University of San Diego

Digital USD

Dissertations

Theses and Dissertations

2000-05-01

Noneconomic Barriers to Health Care Utilization by African-Americans

Johnie M. Tarver PhD, MSN, RN
University of San Diego

Follow this and additional works at: <https://digital.sandiego.edu/dissertations>

Part of the [Nursing Commons](#)

Digital USD Citation

Tarver, Johnie M. PhD, MSN, RN, "Noneconomic Barriers to Health Care Utilization by African-Americans" (2000). *Dissertations*. 293.

<https://digital.sandiego.edu/dissertations/293>

This Dissertation: Open Access is brought to you for free and open access by the Theses and Dissertations at Digital USD. It has been accepted for inclusion in Dissertations by an authorized administrator of Digital USD. For more information, please contact digital@sandiego.edu.

UNIVERSITY OF SAN DIEGO
Hahn School of Nursing and Health Science
DOCTOR OF PHILOSOPHY IN NURSING

Noneconomic Barriers to Health Care Utilization by African Americans

by

Johnie M. Tarver, MSN, RN

A dissertation presented to the
FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE
UNIVERSITY OF SAN DIEGO

In partial fulfillment of the
requirements for the degree
DOCTOR OF PHILOSOPHY IN NURSING

May, 2000

Dissertation Committee
Jane Georges, Ph.D., RN, Chair
Mary Jo Clark, Ph.D., RN
Sandra Bibb, DNSc, RN

Copyright by Johnie Mae Tarver

ALL RIGHTS RESERVED

Abstract

Noneconomic Barriers to Health care Utilization by African Americans

Many efforts have been made to maximize the utilization of health care systems. As a result, the utilization of health care systems by African Americans has increased, improving the health status (Blendon, Aiken, Freeman, & Corey, 1989). While some improvements have been made, recent reports show disparities between African Americans and Caucasians in the utilization of health care systems and in their health status.

Barriers have been identified among those in the lower social economic status (SES). These barriers impede health care utilization and negatively affect health status. However, studies show that among some African Americans when health care is affordable and available, the utilization of health care systems is not maximized. This suggests there are noneconomic barriers impeding access to and the utilization of health care systems for some African Americans.

This phenomenological study was based on Van Manen's hermeneutic phenomenological approach (Van Manen, 1990). Data were collected from participants on their experiences gaining access to and utilizing health care systems. As data were analyzed, six themes emerged. These themes were: delay before seeking health care services, fear, distrust, quality of care, racism, and long waiting time. Six of the original participants formed a focus group and through a dialectic process, gave meaning to the identified themes. Most of these themes continue to affect how African Americans gain access to and utilize health care systems.

DEDICATION

In memory of my Grandparents, Rev. John H. Wilson and Mrs. Mamie Wilson, who valued and promoted education, and my Father.

To my Mother, thanks for your prayers and the piano lessons (a great stress reducer).

To our children, Marcus Neil, Teresa Leah, and Byron Vincent, thank you for the indescribable joy, happiness, and absolute pleasure you have given us all of your lives. It is because of what you gave that propelled me to attempt this challenge. To Joanne, thanks for being our daughter and for your sharing spirit.

To my grandchildren, Brittany Lynn, Tiffany Johnie Mae, and Caleb L. H. You are special gifts only God could give.

To my God-sent husband, Ervin. You helped me to accomplish this. You lived this experience along with me. Thank you for your support, encouragement, and for always being there.

ACKNOWLEDGMENTS

Many have contributed to the success of this project. The guidance of Dr. Thirkettle when I entered the University and her continued interest in my progress is deeply appreciated. I have learned so much from the professors at USD and appreciate them for being so approachable and sensitive to individual concerns. Thank you for this experience.

Thanks to the participants who gave of their time to this project. The experiences you shared touched the heart and brought tears on occasions.

To my committee members, Drs. Mary Jo Clark and Sandra Bibb, your expertise, your knowledge, the time you devoted to this project, and the attention you have given to this project is appreciated beyond what words can express.

To my Committee Chair, Dr. Jane Georges, your quiet gentle spirit, the encouraging interactions we had, your knowledge and the willingness with which you share it without being intimidating is forever appreciated. I thank you.

Many of my colleagues have demonstrated support to me. Some through quiet expressions of kindness others through more open expressions of kindness - thanks.

TABLE OF CONTENTS

Page

Dedication.....	ii
Acknowledgments.....	iii
Table of Contents.....	iv
Appendices.....	x
CHAPTER 1	
Introduction.....	1
Purpose of the Study.....	2
Significance of the Study.....	3
Health Status.....	5
Self-Perceived Health.....	5
Mental Health.....	9
Activity Limitation.....	11
Persons With Activity Limitation.....	11
Number of Days of Restricted-Activity.....	13
Days of Disability.....	15
Mortality Rates.....	15
Diseases of the Heart.....	15
Malignant Neoplasms.....	16
Cerebrovascular Diseases.....	17

CHAPTER 2	Page
Literature Review.....	19
Patterns of Utilizing Health Care Systems.....	19
Utilization of Physicians.....	20
Utilization of Health Care Systems.....	23
Barriers to Utilizing Health Care Systems	25
Economic Barriers.....	25
African Americans and Health Insurance.....	27
African Americans and Regular	
Sources of Medical Care.....	30
Non-Economic Barriers.....	31
Cultural Distrust.....	32
Fear.....	40
Provider Bias.....	41
Conclusion.....	43
CHAPTER 3	
Research Design.....	46
Hermeneutic Phenomenology.....	46
The Hermeneutic Approach.....	47
Assumptions of Hermeneutic.....	48

Chapter 3

Van Manen's Philosophical Underpinnings

of Phenomenology.....	50
Conduct of the Study.....	53
Selection of Participants	53
Data Collection.....	55
Rigor.....	58
Data Analysis.....	58

CHAPTER 4

Findings.....	62
Descriptions of Participants	62
Context of Lived Experiences While Utilizing Health Care Systems.....	63
Identified Themes.....	64
Delay in Utilizing Health Care Systems.....	65
Experiences of Delay for Participants Whose Childhood Years Occurred Prior to Health Care Reform and Civil Rights Movement	65
Alternatives to Utilizing Health Care Systems.....	67

Chapter 4

Experiences of Delay for Participants Whose Childhood Years Occurred Post Health Care Reform and Civil Rights Movement.....	69
Fear.....	73
Quality Care.....	74
Performance of the Physician	75
Lack of Compassion.....	77
Distrust.....	79
Racism.....	81
Waiting Time.....	84
Focus Group Results.....	87
Delay in Utilizing Health Care Systems.....	88
Fear.....	89
Quality Care.....	90
Distrust.....	90
Racism.....	92
Waiting Time.....	93

Chapter 5

Discussion.....	94
Corporeality.....	95
Relationality.....	98
Spatiality.....	105
Temporeality.....	106
Conclusions.....	108
Relevance to Nursing.....	110
Nursing Research.....	110
Nursing Education.....	112
Nursing Practice.....	113
References.....	114

LIST OF APPENDICES

APPENDIX	Page
A: Human Subjects Approval Form.....	123
B: Consent form.....	126
C: Demographic Form.....	128

Chapter 1

Since the 1960's, legislative acts have been implemented to increase utilization of health care systems. Many individuals benefited from these acts, especially African Americans. Blendon, Aiken, Freeman, and Corey (1989), often cited in subsequent literature, conducted a foundational study on "Access to Medical Care for Black and White Americans." In this study, the following was found: (a) in two decades infant mortality declined by 50.0 % for African Americans, (b) the difference between African American-Caucasian life expectancy rates narrowed from 7.4 years in 1960 to 5.8 years in 1985, (c) the proportion of African Americans who saw a physician in 1963 was 18.0 % fewer than Caucasians and by 1982 the gap was almost eliminated, and (d) the proportion of pregnant African American women who received prenatal care during the first trimester increased from 42 % in 1969 to 62 % in 1985.

In spite of the progress made, as shown in the study by Blendon et al. (1989), more recent reports show a continuation of disparities between African Americans and Caucasians in the utilization of health care systems (Lieu, Newacheck, & Mcmanus, 1993) and in health status (Perry et al., 1995; Shea, Miles, & Hayward, 1996). For example, mortality rates among African American neonates, and post-neonates have been shown to be twice that of Caucasians, and the difference in life expectancy between the two groups has increased from 5.8 years in 1985 (Blendon et al.) to 6.9 years in 1995 (Anderson, Kochanek, & Murphy, 1997). In addition, other studies report the health status of African Americans remains more compromised than the health status of

Caucasians. This is evident in differences in death rates between the two groups. For example, Fingerhut and Warner (1997) reported the death rate per 100,000 population from cerebrovascular diseases for African Americans was 45 and 24.7 for Caucasians. In addition, the death rate per 100,000 population from major cardiovascular diseases for African Americans was 198.8 and for Caucasians 133.1. African Americans are more likely than Caucasians to perceive their health status as poor, fair, and good rather than very good or excellent (Benson & Marano, 1994; Livingston, 1994; Pamuk, Makuc, Heck, Reuben, & Lochner, 1998; Shea et al., 1996).

Even though there is a greater need for health care by African Americans, Blendon et al. (1989) found African Americans utilized health care systems less than Caucasians. Similarly, Newacheck, Hughes, and Stoddard (1995) found children of minority groups, the poor, or the uninsured utilized health care systems less often than Caucasians.

Barriers have been identified which impede the utilization of health care systems. These barriers are both economic and noneconomic (Gornick et al., 1996; Powell, 1997). Economic barriers are caused by lack of financial resources. Less is known about noneconomic barriers which exist at income levels where insurance or other means of financing health care are available.

Purpose of the Study

The purpose of this study is to identify noneconomic barriers impeding utilization of health care systems by African Americans. In view of the unique health care needs of this population, it is important that such barriers are identified, eliminated, or minimized. Eliminating or minimizing these barriers will contribute to a healthier nation.

The research question for this study is “What are the noneconomic barriers to African Americans’ use of health care systems?” First, it must be established that a need exists for African Americans to utilize health care systems. This will be done by reviewing the health status of African Americans and comparing to the health status of Caucasians. Second, one must make an observation of patterns of utilization of health care systems by African Americans in order to determine if the use of health care benefits is maximized. Third, it is important to recognize economic barriers and identify noneconomic barriers which impede the utilization of health care systems by African Americans.

Significance of the Study

This study is significant in that it will make a contribution to the body of nursing knowledge, it can potentially affect nursing practice approaches, and it can contribute to the achievement of Healthy People 2010 Objectives (a national effort directed toward improving health status). The knowledge gained from this study will have originated from samples of the population of concern and can be used for the purpose of improving utilization of health care systems within this population and possibly beyond. It has been shown that an increase in utilization of health care systems has resulted in improved health status (Blendon et al., 1989). A delay in utilization of health care systems when there is a need contributes to: (a) an increase in the risk of individuals living in a compromised state of health and becoming less self-sufficient, (b) an increase in the amount of effort and resources required to improve poor health status, and (c) an increase in premature mortality rates.

Since nursing research drives the practice of nursing, it is important that the generation of knowledge on which practice rests is based on scientific findings. Plager (1994) believed since nursing is increasingly involved in the delivery of primary health care for families and their individual members, contextualized findings are needed. Knowledge based on findings from contextualized studies allows nursing practice approaches to become more effective. A benefit of contextualized findings include gaining knowledge of circumstances in success or failure of health promotion interventions. In addition, knowledge can be gained to determine if the health care that is provided is, in fact, congruent with clients understanding of health and their health activities and practices (Plager).

Gaining contextual knowledge of noneconomic barriers to utilizing health care systems can lead to developing interventions to eliminate these barriers. In addition, acquiring this knowledge can contribute to shaping practice approaches for those entering the profession of nursing and changing practice approaches for practicing nurses and other health care professionals. These include techniques for patient assessment and patient education on illness and disease management which demonstrate cultural sensitivity. Failure to base nursing practice on contextual knowledge may perpetuate compromised health statuses, lead to an increase in unmet health needs, and increase premature mortality rates for African Americans, other minorities, and the poor.

Identifying and eliminating these noneconomic barriers for African Americans will contribute to a healthier nation. In addition, noneconomic barriers found to impede access to health care for African Americans may be generalizable to other minority

groups and the poor. Interventions for reducing health needs and improving access to health care systems for African Americans may also be generalizable across populations.

The United States Public Health Service and the public and private organizations around the country are taking action in accordance with Healthy People 2010 objectives to achieve certain national health goals by the year 2010 (U. S. Department of Health and Human Services. Healthy People 2010, 2000). One objective is access to quality health systems, which includes preventive care, primary care, emergency services, and long term care and rehabilitative services. Accomplishing these health goals would make the United States a nation of people with improved health status. It should also show African Americans, the poor, and other minorities maximizing the use of health care systems and achieving a state of health which is at parity with other groups

Health Status

In 1994, a group of health professionals developed an instrument which measures health-related quality of life (HRQOL) (Hennessy, Moriarty, Zack, Scherr, & Brackbill, 1994). HRQOL instruments measure an individual's health status based on self-perceived health, recent physical and mental health, and limitation in usual activities. According to Hennessy et al., these measures are increasingly acknowledged as valid health indicators and can serve to identify and estimate the level of health needs of target groups. Based on HRQOL measurements, days of disability, and mortality rates for African Americans and Caucasians, differences in health status between these two groups become apparent.

Self-Perceived Health

Self-perception of health is a subjective measure and tends to reflect the norms of one's reference group (Livingston, 1994). The reference group in the study being

conducted is African Americans. Even though a self-perception is subjective, Livingston reported it provides a useful measure of how a population perceives their health status and the need for health systems.

Blendon et al. (1989) conducted a study comparing access to health care by African Americans and Caucasians. He stated that individuals' self-reports of their health status have been shown to be good predictors for their physical health, including the presence of chronic conditions, disabilities, and limitations of normal activities due to illness.

Pamuk, et al. (1998) reported on the health status of subjects 18 years of age and older according to income levels. A greater percentage of African American women and men than Caucasian women and men perceived their health status to be fair or poor at all income levels. For example, among poor females, 38 % of African Americans perceived their health status to be fair or poor compared to 30 % of Caucasians. Among near poor females, 26 % of African Americans perceived their health status to be fair to poor compared to 18 % of Caucasians. For middle income females, nearly 15 % of African Americans perceived their health status to be fair to poor compared to 9 % of Caucasians, and for females in the high income group, 9 % of African Americans perceived their health status to be fair or poor compared to slightly higher than 5 % of Caucasians. Similar findings represent African American and Caucasian males. For example, 37 % of African American males who were poor perceived their health status to be fair or poor compared to 31% of Caucasian males. Among the near poor, 23 % of African American males perceived their health status to be poor or fair compared to 21 % of Caucasian males. Thirteen percent middle income African American males reported their health

status to be poor or fair compared to 9 % of Caucasian males. There was only a slight disparity in the self-perceived health status for African American males (6 %) and Caucasian males (5 %) who were in the high income group. Among the females, the disparity was significant at all economic levels. Among the males, though disparities existed, the degree to which they existed was less than for females.

Shea et al. (1996) examined the theoretical connection between health capital and financial capital. This study included 12,652 subjects between 51 and 61 years of age. It was found that whether the wealth was below or above \$100,000, a greater percentage of African Americans felt their health was poor, fair, or good. The percentages of African Americans who felt their health status were very good or excellent were less than the percentages of Caucasians. For example, among subjects whose wealth was below \$100,000, the percentages of African Americans who perceived their health status to be poor, fair, or good were 15 %, 25 %, and 32 %, respectively and for Caucasians, 11 %, 15 %, and 30 %, respectively. The percentages for African Americans who perceived their health status to be very good and excellent were 19 % and 10 %, respectively and for Caucasians 27 % and 18 %, respectively. When data were analyzed from subjects whose wealth was above \$100,000, similar findings were reported. The percentages for African Americans who perceived their health statuses to be poor, fair, or good were 4 %, 15 %, and 30 %, respectively, while the percentages for Caucasians were 3 %, 8 %, and 25 %, respectively. The same pattern was presented when data of subjects were observed without regards to the economic status. For example, among African Americans, the percentages who perceived their health status to be poor, fair, and good, were 12 %, 15 %, and 30 %, respectively, while the percentages for Caucasians were 3 %, 8 %, and 25 %, respectively.

23 %, and 32 %, respectively, while among Caucasians, the percentages who perceived their health status to be poor, fair, and good, were 7 %, 12 %, and 27 %, respectively.

Perry et al. (1996) reported similar findings. The Kansas Department of Health and Environment analyzed data from the 1995 Behavioral Risk Factor Surveillance System supplemental survey of African Americans to determine self-perceived health status. For self-perceived health statuses of poor, fair, and good, the percentages of African Americans reporting were 5 %, 10 %, and 36 %, respectively, while percentages for Caucasians were 4 %, 9 %, and 27 %, respectively. Perceptions of self-perceived health status as very good or excellent were reported by 27 % and 23 % of African Americans, respectively, and 36 % and 24 % of Caucasians.

Lieu et al. (1993) conducted a study on African American, Caucasian, and Hispanic adolescents 10 to 17 years old. One purpose of the study was to describe differences in health care access and health care utilization. In this study, it was found that 39 % of African Americans, compared to 17 % of Caucasians, assessed their health status to be poor, fair, or good, while 61 % of African Americans and 83 % of Caucasians assessed their health status to be very good or excellent. These findings are congruent with findings by Pamuk et al. (1998), Perry et al. (1996), and Shea et al. (1996).

Kim, Bramlett, Wright, and Poon (1998) conducted a descriptive comparative study using data from a previous Georgia Study. After assessing 248 older adults, ranging in age from 60 to 107 years of age, the self-perceived health status of African Americans was found to be poorer than the self-perceived health status of Caucasians. However, when covaried with income and education, racial differences were eliminated.

