health and illness. Therefore, validating medical information and treatment acted like a counter narrative to the "doctors knows best" approach because it challenged the notion of the men of potentially taking poisonous medications. After all, Davies and Rundall (2000) argue that therapeutic relationships can potentially become damaged if patients trust physicians unquestioningly.

CHAPTER 6

RESULTS: TRUST AND DOCTOR-PATIENT INTERACTION

In the last chapter I indicated that trust facilitated medical compliance. This chapter will illustrate how the doctor-patient interaction influenced trust. Many respondents in this study consistently stated trusting physicians and viewed trust as an iterative, bi-directional process that was formed from the initial doctor's appointment. Consistent with trust literature, the findings of the interviews support research that physician behavior and personality are the strongest predictors of patient trust in physicians (Hall et al., 2001). Moreover, the participants revealed having positive perceptions of their doctors. Throughout the participants' narratives they consistently described doctors' relatable, good character (e.g., "She is approachable," "He's down to earth," "They really care about their patients").

Furthermore, almost all of the physicians demonstrated *patient-centered care,* as opposed to *physician-centered care*. As previously discussed, a physician who is patient-centered is one who is attentive, honors patients' voices, encourages dialogue, and does not rush or interrupt patients (Skirbekk et al., 2011). Other characteristics of patient-centeredness involve physicians expressing concerns for patients' worries, including patients in medical decisions, and providing patients with information about medication and treatment recommendations, including follow-up instructions (Aragon et al., 2006). Many men in this study stated that doctors' compassion and sensitivity enhanced trust. Furthermore, communication moved beyond the doctors' offices and medical facilities. Participants described how physicians also called the men at home to offer reassurance and reach out to them virtually (e.g., via e-mail). More physicians that exhibit patient-centered care are needed to help facilitate trust, especially within discordant medical encounters.

The men in this study indicated that having great patient-health care provider communication influenced trust. Communication and language were also important to understanding and making sense of his health. Participants articulated how they appreciated physicians using layman's terms, rather than complicated medical terminology. However, the respondents noted that when doctors did use complex medical terms, they broke down concepts so they could get a clear and thorough understanding of their medical conditions. Also, the men found contentment in physicians giving them the tools and knowledge to maintain good health.

The majority of the men (N=18) positively described their doctor's communication style. However, 34 year-old Anwar and 25 year-old Xavier recounted having negative medical experiences when communicating with their physicians. Xavier stated that he had to initiate the communication between him and his doctor. He also expressed how frustrating he felt that his physician did not try to reach out to him. He explained, "He's not going to seek me out if I call him. He's not—most of the time [he] don't answer." Anwar described his physicians as detached, condescending, and arrogant. He stated that his doctor's bad personality caused mistrust. Like Anwar, Quincy, a 34 year-old man, recalled that his physician was *initially* condescending. However, after establishing a rapport, he developed a respectful, bi-directional relationship with his doctor. Quincy mentioned,

> I think initially that it was kind of that [condescension]—I'm gonna talk at you because this is what you need. Um, but I think she [doctor] realized that I was not the, a passive participant in this relationship—That—[I'm] definitely active. So our relationship now is a dialogue. It's—she comes in and asks me how I've been and I explain to her this is how I've been and this is what's been happening and ah, the last time we spoke this is what we talked about and this is—you know so, this really is her style *now* with me, it's really a dialogue. And I feel like it's—there is a level of respect, on both parts. Like I respect the fact that she is my physician. Um, but I think that more—I'm not saying that you can be replaced because I can go and find another physician somewhere else. But I think that there definitely is an era of he's here to get what he needs and I'm gonna make sure he gets it. [Be]cause that's the way he's presented himself to me. So in that

> sense that um, the way that she talks to me is very much a—collegial. Like we're in this together. You know—to do this thing of making sure you get the care that you need. So it's an alliance.

As discussed previously, the majority of the interviewees (N=18) spoke about physicians' good-natured, *personable* communication style, which promoted trust. Honesty and a sense of relatedness were also qualities that facilitated good doctor-patient interaction. For instance, Lamont, a 56 year-old man and father of 5, embraced his doctor's relaxed communication style. He explained that medical issues were not the only matters they discussed during his doctor's visit. They talked about sports, vacationing, and other non-medical issues. Lamont stated, "It's [a] more [of a] personal feel, it's not just business. That's how I feel, that it's more of a personal relationship." Like Lamont, 46 year-old Julius, described his medical encounters with his physician as collaborative and familial. Moreover, *family* provides a sense of comfort and belonging. Julius raved about his doctor's (and the staff's) interpersonal communication style.

> Umm…I just think he's very forward and he's very honest. He tells me what's going on. I mean, if I need to see a specialist he will tell me um, what specialist he would recommend, um to go see about a particular issue or what have you. And really the whole team that works with him, um, including his wife, other physician assistants, and nurse practitioners—they're all very good and I feel comfortable seeing, if he's [the doctor] not available, if he's not there—like because he was out sick for almost a year. But I still feel comfortable going to any of the other people that work there that would provide care. So, you know, like I've said, I've been with their office for 23 years. So, it's been good. I haven't had any reason to want to change [doctors] right now.

Juxtaposed to Julius's beatific, personalized, and highly communicative medical experiences, Rashad, a 33 year-old man and doctoral student, viewed his latest doctor's visit at an on-campus clinic as a detached, technologically based, assembly line that left him feeling like a number, instead of a person. He explained,

> It's really interesting because when I went to the last appointment everything is [was] so technologically based. Everything is very informal, everything is based

> off of e-mails, you don't really feel that you have an actual…You don't feel a sense of community. You feel like you're a product, you feel like you're a statistic. I feel like almost were in an assembly line. And everything is—there's no…It's not like it was back in the [19]80's when I was a child, I had the pediatrician and I was sitting on the doctor's lap…Playing with building blocks. Stuff like that. Even though I'm not saying that I'm supposed to be sitting on someone's lap at 33 years old. But I'm just saying that I feel that the humanity or the connection between the doctors has changed because we're in such a technologically-driven society that everything is about you got to go from point a to point b, you got a go do this.

The participants in this study were asked to walk me through their last doctor's visit to ascertain the type of care that they received. The men were asked to describe things such as, what happened, what went well, what did not go well, ect. For most participants, their most recent doctor's appointment consisted of having a standard routine check-up or physical examination. Moreover, 18 of the participants indicated having pleasant doctor's appointments where health care providers provided *patient-centered care*. Furthermore, the patient-centered care influenced trust in physicians. However, perhaps the most irritating and frustrating theme that emerged from the men's narratives were the long wait times before seeing their doctors. Nonetheless, the long waits did not negate the men's positive medical experiences. After all, Julius knew why his doctor was late; he was taking his time to provide patient-centered care to other patients. He stated,

> I love my doctor. He's just slow. He's always behind schedule. But the reason [why] he's behind schedule a lot of [the] times is because he takes so much time with each of his patients and the doctor visit isn't usually just about the doctor ['s] visit. You kind of end up talking about in your life and things of that nature.