Differences in this study compared to findings by Lieu et al. (1993), Pamuk et al. (1998), Perry et al. (1996), and Shea et al. (1996), may be attributed to differences in ages of the subjects. Kim et al. studied subjects 60 to 107 years of age when the decline of health may be more generalized across groups, while studies by Lieu et al., Pamuk et al., Perry et al., and Shea et al. included younger subjects. Interpreting the differences in the findings is difficult, however, a combination of variables and the homogeneity of the subjects with respect to age, may be factors to consider. Only the study by Kim et al. included income and education as co-variants. In the study by Shea et al., differences in self-perceived health status were not influenced by economic status.

Livingston (1994) also reported a greater percentage of African Americans than Caucasians perceived their health status to be poor, fair or good. The percentages of African Americans who perceived their health status to be poor, fair, and good were 3.8 %, 10 %, and 29.1%, respectively, compared to findings of 2.7 % poor, 6.8 % fair, and 22 % good for Caucasians. In addition, Livingston reported the percentages of African Americans perceiving their health status to be very good and excellent (25.8 % and 31.3 %, respectively) as less than the percentage of Caucasians (28.9 % and 39.6 %, respectively).

Mental Health

In a report by Bloom, Simpson, Cohen, and Parsons (1997), an assessment of mental health needs was based on subjects' report of inability to obtain needed care for mental health problems in the past 12 months. When subjects who needed mental health care were observed, 1.2 % of African Americans, compared to 1.1 % of Caucasians, had unmet mental health needs. However, when unmet needs for mental health care were

considered according to income levels, 1.9 % of African Americans at an income level less than \$20,000 had unmet mental health needs, compared to 2.9 % of Caucasians. Within the income range of \$20,000 to 34,999, 0.8 % of African Americans had unmet mental health needs compared to 1.0 % of Caucasians. For all subjects above the \$35,000 income level, the percentage of unmet mental health needs was 4 %. Simpson, believed the difference in findings when income is considered is related to the low response rate by African Americans when responding to survey items on income (G. Simpson, personal communication, May 28, 1999). Simpson stated that African Americans frequently omit survey items related to finance.

In a study conducted by Kim et al. (1998) to investigate racial differences in health status and health behaviors, African Americans were found to have significantly poorer mental health than Caucasians. After administering the Mental Health Rating Scale, with scores ranging from 1 to 6, the mean score for African Americans was 4.09 compared to a mean score of 4.44 for Caucasians. When covaried with education and income, differences in mental health decreased but remained significant.

Regarding mental illness, Livingston (1994) stated misdiagnosis must be addressed when mental health research focuses on racial comparisons. According to Livingston, the domain of symptoms for any special psychiatric disorder would be unlikely to remain identical across cultural groups. Livingston further asserted if races belong to different cultures, they may have distinct belief systems, values, and standards for acceptable behavior (p. 259). The disparity between the percentages of African Americans and Caucasians who have mental illness is somewhat inconclusive, but should be monitored.

Activity Limitation

Ries and Brown (1995) reported on (a) the average annual percent of persons with limitation of activity due to chronic conditions and respondent-assessed health status, (b) the average annual percent of persons without limitation of activity due to chronic conditions and respondent-assessed health status, (c) the average number of days of restricted activities per person per year, with limitation of activity due to chronic conditions and respondent-assessed health status, and (d) the average number of days of restricted activities per person per year, without limitation of activity due to chronic conditions and respondent-assessed health status.

A condition was considered chronic if it was noted three months or more prior to the date of the interview or (2) if it was a type of condition that usually had a duration of more than three months (Ries & Brown, 1995). Activity limitation is defined in terms of the level of ability to perform certain major activities associated with specific age ranges, such as the ability of individuals who are 5-17 years of age to attend a regular school (Ries & Brown). Days of restricted activity are those days which a person stays in bed, misses work or school, or cuts down on his or her usual activity because of illness, impairment, or injury (Ries & Brown). In addition to reports on self-perceived health status, activity limitation, and mental health status, the average days of disability and mortality rates for African Americans and Caucasians are presented. These five reports provide a perspective on differences in health status between the two groups.

Persons with activity limitation. Ries and Brown (1995) presented a report on the percentage of persons *with limitation of activities* due to chronic conditions and respondent-assessed health status. In this report, 8.7 % of African Americans with poor to

fair self-assessed health status were limited in activities compared to 5.8 % of Caucasians. The percentage of African Americans with good to excellent self-assessed health status and limited in activities was 5.8 % while the percentage of Caucasians was 8 %. This study showed that among the two groups who assessed their health status to be poor to fair, the more compromised group was more limited in activities, but among the two groups who assessed their health status to be good to excellent, the more compromised group was less limited in activities. This pattern is difficult to explain, however, it could be related to differences in how the two groups defined chronic conditions or one group taking interventions at an earlier point in their condition or illness.

A difference was presented between African Americans' and Caucasians' self-assessed health status and *no limitation in activity* due to chronic conditions. Ries and Brown (1995) reported that among respondents who assessed their health status to be poor or fair, a greater percentage of African Americans (6.7 %) were not limited in activity when compared to Caucasians (3.7 %). However, 78.8 % of African Americans who assessed their health status to be good to excellent, reported no limitation in activity compared to 82.4 % of Caucasians. It is difficult to explain why a greater percentage of African Americans compared to Caucasians who assessed their health status to be poor or fair have fewer limitations in activities. Activity limitations which were not associated with health status were not reported in this study; however, other studies report comparisons of activity limitations between the two groups which have no association with health status.

Benson and Marano (1994) reported the percentage of persons with activity limitations due to chronic conditions was 16.4 % for African Americans compared to 15.6 % for Caucasians. Pamuk et al. (1998) reported on activity limitations among adults 18 to 64 years of age by family income. This report showed a greater percentage of Caucasian adults with activity limitation at all income levels during 1992 to 1995. Among the poor, near poor, and middle or high income levels, the percentages of African Americans with activity limitations were 35 %, 22.5 %, and 10.5 %, respectively, while the percentages for Caucasians were 38 %, 23 %, and 11 %, respectively. Many reports show that when African Americans respond to survey items related to income, the findings change. Simpson (personal communication, May 28, 1999) suggested that such patterns found in the report by Bloom et al. (1997) could have been related to the reduced response rate by African Americans to survey items which are related to income. This could be a contributing factor in other reports showing reverse patterns when income is a variable. Also, the difference in the age groups represented in the three studies could influence the findings. The report by Pamuk et al. included adults ages 18 to 64 years while reports by Benson and Marano (1994) and Ries and Brown (1995) included all ages.

Number of days of restricted activity. Reports have been presented on the number of days of restricted activity for persons who had *limitation of activity* due to chronic conditions and respondents' assessed health status. Ries and Brown (1995) showed African Americans who had limitation of activities and who were in poor or fair health averaged 89.8 days of restricted activity per person per year and Caucasians averaged 87.7 days. While this difference is not significant, the difference when the

health status was reported as good to excellent is more significant. For subjects in this category, African Americans averaged 32.6 days of restricted activity per person per year and Caucasians averaged 28.1 days. While other studies showed a greater percentage of Caucasians than African Americans to be in very good to excellent health, this study show among African Americans and Caucasians who are in good to excellent health, the number of days of restricted activity was greater for African Americans than for Caucasians.

Among the subjects who had *no limitation of activity* due to chronic conditions and were in poor or fair health, however, African Americans averaged 24.3 days of restricted activity per person per year while Caucasians averaged 27.3 days of restricted activity per person per year. Among the subjects who had no limitation of activity due to chronic conditions and were in good to excellent health, African Americans averaged 6.8 days of restricted activity per person per year, while Caucasians averaged 7.6 days.

It is difficult to explain why the average number of days of restricted activities per person per year is lowest among the group within which a greater percentage perceive their health status to be poor or fair and highest among the group who perceive their health status as very good or excellent. Among some possible contributing factors are: the illness causing the chronic condition, timeliness in responding to illness, and the knowledge level of managing diseases and illness.

Benson and Marano (1994) reported the average number of days of activity restriction per year due to chronic conditions for African Americans was 19.2 days compared to 17 days for Caucasians. These findings are not associated with other characteristics of the respondents such as their health status.

Days of Disability

Shapiro et al. (1998) reported the number of days of disability per person per year in 1995 was 17 days for African Americans and 15.6 days for Caucasians. This represented a steady decline from 1993 when the number of days of disability per person per year was 19.2 days for African Americans and 17.0 days for Caucasians. In addition, 16.2 % of African Americans reported work disabilities compared to 9.4 % of Caucasians (Shapiro et al., 1998).

Mortality Rates

African Americans and Caucasians also differ in mortality rates. For many diseases, mortality rates among African Americans are higher than the mortality rates for Caucasians (Anderson et al., 1997; Fingerhut & Warner, 1997; Liao & Cooper, 1995; Livingston, 1994). The following reports on mortality rates by Anderson et al. and Fingerhut & Warner are age-adjusted death rates. Statistically, age-adjusted death rate is a weighted average of the age-specific death rates, where the weights represent the fixed population proportions by age (Anderson et al., 1997, p. 79)

Diseases of the heart. Three leading causes of death in the United States are diseases of the heart, malignant neoplasms, and cerebrovascular diseases (Anderson et al., 1997; Fingerhut & Warner, 1997; Livingston, 1994). Of these three, diseases of the heart has the highest mortality rates for both African Americans and Caucasians (Anderson et al., 1997; Fingerhut & Warner, 1997). In 1995, the mortality rate from diseases of the heart for African Americans was 198.9 per 100,000 population, compared to 133 per 100,000 population for Caucasians (Fingerhut & Warner, 1997).

A retrospective study based on the United States census was conducted by Liao & Cooper (1995). The purpose of this study was to review the continued adverse trends in coronary heart disease mortality among African Americans. It was found that in 1980, the mortality rate from coronary heart disease was 196 per 100,000 population for African American males, compared to 218 per 100,000 population for Caucasian males. This pattern was reversed beginning in 1989 and by 1991 the mortality rate was 144.5 per 100,000 population for African American males compared to 139.7 per 100,000 population for Caucasian males. Mortality rates declined for both groups from 1980 through 1991. However, the rate of decline was not parallel for the two groups. Each year between 1983 and 1991, the average rate of decline in mortality rates per 100,000 population for African Americans was 2.4 %, while the average rate of decline for Caucasians was 3.6 %.

Other studies have shown differences in the decline of mortality rates between African Americans and Caucasians. Fingerhut and Warner (1997) reported that from 1990 to 1995, the mortality rate from diseases of the heart for African American males declined by 7 %, compared to 9 % for Caucasians. Reasons for the difference in the declining rate are unknown, however, one could speculate that African Americans are not experiencing the maximum benefits from health care systems.

Malignant neoplasms. Malignant neoplasm is the second leading cause of death in the United States. According to Fingerhut & Warner (1997), the mortality rate from malignant neoplasms was 171 per 100,000 population for African Americans compared to 127 per 100,000 population for Caucasians in 1995. Even though the mortality rates declined from 182 per 100,000 population in 1990 to 171 in 1995 for African Americans

(6 %) and from 131.5 per 100,000 population to 127 for Caucasians (3 %), the disparity remains (Fingerhut & Warner). In contrast, the mortality rates from colorectal and breast cancer increased slightly in 1995 over 1994 among African Americans (Fingerhut & Warner). Gornick et al. (1996) found that African Americans utilized health care systems for mammograms less often than Caucasians at all income levels. There are unanswered questions about the cause for this disparity.

Cerebrovascular diseases. The third leading cause of death in the United States in 1995 was Cerebrovascular diseases (Anderson et al., 1997; Fingerhut & Warner, 1997). A more recent report by Hoyert, Kochanek, and Murphy (1999) showed cerebrovascular diseases continues to be the third leading cause of death in the United States, however, there was a 1.9 % decline between 1996 and 1997. In 1990, the mortality rate from cerebrovascular diseases was 90 % higher for African Americans (48.4 per 100,000 population) than Caucasians (25.5 per 100,000 population). In 1995, the mortality rate from cerebrovascular diseases was 82% higher for African Americans (45 per 100,000 population) than Caucasians (24.7 per 100,000 population) (Fingerhut & Warner). Even though mortality rates are declining for both groups, the disparity remains.

This review of studies based on health related quality of life (HRQOL) measurements, days of disability , and mortality rates have shown the health status of African Americans to be more compromised than the health status of Caucasians. Because of differences in health statuses, one would expect African Americans to maximize the use of health care systems. If the use of health care systems is not being maximized by African Americans, barriers for utilizing health care systems should be

identified. Chapter II will address patterns of utilizing health care systems and barriers to utilizing health care systems for African Americans.

The research design for this study was hermeneutic phenomenology, based on Van Manen's philosophical underpinnings. It focused on the appearance of phenomena and attempted to understand and interpret the meaning of the lived experiences. The initial interview was with 12 participants. The interview began by asking an initial question, "What have your experiences been as you utilized health care systems?" Additional knowledge was gained on the shared experiences by asking questions based on the four existentials of corporeality (how we believe others view us), spatiality (the degree to which the environment is supportive to our needs), temporality (our experiences related to the temporal landscape of our lives), and relationality (our relationship with health care providers). Data were analyzed following each interview and themes were identified. The second interview was conducted with a focus group. The members of the focus group included six of the original participants who presented the most themes during the initial interview. The purpose of the focus group was to give meanings to the themes. A total of six themes were identified and meanings assigned to each.

Chapter 2

Literature Review

Access, barriers, and utilization are three terms frequently referred to when discussing disparities in health care. Millman (1993) defined access as “the timely use of personal health systems to achieve optimal health outcomes.” Wulbern (1963) defined barriers as “an obstacle, natural or otherwise.” Utilization is defined as “to make use” (Wulbern). These definitions were used as a guide in this study in order to gain knowledge on patterns of access to and utilization of health care systems by African Americans and on barriers for African Americans utilizing health care systems.

This chapter focuses on observed patterns of how African Americans utilize health care systems such as physician offices and ambulatory services compared to how Caucasians utilize these systems. In addition, it focuses on barriers, both economic and noneconomic, for African Americans, compared to Caucasians, in the use of health care systems.

Patterns of Utilizing Health Care Systems

Studies show African Americans utilize health care systems differently from the way Caucasians utilize health care systems (Benson & Marano, 1994; Bloom et al., 1997; Livingston, 1994). These differences are seen in the utilization of private physicians, clinics, and hospitals. The percentage of Africans who utilize clinics and emergency rooms is greater than the percentage of Caucasians who utilize clinics and emergency rooms. At all income levels, the percentage of African Americans who utilize the services

of private physicians is less than for Caucasians. This pattern of utilization was unchanged regardless of the insured status of subjects or whether subjects had a regular source of medical care (Bloom et al., 1997).

Utilization of Physicians

Livingston (1994) reported on behaviors demonstrated by African Americans and Caucasians in the utilization of physicians. This report showed 77.6 % of African Americans contacted private physicians compared to 79 % of Caucasians. For intervals greater than one year and less than two years, 9.6 % African Americans, compared to 11.4 % Caucasians, reported themselves less likely to seek physicians for any cause. Beyond two years, African Americans were more likely to seek care for any cause.

Ries and Brown (1995) reported that African Americans in poor or fair health and *with activity limitation* due to chronic conditions averaged 15 annual physician contacts while Caucasians averaged 17.6 annual physician contacts. African Americans in good to excellent health with activity limitation due to chronic conditions averaged 8.7 annual physician contacts while Caucasians averaged 9.6 annual physician contacts. African Americans in poor or fair health and *without activity limitation* due to chronic conditions averaged 6.9 physician contacts annually while Caucasians averaged 9.4 physician contacts. African Americans in good to excellent health and without activity limitation due to chronic conditions averaged 3 physician contacts annually and Caucasians averaged 4 physician contacts annually. Further more, this study showed the average physician contacts were 4.6 per person per year for African Americans and 5.4 for Caucasians whether or not there were limitations in activities or whether the self-assessed health status was poor to fair or good to excellent.

Benson and Marano (1994) reported African Americans averaged 0.5 telephone calls per person per year to contact a physician, while Caucasians averaged 0.8 telephone calls. The average number of office visits per person per year for African Americans was reported to be 2.6 visits versus 3.5 visits for Caucasians.

Bloom et al. (1997) presented a report on individuals with public health insurance. Among those at income levels less than \$20,000, 49.4 % of African Americans utilized private physicians as a regular source for care compared to 74.3 % of Caucasians. When the income ranged between \$20,000 - 34,999, 65.7 % of African Americans utilized private physicians as a regular source for care, compared to 79.6 % of Caucasians. When the income was above \$35,000, 26.4 % of African Americans, compared to 87.4 % of Caucasians, utilized private physicians as a regular source for medical care. Gordon (1995) reviewed studies on deterrents to access and service for African Americans, Caucasians, and Hispanics. Though the actual percentages were not given, a review of literature revealed fewer African Americans than Caucasians reported utilizing a physician's office as a regular source for medical care.

Newacheck et al. (1995) conducted a study to assess access to and use of primary care systems for poor, minority, and uninsured in the United States. In this study, it was found 8.6 % of children from poor families, 10 % of minority children, and 7.4 % of uninsured children visited hospital out-patient clinics compared to 2.6 % of children from Caucasian, nonpoor, insured families. In addition, this study showed 70.2 % of children from poor families, 70.5 % of minority children, and 74.2 % of uninsured children received care from physician's office and health maintenance organizations (HMO) compared to 93.0 % of children from Caucasian, nonpoor, insured families.