However, unfortunately, Rashad and Anwar recalled having unpleasant and impersonal medical experiences. Rashad reiterated his negative medical encounter (as discussed above) and Anwar described that his most recent doctor's visit was appalling. The only positive comments that he

could highlight was that the office staff were cordial and that he did not have to wait long to be seen by his physician. He described the unpleasant experience.

> *It was terrible!* Besides virtually not giving me any eye contact and that's even when he checked my vitals, his back was facing me almost the whole time because he was too busy typing on his lab top. I'm thinking to myself that you are only in the office with me for 5-7 minutes, at least engage a little *or even pretend* to be interested in me as your patient. And what made it so bad was that even when I tried to spark up a light conversation, because I hadn't had a doctor's appointment in a very long time, he still *didn't* pay me any mind because he was too busy typing away and staring at his computer. Honestly, I don't think he even heard me. [PROBE: *How did that make you feel?*] Ignored and like I was not important. But that is the person he has become. He has definitely changed over the years. He used to be so nice and…attentive. But not anymore.

Participants' Views of Ideal Medical Care

Honesty, kindness, compassion, sensitivity, demonstrating professionalism, and patient centered-care were the main themes that emerged from the men's responses in this study when asked to explain what good care looked like. These characteristics increased trust. Also, being personable and providing information to improve and maintain good health (mental and physical) were other common themes that arose. Great communication and an excellent rapport made the respondents feel comfortable, which also increased trust in physicians. Moreover, participants explained that they wanted to engage in a dialogue that was not unidirectional, but rather bi-directional. Overall, the participants' doctors exemplified the humanity of providing quality care. Additionally, having a *choice* in physicians and treatment were also important qualities when explaining what good care looked like. That gave patients agency to be in control of their minds and bodies, which enhanced medical trust. However, for Malcolm and Quincy, racial and gender concordance and doctors taking responsibility, especially for medical mistakes were salient factors for providing good care. Malcolm explained,

> Good care for me is someone that looks like—Good care no matter who it is that I deal with I want a person to come that looks like me. That's a male….Someone who is knowledgeable but also is able to explain, explain things in terms that I can understand. If follow-up is needed they're accessible and which I've never had any problems, but I've never really contacted people either after my follow-up. So I guess that's it! And also—someone, just there appearance is one that reflects that they too can follow doctor's orders and be healthy.

Quincy elucidated,

> …It looks like the type of care that if the doctor does make a mistake, the doctor will say, "I apologize, I made a mistake." We—I understand that medicine is *not perfect* [and] physicians understand that physicians are not perfect but they do the best they can—they're not perfect themselves. But just um, sort of honoring that, honoring the fact that they're not perfect [that] medicine's not perfect. But that they're *human*…If you don't have all of the information, *say you don't have the information*! *Don't try to create something when you don't know it*! Cause that's the worst…

In addition to explaining that patient-centered was an essential quality of what good care looked like, Jamal, Ervin, Julius, Anwar, and Rashad foresaw good care more *broadly*. The men also envisioned good care from a macro lens, such as explaining the importance of examining and improving converging systems of power and oppression that are needed to improve health care disparities. Having *access* to resources and receiving *quality* health care were very important qualities of good care, which increased trust. Jamal not only profoundly highlighted what good care looked like from an intersectional lens, but what it *felt* like; he described it as being affordable and inclusive for *everyone*.

> I would want good care to look…to *feel* like I am…like all resources are at my disposal if I need it. I don't want to feel like my financial situation will impact my treatment. Or I don't want to feel like my cultural background or whatever—I really don't but I know a lot of people do. I don't want to feel like cultural biases or prejudices interfere with treatment. Um, in a perfect world…I would want…to have definite answers with all types of treatment—I wouldn't want any type of experimental drugs. You know I would want you know, [that] this [medication or treatment] would definitely help my illness. You know…Doctor's speak all types of languages. You know…

Similarly, Ervin explained,

> Good care looks like a patient being able to trust a physician. Be comfortable with that physician's diagnosis and recommendations. Being able to afford health care. Being able to have access to special things that may be needed and/or prescribed— recommended by a doctor. Whether it be specialists or therapy or visiting other doctors or taking certain tests or whatever it is. I think that's—I think that's good care. To be able to—now I don't have some of these issues but I think this is good care. Being able to have adequate transportation to and from visits and such and not having to worry about as I sometimes do the balance of lack of prescriptions and/or needing prescriptions and/or money because that is a rather stressful situation and scenario that *no one* should have to experience. I experience it sometimes, thank God that I don't experience it as much as many others do---as certainly seniors and I worry about that for them. But I suppose that's the general recipe for me…

Furthermore, when describing good care, Julius and Anwar explained how people's social locations, health insurance, and pharmaceutical companies impact people's fundamental quality of health and life nationally and globally. Rashad described that good care involved patients from all socio-economic backgrounds having the *choice* in selecting their physicians. Moreover, the participants in this study generally received good care. However, some broader forces of health care were out of their control, such as having access to health insurance and choice in physicians. Also, *all* 20 men indicated that their physicians listened to their health concerns.

A little less than half of the men (N=8) reported feeling rushed at appointments by their doctors. However, the men discussed that feeling rushed was *not* a consistent pattern and it only occurred in maybe a couple of instances. The men recognized and understood physician's busy schedules and time constraints that influenced physicians rushing treatment and care. For example, Gerren explained,

> There are times that I do feel rushed at appointments because I seem to always get scheduled at their busiest times. But it's nothing to where I feel like he's trying to hurry up and kick me out. He's been very respectful and patient with me.

The participants explained that feeling rushed make them feel like a number or a product, instead of a person. Nevertheless, 12 of the participants did *not* feel rushed by their physicians during doctor's appointments. The majority of the men described their physicians as being attentive, providing them with information about their health, and addressing all of their questions before leaving the doctor's visit. Dwight, a 65 year-old man and the eldest participant, and 54 year-old Larry stated that they did not feel rushed by their physicians. Dwight explained, "No. He's laid back. He likes to talk. [Laughs]. No, I have in the past [felt rushed] but the one [physician that] I have now, no!" Larry suggested that his doctor's thoroughness impeded *his time*. He humorously noted,

> Naw. Sometimes, I have to wait like hell, but I don't feel rushed—She keep [s] me back there too long to tell you the truth! She be looking through that damn computer like two or three times, it seems like [that] to me. She probably is just that long. She keep[s] me back there [for] too long. No, I ain't rushed. She don't rush—she keeps me—I be like, "Lady gawn and do this so I can go."

Responses Based on Social Class, Location of Care, and Residence of Medical Facility

With the exception of Anwar and Rashad, irrespective of participants' social locations, or the city of residence of medical facilities, there were *no* differences among respondents who viewed doctors as being attentive or at least understanding why their doctors could not be more attentive or were often late with those that believe that their doctors were not patient-oriented and could not understand why they had to wait so long to see their doctor. However, there *were* differences in responses and/or emphases of certain aspects of perceptions of comfort with the time that one's health care professional spent with them based upon whether or not they visited their doctor based on in the city/suburbs, their social class level, and type of health insurance.

For instance, Anwar, Rashad, and Jamal were in the lowest income level and had Medicaid. They also received medical care in *clinics* in the city as opposed to receiving care in doctor's offices in the suburbs. On the other hand, the men who had higher incomes and received health care in the suburbs were less likely to indicate feeling rushed or that the time that they spent with doctors was limited. However, for Malcolm, who received medical care in the city, his HMO health insurance did not prevent his perceptions of feeling that his doctor slighted him of *time* during office visits. He stated,

> My most recent appointment I did feel as if though—it felt almost like a meal…They take you in for processing, they give you a stamp, check you in, you see a person, bam! Where as,..In my previous—the youngest doctor that I had, while the process was swift, but it wasn't rushed like, oh we have ten people coming after you. A part of their relationship there was, we all chip in together to do this so that you have a great experience and a quick experience because we know you're a busy person. Whereas this one [doctor] was…he was late. And so he still rushed me [be]cause he had another appointment coming in. [PROBE: *How did that make you feel*?] It actually helped me to decide to go out of the network so I can actually pay for someone that I think would give me better service. It cost me ten dollars but it will be worth it.

Summary

Many respondents in this study were trusting patients and viewed trust in their physicians as an iterative, bi-directional process that was formed from the initial doctor's appointment. Consistent with trust research, the findings of the interviews support research that physician behavior and personality are the strongest predictors of patient trust in doctors (Hall et al., 2001). Overall, most interviewees indicated having positive perceptions of their doctors. As opposed to feeling rushed and being provided with physician-centered care, almost all of the men's doctors demonstrated patient-centered care, which increased trust. Furthermore, the majority of the participants (N=18) expressed that being provided with great patient-health provider information,

enhanced trust. Excellent communication and language were also salient factors to understanding and making sense of their health and medical conditions. The men articulated that they embraced their doctor's relatable and "human side," as well as their clinical demeanor, such as clarifying and explaining complicated medical terminology during medical encounters, which also influenced trust. Also, several participants revealed that receiving good care did not solely consist of the micro doctor-patient dyad. Many respondents also viewed medical trust from a macro perspective. The men explained that examining and improving the interwoven systems of power and inequality within the health care system, is needed to increase trust.

Furthermore, the narratives revealed that it was important for health care to involve connectivity and inclusivity, irrespective of an individual's race, gender, or SES. Lastly, responses based on social class, location of care, and residence of medical facility impacted the men's perceptions of certain aspects of comfort and time with health care professionals. The men with the lowest income levels, those with Medicaid, and those that received medical care *clinics* in the city rather than receiving care in doctor's offices in the suburbs were more likely to indicate feelings of being restricted with time with their physicians. Nonetheless, the men who had higher incomes and received health care in the suburbs were less likely to indicate feeling rushed or that the time that they spent with doctors was limited.

CHAPTER 7

CONCLUSIONS

This qualitative study investigated how twenty African American men conceptualized trust in physicians and it explored factors that influenced trust. The participants were 25-65 years-old who had received some form of medical treatment at a health care facility in the past 12 months. The interviewees were recruited via purposive and snowball sampling. In-depth, semi-structured face-to-face interviews examined three questions that were important in guiding this study:

1. What factors influence trust in physicians?
2. In what ways does trust in physicians influence medical compliance?
3. How does doctor-patient interaction impact trust in physicians?

Moreover, trust is essential to the doctor-patient relationship because it promotes healing. Fundamentally, trust in physicians occurs when doctors act in their patients' best interests (Hall, et. al., 2001). Nevertheless, as previously noted, Hall et al. (2001) define distrust as patients "having anxious or pessimistic views of motivation and expected results" (p. 618). Participants were asked 20 questions and the interviews lasted approximately 25-55 minutes. Respondents were asked to define what *trust in doctors meant to them* and they described qualities/characteristics that increased trust. I also asked participants about their experiences that led them to trust a physician and situations that have caused them to establish or lose trust. Interview transcripts were imported into the qualitative data analysis software, ATLAS.ti for organizing and coding the qualitative data. Moreover, salient themes emerged from the interviews and transcripts were coded using grounded theory. Developed by Glaser and Strauss (1967), grounded theory is derived from data that analyzes the patterns, themes, and common

categories discovered in observational data (Strauss & Corbin, 1998). The categories for this research included: 1) Caring, 2) Communicating clearly and completely, 3) Honesty/respect for patient, 4) Providing appropriate and effective treatment, 5) Thoroughness in evaluation, 6) Partner-building, 7) Understanding the patient's individual experience, 8) Technical Competence, 9) Time, 10) Being personable, and 11) Feeling a sense of security.

Summary of Major Findings

Factors that Influence Trust

The men in this study discussed various factors that influence trust in physicians. Most of the participants were trusting patients. However, five out of the twenty men revealed either being unsure if they trusted their doctor, that they *somewhat* trusted their physicians, or that they *did not* trust their doctor. Some of the responses that promoted trust in physicians included, caring, technical competence, thoroughness in evaluation, providing appropriate treatment and information, good communication, partnership-building, being personable or relatable, and feeling a sense of security. Moreover, physicians taking *time* with patients and viewing patients' health holistically were important variables that increased trust. Respect, kindness, compassion, empathy, sensitivity, and maintaining confidentiality also increased trust in doctors. Participants who trusted their physicians also indicated feeling like they *mattered, and that their lives had value*. Consistent with trust literature, the majority of the African American men's interactions with physicians were racially discordant (Penner et al., 2013).

Racial/cultural patient-physician concordance facilitated trust and mitigated the judgments of being a Black man in dominantly White medical spaces. However, with the exceptions of a couple men, racial/cultural discordance *did not* impact the men's *overall*

perceptions of trust in doctors. Nonetheless, perceptions of implicit and explicit biases (e.g., stereotyping), *feeling unheard,* apathy, greed, and condescension increased mistrust. Furthermore, based on this research, participants who trusted their physicians were more likely to feel unafraid, unashamed, and comfortable with sharing sensitive and pertinent information with medical professionals, which promote healing and medical efficacy.