Newacheck et al. (1995) also reported on physician visits. The average annual physician visit per 100 bed days were 84.1 visits for children from poor families, 96.7 visits for minority children, and 78.6 visits for uninsured children compared to 149.2 visits for children from Caucasian, nonpoor, insured families. The average annual number of physician visits for children in poor or fair health was 3.0 visits for children from poor families, 2.4 visits for minority children, and 2.6 visits for uninsured children, compared to 6.0 visits for children from Caucasian, nonpoor, insured families. The average annual number of visits for children in good to excellent health was 1.2 visits for children from poor families, 1.3 visits for minority children, and 1.2 visits for uninsured children compared to 2.7 visits for children from Caucasian, nonpoor, insured families. In addition, 22.5 % of children from poor families, 24.5 % of minority children, and 18 % of uninsured children were inadequately vaccinated for measles compared to only 9.2 % of children from Caucasian nonpoor, insured families. For selected symptoms, 41.3 % of children from poor families, 41.9 % of minority children, and 45.8 % of uninsured children were not seen by a physician compared to 27.8 % of children from Caucasian nonpoor, insured families. Differences in utilization of physicians by the poor, minority, and uninsured compared to Caucasian nonpoor, insured families are explicit in this study.

In the study conducted by Lieu, Newacheck, and McManus (1993) to describe differences in health care access and use, it was found that insured African Americans had an average of 2.2 physician visits during the past year compared to an average of 2.8 physician visits for Caucasians during the same period. The same was true for the uninsured. The average physician visits were 1.4 visits for African Americans who were uninsured compared to 2 visits for Caucasians.

Gornick et al. (1996) conducted a retrospective study to determine the effects of race and income on mortality and use of systems among Medicare beneficiaries. Census data on median income according to zip code were linked with 1993 Medicare Administrative data on 26.3 million beneficiaries 65 years of age or older. In this study, it was found that the disparity in physician visits between African Americans and Caucasians increased as the income level increased. When the income was \$13,100 and under, African Americans had 7.1 physician visits per beneficiary per year and Caucasians had 7.3 physician visits per beneficiary per year. At the income range of \$16,301 to \$20,500, the disparity increased. African Americans had 7.4 physician visits per beneficiary per year and Caucasians had 8.3 physician visits per beneficiary per year. As the income range became greater, so did the disparity in physician visits per beneficiary per year, to the extent that at the income level of \$20,501, African Americans had 8 physician visits per beneficiary per year and Caucasians had 9 physician visits per beneficiary per year.

These studies represent different age groups. Even though subjects in each study represented different age groups, one finding was constant, African Americans did not utilize physician visits for health care to the extent that Caucasians utilized physician visits and SES was not always a factor.

Utilization of Health Care Systems

Bloom et al. (1997) showed a greater percentage of African Americans than Caucasians at all income levels utilized clinics and emergency rooms over private physician offices. This report showed among subjects with private insurance, 2.5 % of African Americans utilized emergency rooms as a regular source of medical care

compared to 0.7 % of Caucasians. Even when annual incomes were above \$35,000, the percentage of African Americans (1.1 %) who utilized emergency rooms as a regular source of medical care was nearly twice the percentage of Caucasians (0.6 %). These findings suggest factors other than income influence utilization of health care systems by African Americans. The high utilization of emergency rooms found by Bloom et al. suggests that perhaps timeliness is a factor in determining the site for health care and a delay in meeting health needs possibly occurs among African Americans until the condition has become urgent or emergent.

Blendon et al. (1989) reported the following: the percentage of African Americans (6.3 %) hospitalized during the year was less than the percentage of Caucasians (6.9 %); the percentage of African Americans (37.2 %) who were without ambulatory visits during the year was greater than the percentage of Caucasians (31.7 %); and a greater percentage of African Americans (25.1 %) than Caucasians (16.6 %) with chronic or serious illness did not have ambulatory visits within the last year. In addition, Blendon reported fewer mean ambulatory visits by African Americans (3.4 mean visits) than Caucasians (4.4 mean visits) during a year, and among hypertensive individuals, 30 % of African Americans were without an annual blood pressure check compared to 19 % of Caucasians.

Both objective and subjective reports examining the health status of African Americans show the health status of African Americans to be more compromised than the health status of Caucasians. However, the compromised health status has not led to maximizing the utilization of physician offices and hospitals by African Americans. In spite of poorer health status, emergency rooms are highly utilized by African Americans

and the use of physician offices is minimized. The problem with this pattern is education on disease prevention and illness management is provided in physician offices and clinics while the goal for emergency rooms is to provide care to meet the emergent need. It is important for health care consumers to maximize the use of health care systems by selecting the site designed to provide maximum benefits. However, barriers, some of which are undetermined, have impeded the utilization of health care systems by African Americans, other minorities, and the poor. Powell (1997) stated both financial and non-financial barriers impede utilization of health care systems by African Americans. In addition, Powell, who presented a report on prostate cancer and African American men, believed non-financial barriers had a greater impact than financial barriers on delayed diagnosis presentation of advanced prostate cancer and worse survival among African American men.

Barriers to Utilizing Health Care Systems

A review of patterns of utilizing health care systems by African Americans shows that barriers exist which impede health care utilization. These barriers possibly influence the choice of site for regular medical care. One way of taxonomizing or categorizing barriers is by labeling them as economic and noneconomic barriers, both of which are noted in the literature.

Economic Barriers

Andersens' (1995) behavioral model for use of health care systems predicts that certain factors facilitate utilizing health care systems. Andersen stated that having health insurance and a regular source of care facilitates the use of health care systems and provide timely entry into medical care systems when acute care is needed. However, the

social economic status (SES) of an individual can become an economic barrier, preventing the individual from acquiring health insurance and limiting the opportunities for having a regular source of medical care.

Economic barriers are those factors related to social economic status which impede the utilization of health care systems. Education, type of job, and income are major determinants of SES. The level of education influences the type of job availability, which in turn, determines income level.

Singh and Yu (1996) conducted a study to examine trends and differences in U. S. childhood mortality rates from 1953 to 1993 according to sex, race/ethnicity, education, and family income. SES was found to be a major underlying determinant of childhood mortality and both education and income showed a profound net impact on childhood mortality. It was found in this study that the lower the level of educational attainment and the greater the degree of poverty, the higher the childhood mortality rates.

Adler, Boyce, Chesney, Folkman, and Syme (1993) reviewed several studies on SES inequalities in health and found one explanation for the SES-health decline to be that individuals lower in the SES hierarchy do not have the same access to medical care. Adler et al. found that individuals who are in the lower SES hierarchy suffer disproportionately from every disease and have higher mortality rates compared to those of higher SES. This association is found within all SES components; education, income, and occupational status.

Kawachi, Kennedy, Lochner, and Prothrow-Stith (1997) hypothesized that a relationship existed between income inequality and reduction in social cohesion and that disinvestment in social capital is in turn associated with increased mortality. This was a

cross-sectional ecological study based on data collected on subjects from 39 states. The study showed a strongly positive correlation between income inequality and the two components of social capital, membership in voluntary groups and level of social trust. In turn, both social trust and group membership were shown to be related to mortality rates in general as well as several disease entities.

These findings by Adler et al. (1993), Kawachi et al. (1997), and Singh and Yu (1996) support the concept that SES influences access to and the utilization of health care systems. In addition, these findings showed lower SES negatively affects health status. Because of these findings, it is important to examine the extent to which African Americans acquire health insurance and have regular sources for medical care, which are potential indirect effects of SES.

African Americans and health insurance. Members of all ethnic groups are represented at all SES levels. However, representation at the lower SES is disproportionately higher for African Americans than for Caucasians. Daley, Price, and Fransworth (1997) reported 19.4 % of African Americans at an income below \$10,000 compared to 5.8 % of Caucasians, 10.9 % of African Americans at the income level of \$10,000-\$14,999 compared to 5.8 % of Caucasians, and 18.3 % of African Americans at the income level of \$15,000 compared to 13.9 % of Caucasians. Individuals with low income are less likely to purchase insurance, have employer provided insurance, and in some cases, qualify for public insurance. Because of the disproportionate representation of African Americans at low income levels where health provider insurance is not available and purchasing health insurance is less affordable, African Americans are less likely to be insured than Caucasians.

Blendon et al. (1989) reported that 9.1 % of African Americans did not receive health care for economic reasons compared to 5 % of Caucasians. Pichert and Brisco (1997) found one problem for African Americans utilizing health services was the inability to pay for care.

A greater percentage of uninsured than insured individuals lack the ability to obtain health care. Berk and Schur (1998) reviewed reports of surveys conducted by the 1993 National Medical Expenditure Survey on unmet needs for health care. These surveys were conducted to measure access to health care. Estimates from six different surveys presented the percentage of the U. S. population reporting inability to obtain care. In all surveys on populations reporting inability to obtain care, the percentage of uninsured individuals was significantly greater than the percentage of insured individuals. In the Berk and Schur report, the 1993 National Health Interview Survey reported 1.7 % of insured and 9.6 % of uninsured persons were unable to obtain health care. In addition, a 1995 Kaiser survey reported 11 % of insured and 45 % of uninsured persons unable to obtain health care (Berk & Schur)

Researchers acknowledged the inconsistent estimates in measuring access to health care. Even though access surveys present a confused and inconsistent picture of Americans' problem with obtaining care, they have been successful in showing consistent patterns in several regards. First, all access surveys conducted have shown that health insurance coverage is an important predictor of the use of health care systems. Second, access surveys have shown that individuals who are not Caucasian experience greater barriers to care when compared to Caucasians. Third, access studies have shown the dramatic effect Medicare and Medicaid programs have on access to care for the elderly

and poor (Berk & Schur, 1998). The lack of insurance resulting in the lack of access to health care has been suggested as a cause for worse prostate cancer survival rates among African American men versus American Caucasian men (Powell, 1997, p. 601).

Seccombe and Amey (1995) conducted a study to examine the health insurance patterns of the working poor and to compare the antecedents of employer-sponsored insurance of this group to those with higher incomes. It was found that 48.4 % of the working poor were without insurance from any source, compared to 9.1 % of persons with incomes above 200 % of the poverty level. In addition, the working poor were found to be one-third as likely to receive insurance from their employer as the non-poor and over five times as likely to be without insurance from any source.

Lieu et al. (1993) conducted a study to describe differences in health care access and use among African Americans and Caucasians. This study was conducted on 7,465 children 10 to 17 years of age. They found that a greater percentage of African Americans (16 %) than Caucasians (11 %) were uninsured. Similarly, Shapiro et al. (1998) reported the percentage of African Americans covered by private insurance was 51.8 % while 73.5 % of Caucasians were covered by private insurance. The percentage of African Americans who were not covered by health insurance was 21.7 % while 14.4 % of Caucasians were not covered by health insurance. In all cases, the percentage of African Americans covered by insurance was less than the percentage of Caucasians and the percentage of African Americans who were not covered by insurance was greater than the percentage of Caucasians.

Pamuk et al. (1998) reported a greater percentage of African American men than Caucasian men who were poor, near poor, middle income, or high income had no health

insurance. When women from the two groups were compared, the percentage of African American women without health insurance was less than Caucasian women at all levels of income except high income. The percentage of African American women at high income level without health insurance was approximately 6 % while the percentage of Caucasian women was approximately 4 %. The significance of this is that health insurance is more affordable for those at the high income level, but African American women at the high income level are less likely to be insured than Caucasian women.

African Americans and regular sources of medical care. Bloom et al. (1997)

conducted a study on regular source of medical care in relation to health insurance status. This was a retrospective study based on data from the 1993 Access to Care and the 1993 Health Insurance surveys of the National Health Interview Survey. Among the issues addressed in the study were regular sources of medical care for individuals with private health insurance, public health insurance, and no insurance.

Among individuals with private insurance, 83.9 % of African Americans utilized private physicians as regular sources for medical care compared to 92.2 % of Caucasians. However, the percentage of African Americans (10.9 %) who utilized clinics as a regular source for medical care was greater than the percentage of Caucasians (4.8 %). Emergency rooms were utilized as a regular source for medical care by 2.5 % of African Americans compared to 0.7 % of Caucasians.

When data were analyzed to determine the place of regular source of care for subjects who had public insurance, it was found that 49.3 % of African Americans utilized private physicians, 41.2 % utilized clinics, and 6.5 % utilized emergency rooms.

For Caucasians, with public health insurance, 75.1 % utilized private physicians, 16.5 % utilized clinics, and 4.8 % utilized emergency rooms.

Among subjects with no health insurance, 60.6 % of African Americans compared to 83.5 % of Caucasians utilized private physicians as a place of regular source of care; 28.8 % of African Americans utilized clinics as a regular source of care, compared to 9.5 % of Caucasians; and 7.7 % of African Americans utilized emergency rooms as a regular source of care compared to 3.4 % of Caucasians. When income was considered, the pattern remained.

Gordon (1995) reviewed studies on deterrents to access and service for African Americans, Caucasians, and Hispanics and found more African Americans than Caucasians reported they had no regular source for medical care. Gordon also found twice as many African Americans as Caucasians reported they used hospitals clinics as a regular source for medical care. In the study conducted by Newacheck et al. (1995) to assess access to and use of primary care systems for poor, minority, and uninsured children, it was found that children without health insurance were least likely to have a regular source of medical care.

Reports have shown a lower SES of an individual impedes the utilization of health care systems. However, reports have also shown disparities in utilizing health care systems for African Americans who are not economically disadvantaged compared to Caucasians (Blendon et al., 1989; Gornick et al., 1996).

Noneconomic Barriers

While SES influences the ability to have health insurance, SES alone does not explain the disparity between African Americans' and Caucasians' health status and

utilization of health care systems. Even though both theoretical (Powell, 1997) and empirical reports (Blendon et al., 1989; Newacheck et al., 1995) refer to SES as a barrier to health care utilization, some studies show that disparities in utilizing health care systems are greatest at the upper income level (Blendon, et al.; Gornick et al., 1996). Gornick et al. reported that a greater disparity existed between African American and Caucasian Medicare beneficiaries at the income level at which health care is more affordable. These studies indicate factors other than income influence the rate at which African Americans access health care systems.

Powell (1997) stated that while both economic and noneconomic barriers exist, noneconomic barriers may contribute to impeding health care utilization by African Americans to a greater degree than economic barriers. Some of the noneconomic barriers include distrust, fear, and provider bias.

Cultural distrust. Distrust is defined as to feel no trust or confidence; to be suspicious (American Heritage Dictionary, 1994). Distrust and mistrust are used interchangeably in this report. Terrell and Terrell (1981) defined cultural mistrust as the African American's tendency to distrust Caucasians.

Earlier psychologists (Erikson, 1963; Grier & Cobbs, 1968; Terrell & Terrell, 1981) have presented theories on how cultural distrust evolved. Erikson believed the first elements of distrust were thought to develop in the home, where parents and siblings provided some of the initial definitions, parameters, and cautions of being an African American in a predominantly white society. Grier and Cobbs suggested African Americans developed feelings of distrust through a process of being exposed, directly and/or indirectly, to prejudicial and discriminatory practices on the part of the dominant

white society. Terrell and Terrell (1981) stated that African Americans developed suspicion and cultural mistrust in response to racism and mistreatment by the larger American society. According to Terrell and Terrell, cultural mistrust is characterized by having a lack of trust in other people, being suspicious of motives, having uncertainty about the consequences of events, and a belief that caution is necessary in order to avoid trouble.

Theoretical reports (Alston & Bell, 1996; Franklin, 1992) show cultural mistrust as a barrier to utilizing health care systems. Franklin reviewed several reports on African Americans and their participation in psychotherapy and found African American males showed a low participation rate in psychotherapy. Even though one seeking mental health service may be stigmatized and there are gender differences in seeking help, Franklin believed the reason is more complex than attitudes toward mental health or gender differences, and saw distrust as a factor. He concluded that trust is a fundamental issue at work with the African American male and without it, therapy will not be successful.

Similar propositions were suggested by Alston and Bell (1996), who examined cultural distrust as an impediment to rehabilitation entry and as a barrier to successful completion of rehabilitation programs by African Americans. The specific type of rehabilitation is not mentioned, however, this report addressed several manifestations of cultural distrust, such as, (a) low expectations about counseling with Caucasian therapists, (b) negative attitudes about seeking help from clinics where the primary staff was Caucasian, (c) lower numbers of self-disclosures to Caucasian counselors compared to the numbers of self-disclosures to African American counselors and, (d) high levels of premature termination from therapy with Caucasian counselors in comparison to African

American counselors. Alston and Bell concluded that cultural distrust is one of several characteristics among African Americans with disabilities that may influence both how rehabilitation systems are approached and interactions with professionals. These authors suggested the level of distrust in a provider of services influences the degree to which the service will be valued and possibly utilized.

Many empirical reports show cultural distrust exists and indeed influences use of health care systems (Grant-Thompson & Atkinson, 1997; Herek & Capitanio, 1994; Herek et al., 1998; Klonoff & Landrine, 1997). Some studies report historical events which facilitated cultural mistrust (Berger, 1998; Green, Maisiak, Wang, Britt, & Ebeling, 1997). Herek and Capitanio found that distrust was more prevalent among individuals from relatively powerless sectors of population (African Americans and lower SES).

Data from a national telephone survey were analyzed by Herek and Capitanio (1994) to; (a) investigate the relationship between trust and public reactions to AIDS, (b) describe characteristics of individuals most likely to express distrust, (c) assess the relationship between the lack of trust and information presented on AIDS, and (d) describe the relationship between the lack of trust and AIDS-related beliefs, attitudes, and behaviors. The subjects included 607 African Americans and 538 Caucasians. Findings on the relationship between trust and public reactions to AIDS included: (a) a greater percentage of African Americans (27.5 %) compared to Caucasians (14.1 %) expressed distrust of scientists and doctors who said AIDS is not spread by casual contact, (b) 20 % of African Americans compared to 4 % of Caucasians believed the government was using AIDS to kill off minority groups, and (c) nearly one-half of African Americans (43 %)

and one-third of Caucasians (37.1 %) believed that information on AIDS was being withheld.

Further analysis of data showed distrust to be more prevalent among individuals who are relatively powerless (minorities and the poor). In addition, the following findings were noted: African Americans who perceived AIDS as genocide were also more likely to believe that information on AIDS was being withheld; the higher the level of education and income, the less likely subjects were to believe AIDS as genocide; and the more trusting attitudes toward medical authorities and withholding information were associated with having a college degree or completing some graduate work. It was found that distrust was not associated with respondents' exposure to information about AIDS.

African Americans with distrust were more likely to support quarantine and public identification of people with AIDS. In addition, African Americans and Caucasian who were distrustful exhibited an increased willingness to stigmatize people with AIDS.

Quinn (1997) conducted a study which explored belief in genocide and distrust in federal government. In this study, 1,054 African American church members, 371 males and 606 females, and 80 respondents not responding to gender, were tested on the Reducing AIDS Through Community Education instrument. A substantial number of participants, 343 (35 %), believed AIDS is a form of genocide. Further belief in genocide was not accounted for by the level of knowledge on AIDS. Quinn believed distrust was a key factor associated with the fear of genocide and manifested itself in lack of willingness either to be tested for HIV or participate in available treatments for HIV disease. This belief implies that even though African Americans are aware of the need for health care

when such a disease is present, there may be some degree of hesitancy to seek out treatment because of fear as well as distrust or because of fear as a result of distrust.

Quinn (1997) addressed events which supported fear of genocide among African Americans, such as reports of drugs shipped into the United States by the Central Intelligence Agency (CIA) and allowed to be sold without criminal charges. Quinn noted other events which created the fear of genocide among African Americans included media reports of AIDS as a genocide weapon; African American leaders stating, “Genocide is the policy of the U. S. government”; and the fear of genocide from selective family planning efforts in the 1970’s. Such events and reports contribute to cultural distrust.

A total of 105 undergraduate African American subjects (54 females and 51 males) participated in a similar study conducted by Nickerson, Helms, and Terrell (1994). The purpose of the study was to explore relationships between African American students’ distrust of Caucasians, opinions about mental illness, and attitudes toward seeking professional psychological help from Caucasian counselors. It was found that cultural distrust was the most consistent predictor of the help-seeking attitudes of African American student participants. Higher levels of cultural distrust of Caucasians were associated with more negative general attitudes about seeking psychological help from clinics staffed primarily by Caucasians and with an expectation that services rendered by counselors would be less relevant, effective, and gratifying.

These studies showed distrust (a) created barriers to accepting clinically proven information on AIDS, (b) caused expressions of inappropriate behavior toward those diagnosed with AIDS (Herek & Capitanio, 1994), (c) influenced attitudes about seeking

psychological help in a negative way, and (d) created an expectation of receiving substandard services (Nickerson, Helms, & Terrell, 1994).

Ethnicity influences the level of credibility assigned to both an individual and the message provided by the individual regardless of the content or validity of the message. Grant-Thompson and Atkinson (1997) conducted a study with 74 undergraduate African American male students. The purpose of the study was to examine the effects of mentor ethnicity, cultural sensitivity, and student level of cultural mistrust on perceptions of mentor credibility and cultural competence. Scales were used to measure levels of cultural distrust, counselor effectiveness, and respondent perceptions of counselor cross cultural competence. An analysis of the data showed that mentor ethnicity, mentor cultural sensitivity, and the level of student mistrust influenced how African American male students perceived faculty members. African American males who scored low in cultural distrust scored higher in levels of credibility of the European faculty mentor. African American males who scored high in cultural distrust scored low in the credibility of the European faculty mentor.

Green et al. (1997) conducted a study to investigate the effects of the Tuskegee Syphilis Experiment on participation in health promotion activities and research studies by African Americans. Among 218 participating African Americans and 203 participating Caucasians, the authors found that African Americans, in general, were less interested in participating in health promotion and research because of their knowledge of the Tuskegee Syphilis Experiment. African American males seemed to hold the most distrust of the “system” and African Americans, compared to Caucasians, seemed to exhibit increased resistance in terms of health research and education and health promotion

activities. This resistance to health research and education and health promotion activities may be due to factors such as distrust of health care workers, physicians, or researchers brought on by the Tuskegee study. In addition, continuous exposure to discriminatory practices may reinforce this resistance.

When data were examined on the perception of how people are treated in a variety of health settings, Green et al. (1997) found that African Americans were twice as likely as Caucasians to have felt unfairly treated while seeking help for a medical problem because of their ethnicity. In addition, a significantly higher percentage of African Americans than Caucasians believe that African Americans are more likely to be treated poorly in health research studies, and 40 % of Caucasians expressed this belief was true.

According to Berger (1998), African American slaves being used as research subjects, the deception and mistreatment of subjects in the Tuskegee Syphilis Experiment, negative experiences from sickle cell treatment, and minority-focused sterilization initiatives in the 1970's are historical experiences which shed light on African Americans' health preferences and distrust of the medical profession. Whatever the origin, recent empirical studies show cultural distrust exists.

Acculturation and education affect the level of cultural distrust. Acculturation is defined as the process by which one culture is affected by another (Wulbern, 1963). An example of acculturation is for individuals, whose culture traditionally utilizes folk medicine to change and utilize medical services based on the medical model of another culture. Examples of how African Americans and other ethnic groups become acculturated to Caucasians is by living in neighborhoods predominately inhabited by

Caucasians, working in environments where the work population is predominately Caucasian, or attending schools where the predominate population is Caucasian.

The degree to which African Americans are acculturated affects the level of cultural distrust. Klonoff and Landrine (1997) conducted a study to explore the relationship between acculturation, distrust of Caucasians, and AIDS knowledge for African Americans. It was found that African Americans who had high levels of knowledge on the behaviors that spread AIDS were more acculturated than those who had lower levels of knowledge. In addition, African Americans with high levels of knowledge on AIDS scored significantly lower on the cultural mistrust sub-scale. African Americans who exhibited low levels of knowledge on AIDS had the highest scores on the cultural distrust sub-scale. African Americans who scored high in acculturation were more trusting of Caucasians and more receptive to education on AIDS.

The demonstration of cultural sensitivity by mentors ameliorated students' perceptions of mentor credibility in the study by Grant-Thompson and Atkinson (1997). The effects of cultural sensitivity were measured by having subjects view two versions of an audio-taped mock mentoring session with a Black student and mentor. The mentoring session demonstrated cultural unresponsiveness and cultural responsiveness of mentors to a Black student with a stressful experience. The authors found that cultural competence ratings were enhanced for both the European and African American faculty mentors when the mentors demonstrated cultural sensitivity toward the stressful experience of the Black student (acknowledging the role of ethnicity and culture in the student's experience). This study shows that demonstrating cultural sensitivity is a technique which can minimize cultural distrust.

Herek, et al. (1998) conducted a study on the effects of culturally sensitive AIDS education. In this study, culturally sensitive and multicultural videos on the prevalence and spread of AIDS were shown. It was found that culturally sensitive messages were rated as more credible, more attractive, and of higher quality than was the video with a multicultural message. When the multicultural message was delivered by a Caucasian announcer, it was rated less favorably than when the same message was delivered by an African American announcer. The same pattern was replicated with another community sample and a campus-based sample in a second study. In this study, the researchers found that a multicultural message was more effective if delivered after audience members watched a cultural-specific video. AIDS-related beliefs, attitudes, and behavioral intentions showed little change. This study indicated that the level of distrust is influenced by the ethnicity of the messenger and whether or not the message is culturally specific. Herek et al. argued that influencing credibility and attractiveness is necessary, though not sufficient, to effect long-term change in AIDS-related attitudes, beliefs, and behaviors.

Fear. Fear is defined as an agitated and anxious feeling caused by an impending feeling of or imminent danger (American Heritage Dictionary, 1994). Fewer theories have been presented and fewer studies have been conducted on how fear influences African Americans utilizing health care systems, compared to studies on distrust. However, there are reports of the experience of fear influencing decisions regarding use of health care systems (Jennings, 1997; Livingston, 1994; Powell, 1997).

Powell (1997) suggested possible reasons for African Americans' untimely access to health care systems included fear of awareness of the diagnosis, fear of

treatment complications, and fear of death. Livingston (1994) referred to attitudinal barriers impeding access to health care by African Americans. Attitudinal barriers were defined by Livingston as beliefs about health and health behaviors, including fears about medical care, physicians, and diseases. According to Livingston, these beliefs stem from the socialization and religious experiences of African Americans.

Jennings (1997) conducted a study to identify barriers and facilitating factors associated with Papanicolaou (Pap) smear use among African American and Latino females. Four sources of fear were noted by the subjects: fear of discomfort, fear of the results of the examination, fear of a false negative pap smear report, and fear as a motivator to obtain a pap smear. This study showed that while fear motivated subjects to use systems on occasions, there were more times it could have served as a barrier to utilization of health care systems.

Provider bias. Several reports, intentionally or unintentionally, identify racial bias as a barrier to the use of health care systems by African Americans (Livingston, 1994). Livingston believed that while discrimination practices such as long waits, inability to shop for services, and inadequate care are experienced by the poor, the poor are more likely than non-poor to be victims of the health care systems. In addition, Livingston addressed two types of racism, overt and covert, and stated that state and federal laws have eradicated neither.

Blendon et al. (1989) found a greater percentage of African Americans (23.0 %) than Caucasians (9.0 %) felt their physician did not inquire sufficiently about their pain nor told them how long it would take for medication to take effect. In addition, Blendon et al. found the following: a greater percentage of African Americans (44.2 %) than

Caucasians (27.5 %) felt their physician did not explain the seriousness of their illness or injury. A greater percentage of African Americans (45.0 %) than Caucasians (31.6%) were not told how long it would take for medicine to work; a greater percentage of African Americans (22.7 %) than Caucasians (14 %) did not have test or examination findings discussed with them; and a greater percentage of African Americans (18.9 %) than Caucasians (7.2 %) felt their hospitalization time was too short. Disparities in the level of satisfaction between the two groups were also found. The percentage of African Americans (57.5 %) who were completely satisfied with care during their last hospitalization was less than the percentage of Caucasians (77.4 %). The percentage of African Americans (79.5 %) who were completely satisfied with care during the last ambulatory visit was less than the percentage of Caucasians (84.3 %). Finally, a greater percentage of African Americans (25.1 %) than Caucasians (18.1 %) reported having to wait longer than one-half hour at the last ambulatory visit.

Newacheck et al. (1995) found children who were poor, of minority groups, or uninsured were more likely than children of Caucasian, nonpoor, insured families to experience office waits extending 60 minutes or more. It cannot be determined that all findings by Blendon et al. (1989) and Newacheck et al. are driven by provider bias, but the correlation between the poor and minority and the related experiences indicate provider bias is likely to be a contributing factor. Livingston (1994) stated poor African Americans still do not have priority in the delivery of health care systems and their utilization behaviors tend to decline in direct correlation with perceived racism in health service institutions. Grant-Thompson and Atkinson (1997), while examining African American student's level of cultural distrust on certain variables, stated the history of

African Americans in the United States from their forced enslavement until the present resurgence of racism, has been an experience permeated with oppression and discrimination (p.123).

Conclusion

In contrast to Caucasians, African Americans perceive their health status to be more compromised and perceive themselves as having more unmet needs. Reports on mortality rates support this perception. However, patterns of utilization of health care by African Americans does not reflect the compromised health status when compared to patterns of utilization of health care by Caucasians.

While health needs among African Americans are greater than health needs of Caucasians, the percentage of African Americans utilizing health care systems such as private physician offices (Bloom et al., 1997), ambulatory care systems, and hospitals (Blendon et al, 1989) is less than the percentage of Caucasians. A review of studies on measurements of utilization of health care systems (having a regular source for medical care, the availability of insurance, physician visits, and hospital utilization), show disparities in utilizing health care systems between African Americans and Caucasians. In addition, regular sources of medical care utilized by African Americans are clinics and emergency rooms while private physicians are utilized less. The disadvantages of this pattern of access are: (a) preventive and disease management needs may not be met in the emergency room where the goal is to meet emergent needs and (b) utilization of emergency rooms for regular source of medical care increases the cost of care.

SES is a determinant of health status, health needs, and mortality rates. In addition, lower SES has been shown to be a barrier to health services for African

Americans, other minorities, and the poor. SES specifically influences having insurance and physician, hospital, and ambulatory care site visits. While it is clear the SES can be a significant barrier to utilizing health care systems, some studies show the disparity between African Americans and Caucasians utilizing health care systems is greatest at the income level of \$35,000 and above.

Cultural distrust, fear, and provider bias have been shown to impede the utilization of health care systems. Cultural distrust is believed to have been initiated by slavery. Continued experiences of discrimination, inequities, and racial bias have perpetuated cultural distrust. Cultural distrust has a significant effect on the credibility given providers and how information is accepted. Factors which reduce cultural distrust include cultural sensitivity, acculturation, and education. When levels of cultural distrust are high, African Americans are less receptive to services offered by Caucasians. Conversely, when levels of cultural distrust are low, African Americans are more receptive to services offered, regardless of the ethnicity of the provider. Demonstrations of cultural sensitivity have been shown to increase credibility, regardless of the ethnicity of an individual, causing one to be more receptive to services offered.

Fear and racial bias are additional barriers for African Americans utilizing health care systems. Some aspects of fear are the consequences of distrust. For example, the fear African Americans have that services provided will not be at parity with those provided to Caucasians is associated with cultural distrust.

The barrier of racial bias is more difficult to ameliorate for at least three reasons. First, behaviors demonstrating racial bias are often based on ideological beliefs which have been accepted as ethical practices. These beliefs may influence a provider to base

the quality of service on the ethnicity or SES of the consumer. Second, behaviors may be misinterpreted as racial bias and consequently responded to as if they were indeed racially biased, creating the same barrier as racial bias would create. Third, covert racial bias is difficult to recognize and may be interpreted by the victim as other than “racial bias.” Thus, the act of racism continues unidentified, and interventions cannot be implemented. Conversely, overt racism allows for identification, therefore possible intervention. Whatever the case, racial bias, whether it originates in the provider or consumer, is a detriment to maximizing the benefits of health care systems.

It is important for nursing research to continue to identify barriers to accessing health care. One may tend to agree with the recommendation made by Carey et al. (1995) that in order to significantly advance the health status of people it is essential to have a nursing paradigm that examines both economic and noneconomic barriers to health care and initiate a systematic infrastructure and process to build a scientific database which would measure and interpret noneconomic barriers to health care. Nursing research can help achieve this goal.

Chapter 3

Research Design

The design for this study is qualitative phenomenology. Phenomenology is the study of phenomena, a study of the appearance of things (Cohen, 1987). It is an inductive, descriptive research method (Omery, 1983). It was conceived by a German philosopher, Husserl, in the early twentieth century (Baker, Wuest, & Stern, 1992). Phenomenological researchers are concerned with understanding both the cognitive subjective experience of the person and how that lived experience affected the behavior of the person (Omery). The goal of the phenomenological method is to describe the total systematic structure of lived experiences including their meaning (Omery). Some concepts of phenomenology are: (a) it strives to be rigorous in its scientific method, (b) it begins by going to the issues of concern rather than beginning with theories, (c) it is intersubjective in that it believes in the existence of others who share a common world, and (d) it believes in the phenomenological reduction process called bracketing. Bracketing is a process by which researchers examine their prejudices and commitments and 'bracket' them out so phenomena can be seen as they really exist (Cohen). These concepts and goals describe Husserlian phenomenology. As more researchers became involved with phenomenology, variations of the Husserlian philosophy evolved.

Hermeneutic Phenomenology

One variation of Husserlian phenomenology was the introduction of hermeneutic phenomenology by Heidegger, who was a former student of Husserl. Hermeneutic

phenomenology refers to a broad range of theoretical and practical approaches which are concerned with interpretation (Cohen, 1987). Hermeneutics focuses on acts of interpretation and understanding of experiences that are found in academic disciplines and of experiences that are fundamental to human life (Thompson, 1990).

Benner (1994) stated the goal of interpretive phenomenology is to uncover differences and commonalties. Though interpretive phenomenologists are interested in distinctions and differences, they are also interested in the human conditions and commonalties that create these distinctions and differences.

Benner asserted that rational empirical studies decontextualize in order to achieve patterns, trends, and commonalties. By decontextualizing, one removes elements such as historical, timing, and world events which would create accurate predictions. In addition, Benner stated the very elements of maturation, history, and learning, which are threats to validity in empirical studies, are all aspects of human agency, world, and temporality that form the interpretive phenomenological project. So if these elements are excluded from phenomenological studies, it is impossible to uncover transitions over time.

The Hermeneutic Approach

The approach taken for this phenomenological study is hermeneutic.

Hermeneutics is an ancient discipline traceable to early Greeks (Leonard, 1994). The early Greek works of hermeneutics suggest the idea of bringing understanding to human action (Benner). To bring understanding to human action involves an interpretive process including the researcher and those persons being studied. Hermeneutics is an interpretive approach by which knowledge is gained and is both the theory and practice of interpretation (Van Manen, 1990).

The goal of the hermeneutic or interpretive approach in this study is consistent with the goal as stated by Leonard (1994), which is to understand everyday skills, practices, and experiences; to find commonalties in meanings, skills, practices, and embodied experiences; and to find exemplars or paradigm cases that embody the meanings of everyday practices in such a way that they are not destroyed, distorted, decontextualized, trivialized, or sentimentalized (cited in Benner, 1985, p. 5-6). Efforts were made to understand the experiences of African Americans utilizing health care systems; to find commonalties in meanings and embodied experiences; and to find paradigm cases which embody meanings of everyday experiences. Every attempt was made to avoid altering the interpretations of related experiences.

Assumptions of Hermeneutics

Leonard (1994) presented two assumptions of the hermeneutic approach. First, the researcher has a preliminary understanding of the human action being studied. Thus, the interpretive project is approached with some understanding (or a forestructure of understanding). For this project, theoretical and empirical reports were reviewed to gain a forestructure of understanding the health status of African Americans, patterns of utilization of health care systems by African Americans, and economic and noneconomic barriers for African Americans utilizing health care systems.