Trust and Medical Compliance

The results of this study indicate that trust in physicians positively influenced medical compliance. The majority of the men in this study indicated following treatment recommendations. Moreover, trust in doctors, along with being provided information regarding medications or treatment recommendations facilitated medical compliance, which promoted trust. Furthermore, medical adherence was also based on the rapport and the well-established relationships that the men had with their doctors. This enabled them to ask questions and in some cases challenge their doctor's treatment recommendations. However, they did so in a non-threatening manner that allowed for them and their doctors to have a conversation about their health. Similarly, *following up* with physicians was facilitated by trust, good rapport, and the meaningful relationships among the doctors and patients. It seemed that in most instances, participants' social location (race, gender, SES, ect.) and positionality impacted their medical care because men who were educated and were of higher SES, were more skeptical of treatment recommendations and more likely to negotiate their treatment options. Also the majority of the participants preferred shared-control in decision-making with their physicians. Inquiring about medications provided an understanding of how drugs impacted the men's bodies (and minds) in relation to health and illness. Therefore, validating medical information and treatment acted like a counter narrative to the "doctors knows best" approach because it challenged the idea of the

men of potentially taking toxic medications. In the end, trust research demonstrates that therapeutic relationships can potentially become damaged if patients trust physicians unquestioningly (Davies & Rundall, 2000).

Trust and Doctor-Patient Interaction

Most respondents in this study trusted their physicians and viewed trust as an iterative, bi-directional process that was formed from the initial doctor's appointment. Consistent with trust research, the findings of the interviews support research that physician behavior and personality are the strongest predictors of patient trust in physicians (Hall et al., 2001). Almost all of the men's physicians demonstrated *patient-centered care,* which increased trust. Furthermore, all, but two of the participants expressed that having great patient-health provider information increased trust. Listening, great communication, and language were also salient factors to understanding and making sense of their health and medical conditions. The men expressed that they appreciated their doctors being personable and relatable. Furthermore, when doctors did use complicated medical language during medical encounters, they explained and clarified it in layman's terms, which influenced trust. Lastly, the participants in this study indicated with the exception of a couple of instances, they did *not* feel rushed at their appointments with their doctors. The majority of the interviewees described their physicians as being attentive, providing them with information about their health, and addressing all of their questions before leaving the doctor's visit, which increased medical trust. Furthermore, many respondents not only envisioned trust from a micro lens, but also from a *macro* perspective. The men explained that examining and improving the converging systems of power and inequality within the *health care system*, is needed to increase trust. Furthermore, the narratives revealed

that it was essential for health care to encompass connectivity and inclusivity for *everyone*, irrespective of an individual's race, gender, SES, and other variables.

Lastly, responses based on social class, location of care, and type of health insurance impacted the men's perceptions of certain aspects of comfort and time with health care professionals. The men with the lowest income levels, those with Medicaid, and those that received medical care *clinics* in the city as opposed to receiving care in doctor's offices in the suburbs were more likely to indicate feelings of being restricted with time with their physicians. Nevertheless, the men who had higher incomes and received health care in the suburbs were less likely to indicate feeling rushed or that the time that they spent with doctors was limited.

Discussion of Findings

The majority of the respondents in this study were trusting patients and viewed trust as an iterative, bi-directional process that was formed from their initial doctor's appointment. Consistent with trust literature, the findings of this project support research that physician behavior and personality are the strongest predictors of patient trust in physicians (Hall et al., 2001). Moreover, trust research reveals that minority patients have less positive perceptions of physicians than White patients (Doescher et al., 2000). However, the majority of the interviewees indicated having positive perceptions of their White physicians. Throughout the participants' narratives they consistently described their doctor's respectful character and personable communication style.

Furthermore, in most cases it seems quite clear that the rapport the men have with their doctors enable them to ask questions and in some case challenge their doctor's recommendations. But, they do so in a respectable manner that allows for them and their doctor

to have a conversation about their health. The men's excellent rapport with their physicians is due to their well-established relationship that has evolved over the years from when receiving care.

I believe that the participants' social location positively impact their medical care because I speculate that many of the men may be perceived as a middle class professional, and therefore treated as such. I also feel that their positionalities or situated knowledge that is located within their multiple identities allows them to frame how they view their Caucasian physicians' medical knowledge. Thus, this may influence the men's medical assumptions and the knowledge they seek within the world.

As previously mentioned, although challenging, Mechanic (1996) argues that it is necessary for patients to find a balance between trust and distrust, especially under clinical uncertainty. Similarly, Thom and colleagues (2004) note that some patients' trust in physicians can be associated with poorer health care because patients may be less likely to question physicians' treatment and inappropriate medical advice. Many of the men's social location and positionalities may also play a salient role in asking questions about medical terms and being comfortable in questioning or challenging their doctors in terms of the medicine prescribed. Inquiring about medications is how the respondents understand how drugs impact their body in relation to health and illness. Therefore, authenticating and questioning medical information and treatment acts like a counter narrative to the "doctors knows best" approach because it challenges the notion of potentially taking toxic medications. After all, Davies and Rundall (2000) argue that therapeutic relationships can potentially become damaged if patients trust physicians unquestioningly.

Trust literature indicates that institutional trust (trust in the health care system) and perceived cultural similarity are significantly correlated to trust in providers among African Americans. This study's findings also support previous research that indicates that Blacks' lack of institutional trust is more than an interpersonal issue (Earl et al., 2013; Boulware et al., 2003). Rather it is beliefs and fears about the medical community as a whole. For instance, some respondents stated that although they were trusting patients, they were skeptical of receiving medical treatment from *just any* doctor. They also explained how distrust in the health care system is rooted from experiences of racial discrimination, implicit biases, medical mistakes, and unethical medical practices. Some participants even described other people they knew who have had negative medical experiences with doctors and the health care system, which influenced medical distrust. Moreover, the men's attitudes about provider racial discordance suggests that providers' interactions and communication style are important for reducing trust because African American patients may perceive that the physicians are detached due to the lack of cultural similarities and therefore unable to identify with them as patients.

Furthermore, Hammond (2010) argues that social constructionist ideologies of masculinity may be associated to men's health behaviors and trust/mistrust. African American men are more likely to receive *physician*-centered care, rather than patient-centered care (Penner et al., 2013). Physician-centered care focuses more on the physician than the patient. *Physician*-centered care increases mistrust among African American men because some Black men may view this particular type of interaction as a form of disrespect because it limits their agency and control during decision-making processes (Hammond, 2010; Peek et al., 2013). However, in this study almost all of the men's doctors demonstrated patient-centered care, which increased trust. As previously discussed, a physician who is patient-centered is one who is attentive, honors

patients' voices, encourages dialogue, and does not rush or interrupt patients (Skirbeekk et al., 2011). Other characteristics of patient-centeredness involve physicians expressing concerns for patients' worries, including patients in medical decisions, and providing patients with information about medication and treatment recommendations, including follow-up instructions (Aragon et al., 2006). More physicians who provide patient-oriented care are needed to help facilitate trust within discordant medical encounters. This study challenges existing theoretical precepts about race and trust because the narratives reveal that almost all of the participants in this study received *patient-centered care*, which increased the men's agency and control during medical interactions, which encouraged them to engage in shared decision-making.

Nevertheless, apathy, disrespect, and technical incompetence emerged as the most salient factors that reduced trust the men's physicians. The respondents recounted that trusting their doctor, along with being provided with information regarding medications or treatment recommendations facilitated medical compliance. Furthermore, the participants indicated that having great patient-health provider communication influenced trust. Communication and language are also important to understanding and making sense of their health. Moreover, the eleven main categories that were created from the interview were: Thoroughness in Evaluation, Caring, Respect, Providing Appropriate Treatment, Good Communication, Partnership-Building, Technical Competence, Time, Being Personable, Feeling a sense of security, and Understanding the patient's individual experiences. These categories are cyclical in nature because caring, respect, effective communication, and being personable are incumbent upon partnership-building among the patient-physician dyad. These positive predictors are likely to encourage physicians to be thorough in evaluating patients and providing patients with appropriate care (Dovidio et al., 2008; Thom & Campbell, 1997).

Theoretical Application

Symbolic interactionism is a micro theory that emphasizes that humans construct subjective meaning through human interaction and communication. When individuals engage, their verbal and non-verbal communication reflect symbols that are interpreted by others. W.I. Thomas's notion of the definition of the situation occurs when people align to the actions of others. For instance, individuals may atone to others when they are in particular situations or social contexts. Symbolic interactionism explains the existence of patient trust (and distrust) in physicians and increases our understanding of the rapport/communication problems that may persist among Black patients and medical professionals. The theory also helps us to understand the role that trust (and distrust) and race plays in doctor-patient interactions because it explores the subjective nature of medical interaction that occurs between patients and physicians. As previously mentioned, clinicians' implicit or unconscious racial biases impact patient trust and health care disparities because implicit attitudes may negatively influence how health care providers diagnose and treat African Americans and other disadvantaged patients. Social psychological studies have also revealed the subtle influences that stereotypes can have on doctors' judgments and perceptions, which then are manifested in behaviors that affect medical care.

Dovidio and colleagues state that subtle biases impact treatment delivery and medical interactions and it influences medical mistrust among Blacks and other people of color. They explain that research indicates that Whites receive more information from doctors and offered greater opportunity in the decision-making process than Blacks (Dovidio et al., 2008). Also, within the doctor/patient dyad, Whites are significantly more likely to be referred for further testing, and doctors view Black as less intelligent, more likely to abuse drugs, and less likely to

comply with medical recommendations compared to White patients based on previous studies that have examined the consequences of racial bias in health care. Hence, stereotyping and labeling patients contributes to persistent health care disparities because physicians are assuming that particular groups will not comply with medical treatment, potentially based on physicians' racial biases.

To the point, Symbolic interactionism is often the byproduct of Whites and Blacks traveling in different worlds. Unfortunately, in some cases, doctors' interactions with African American patients many times may be based on stereotypical assumptions. However, Black patients (and other disadvantaged groups) are sensitized to implicit biases (symbols) and may view their doctor-patient relationship negatively, which causes mistrust. To reduce inter-group biases, Penner et al., (2013) propose using The Common In-Group Identity Model as a way to reduce intergroup biases. This model encourages individuals to conceive themselves as being part of the out-group, where they may develop positive thoughts about the out-group, which will lessen the implicit bias towards others. The Common In-Group Identity Model may be useful especially for physicians' because it teaches them not to be biased, which helps to reduce stereotyping and health care disparities among African American patients and other disadvantaged groups.

Moreover, in chapter 4, several participants in this study stated that they believed that their race and gender at least initially, negatively influenced how physicians treated them (i.e., Anwar, Reginald, Quincy, Rashad, Larry, Jamal, and Dwight). For instance, themes of feeling ignored and perceptions of physicians thinking that the men were unintelligent resonated throughout some of the respondents' narratives. Furthermore, a couple of the men even believed that physicians felt that they needed to police their health care. Since patient trust in physicians

is subjective and socially constructed, it necessitates examinations of social interaction and communication that occurs between individuals (Weitz, 2012). From a symbolic interactionist perspective, the men's feelings and experiences of racial and gender biases may explain why this increased medical distrust during medical encounters. Also in this study, it was insightful to know how close the provider was to Detroit and the SES, insurance rates and types of insurance (e.g. private vs. Medicaid) and racial demographics of the community in which the clinic/hospital was located. For example, it is conceivable that clinics that are located in Detroit and inner ring and working class suburbs experiencing racial transition (e.g., Harper Woods, Southfield, Oak Park) take more Medicaid patients and provide emergency care for poor inner city and/or inner ring suburban blacks. Symbolic interactionism illuminates that providing such treatment to patients that are a financial drain and do not "act" middle class, which are likely disproportionately Black, may reinforce stereotypes among Black and White clinicians and staff, most of whom do not have a sufficient understanding of forces behind race and poverty (Williams, 2012). Furthermore, a few of the participants in this study suggested that doctors' behaviors changed from condescension to a having a respectful demeanor when they noticed that the men were intelligent, articulate, and did not "act stereotypically Black."

In contrast, I can imagine that the primary contact that health care professionals working in clinics located deeper in the suburbs (i.e., Birmingham, Beverly Hills, Farmington Hills, Troy) would have with African Americans would be professionals, and as such, they be less susceptible to buy into negative Black racial stereotypes. As such, if my speculation is correct, the staff at Julius's (a 46 year-old man, with high SES, and private health insurance) current health care provider assumed that he was a middle class professional and treated him as such (with respect and dignity). In contrast, Rashad's (a 33 year-old man with low income and Medicaid health

insurance) clinic provider, may have assumed that he was a poor Black man and treated him disrespectfully. This fits in well with the symbolic interactionist thesis of how prior histories of dominance and marginalization inform interactions and subsequent meanings drawn from these interactions. In this study, it was worth looking into where these individuals receive treatment (e.g. inner ring suburb/affluent suburb, inner city and poverty level of community in which the hospital is located) and the type of health care facility they most often received treatment (e.g. private clinic, emergency care/urgent care, hospital) and if they have a primary care physician from whom they most often receive treatment. And, subsequently, it was important to ask them how did they believe that their interactions with their doctor's inform their trust that their doctors are doing all that they can to keep them well, their willingness to open up to their doctors about their health concerns, and their follow through with their doctor's recommendations.