Another assumption of the hermeneutic approach, according to Leonard (1994), is that objectivity is no longer a process of decontextualization or securing external truths that correspond to things as they are. Instead, objectivity is findings which can show up in agreement in our local cultural "clearings". Local clearings as described by Plager (1994) are the special events, practices, or things in our lives that from time to time, may present

special significance for us. Theory resulting from hermeneutics includes presentations of revealed meanings or practical knowledge that is hidden from traditional empirical research (Leonard).

According to Plager (1994), the hermeneutic methodology fills gaps in understanding that are left unfilled by empirical science research approaches. The hermeneutic phenomenological approach allows one to understand a person's behavior or expressions by studying the person in context (Leonard, 1994). Leonard stated that what a person values and finds significant only shows up in context.

Operationalizing the hermeneutic methodology was done by using a dialectic process. A dialectic process allows researchers to arrive at the truth by the exchange of logical arguments (American Heritage, 1994). This process took place during the focus group.

A hermeneutic phenomenological study will benefit nursing because insight gained from the method discloses what is at stake, issues and concerns in everyday activities, and understanding of these activities in the context in which they occurred (Benner, 1994). According to Benner, the phenomenological method is a philosophical investigation, which provides nursing with a theoretical basis for conducting further research projects. It does not allow issues of human beings to be reduced to brute data or absolute properties (Benner).

Since phenomenology, as a method for research, grew out of a philosophical movement that is still in the process of being clarified, there are multiple interpretations and modifications (Omery, 1983). This study is based on Van Manen's (1990) interpretation of hermeneutic phenomenological human science. Van Manen posited that

hermeneutic phenomenology is a human science which studies persons. He stated that phenomenology describes how one orients to lived experiences and hermeneutic describes how one interprets the recalled experiences of life.

Van Manen's Philosophical Underpinnings of Phenomenology

Van Manen's (1990) hermeneutic phenomenological human science approach includes eight philosophical underpinnings. The first philosophical underpinning is the lived experience. The aim of study is to gain a deeper understanding of the nature of our everyday experiences. The difference in phenomenology and almost all other approaches to inquiry is that phenomenology attempts to gain insightful descriptions of the way we experience the world before we meditate on these experiences, without taxonomizing, classifying, or abstracting them. Subjects for this study initially reflected on experiences of utilizing health care systems without explication or giving explanations for the experiences.

Second, consciousness is always present while reflecting on the lived experience. Consciousness is the only mechanism through which human beings have access to the world, therefore, all one can ever know must present itself through consciousness.

Third, phenomenological research is the study of the essence of things. It is the systematic attempt to uncover and describe the internal meaning of lived experiences. It does not ask "how do you go about utilizing health care systems," rather, it asks, "what is your experience utilizing health care systems?" Through a systematic dialectic process, the essence or meaning of this experience is reached.

Fourth, phenomenological research is the description of the experiential meanings we live, as we live them. The focus on meaning causes phenomenology to differ from

some other methods of inquiry which focus on statistical relationships among variables, on the predominance of social opinions, or on the occurrence or frequency of certain behaviors. Subjects in this study were requested to focus on and describe their experiences utilizing health care systems and the meaning of those experiences.

Phenomenology does not aim to explicate meanings specific to particular cultures (ethnography), to certain social groups (sociology), to historical periods (history), to mental types (psychology), or to the personal life of an individual (biography). Rather, phenomenology attempts to explicate meanings of the experiences as we live them in our everyday existence in the world (Van Manen, 1990). The data collection process for this study was guided so that subjects remained focused on lived experiences without reference to a specific culture, to a social group, to issues involving aspects of personal lives of subjects except as they related to experiences utilizing health care systems.

The fifth philosophical underpinning in phenomenological research, according to Van Manen (1990), is the human scientific study of phenomena. Science derives from “scientia” which means to know. Since the phenomenological approach is systematic, explicit, self-critical, and intersubjective, it is scientific in a broad sense. It is systematic in that it uses specially practiced modes of questioning, reflecting, focusing, and intuiting. Phenomenological human science is explicit in that it attempts to articulate through the content and form of the text based on the lived experience rather than giving implicit meanings such as in poetry or literary texts. Phenomenology is self-critical in that it continually examines its own goals and methods in an attempt to come to terms with strengths and possible short-comings of its approach and achievements. Phenomenology

is a human science, as opposed to a natural science, since the subject matter is always the structures of meaning of the lived human world.

Sixth, phenomenological research is a research characterized by thoughtfulness. Thoughtfulness is described as a heedful, mindful wondering about the project of life, of living, of what it means to live a life (Heidegger, as cited in Van Manen, 1990).

Seventh, hermeneutic phenomenological research is a search for the fullness of living. This study included listening to experiences of utilizing health care systems in ways that only African Americans could possibly experience the utilization of health care systems.

Finally, phenomenological research is a poetizing activity in that, like poetry, one listens in vain for the punch line, latest information, or big news. The language used by African Americans in this study, as Van Manen (1990) posits, transcended mere words and represented memories of experiences that paradoxically were never thought or felt before.

These philosophical underpinnings of phenomenology allowed this study to present a thoughtful and systematically explicated description of the lived experiences of African American subjects utilizing health care systems. The language used represented the essence of the experiences.

According to Van Manen, (1990) the methodology of phenomenology includes an approach toward research that aims at being suppositionless. This researcher warded off tendencies toward constructing a predetermined set of fixed procedures, techniques, and concepts that would govern the research project. Yet, phenomenology and hermeneutics have a method by which the research is conducted. This method was

discovered or invented as responses were given by subjects. Consequently, the researcher attempted to be a sensitive observer of the subtleties of everyday life.

Conduct of the Study

The study was conducted beginning with the selection of subjects who met the criteria. The criteria included participants who were African American, had an annual income of \$35,000 or above, spoke English as their first language, and were not presently or previously employed in the health care system. Following the selection of subjects, data collection began. Two interviews were held. The first interview included twelve subjects. The second interview was with a focus group. The focus group was formed by selecting the six participants who had the greatest number of themes in the data collected during the first interview

Selection of Participants

For the purpose of this study, the University of San Diego (USD) Committee on the Protection of Human Subjects (CPHS) was presented with a proposal for review. Following CPHS approval (Appendix A) participant selection began. The following inclusion criteria were used for selecting participants:

The participants were self-identified as African American. The focus of the study was on African Americans. Since there are variations in phenotypes among African Americans, accuracy was assured by self-identification.

Participants were required to have an annual income of \$35,000 or above. The income level of \$35,000 was selected because it is well above the poverty level and above the level at which one would expect public assistance to be provided. In addition, this income level served as a mean of controlling for economics as a barrier.

Participants were required to be able to read and speak English. It was felt that if the participants and the researcher were proficient in the same language, accuracy in interpreting the lived experiences would be facilitated.

Participants must not have been previously or be presently employed in the health care profession. This researcher believed that participants who were never employed in the health care system may best represent the general population. Individuals who are associated with health care systems may find utilization easier because of familiarity with health care systems and health care providers.

Parishes were the target sites from which participants were recruited.

Appointments were made with parish leaders to explain the study, explain the need for participants, request permission to recruit participants, and plan methods of recruiting parishioners. Parish leaders provided assistance with the screening process in order to meet the criteria for income level of subjects. Upon speaking with potential participants in person or by telephone, the researcher self-identified as a student in the doctoral program at the Hahn School of Nursing and Health Science at the University of San Diego, conducting research on "Noneconomic Barriers to Health Care Utilization by African Americans." Potential participants were informed that the researcher conducting this study was fulfilling a scholastic requirement. They were further informed that the purposes of this project were to: (a) increase the knowledge level regarding noneconomic barriers for African Americans utilizing health care systems and (b) make a contribution to the health status of African Americans, specifically, and to all persons, in general. Information was provided on what was required of participants, such as to reflect on and describe their experiences utilizing health care systems and possibly participate in an

audio-taped dialectic process with a focus group to explore the meaning of these experiences. Upon agreement to participate by the potential participants, a meeting place and time that was convenient for each participant and the researcher was determined. A signed informed consent was obtained prior to beginning the interview process. Participants were informed that the extent of potential risk was limited to possible fatigue and that the benefits of such a study would contribute to improving health status and access to health care systems for African Americans of upper SES and other minorities. For this study, a minimum of 12 participants were interviewed. Baker et al. (1992) stated that sample size is a function of theoretical completeness and is deliberately small so the richness of individual experiences can be illuminated.

Data Collection

Each participant was interviewed an average of one hour during the first interview. With the permission of participants, interviews were audio-taped and notes were taken. The process began by having the participants review the consent form (see Appendix B). Each participant was encouraged to ask questions if clarification was needed, followed by a request to become a participant in the study. A demographic form, which is part of the data collection tool, was provided each participant (see Appendix C).

There was no formal set of questions prepared for the interview. Rather, participants were initially asked, "What has your experience been obtaining health care"? Subsequent questions reflected the four fundamental existentials of corporeality, spatiality, relationality, and temporality. Van Manen (1990) believed these four existentials may be a way all humans experience the world .

Questions relating to corporeality reflect the phenomenological perspective that bodily, we are always in the world and in our physical or bodily presence, we both reveal and conceal something about ourselves (Van Manen, 1990). Inquiries relating to corporeality focused on how subjects felt about themselves during and after their experiences and when significant information was revealed or concealed about themselves during their experiences. Relationality is described by Van Manen as the real relation we maintain with others within the personal space we have. One question which would focus on relationality would be, “What relationship did you have with your health care provider”? Another question could be, “What effect has the interpersonal interactions experienced in this environment had on subsequent attempts to utilize health care systems and subsequent relationships with health care providers”? Spatiality addressed how participants felt in the physical environment as they utilized health care systems. Participants were asked what the environment was like. Van Manen stated that lived time is our temporal way of being in the world. It is the time that accelerates when we are enjoying ourselves and slows down as we experience boredom or anxiety. Questions about the urgency of meeting the physical need and the time factor involved in the process related to temporality. This method was used to guide the interview, and to prevent irrelevant discussion.

Following the initial interview, a focus group, consisting of six of the 12 participants met. Members for the focus group were selected based on the six participants who presented the greatest number of themes. Benner (1994) asserted the advantages of a focus group include; (a) a natural communicative context for telling stories, (b) a rich basis for practicing active listening, (c) a setting which allows the enrichment of

stories by others to contrast, counter, or present similarities, and (d) a small group which stimulates a work atmosphere.

According to Frey and Fontana (1993), the purpose of phenomenological group interviews is to determine meanings on another level beyond one-to-one. A variety of experiences from a variety of persons were given meanings during the interview with the focus group. By elaborating on a variety of themes and applying meaning to experiences the researcher and group members demonstrated harmony. Themes identified in the initial interviews were presented and through a dialectic process, meanings were applied. For this study, the researcher presented each theme along with exemplars specific to the theme presented. It was felt by this researcher that the variety of exemplars would stimulate group members to view themes from different perspectives before offering meanings of experiences. Some valuable things that take place in a group setting according to Frey and Fontana include the feedback that can be gained on one's views of reality, response of group members to other or differing views, and the experience of reality in the same manner for the researcher as the respondent through interaction and unstructured interviewing. Frey and Fontana stated that in phenomenological groups, unstructured, open-ended questions are normally implemented. The focus group was led by the researcher who kept subjects focused on the presented topic.

According to Van Manen's (1990) approach, themes become objects of reflection in which a dialectic interaction between the researcher and the interviewees takes place. The purpose of this interaction is to interpret the significance of the preliminary themes. This method of inquiry allowed for a description of the lived experience of African

Americans utilizing health care systems and the assignment of meaning to those lived experiences. Noneconomic barriers were identified and isolated through this process.

Rigor

Applying rigor or rigidity to the process of human science is not the same as for natural science. In natural science, rigor is applied by adhering to specific standards and having specific aims. The standards of applying theoretical and practical procedures and rules and regulations allow for consistency in research projects and allow studies to be generalizable (Plager, 1994).

For hermeneutic phenomenology, rigor arises from three factors: the unavoidable retrospective and historical nature of interpretive work, the intricate and time-consuming need for studying participants in their everyday situations, and the laborious commitment involved in interpreting the text.

Cohen (1987) stated the method phenomenology uses to be a rigorous science involves going to the root or foundation to gain clarity about what the basic concepts are and what they mean. Benner (1994) stated interpretive phenomenology involves a rigorous scholarly reading of text, that involves questioning, comparing, and imaginatively dwelling in situations of participants.

Data Analysis

All taped data were transcribed by the researcher. Transcribed tapes were placed under lock in a file box at the researcher's home. Data analysis was carried out in three interrelated processes: thematic analysis, analysis of exemplars, and the search for paradigm cases, (Benner, 1994).

Van Manen (1990) described a theme as the experience of focus and of meaning, the form of capturing the phenomenon one tries to understand. In uncovering thematic aspects of data, Van Manen stated that, metaphorically speaking, themes are more like knots existing in the webs of experiences, around which certain lived experiences are spun and lived through. The functions of a theme (or relationship of theme to the phenomenon) is that (a) theme is the mechanism by which one gets to the meaning of the experience, (b) theme gives shape to the shapeless by expressing the essence of the phenomenon, (c) theme touches the core of the phenomenon which is attempted to be understood, and (d) theme unlocks a portion of the deep meaning of the phenomenon (Van Manen). Among qualities that Van Manen ascribed to theme are the desire to make sense, openness to something, and the process of insightful discovery or disclosure.

The approach for isolating thematic statements was by the selective or highlighting approach. Van Manen (1990) described this approach as listening or reading a text several times and identifying phrases or statements which are essential to the experience being described. These phrases are then highlighted or circled. As this process is repeated with all phrases, one discerns the themes which are emerging and captures these phrases in singular statements. Benner (1994) stated this process of analysis is called thematic because rather than focusing on words or phrases, patterns, stances, or concerns are considered. During the analytical process, this researcher shifted back and forth between portions of texts and themes which had been analyzed.

An exemplar is a strong example of particular meaningful transaction, intention, or capacity (Benner, 1994). An analysis of exemplars involves encompassing the individual's concerns, actions, and practices which are found in specific episodes or

events (Benner). Exemplars present aspects of paradigm cases or thematic analysis and may be extracted from text to show similarities or contrasts (Benner). Exemplars allow one to capture the meaning in a situation in such a way that the meaning can be recognized in another situation that may have very different objective circumstances (Benner). Multiple exemplars may be presented from a variety of cases to support a single theme.

Paradigm cases are those cases which provide strong examples of a particular pattern of meaning. They embody rich descriptive information which is necessary for understanding how the actions and understandings of individuals emerge from their situational context (Benner, 1994). Contrasts and similarities between paradigm cases were made.

Exemplars and thematic analysis were used to augment paradigm cases. These three strategies guided this researcher systematically to gain knowledge about a phenomenon in interpretive phenomenology. The phenomenon itself was noneconomic barriers for African Americans utilizing health care systems.

Because the hermeneutic methodology includes a dialectic process between the researcher and the participants, it allows nursing to study how the participants of interest utilize health care and manage illness and disease. In addition, it allows nursing to identify reasons for these patterns and management practices. Plager (1994) saw such studies as a means for nursing to study health and health promotion in families in addition to allowing researchers to explore patient and family perspectives on the significance of health and well-being.

One recommendation made by Cary et al. (1995) was the development of a national infrastructure for research in primary care and for primary care research initiatives that measure non-financial variables related to access, utilization, and health outcomes. Through nursing research, a framework could be developed to (a) identify barriers to utilizing health care systems, (b) develop nursing practice approaches which address identified barriers, (c) develop nursing practice approaches that demonstrate sensitivity to ethnic and individual differences, and (d) include ways of ensuring that health care consumers understand the benefits of maximizing the use of health care systems. Ultimately, the health status of African Americans, other minorities, and the poor would be improved by eliminating barriers or, at least, minimizing barriers to utilizing health care systems.

Chapter 4

Findings

This chapter presents a description of the participants and findings from the thematic analysis. Findings from the thematic analysis include themes discovered from data collected during initial interviews with 12 participants. These findings are presented using the format of themes, exemplars and, on occasion, paradigm cases. Findings from the focus group are presented in the form of assigning meanings to each theme.

Description of Participants

The total number of subjects interviewed was twelve. The participants varied in ages, income levels, and educational levels. The ages represented formed a perfect bell shape. Twenty-five percent of participants ranged between ages 18 to 44 years of age. Fifty percent of participants were between 45 and 65 years of age, and twenty-five percent of participants were 66 years of age and over. Seven participants were African American females and five were African American males.

All income ranges were not equally represented by participants. Eight participants (67 %) were represented in the income range of \$35,000–45,000. One participant (8 %) reported an annual income between \$46,000–55,999. There were no participants with annual incomes between \$56,000–75,999. Three participants (25%) reported annual incomes of \$76,000 and above.

Most participants were educated beyond the 12th grade level. The educational level of one participant (8% of all participants) was below the 12th grade. Three

participants (25%) completed the 12th grade. There were five participants (42%) who had 1-2 years of college or had vocational preparation. Two participants (17%) had master's degree, and one participant (8%) had a doctoral degree.

Context of Lived Experiences While Utilizing Health Care Systems

The context or circumstance in which the experiences took place included the era pre and post health care reform and the Civil Rights Movement and the immediate structural environment. A combination of SES among African Americans and the Civil Rights Movement created driving forces which influenced how African Americans met their health needs. Consequently, many health needs were met by utilizing other alternatives.

Many African Americans could not afford health care services. As a result, health care needs of African Americans were met by practicing various home remedies or folk medicine. When the needs were not met by using home remedies, as a last resort, health care systems were utilized.

In addition to lack of affordability, discriminatory practices caused health care services to be provided unwillingly in many cases or withheld completely. The overt practices of discrimination created an unfriendly environment for African Americans while utilizing health care systems. After the 1960s when health care reform was implemented and when the conscious of many was heightened regarding the need of Civil Rights for all ethnic groups, African Americans utilized health care systems to a greater extent. The Civil Rights Movement contributed toward creating an environment in which the practice of discrimination was less overt, although covertly it continued to exist in many places.

The immediate structural environment focuses on settings such as emergency rooms, in the office of physicians, or within hospitals. Some lived experiences included those which occurred as participants sought health care services for themselves. While other lived experiences occurred as participants sought health care for family members.

Identified Themes

Benner (1994) stated that uncovering commonalties and differences is the goal of interpretive phenomenology. Themes were identified by observing a commonality among the concerns of subjects. Six essential themes were identified as data were analyzed. The themes included delaying before gaining access to or utilizing health care systems, fear, racial bias, the quality of service provided, distrust, and long waits in the doctor's office. There were personal reasons for delay among some participants which could be considered either a cultural practice, an idiosyncrasy, or the feeling of an invasion of privacy. Since it is difficult to distinguish, the personal reasons are not being considered as exemplars supporting a theme. Each theme was supported by exemplars representing different experiences.

In addition, experiences related to being uninsured were shared by two participants. Since being uninsured is more commonly recognized as a barrier for those of the lower SES, it will not be addressed as a barrier for participants in this study. The participants in this study chose to be uninsured. Harry, one of the uninsured participants, admitted he could afford insurance, but stated, "Probably could afford it, but, (he laughs) but, I just hate to spend money...a lot of money spent there when you go, and, I guess the fact that I feel good, healthy, I just hate to spend that kind of money." Experiences of

being uninsured were associated with establishing relationships and will be addressed in the discussion section under the sub-topic, Relationality.

Delay in Utilizing Health Care Systems

Two distinct patterns of delay in the utilization of health care systems were observed during the initial interviews. These patterns included (a) the reasons for delays in utilizing health care systems by subjects whose early childhood years were before health care reform and before the Civil Rights movement (during the 1930's through the 1950's) and (b) the reasons for delays in utilizing health care systems by subjects after health care reform and after the Civil Rights movement. Because health care reform had not taken place and because there was little inhibition of the practice of segregation in most of America, for many participants, most delays in utilizing health care systems were related to affordability and the withholding of health care.

Experiences of delay for participants whose childhood years occurred prior to health care reform and Civil Rights Movements. The socioeconomic status of many African Americans created barriers to utilizing health care systems. Erin recalled her childhood experiences utilizing health care systems.

My parents were very poor and they didn't have health maintenance organizations (HMO) and things like they have now, so when you went to the doctor you had to pay, so as a child growing up, we did not go to the doctor unless we were sick and we had to be really, really sick. My parents' thoughts were 'you go to the doctor at the last. After you've done everything that you can, the doctor is the last resort' and we didn't go to doctors when I was growing up unless we were really,

sick. My Mom tried home remedies.

Erin stated that her childhood experiences did not carry over into adulthood. She stated she frequently has check-ups and experiences no barriers to utilizing health care systems.

Allen recalled how health care systems were utilized when he was a child and stated “They would do so much and that’s it, and if you could afford it, you just couldn’t because you got to have the resources.”

Matt recalled utilizing health care systems as a child only for emergencies because of the cost. Today, Matt has regular visits with his doctor, whom he enjoys visiting. Matt stated “ I look forward to seeing my doctor. We have a real good relationship. They respect me and are nice.”

Other experiences with delay in health care utilization during this era were shared by Stephanie, Wyle, and Stephen. As a child, Stephanie experienced utilizing health care systems only for urgent or emergent needs. She recalled:

Uh, as a child, you know, from a large family, I, uh, we only saw doctors or had care when it was absolutely necessary. Uh, maybe a temperature. At that time, we had doctors that would come to your house, but we had schools that would have nurses come by the schools and check the things out and find out whether they had all their shots and what have you.

However, after Stephanie became an adult, which was also during the health care reform and Civil Rights movement era, she utilized health care systems to a greater extent. She stated:

As I got older, I'er went to the doctor pretty frequently because I had my children, I got pregnant. Each time I got pregnant, I was definitely under health care with every one of my child, children. I stayed pretty consistent with whatever the doctor recommended.

Wyle jokingly stated his philosophy regarding utilizing health care systems for preventive purposes: "If you've never been told, you live longer. As soon as you know, you die." However, as a child, he did not utilize health care systems except for urgent health needs. During this time, Wyle does not recall negative experiences other than being cared for in a segregated ward and being left in the hospital by his parents.

Stephen utilized the health care services provided by an African American nurse rather than a medical doctor except for an emergency when he was in a car accident. At this time, he sought health care 70 miles away from his home because medical service by the local medical doctor was withheld from him because of his ethnicity.

The consistent theme with all subjects is the practice of consciously delaying the use of health care systems. The exemplars for delay in health care utilization includes delay because of cost, the common practice of utilizing health care systems as a last resort, and withholding of medical services. As a result of not utilizing health care systems, alternatives were practiced. These alternatives included utilizing the health care systems provided by a local nurse, praying for the condition, and practicing home remedies or folk medicine.

Alternatives to utilizing health care systems. Because utilizing health care systems was the last resort for many participants, alternative methods were sought to meet health needs. These alternatives were prayer, home remedies, folk medicine, and use of

herbs. Allen talked about these ways. He stated, "My father tried his best to pray for us or avoid medical care."

Erin continues to use prayer even though she sees her doctor regularly. She stated when she is asked if she has an aspirin, she quickly responds, "I take prayer."

Allen was involved with folk medicine to a great extent because his great aunt was a healer in the community and because Allen would collect some of the herbs his aunt would use for treatment. Allen described the practice:

We had a lot of folk medicine in our house. My great great aunt was definitely a healer. She would wrap stuff around our faces, pack stuff with mud and charcoal and all kinds of stuff can't think of all the bags I used to wear around my neck. I used to go and collect all the herbs for her in the woods in Birmingham. So she believed in packing stuff and she could do splints.

Allen felt the delay utilizing health care was related to the culture. He stated, "Seeing the doctor was the last resort, the last resort, the last resort. Now, that was part of the culture, you didn't go to the doctor 'til it was absolutely an emergency and you had to then."

Some participants did not have access to the medical doctors in their home town because the service provided by the medical doctors was not extended to African Americans. The service of a local nurse, who was well respected by the community, was utilized. Stephen stated the nurse also utilized home remedies for patients as well as performing within the scope of her professional practice.

Celestine, unlike Erin, Allen, or Stephen, believes her health care needs are best met if she tells her friends about her problems. If her friends at 47th street, whom she

refers to as ‘doctors at 47th street’, have had similar problems, Celestine implements the same treatment used by her friends. When asked why she use the ‘doctors at 47th street’, she replied, “Cause, I don’t know. If they tell me what they (referring to the medical doctors) gave them, that’s just money I can save.” Celestine further asserted:

I feel like if I can fix it, I don’t have to go I don’t have to go to the health care system. If you, you know, if I can feel better, ‘cause when you go, to me, I don’t know, Sister T. But, I don’t like this especially, I don’t know, I just hate to bother people and I feel like, you know, if I’m going to the doctor and I’m going to be a bother to him, I can just take care of myself, you know?

Stephanie utilize herbs as an alternative to utilizing the traditional medical model as a regular source for health care. She stated:

Because of some negative experiences, I begin to er research other ways I could have my health care needs addressed. I began to read a lot of herbal books and talk with herbaologist (herbalist) and er, deal with alternative healing a-and so, that’s been very effective for me.

Experiences of delay for participants whose childhood years occurred post health care reform and Civil Rights Movement. Different patterns of delay in health care utilization were found among participants whose early childhood years were during and after the health care reform and during and after the Civil Rights Movement in the 1960’s. Most of these participants utilized health care systems only for emergency needs during their early childhood. Today, they are very consistent in utilizing health care systems for their children and in most cases, for themselves. In the process of utilizing emergency rooms or physician offices, these participants have had no awareness of a

reluctance on the part of health care providers to provide service, nor have they experienced being sent to separate waiting rooms or different areas to receive care because of their ethnicity. There was no mention of seeking health care systems as a last resort. Nashti, in recalling her experience utilizing health care systems as a child, stated:

The only time I recall ever going to the doctor was like in an emergency. You know, get a cut or step on a nail, never just for regular check-ups. And shots we always got at school, you know they gave them at the school, so we never went unless there was an emergency. When we went, it was, it was an emergency. It wasn't, you know, just because, oh she has a bad cold. It was like, we didn't go for colds or anything, it was like a cut that had to be stitched up, or a rusty nail, something like that, or swallowed something, you know. To me, I thought that was just the norm. I didn't know you were suppose to go to a doctor on a regular basis. That was norm to me.

Nashti believed they did not have health insurance, however, her father was in the navy and as a service person, he and his family were entitled to medical benefits. Evidently, knowledge of the availability of health care systems was neither recognized or utilized. Nashti stated, "well, when I was younger, I don't think we had health insurance."

After Nashti's father became a civilian and acquired insurance through a HMO, Nashti's family increased their utilization of health care systems. She stated when her father became a civilian, "We signed up for Kaiser. After that, we started going on a regular basis because we had the insurance and we know we could go because it wouldn't cost, that was the thing, it was the cost." When Nashti became an adult, her husband always had insurance. She indicated that having insurance was essential for her family.

When I got married, we had insurance from the very beginning. I mean, we didn't even, that wasn't uh, that was just something, we were gonna do it whether, 'well we don't need it right now, we don't have kids'. We knew we needed it because anything could happen. I utilize it all the time. I mean, that's just the way I am.

Another participant, Nonia, also utilized the emergency room during her early childhood to meet health needs. Bette's experience utilizing health care systems was very limited. She recalled, "I have not utilized health care systems much in my life. When I was a child about 5 years of age, I had shots in school." Reflecting on her current pattern of utilizing health care systems, she stated, "I wait long before I go to doctor. I keep thinking I may get better." When asked what was the usual source of care after waiting so long', she answered, "I use the emergency rooms." Bette waits long before seeing a doctor because she thinks she may get better, but she always does preventive care. "I always do preventive care. I have my cholesterol checked, I am checked for diabetes. I would hate to have to have surgery, I think it would be scary."

Joy's childhood experiences utilizing health care systems were not unlike Nashti's or Nonia's experiences. She recalled: "when I was a child, we never used the health care system except for emergencies, such as nose bleeds or facial cuts or things like that". Unlike Nashti or Nonia, Joy does not utilize health care systems, even though it is available to her. When asked how she utilize health care systems now, she replied "I don't. I just haven't taken time for myself as I should. I am a single parent and I just haven't taken the time I need for myself."

Exemplars for the delay in utilizing health care systems which were presented by subjects whose childhood years were during or post health care reform and the Civil

Rights movement were different from exemplars presented by the subjects whose childhood years were prior to health care reform and the Civil Rights movement. While the former did not participate in health prevention measures during their early childhood years, they had access to emergency rooms without feelings of rejections or discriminatory practices and they were satisfied with the quality of medical care they received. For these subjects, one can assume their parents had not yet come to know how to maximize the benefits of the health care reform. Consequently, regular check-ups were not sought by the parents and the use of preventive measures were not maximized. In addition, one could also assume that the Civil Rights movement contributed to increasing the awareness of prejudicial practices in health care as well as other social environments. This increase in awareness may have decreased the practice of discrimination, at least overtly. In addition, the increase in awareness of prejudicial practices affected the corporeality, spatiality, relationality, and temporality experiences of African Americans as they utilized health care systems.

One participant, Erin, believed that one reason African Americans continued to delay utilizing health care systems was because of perpetuating cultural practices, even though reasons for those practices may have been removed. When asked if she thought people realized that we no longer had to share information on health remedies, though it was necessary during earlier years, Erin replied:

I don't think so. I think you know, we just, we were brought up this way and it's carries from one generation into another into our culture. I think that's one of the reasons that people don't go is that they were brought up that way. They tried

everything before they went to the doctor, you know, the doctor was the last place you went.

Allen stated ...“The last resort, now, that was part of the culture, you didn’t go to the doctor ‘til it was absolutely a emergency and you had to then, you’d go to the doctor.”

Another barrier contributing to the delay in utilizing health care systems was the scarcity of African American physicians. Allen stated there were determinants for utilizing health care systems in his early childhood years. “One determinant was ethnicity, plus you didn’t have the significant number of facilities run by African American doctors, so you had to utilize the system that was available and those were Angelo, White systems.” When Harry was asked how would he feel if there were more African American health care providers, he replied, “Oh, yes, definitely. It always make you feel better about yourself when you see one of your own providing care. That’s healing for people. That’s the way you heal, to be part of it.”

Fear

When Erin’s parents sought help from physicians, Erin thought something was really wrong. She stated, “You thought ‘I’m going to the doctor, I must be fixing to die’ so it was a frightening experience.”

She remembered the first time seeing a doctor and stated, “I was scared going. It was the time of segregation, you know, and the Caucasians were in front and the Blacks were in the back, so it was frightening.” When asked how would she compare the earlier experience of not feeling comfortable with more recent experiences since she has become an adult, Erin replies, “You know, even that frightening experience I had, the experience of my childhood didn’t carry over to the adult experiences.” Erin stated when she first

went to the doctor after marriage, she was not afraid and was unaffected by the childhood experiences.

Bette presented a different exemplar of fear. Bette is fearful of needles and strangers. Joy presented exemplars of fear which were different to those presented by Erin or Bette. When asked how she felt about going for mammograms or check-ups, Joy replied, "I don't go. I am afraid. I have a fear they will find something wrong." When asked what about dental check-ups, she replied, "I have a fear of dentist. I would rather have the pain as long as I can take it."

The theme 'fear' experienced by African Americans in the use of health care systems is supported by a variety of exemplars. Additional research such as empirical studies can show the extent to which a specific exemplar is generalizable across this population.

Quality of Care

Exemplars of the quality of care which participants recalled were not all negative. Some participants related an initial experience when the quality of care was poor, followed by many experiences when the quality of care was very satisfactory. The quality of care post health care reform and the Civil Rights movement has been generally reported as satisfactory by all subjects except for Harry and Celestine. Their negative health care experiences have been associated with being uninsured.

Two aspects of quality of care were mentioned by the participants. One aspect of quality of care was associated with the performance of the physician. The second aspect was associated with the degree to which interpersonal interactions and medical interventions resulted in experiences which had negative emotional effects.

Performance of the physician. Erin had two experiences when she felt the quality of care from her doctor was unsatisfactory. The first experience Erin recalled was when she was a child and her mother took her to the doctor because there was a knot on her side. The examination was performed while Erin was standing. “He didn’t lay me down on the table or anything, but he was just feeling around on my side.” The second experience was as follow:

When the doctor came in to see me, ...he got my chart from the door and he looked it over and he went to the chair and sat down and looked at it and then said to me, ‘what brings you in today’? So I told him what brought me in and he says to me, ‘I’m gonna give you this prescription’, and he told me how to take the medication and he said, ‘I want you to go to x-ray and get x-rays and make an appointment to see me in two weeks’. And as close as he got to me was to hand me these prescriptions, you know. He didn’t check nothing. And I was there for my hands, which were giving me problems. He didn’t even look at them. I didn’t think he was concerned about me and he was just, that was his job....so I changed and got another doctor. The next one I got was excellent.

In discussing this second experience further with Erin, she believed the first doctor was a person who really did not want to be where he was. She believed that he was there to fulfill military duty and treated her no different to the way he treated other patients, regardless of the ethnicity.

Celestine felt the quality of care provided her during some of her visits to the emergency room was substandard because the doctor did not conduct a thorough physical assessment. She related the following paradigm case:

Well, here now, I had to go to the emergency room because uh, sometimes my back gives out and I can't move, and if I move, it's just a pain that I can't handle and you have to stay in one position. They had to rush me to the emergency room, and when I got there, uh, they just told me that, they gave me motrin and told me nothing, nothing was wrong. And I asked them if it was coming from the knot in my side, they said no, it was not coming from that. And they gave me motrin and told me to go home and if it got any worse to go to a doctor. Kicked me out, you know? That was it. They didn't take any x-ray or anything.

Another paradigm case related to poor quality of service involved Celestine and three other family members who required emergency care. Celestine recalled the experience while in the emergency room:

He (the doctor) was so upset with us, all of us, that he was just hateful, you know, and do you know he did not wash his hands? He went from one room, although we were relatives, he went, you know like, like say he gives you a shot and go to the other room and goes to working on all, I think it was four of us. He didn't wash his hands. He just came right in and start working with me, you know? Come and start working went back to the other room took care of Sylvia, went back to the room, took care of Jim, came back to me took care of me, then went to Yolanda, took care of her and never washed his hands, you know? I got an attitude then. He really didn't want to be there the way he was doing them, you know?

All experiences with the quality of care were not negative. Stephanie relates positive and negative experiences. Speaking of the positive experience, Stephanie stated,

“I had some very good doctors that took care of me during my prenatal time. Uh, they were very attentive. Uh, very concerned, and, uh, I really didn’t have a lot of negative things to say about those doctors.”

Stephanie related a paradigm case which presented exemplars for poor quality of care. It involved the hospitalization of her mother. Stephanie stated the paradigm case:

They gave her an operation and a colostomy that she didn’t even need. She passed away as a result ‘cause her body was not strong enough to endure. We had uh, an autopsy and we uh, asked the person who did the autopsy what was the real problem? He said it was not from the kidneys, uh, you know what? The doctor had thought it was kidneys, went in and performed that operation, actually performed that operation, and when the autopsy report came out, it said that was nothing wrong with her kidneys. You see, that just really turned me off.

Lack of compassion. On occasion, the quality of care was related to a lack of compassion by the health care provider. Steven recalled an experience he had that required medical care:

I never visited a doctor until I was in an automobile accident when I suffered broken arm in 1950, I was 17 years old and was taken to Memphis to have the bone set. I remember that uh, the first time I’d seen a White, I mean been to a doctor. He did not give me any kind of anesthesia to set the bone. He just simply located the fracture in the arm and began to juggle move the bone until he got it to the place put it there and put the cast on. I fainted, of course. That was my introduction to health care.