Contributions to Trust Literature

This is the first study that I know of that *qualitatively* and exclusively explores *African American men's* perceptions of trust in physicians. The aim of this study was to examine the role that trust plays in the health behaviors and attitudes of Black men. Moreover, this research of how physicians behave and communicate with patients may improve our understanding about Black men's views of trust in medical relationships. Furthermore, this qualitative study that investigated Black males' perceptions of interpersonal trust in physicians may provide a deeper understanding of the underlying issues, attitudes, and experiences that Black men have in medical encounters (Timmermans, 2013). Also, the qualitative approach provides a rich, in-depth, holistic understanding and description of people's experiences of trust or mistrust (Murray, 2015; Timmermans, 2013; Creswell, 2013; Branch, 2014; Andersen & Taylor, 2008).

This research approach gives greater voice to participants' medical experiences. The narratives allowed me to examine the nuances in attitudes when describing medical encounters.

Moreover, conducting qualitative research of patient trust in physicians may examine patients' (and physicians') implicit and explicit attitudes in discordant medical conditions. Such studies may also provide interventions to reduce in-group-out-group biases (Penner et al., 2009; Dovidio et al., 2008). Such research can increase health care providers' sensitivity in how they interact and communicate with their patients from all racial/ethnic backgrounds. This study adds to the knowledge and understanding of Black men's perceptions of trust in physicians and its implications may combat health care disparities, increase medical compliance, and improve overall health among all individuals (Penner et al., 2013).

Political Recommendations and Implications for Future Research

Understanding ways to increase African Americans' trust in health professionals has the potential to inform legislators interested in increasing equity in health care access and health outcomes. Countless studies indicate that African Americans, particularly the men, fare the worst among all other racial/ethnic groups on nearly all health indicators. Moreover, patients' trust and understanding of the recommendations of their physicians correlate with patient follow through on health behavioral recommendations and on appointments. We know that patients that trust their doctors are more likely to disclose sensitive information and adhere to treatment recommendations, which associates with more positive health outcomes. In the long run, heightened patient trust in health care professionals has the potential to reduce the health care costs as it may reduce the likelihood of unnecessary referrals and diagnostic testing. Along these lines, validated measures of medical trust may help inform public policy and balance market forces as they strive to deliver care in a manner that builds or does not reduce trust between

patients and health care professionals. For instance, surveys and in-depth interviews and/or focus groups that assess patient trust in physicians can be used to evaluate how provider and payer organizations monitor and provide incentives to improve physicians and organizations' behaviors to promote patient trust and increase healthy behaviors (Thom & Campbell, 1997). Hence, this research aligns with the interests of legislators who are supporters of health justice. At a more structural level, my research may help legislators make the case for the need for greater access to social-economic resources, particularly greater access to more resource rich communities that allow for a better quality of life, as a means to increase health outcomes, particularly for the poorest and marginalized Americans.

Policy proposals aimed at providing health care professionals instruction on the social-economic contexts in which they work and provide care can heighten understanding among health care professionals, particularly those working in under-resourced and racially isolated communities, of the social-economic related pressures under which their patients live. Such programs may increase the understanding among health care professionals of the factors impacting their patients, particularly those of more limited means, to follow through on treatment options and health behavioral recommendations more generally. Continued training on the linkage between health and society, via government funding, are necessary to reduce inevitable stereotypes based upon limited interaction with patients and a limited understanding of the social-psychological conditions that health behaviors, outcomes, and trust.

There is a need for policy proposals aimed at providing greater social-economic opportunities for those on the bottom of social class ladder are framed in a manner that more universally appeals to the mainstream public. It is also essential for greater empirical understanding of how African American men define and come to increase their trust in health

care professionals. This line of research stems from a steady line of studies that suggests that health care trust is associated with a host of positive health outcomes. That Blacks, particularly the men, fare the worst among all other racial/ethnic groups on nearly all health indicators is, in some regard associated with their relatively poor conversations had with their physicians. This has the potential for poor, informational exchanges and understanding of the saliency of health recommendations both of which may weaken the doctor-patient relationship and fuel distrust. That said, much of the poor interaction and potential distrust/misunderstanding is associated with the reduced opportunities for social-economic mobility that exists within poor and economically isolated black communities.

Political implications from this study might also encourage those government bodies charged with implementing health care policies to methodologically and theoretically apply qualitative methods to fully understand medical trust (and mistrust). Qualitative researchers' methodological expertise with qualitative software packages are particularly well-suited to issues relevant to constituent concerns. As you are aware, qualitative research provides a rich, in-depth, holistic understanding and description of people's experiences and worldview. And, as such allows for a relatively thorough examination of how people come to make sense of their social world and act accordingly. This methodological approach is particularly useful in identifying themes that may emerge from town hall meetings aimed at identifying and understanding the root causes of constituent concerns, such as patient-health professional communication and other issues related to health care policies. Along these lines, the qualitative researchers' approach to adjusting interview questions and probing for more information depending upon the conversation had with respondents is particularly well-suited to developing questions and assisting in the leading town hall meetings with varying constituent groups. Finally, the qualitative researchers'

ability to succinctly write up and present salient information gleaned from interviews in a coherent and intelligible manner as well as discuss the social-political and health implications of such information is seemingly particularly on policy issues relevant to race, health, and medical trust.

APPENDIX A
HIC NOTICE OF APPROVAL

WAYNE STATE UNIVERSITY

IRB Administration Office
87 East Canfield, Second Floor
Detroit, Michigan 48201
Phone: (313) 577-1628
FAX: (313) 993-7122
http://irb.wayne.edu

NOTICE OF EXPEDITED APPROVAL

To: Rondrell Taylor
Sociology
656 W. Kirby

From: Dr. Deborah Ellis or designee D. Ellis / PB.
Chairperson, Behavioral Institutional Review Board (B3)

Date: October 07, 2014

RE: IRB #: 095614B3E
Protocol Title: African American Men's Perceptions of Trust in Physicians
Funding Source:
Protocol #: 1409013404

Expiration Date: October 06, 2015

Risk Level / Category: Research not involving greater than minimal risk

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The above-referenced protocol and items listed below (if applicable) were **APPROVED** following *Expedited Review* Category (#7)* by the Chairperson/designee *for* the Wayne State University Institutional Review Board (B3) for the period of 10/07/2014 through 10/06/2015. This approval does not replace any departmental or other approvals that may be required.

- Revised Protocol Summary Form (received in the IRB Office 9/28/2014)
- Protocol (received in the IRB Office 9/8/2014)
- A waiver of requirement for written documentation of informed consent has been granted according to 45 CFR 46 116(d). This waiver satisfies: 1) the research involves no more than minimal risk to the participants. Interviews regarding experiences with physicians only; 2) the research involves no procedures for which written consent is normally required outside of the research context. Interview only; 3) the consent process is appropriate and 4) an information sheet disclosing the required and appropriate additional elements of consent disclosure will be provided to participants.
- Research Information Sheet (dated 10/2/2014)
- Recruitment Flyer
- Pre-Screening Survey Script
- Data Collection Tools: Demographic Survey and Interview Guide

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* Federal regulations require that all research be reviewed at least annually. You *may* receive a *"Continuation Renewal Reminder"* approximately two months prior to the expiration date; however, it is the Principal Investigator's responsibility to obtain review and continued approval ***before*** the expiration date. Data collected during a period of lapsed approval is unapproved research and can never be reported or published as research data.