When asked how he felt he was viewed by the health care providers, Stephen replied, “It was not with much compassion, no bedside manners. I don’t suppose that ter an animal would have received less compassion.” When asked how did that experience influence his utilization of health care systems, Stephen replied:

I got over it. And I recognize that those who are involved in delivering health care are in fact, agents for good and righteousness and really servants of God because all healing, I believe is-is God’s work. From the uh, I think the Greeks had it right when they gave us the word ‘therapy’, therapeutic meaning ‘God heals’.

Stephen was asked if he was familiar with the Tuskegee syphilis incident. His reply was, “Yes.” When asked if it influenced his decision in the utilization of health care systems, he replied, “ No. I understand man’s inhumanity to man. That was a terrible thing that happened, a terrible thing that happened.”

Even though the initial experience of utilizing health care systems in a hospital setting for Stephen was unpleasant, subsequent experiences were very pleasant. He related several experiences when he was treated with great respect. He felt that the environment in Jonesbourrough was associated with Tennessee cradling the confederacy, even today.

Stephanie also had an experience when she felt there was no compassion demonstrated by the health care provider.

And another thing, that happened during the time that I lost my mother is, the head doctor on her case stepped on when she had died, immediately after my Mom died. She stood so far away from us to tell us, she stood across the hall and

said, 'your Mom just passed', rather than walking up close and showing concern, and that was just hard for us. You know, we were just devastated uh, to know the coldness that this doctor exemplified. Not only was my Mom dead now, but they performed an operation that she really didn't need and then to respond with coldness. No matter if they did everything they could do, and-and hugged you and gave you the assurance that they did everything, you still, you would still hurt. But, to know that they did their best would make you feel better.

Wyle felt the care he received as a child for a hernia was of poor quality. The evidence of poor quality was the resulting scar tissue.

Distrust

Few subjects expressed a feeling of distrust toward health care providers as a barrier for utilizing health care. Most subjects enjoyed their doctors. The subjects who were distrustful communicated strong feelings. It was as if when they had access to health care systems, they anticipated unfavorable experiences. Harry stated:

There was an experience also when I was in the institution coming off drugs where they turned me off. I was taken to a place where they had five psychiatrists to determine my mental state and they determined 'he's O.K. It's nothing wrong with him. He's just militant'. I went home. It wasn't but maybe a couple weeks, I had to be readmitted. I thought a revolution had started, you see. I was really crazy. I had a gun. The drugs had driven me to the point where I couldn't determine what was reality and they had to take me back. That's after I had set down with five psychiatrists. Since that time, I have no confidence in psychiatrists. I

know they can be fooled. When they determined there's nothing wrong, I myself knew something was wrong, but I thought it was the drugs and it would soon wear off.

Harry believes the distrust felt by African Americans extends beyond health care.

He stated:

When you're talking African Americans, most African Americans have experienced pain because they are African Americans. There has been developed an attitude of distrust among African Americans. Even in the church not among themselves. Not among themselves, but, I'm saying developing an attitude of distrust within the African American race toward religion.

Stephanie developed distrust for other reasons. She experienced two family members' deaths which seemed unnecessary to her. When she was eight years old, her brother incurred what appeared to be minor burns. After being admitted to the hospital, her brother died. The unexplained deaths of her young brother and her mother has contributed to Stephanie losing confidence in the medical profession. Stephanie stated, "I believe that if I could have found that my mother was well taken care of and my little brother who died many years before, uh, I believe that I could have more confidence in the medical profession."

In addition to experiencing unexplained deaths of two family members, Stephanie recently heard on the news that multiple deaths occurred each year because of errors by physicians or pharmacists. Her response to this report was:

And this thing I heard, I guess a few days ago about how many people uh, uh, died

because of uh, uh, taking a prescription that's not what they need or over medication or, or, many reasons the doctors haven't given the right thing, or even the pharmacist filled it out wrong, filled your prescription out, your, uh, uh, medicine out wrong, and then, uh, it's scary, and operations and all that, you're reluctant, I don't want it.

Racism

Several subjects felt that physicians provided health care unwillingly. While Celestine was careful to refrain from stating her doctors practiced discrimination, some of her lived experiences implied a covert practice of discrimination. She talked about an experience with her doctor during the years of childbearing and compared them with an experience she had with her African American doctor.

It was just totally different, like day and night, you know. They (the Caucasian doctors) knew they had to wait on you, but they accepted it because they had to. You know, 'a law can change and you can go here, I'm just serving you because of the law'.

She also spoke of an experiences with another Caucasian doctor and described the doctor as "real sweet. I had to go to him because I had a wreck. That's how I met him, but he was real sweet."

Allen's memories of his visits to physician's offices during his childhood also refer to behaviors that denote discrimination.

Of course, I can recall running into a couple of doctors where they didn't want you in their office. Especially when you could afford it. So, but they would do it, you

know. You would go and in the Colored section and they would do what they had to do and move you on out of there, O. K.?

When asked how did he feel about that, he replied, “ I, it was oppressive, but at the time, I was a kid, and I was with my parents.” Allen’s parents had developed coping strategies for living with discrimination. One coping strategy was to ‘look at the big picture.’ He recalled:

I was taught you know, ‘you needed this, if you didn’t need this, we wouldn’t be here, but you need this’. So certain things you had to do, and you had to look at the big picture. ‘If you don’t need this, you wouldn’t be here, but you need it, so we gone be here, so you gotta bear up to survive’.

Another time Allen recall his parents sharing coping strategies with him:

Yeah, my mother and father, my dad was really a strong person and he always told us that ‘you know, you need to do this, go look at the end result, you have to, you have to get well, so you need to do this, cut through all the racial stuff, cut through all the relationship stuff, you need to, that’s the only one little facet, or one little area of life that you are a person, you know’, so we had that approach, my dad was always telling us boys, ‘you’re a man, you guys work hard’. So I, we never did have problems that. Uh, my dad would just tell us, ‘you know, that people are crazy, no need for you to be crazy’.

Allen related to another paradigm case within which are exemplars of racism.

The only hostile uh, uh, event in my life is when my brother, when he flew off that truck. I won’t forget that, and uh, we had to go to the hospital emergency ward.

And so, they checked him into the White side, but we had to go under the street to the Black side, but the doctors they treat, you know, they bandaged him up, gave him the shots, x-rayed him nice, and that was it.

Allen continued to comment on his view of how the country regards race. He stated, "This country is not color blind. No, its not color blind. Should be, but it isn't."

Under-utilization of health care systems by Steven's family was directly related to racial bias which was to the extent that medical systems were withheld from African Americans. Stephen stated:

I was born in 1932 back in Arkansas. At that time, it was segregated and Blacks had access to some of the systems. For example, there were no Black physicians in the city, and ,uh, the Black, the only hospital in Jonesburrough is not really catered to serving Blacks. If there was a serious medical problem, we needed to go 70 miles to Memphis. The only practitioner for medical systems was a Black, for the Black community was a Black nurse who actually operated uh medical offices, you see. If we had problems, we went to her. So I never visited a doctor until I was in an automobile accident when I suffered a broken arm. In 1950, I was 17 years old and was taken to Memphis to have the bone set.

Consequently, when health needs of African Americans were outside the scope of practice of the local nurse, African Americans were required to drive 70 miles to Memphis in order to gain access to health care systems which could have been provided in Stephen's home town.

Stephanie believed the behavior demonstrated by the obstetrician who cared for her while her doctor was away was racially based. After observing the doctor to have a poor attitude, to be impatient, to not be as kind as she expected, she stated:

The doctor was impatient and wanted me to move on and have that baby so he could get on with his business. It was like, and I kind of felt it was a racial thing by being, I say, well, maybe he's not accustomed to dealing with minority women."

As a result of lack of affordability, withheld medical services, and practices based on ideologies, African American families resorted to home remedies and practices directed by individuals in the community who were believed to have advanced medical knowledge for treatment of illnesses. Even though the medical knowledge was not empirically based, some degree of satisfaction was experienced by those to whom services were provided.

Waiting Time

Many subjects experienced excessive waiting time. Erin remembers experiencing long waits and how she adapted and continued to maximize the use of health care benefits. There were times when her children would try and convince her there was nothing wrong with them, and there were times when the doctor would tell her that there was no problem, Erin preferred taking no chances. She stated:

And I did take them you, know, when they needed to go. When I felt like they needed to go, I taken them although I knew it would be, you know the wait. I wasn't working or anything, so I was available just to go and spend the day if I

needed to.

Erin had pleasant experiences even though the waits were long. She recalled:

All the physicians, they have all been very uh concerned uh excellent, I feel like I got good care, you know. So I haven't really had any bad experiences and with the children, and I've taken the children at times when really, they didn't need to go, I mean, you know how some mothers are? You know you feel like this kid is really sick and its really not sick., you know. And they always nice, you know even you know when I went and uh, they didn't really need to go.

The waiting was related to the way the system operated. Since that time, Erin says she sees her physician within 10-15 minutes of the scheduled appointment and no longer are there long waits.

Allen had one experience with a long wait when he insisted on seeing an orthopedist instead of an internist for his injured Achilles. The hospital had an internist on duty, however Allen felt an orthopedist would be the most appropriate provider to meet his needs. When he insisted on the care of the orthopedist, he stated, "They made me wait a couple of hour, but I saw a specialist. And that was it, that was the only experience I had with getting health care."

Joy recalled experiences she had waiting in the emergency rooms, "I remember that we had to wait long when I went for the nose bleeds. When we go in, I would have a bowl of blood holding it under my nose. They would take so long before they see me." When asked what about when she went in for other problems, she replied, "I still had a long wait. When I got a cut on my face, I had to wait a long time."

Stephanie recalled:

You can come, or go to a doctor's office and you have to wait, even though you have an appointment, you know, for I mean, say, 4 o'clock appointment. What does an appointment mean? You can't see the doctor the time you're suppose to see him. And that turns people off. They know, you know, I'll be at the doctor's you know, its no telling when I'll get a chance to leave.

There were personal idiosyncrasies for delaying utilizing health care systems.

Allen felt there were examination procedures which he did not like. When asked what determines his decision to utilize health care systems at this point in time, he replied:

Even though I have a HMO, I still don't like going to doctor. I wait until it's necessary. I've gotta go, I just gotta go, I cannot take care of this any more. I say, 'this is bad' and all I do is call Kaiser and make an appointment. I say, ah, I don't want to do this'. That, that's something else.

Allen was asked if he practiced utilizing health care systems in this manner because it is typical of the practice he was exposed to as a child. He stated:

You know, I think it's just a male thing, it's ah no, it's just a man male, you know? My wife say, 'Allen, go to the doctor', then I say, 'nah, it's O. K.'. I think it's a man thing. I don't know.

Allen became more specific about what the 'male thing ' was. He stated:

I'm going to tell you what, now, I do have one African American characteristic that is common for a lot of them. I do not like people prodding and picking on me, medical stuff. don't like that. I mean, I think that is so intrusive. I mean, yeah, I-I

it's so intrusive when they picking and prodding, its so intrusive. To me, that's the most uncomfortable thing it is, you know, once I get through, O. K., you gotta, you gotta tell what's wrong, they gonna prod and pick you.

When asked if this was a factor for him utilizing health care systems, he replied, "Definitely for me. For me, I know it is. I just don't want no doctor saying, 'O. K. now bend over, O. K., I'm gonna stick you'."

When Celestine was asked how would she feel about utilizing health care systems if all of her experiences were as the one when she felt the doctor accepted and respected her, she replied:

I don't know. Even when I was pregnant, putting my legs up in the doctor's office and he checking me, maybe, maybe it's the way you're brought up, you know?

You're taught don't do this and don't do that and you go to the doctor's office and they make you pull your clothes off, you know? And I say, 'I'm pulling my clothes off in front of this stranger', you know? When you go in that office and say pull your clothes off and you laying there and they feeling all over you.

These reasons for under utilization of health care systems are difficult to categorize. They could be viewed as idiosyncratic or they could be culturally related.

Focus Group Results

The second interview was conducted with a focus group at a pre-designated site. The focus group consisted of six subjects of the original twelve whose interviews contained a high number of themes. The focus group interview was tape recorded and notes were taken. With the researcher serving as moderator, members of the focus group were requested to introduce themselves. The moderator explained to the subjects that data

from previous interviews had been analyzed and themes had been identified. Themes were defined to the focus group as the experience of focus (Van Manen, 1990). In addition, it was explained that metaphorically speaking, themes can be considered as knots in the webs of our experiences, around which certain lived experiences are spun (Van Manen). It was then explained that the purpose of the focus group interview was to interpret these themes. As each theme was presented, participants were asked to give meaning to the theme.

The function of the focus group process is synonymous with Heidegger's philosophical perspective of 'the clearing' (Van Manen, 1990). According to Van Manen, Heidegger believed that all of our possibilities and potentialities are from the shared background of practices and familiarities. This shared understanding enables us to become involved with relations, things, and situations in our world, to cope smoothly and skillfully in our everyday life, and to take a stand on what it is to be human beings in our world. Heidegger called this shared background familiarity that discloses our shared world and makes it possible for us to have shared and individual interpretations of our world 'the clearing'. Heidegger discussed focal, local clearings which are specific for individuals or groups, such as families or friends. He described the focal local clearings as events, things, or practices in our lives that gather special significance from time to time. Clearing, according to Heidegger, is an interpretation or understanding which is possible only because of our shared background understanding.

Delay in Utilizing Health Care Systems

In reference to the theme of delay in seeking health care, the subjects were asked what meaning would they give to this pattern of behavior. Allen responded:

I think it's a cultural thing. I know when I was a kid, my parents didn't go to the doctor until you were really, really sick. We used home remedies, hot packs or packed in grease until the fever broke. We used herbs. We did what we had to because we could not always see the doctor. We couldn't afford to, so we saw him only when we had to. Now, I put off seeing the doctor until I just have to go. My wife tells me, 'Allen, go to the doctor'. Now, my son and his friends, they want to get to the doctor quick, 'get rid of this pain', they don't hesitate.

Several participants agreed their children seek health care immediately if they feel there is a need. The participants felt that differences in how the two generations utilize health care systems is related to the cultural changes in the younger generation influenced by television, the immediate availability of medications, and the variety of medications. The change in patterns of utilizing health care systems by children of the participants from the way the participants utilized health care systems is called acculturation. Most participants agreed, however, that the way their parents utilized health care systems has had some influence on the way they utilize health care systems.

Fear

When asked what is the meaning of fear in the utilization of health care systems, Wyle stated, "I think if you have never been told something's wrong, you live longer, so you don't go. You just afraid of really knowing." Bette believes that you never know what treatments will be needed and some treatments require injections. This frightens Bette. She has not been able to eliminate the of fear of being hurt with a needle. Bette stated, "I got shots as a child when I was in school and the needles still hurt."

Celestine stated, “I think it always bring on fear when you know something is wrong, but do not know what it is. You hope it’s not bad, but you don’t know.”

Quality of Care

Subjects expressed that while the quality of care may not be satisfactory, African Americans need to be aggressive about their care. They believe that some African Americans are accustomed to listening to the doctor and do not know to take the initiative to inquire about treatments provided to them or inquire about their health status. They believe that doctors are revered to some degree, consequently, African Americans find it difficult to question doctors. Allen stated:

African Americans need to be more aggressive about their care. You can’t wait and hope to get good care, you have to tell doctors what you need. The problem is technology is changing things so fast you don’t always know what’s out there. You gotta know what’s out there before you can know to ask for it.

Another perspective on reasons for the pattern of delay was expressed by Harry. He stated, “I think that the care you got was so bad that you just wait to the last minute, hoping it will get better. You felt like they didn’t want to be bothered with you, especially if you don’t have insurance.”

Distrust

Some subjects believed the exemplars presented are credible and indeed are valid cause for distrust. They believed that cultural distrust is the result of both historical events and lived experiences African Americans continue to have (valid or invalid). One subject, Harry, believed one cannot trust the health care system to be objective in meeting health

needs. This failure to be objective is motivated by economics. He believed you cannot trust the health care system to provide high quality of care if you are uninsured.

I don't believe you get the same quality of care if you don't have insurance. We took our son to the hospital and they were sending him home until they found out we had insurance, then they said, 'well, let's keep him overnight.' The child was so sick, they had to put him under a tent for oxygen. If they had sent him home, he would have died, you know. I they treat you different sometimes, especially when it comes to whether or not you have insurance. You cannot always believe what they say.

Harry believe that distrust is not only related to economics, he believes there are times when doctors simply make the wrong diagnosis and you are afraid to trust what they say the next time. He stated "And sometimes if you don't really understand what's happening, it causes you to have distrust and that is why it is important for doctors to spend time explaining things to patients".

Stephen asserted that recent news reports on the number of deaths related to errors by doctors and pharmacists causes one to be distrustful of health care services to some degree, "you never know when it will be you who is the victim of one of their mistakes." In any case, all subjects believed there are valid reasons for having some distrust of health care systems. Some subjects believed that more African Americans as health care providers would increase their level of trust in health care systems. Other subjects felt very strongly that there need to be more African American doctors.

Racism

The exemplars for racism were presented to subjects. They included feelings of oppression, substandard or low maintenance care provided to African Americans, lack of compassion, denial of local medical services, and Caucasian doctors did not want African Americans in their office. When asked what was the significance of these experiences, Wyle replied, "African Americans will always experience discrimination. There are just not enough Black doctors for African Americans to see." Harry stated when he attempts to utilize health care systems he gets defensive. When asked what was the meaning of negative attitudes by African Americans when utilizing health care systems, Harry believed:

Many African Americans have been discriminated against during their formative years as well as adult years and develop an attitude. When they go for health care, they go in with an attitude because they have had bad experiences maybe not always with health care, but in general and this perpetuates the racial thing.