* All changes or amendments to the above-referenced protocol require review and approval by the IRB **BEFORE** implementation.

* Adverse Reactions/Unexpected Events (AR/UE) must be submitted on the appropriate form within the timeframe specified in the IRB Administration Office Policy (http://www.irb.wayne.edu/policies-human-research.php).

NOTE:

1. Upon notification of an impending regulatory site visit, hold notification, and/or external audit the IRB Administration Office must be contacted immediately.
2. Forms should be downloaded from the IRB website at **each** use.

*Based on the Expedited Review List, revised November 1998

APPENDIX B
PARTICIPANT INFORMATION SHEET

Research Information Sheet
Title of Study: African American Men's Perceptions of Trust in Physicians

Principal Investigator (PI): Rondrell Taylor
Sociology, Wayne State University
(517) 764-8017

Purpose:
You are being asked to be in a research study to explore how African American men perceive trust in their physician because you are 18 years or older, identify as Black or African American, reside in Michigan, and have received some form of medical treatment at a health care facility in the past 12 months. The purpose of the study is to examine Black men's views of trust and distrust in physicians. This study will recruit between 20-25 participants. This study is being conducted at Wayne State University.

Study Procedures:
If you take part in the study, you will be asked to complete a 30-45 minute interview with the principal investigator. In the interview, you will be asked about your attitudes and experiences with doctors who have treated you regarding doctor-patient communication, treatment recommendations, the decision-making process, and follow-up care. You will be asked to complete a 1-minute questionnaire about your education, income, and other background information. The initial interview will be audio-recorded and transcribed. These transcripts will serve as data for this study. The audio file and demographic survey will be kept in a locked file until transcribed, after which they will be deleted. Once the dissertation has been completed the audio files will be erased and destroyed, however the non-identifiable transcripts will be kept.

You will also be contacted approximately two weeks after the interview and provided with a copy of the transcript of your interview via e-mail. You will be asked to read through the transcript and provide feedback on its accuracy. If you make any changes you will be asked to return the corrected responses to me via e-mail. This will take approximately 15-20 minutes.

Benefits
As a participant in this research study, there will be no direct benefit for you; however, information from this study may benefit other people now or in the future.

Risks
By taking part in this study, you may experience some discomfort or anxiety in thinking and talking about your experiences of trust or lack of trust with your doctors.

Although every attempt will be made to protect your personal information, it is possible that unauthorized persons could gain access to the study data.

TITLE: African American Men's Perceptions of Trust in Physicians

Costs
There will be no costs to you for participation in this research study.

Compensation
For taking part in this research study, you will receive $10.00 after completing the in-person interview and demographic survey.

Confidentiality:
All information collected about you during the course of this study will be kept confidential to the extent permitted by law. You will be identified in the research records by a code name or number. When the results of this research are published or discussed at conferences, no information will be included that would reveal your identity. Also, audio files and written information will be kept in a locked file and only accessible by the investigator. Information that identifies you personally will not be released without your written permission.

Voluntary Participation /Withdrawal:
Taking part in this study is voluntary. You may choose not to take part in this study, or if you decide to take part, you can change your mind later and withdraw from the study. You are free to not answer any questions or withdraw at any time. Your decision will not change any present or future relationships with Wayne State University or its affiliates.

Questions:
If you have any questions about this study now or in the future, you may contact the Principal Investigator, Rondrell Taylor at (517) 764-8017. If you have questions or concerns about your rights as a research participant, the Chair of the Institutional Review Board can be contacted at (313) 577-1628. If you are unable to contact the research staff, or if you want to talk to someone other than the research staff, you may also call (313) 577-1628 to ask questions or voice concerns or complaints.

Participation:
By completing the interview and survey you are agreeing to participate in this study.

APPENDIX C
PRE-SCREENING QUESTIONS

Thank you for contacting me regarding your participation in this study. The study is about African American men's perceptions of trust in physicians. If you are eligible and chose to participate, you will be interviewed in-person for about 30-45 minutes and asked to complete a brief demographic survey. I will also ask that I be able to contact you after the survey in case I have any further questions or need to clarify anything that was discussed during the interview.

Are you interested in seeing if you meet the criteria to participate in this study?

Criteria #1 – Are you a male?

Criteria #2 – Are you 18 years or older?

Criteria #3 – Are you African American?

Criteria #4 – Have you received some form of medical treatment at a health care facility in the past 12 months?

Criteria #5 – Are you willing to participate in a face-to-face interview?

If all of the answers to the above questions are yes, you are eligible to participate in this study. Would you like to schedule the interview? When would be a good time to meet?

Date:_____Time:_____Location:_____

Contact Phone #:_____

Thank you for participating in this study!

APPENDIX D
DEMOGRAPHIC SURVEY

Background Information
Please check the box or fill in the blank.

1. What is your age? _____

2. Education Level:
   - □Less than High School
   - □High School Diploma or GED
   - □Some College
   - □Bachelor's Degree
   - □Master's Degree
   - □Doctorate Degree (M.D., DDS., Ph.D., Ed.D., or other Doctorate Degree)

3. Marital Status:
   - □Married
   - □In a relationship
   - □Single
   - □Divorced
   - □Widowed

4. Number of Children: _____Age/s of children: _____

5. Employment Status:
   - □Unemployed
   - □Employed part-time
   - □Employed full-time
   - □Retired
   - □Other

6. Income level:
   - □$0-$24,999
   - □$25,000-$49,000
   - □$50,000-$74,999
   - □$75,000-$99,999
   - □$100,000-$124,999
   - □$125,000 or more

7. What type of health insurance do you have? Check all that apply.
   - □No health insurance
   - □Medicaid
   - □Medicare
   - □HMO Insurance
   - □Other Private Insurance
   - □Other, please explain _____

8. City of Residence: _____

9. City of Residence of Medical Facility: _____

10. In general, how would you rate your health?
    - □Excellent
    - □Good
    - □Fair
    - □Poor

Thank you for your participation!!!

APPENDIX E
SAMPLE DEMOGRAPHIC PROFILE

AGE	25-65 years old
EDUCATION	High school Diploma or GED (2) Some College (9) Master's Degree (9)
MARITAL STATUS	Married (4) In a Relationship (3) Single (12) Divorced (1)
CHILDREN	No Children (12) Children (8)
EMPLOYMENT STATUS	Unemployed (1) Employed Part-Time (7) Employed Full-Time (8) Retired (3) Other (1)
INCOME LEVEL	$0-$24,999 (8) $25,000-$49,000 (8) $50,000-$74,999 (3) $75,000-$99,999 (1)
TYPE OF HEALTH INSURANCE	No Health Insurance (2) Medicaid (3) Medicare (1) HMO Insurance (5) Other Private Insurance (4) Other Health Insurance (5)
CITY OF RESIDENCE	Detroit (8) Metro Detroit (5) Lansing(5) East Lansing (1) Grand Rapids (1)
CITY OF RESIDENCE OF MEDICAL FACILITY	Detroit (5) Metro Detroit (8) Lansing (5) East Lansing (1) Grand Rapids (1)
RATING OF HEALTH	Excellent (4) Good (11) Fair (4) Poor (1)

APPENDIX F
RECRUITMENT FLYER

Seeking African American Men for a Research Study on the Doctor-Patient Trust

A study at Wayne State University is searching for African American men who are 18 years or older and who have received some form of medical treatment at a health care facility in the past 12 months. Men will participate in a 30-45 minute interview and complete a brief demographic survey.

Participants will be paid $10.00

The focus of the study is to explore men's perceptions of trust in physicians. Men must be willing to share information about the medical encounters they have with their doctors.

If interested please contact:

Rondrell Taylor ba2219@wayne.edu 517.764.8017	Rondrell Taylor ba2219@wayne.edu 517.764.8017	Rondrell Taylor ba2219@wayne.edu 517.764.8017	Rondrell Taylor ba2219@wayne.edu 517.764.8017	Rondrell Taylor ba2219@wayne.edu 517.764.8017	Rondrell Taylor ba2219@wayne.edu 517.764.8017	Rondrell Taylor ba2219@wayne.edu 517.764.8017	Rondrell Taylor ba2219@wayne.edu 517.764.8017	Rondrell Taylor ba2219@wayne.edu 517.764.8017

APPENDIX G
INTERVIEW GUIDE

Section A: Background Questions

1) Please tell me about your current health status (Do you have any health conditions?)
2) In your opinion, how does being an African American male affect how your doctor treats you?

Section B: Factors that Influence Trust in Physicians

3) What does trust in a doctor mean to you?
4) Describe qualities that increase trust in your doctor?
5) Do you trust your doctor? PROBE: Why or why not?
6) Do you feel respected by your doctor? PROBE: Why or why not?
7) Do you feel that your doctor cares about your well-being? PROBE: Why or why not?
8) Please describe a time when trust in your doctor was created, maintained, or breached?

Section C: Trust and Medical Compliance

9) Do you follow your doctor's treatment recommendations? PROBE: Why or Why not?
10) Does your doctor provide you with information regarding your medications or treatment recommendations? PROBE: If yes, in what way/s? If no, how does that make you feel?
11) Do you feel that your doctor is concerned about how your medications or treatment affects you? PROBE: Why or Why not? (This experience can be based on your past or present medical experience/s).
12) Do you follow-up with your doctor? PROBE: Why or why not?
13) Are you involved in the decision-making process regarding medication or treatment recommendations? PROBE: Why or why not? How? In what way/s?

Section D: Trust and Doctor-Patient Interaction

14) How do you describe your doctor's communication style? PROBE: In other words, how does your doctor communicate with you?
15) Please walk me through your last doctor's visit. (Where were you? What happened? What went well? What did not go well?)
16) Ideally, what do you want good care to look like?
17) What kind of care do you receive from your doctor?
18) Does your doctor listen to you and your concerns?
19) Do you feel rushed at your appointments with your doctor? PROBE: Why or Why not?

Section E: Additional Information

20) Is there anything else you would like to address that I have not about trust in your doctor?

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ABSTRACT

AFFIRMING EXPECTATIONS:
AFRICAN AMERICAN MEN'S PERCEPTIONS OF TRUST IN PHYSICIANS

by

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Trust is the foundation of the doctor-patient relationship. It promotes healing and medical efficacy. Patient trust in physicians exists when doctors act in their patients' best interests. Moreover, trust literature demonstrates that historically (and contemporarily), African Americans are less likely than Whites to trust clinicians and the medical community due to the history of discrimination, clinical racism, unethical medical practices, implicit or unconscious racial biases, and exploitation by the health care system. This is the first study that *qualitatively* and exclusively examines how *African American men* conceptualize (define) trust in physicians. It specifically explores factors that influence trust, how trust in physicians impact medical compliance, and how the doctor-patient interaction impacts trust in physicians.

Using a qualitative, grounded theory methodology, this study explored 20 African American men's perceptions of trust in physicians. The project revealed that most of the participants were trusting patients and they viewed trust as an iterative, bi-directional process that was formed from the initial doctor's appointment. Some of the responses that promoted trust in physicians included, caring, technical competence, thoroughness in evaluation, providing

appropriate treatment and information, good communication, partnership-building, being personable or relatable, and feeling a sense of security. Respect, kindness, compassion, empathy, sensitivity, and maintaining confidentiality also increased trust in doctors. Participants who trusted their physicians also indicated feeling like they *mattered, and that their lives had value*. Nevertheless, apathy, disrespect, and technical incompetence emerged as the most salient factors that reduced trust the men's physicians.

The results of this study reveal that trust in physicians positively influenced medical compliance. The majority of the men in this study indicated following treatment recommendations. Moreover, trust in doctors, along with being provided information regarding medications or treatment recommendations facilitated medical compliance, which promoted trust. Furthermore, medical adherence was also based on the rapport and the well-established relationships that the men had with their doctors. Consistent with trust research, the findings of the interviews support research that physician behavior and personality are the strongest predictors of patient trust in physicians. However, this study challenges existing theoretical precepts about race and trust because the narratives reveal that almost all of the participants in this study received *patient-centered care*, which increased the men's agency and control during medical interactions, which encouraged them to engage in shared decision-making.

Also, many respondents viewed medical trust from a macro perspective. The men explained that examining and improving the interwoven systems of power and inequality within the health care system, is needed to increase trust. Furthermore, the narratives revealed that it was important for health care to involve connectivity and inclusivity, irrespective of an individual's race, gender, SES, or other variables. This study may raise consciousness and encourage physicians and other health care professionals to interact and communicate differently

and more effectively with Black male patients, which may reduce health disparities and increase medical compliance. Further qualitative studies are needed to gain a deeper understanding of the underlying issues, attitudes, and experiences that Black men have in medical realms.

AUTOBIOGRAPHICAL STATEMENT

Rondrell Taylor received his Bachelor's degree and Master's degree from Michigan State University. He received his doctorate in Sociology (Medical) from Wayne State University in August 2015.