Most exemplars for experiences related to racism were experienced prior to health care reform and the Civil Rights movement. Most subjects believed that discrimination continues to exist, but it is not always easily identified because it is practiced covertly. Many subjects have not allowed earlier experiences of racism to affect how they utilize health care systems today. Wyle believe that attitude has a significant influence on how African Americans are responded to when utilizing health care systems. He stated:

I had an experience of being in the hospital. I was treated with a lot of respect and the staff was so nice. They couldn't do enough for me. I believe it was because of my attitude. I tried to make them feel like medical attendants rather than servants. You can't go in there with the attitude, 'you take care of me, I'm paying your salary.'

When the personal idiosyncrasies or culturally influenced behaviors were addressed, (Allen who disliked the probing and prying and Celestine who disliked getting undressed and putting her legs up) subjects believed these are not idiosyncrasies, but are related to a violation of ingrained teachings among African Americans. They felt it is just a matter of when one feels uncomfortable with procedures, regardless of how necessary the procedure is. Allen stated, "I stay away as long as I can because I just don't like the probes and prying. It is not the doctor's fault. So it's a man's thing, yea, it's a man's thing."

Waiting Time

Long waiting periods to receive health care services did not appear significant to the subjects. Most subjects expressed recent experiences showed a significant improvement in the time spent waiting. Some believed that it is related to changes in systems operations.

Chapter 5

Discussion

One goal of this study was to look for conditions and commonalties that created the differences in how African Americans utilize health care systems compared to Caucasians. An application of the four existentials of corporeality, relationality, spatiality, and temporality to the themes that were identified showed conditions and commonalties existed pre and post health care reform and the Civil Rights movement. First, prior to health care reform, a commonalty among African Americans included a climate where few knew the significance of practicing preventive medicine, and few could afford to participate in such practices. Second, the social condition of injustice toward African Americans cultivated an environment which led to most of the themes found in the data. These themes, a delay in utilization of health care systems, cultural distrust, fear, racial bias, and long waits for health care service were recognized prior to health care reform and the Civil Rights movement in 1960. Post health care reform and the Civil Rights movement have shown, shorter waiting time for health care, less acceptance of practices of discrimination by African Americans and society in general, and most subjects participating in disease prevention. However, experiences of delay in utilizing health care systems, fear, cultural distrust, and racial bias continue. Van Manen (1990) stated that these existentials can be differentiated, but not separated because they all form an intricate unity called our lived world.

Corporeality

Van Manen, (1990) stated corporeality refers to the phenomenological fact that we are always bodily in the world and when we meet another person in their world, or in their landscape, we meet that person first through their body. He stated that in our bodily presence, we both reveal something about ourselves and we conceal something at the same time not necessarily deliberately, but in spite of ourselves. Our body may change in one of two ways as others are viewing us. If the view is a critical gaze, the body may become awkward or clumsy while if the gaze is one of admiration, the body surpasses its usual grace and its normal abilities (Van Manen). When Harry was asked how did he feel he was viewed by health care providers as he utilized health care systems, he replied:

People will look at you and it makes you feel less acceptable as far as they are concerned. It makes you decrease your desire to go to the doctor sometimes because of that. Yes, that affect me, and I've experienced a lot of that where people just don't seem like they are totally accepting of you.

Celestine's response to the question was:

A lot of them did (look at her with critical eyes), and when they did, then I responded the same way, you know? Ugh, the worse experience that really got me was, I guess is when you walk in and they look at you and, I don't know, Sister, I just retaliate.

Comparing two bodily experiences, one involving care received from an African American doctor and a Caucasian doctor, Celestine stated:

They (the Caucasian doctor) knew they had to wait on you, but they had accepted it because they had to. You know, a law can change and you can say, 'go here, I'm just serving you because of law, not because I want to.'

With both experiences, Celestine did not feel that she was viewed as being accepted or viewed through eyes of admiration by the health care provider. However, Celestine referred to a Caucasian doctor who cared for her when she in an automobile accident. She stated, "My last doctor I went to before I came out here, he was real sweet." One paradigm case Celestine shared was about a visit to the clinic. She stated:

I was having this bad indigestion, I thought. My food wouldn't go down and I got in there and sister, T, they looked at me so strange I thought I was from the zoo. And I told him what was going on, he said, 'well, uh, you go home and you can take some mylanta.' I said, 'oh yeah?' He never checked me, the nurses looked at me and weighed me.

Twice Celestine mentioned feeling there was a lack of respect demonstrated toward her by health care providers. Once, she felt the response to her by health care providers caused her to feel that she was a bother.

Nashti, on the other hand, only remembered experiences where her bodily views from health care providers were positive. She stated:

I guess because so many people don't go until something's wrong I guess they thought, you know, that, you know, we were pretty unique to use your, you know, make your regular check-ups and come in to prevent any, basically, it's preventive medicine, so it's to keep you from, anything from happening, they would know in

advance so, I think they kind of admired the ones that did.

The view Joy felt her health care provider had of her was somewhat different. She was generally seen by a physician's assistant. Joy felt they saw her as an experimental object. She preferred being seen by a medical doctor.

Stephen felt he was devalued when he was provided care that was unequal to that provided to Caucasians. After driving 70 miles for care because medical care was withheld from him in his home town, Stephen felt the reason he waited long for a doctor to care for his broken arm and the reason he was not anesthetized during a closed reduction was because he was Black. In addition, Stephen felt that Black pain and Black life was not considered to be as important as the pains experienced by White folk. However, later experiences were different for Stephen. When asked how he felt he was viewed while receiving health care three additional times, he replied, "With respect," "With a lot of respect," and, "With great respect."

Stephanie had one experience when her labor was not progressing as quickly as the attending physician wished. She felt that she was an inconvenience to him and felt to be a source of aggravation to the physician.

Our bodily experiences of how we are viewed by others have a significant effect on how we prepare ourselves to respond to life experiences. One can assume that repeated experiences of being viewed critically prepares one to approach life experiences with a defensive attitude. Harry and Celestine had repeated experiences of feeling that health care providers viewed them through critical eyes. Harry believed that as he repeatedly experienced racism, he developed a defensive attitude. Consequently, when he approached health care providers, he had an 'attitude' because of racial experiences

external to the health care setting. As a result of the bodily experiences by Celestine, she preferred seeking advice from her friends for health care needs.

Stephen's experience with the black nurse was his initial exposure to health care. It was a totally pleasant experience. Even though he continuously lived with the fact that local health care was withheld because of his ethnicity, and even though the magnitude of his first experience with medical care was greatly negative, he maintained a positive perspective of health care providers. He stated, "I got over it, and I recognize that those who are involved in delivering health care are in fact agents for good and righteousness."

Allen has not been affected by the experiences of discrimination in health care systems as a child. Allen's parents promoted two coping strategies. One was to, 'look at the big picture,' and the other was to building self esteem by saying to their sons, "You're the E----- boys."

One may assume that the type of coping strategies have a significant effect on how strong people can be when viewed through critical eyes. Even though the duration and intensity of the critical eyes may exist, it is easy to believe that if coping strategies can sustain a demonstration of strength, views of admiration are likely to follow.

Relationality

Van Manen (1990) described relationality as the lived relation we maintain with others in the interpersonal space we share. The relation maintained by the subjects with health care providers varied. Relationships prior to health care reform and Civic Rights movement are more similar than those after health care reform and Civil Rights movement, with few exceptions.

Subjects whose early childhood years were prior to the health care reform and prior to the Civil Rights movement did not report positive relationships with health care providers except with the Black nurse. Few of those subjects continue to report relationships which are not positive.

Erin whose early childhood was during this era, stated, “There really wasn’t any interactions with me. It was with my mom. See, like doctors now talk to children and everything, see then, he just talked to my mom.”

Allen felt that close relationships did not develop, however, the quality of care was very good. He stated, “His (the doctor) job was predicated upon taking care of workers, and if he failed on that, they would fire him, so they gave good service, but they didn’t break bread and say, ‘hi’ or give me lollipops, but they were nice.” He reported an experience that was somewhat different, “Some of the staff there took a standish or hands-off approach, did what they had to do and kept you at arms length.” Speaking of another experience, Allen stated, “They didn’t call me in and pat me on the head and kiss my cheek, but they did it very well. It wasn’t bad. I didn’t have no negative feelings. Over all, Allen gave no account of a negative relationship with health care providers except the staff members who took a hands-off approach.

Harry’s account of experiences relative to relationality was that doctors gave quick answers and it looked as if they did not want to take time to explain things. However, this could be a behavior demonstrated if one was operating behind schedule. An interpretation of such behavior may tend to be quite subjective. In any case, the climate for developing a relationship did not seem to exist.

In relating to other experiences utilizing health care services, Harry presented exemplars of treatment differences. In both cases, he felt that if you did not have insurance you were treated differently. These experiences have caused Harry to delay utilizing health care systems. Harry stated, "There was, you know, there was one other time where, and I think the physician treated us cold. We've been to hospitals before if you didn't have a certain insurance, you know, they treated you cold." Being treated "cold" defines the relationship with health care providers who were involved in this experience, at least from Harry's perspective. When asked if such experiences had an influence on him utilizing health care systems, he replied:

Well I would think it had some influence on me in the sense that I feel that when you go to the hospital and if you don't have some type of insurance or enough insurance or don't have any, that they gonna treat you different. They gonna treat you different than they do people that have money or have the insurance.

One paradigm case recalled by Harry which embodied this exemplar is:

I took my son to the hospital and he had this bronchitis and so they examined the child and because, and I showed them that I did have insurance, they decided to keep him. So, they made a decision to keep the child after we showed we had insurance. But when they kept the child, he got so sick if he had gone home, he would have died, you see. But by them keeping him and by us showing them we had some insurance, they changed their mind and said, 'well, let's keep him overnight.' So that showed me that there are people out there that are losing, people have died, you know, because they didn't have insurance. It makes a difference in a

hospital.

When Harry was asked about the relationship he established with the health care providers, he stated, “I was so concerned about my son that I didn’t think of anything else.” On several occasions, Celestine found it difficult to develop a positive relationship because she chose to pay for her health care rather than purchase insurance to cover the cost. As she attempted to utilize health care systems, but prior to receiving care, she had a negative experience associated with the method of paying for health care services. She stated:

My experience has been that no matter how sick you are, they want to know how you’re gonna pay for it. I don’t like that. I went to the doctor and they asked how was I gonna pay for it. It cost \$90.00. I started paying for it and she looked like she didn’t believe I had \$90.00. I went to the doctor before so I knew I was going to have to pay it. It’s just I don’t like going to the doctor and I don’t go unless I have to.

When Celestine was asked how does it make her feel when people demonstrate respect toward her, she answered, “ I open up.” Stephen experienced a positive relationship with the Black nurse who served the Black community in Jonesburrough. All other interpersonal interactions recalled by Stephen were positive, except he had no comments on the interpersonal interaction with the doctor who performed a closed reduction without anesthetizing him. Perhaps it was because Steven fainted. Stephen lost consciousness with his lived world. Van Manen (1990) stated that the only access we have to our world is through consciousness and it is because of the fact that we are conscious that we are related to the world. Van Manen posits that if an event falls outside

of consciousness then it fall outside of the bounds of our possible lived experience. One can likely assume that it would be rather difficult to experience a positive relationship with a health care provider who would demonstrate a lack of compassion of this magnitude. Subsequent experiences of interpersonal relationships by Stephen with health care providers were very positive, even the experiences occurring prior to health care reform and the Civil rights movement.

Wyle, whose early childhood years were prior to health care reform and the Civil Rights movement, did not recall negative interpersonal relationships with health care providers. His most recent experience was positive, to the extent that it was beyond what Wyle could have imagined. The relationship developed with the staff in the emergency room was very positive. Wyle believes that his approach influenced the response from the staff. He stated:

When I walked up to the window, I think that the sensitivity of the nurse that was there when I said to her, 'mam, I fell and I hurt my arm, and I'm in great pain.'

And I don't think it was the expression that got her, it was the words when I said to her earnestly, 'I'm in a lot of pain.' and I said, 'I think my arm is seriously injured.' She took me serious.

Wyle experienced a positive relationship with the nurse as the assessment process occurred. The interpersonal relationship with the doctor also surpassed Wyle's expectation. When the doctor approached Wyle, he asked:

'Doctor (the medical doctor referring to Wyle, who is doctor emeritus), what did you do? You have a mess here. This is the biggest mess I've seen. Not so much

the arm, but what can I do about it?' He says, 'let me take you to x-ray.' And he took my bed, and he took me to x-ray. He took me himself. Took me back there and stayed in the room and went back there with the girl and shot every shot.

As the doctor pondered audibly, about what he was faced with and what approach he would take, Wyle replied to the doctor:

Doctor, I can appreciate the engineering of what you have to do to make a correction because this is kind of what I do. I understand that kind of creativity. So, and I said to him, just being comical, 'now out of all these years you been in this business, you can't fix a little old shock-absorber like this? I mean, come on, you should be able to take care of this', and he smiled and said, ' I don't know,' and every since then, we are just like that, until this day.

When Wyle went for the first office visit, as he entered the office, the staff inquired, "You must be Mr. Wyle." Wyle felt the doctor had informed his staff about him in a positive way.

Among subjects whose early childhood were during or after the health care reform and Civil Rights movement, none reported negative experiences with their health care providers. Nashti related to a paradigm case within which was an exemplar of positive interpersonal relationship between she and her health care provider:

They were all friendly. I recall one time I had to have stitches on my thigh and he went to inject it to numb it and I grabbed his hand. He could have been ugly, but he said, 'Oh, no, no, no, you can't touch my hand. Now, I have to change gloves, you know? He was really nice about it. He could have said, 'this kid down here',

you know, but he was really nice.

Another experience was also seen to be an exemplar of a positive relationship.

When asked how was her relationship with other health care providers, Nashti recalled, “Oh it was nice. I-I loved everybody. When we went to Kaiser. I, you know, when they closed up Kaiser, was like, ‘Oh man,’ cause I missed all my doctors.” The interpersonal interactions between Nashti and her doctor extended beyond the doctor’s office, also, beyond Nashti and the doctor. The doctor’s and his wife were customer’s of Nashti at the bank. When either would come into the bank they would have friendly conversations with Nashti, inquiring about her family. Joy also reported viewing her doctors as being pleasant.

Perhaps one could assume that one important factor was present in both Wyle and Nashti’s experiences. That factor was mutual respect. Wyle, being sensitive to the work load of the staff, made efforts to decrease the work load by offering to do more for himself than what the staff expected him to do. The staff respected and valued his efforts. As a result, other than Wyle’s nurses were frequently available to assist him. His doctor even transported him by bed to x-ray.

Nashti’s doctor valued her efforts to practice preventive measures of health care and his respect for her was obviously communicated to his spouse. The sum of thought behind relationality is, each individual has some responsibility toward facilitating positive interpersonal relationships. When we can view others and see commonalties rather than differences, positive interpersonal relationships are likely to occur.

Spatiality

Spatiality or lived space according to Van Manen (1990) is felt space (p 102).

Lived space is more difficult to discuss compared to space that is expressed mathematically (space expressed in miles, inches, or driving hours). Yet, Van Manen believe the way we feel is affected by the space within which we find ourselves. For example, a large open space may cause a feeling of freedom or may cause one to feel small. Feelings from open spaces are different from feelings experienced in a close area such as an elevator (Van Manen). According to Van Manen, we may say we become the space we are in. Our emotions are affected by the space we are in.

Erin remembers an early childhood experience prior to health care reform and Civil rights movement visiting the doctor for the first time. She stated, “ We had made a move, and ugh, I don’t know, it was, ugh, it was a little dirty, dingy place. I can remember that and there was some more people that, you know, I don’t know how I really felt.” Post health care reform and Civil Rights movement, Erin experienced a friendly environment and had a good feeling about the spatial experience.

Allen’s spatial experiences in the offices of the Caucasian doctor and the African American doctor contrasted. When asked about his experience in the office of the African American doctor, he replied:

It was more comfortable. The people in the office was all, you know we could talk about things, the kids, in fact, I remember kids like most of the doctors station now they had more stuff you could play with. I just know I was a kid I was having fun and just going running around being wild, I thought that was fun, You know,

the doctor had toys, running around being wild as a kid.

When speaking of the environment in the Caucasian doctor's office, he stated:

It was a difference in terms of that when we would go to the White doctor, you had to sit and be very proper, that in that office (speaking of the African American Doctor's office), we were more free to run around play with the toys, read the magazines and other kids were there, so you were kids.

When Harry was asked about his spatial experience, he stated:

I'm trying to think back, ugh, ugh, I won't say I felt totally at ease. I don't think I ever feel totally at ease when I go in there. Oh man, there are some, I won't call the name of the hospital, uh, some have an environment where people are cursing, the waiting room is loud. Oh my goodness, unsafe.

Stephen remembers the lived space of the Black nurse's office was one which you felt comfortable. He said, "It was an environment that made you feel like you belonged there". The environment where the closed reduction was performed was described as crowded and old, but clean. Another description of the spatial aspect of his experience was described as 'first class', another was described as 'good, It was clean, it was quiet, it was good' and another was described as 'outstanding.' Stephanie felt the spatial aspect of her experience was great, even though the doctor demonstrated an attitude of being aggravated because her labor did progress as rapidly as he wanted it to.

Temporality

Temporality or lived time refers to one's subjective perspective of time rather than time expressed in minutes or hours (Van Manen, 1990). Benner (1994) stated that the Heideggerian phenomenological notion of person includes a view of being-in-time that

differs from traditional Western notions of time. Also, temporality is constitutive of being. Benner stated the Heideggerian philosophical perspective of time is not related to physical objects, but is directional and relational and applies to being. Benner further asserted that temporality, the experience of lived time, is the way one projects oneself into the future.

Stephen experienced a lack of compassion during his first introduction to medical care. However, over time, Steven has had many positive experiences utilizing health care systems. Erin, somewhat like Stephen, had some negative experiences during childhood, but Erin stated, “Those experiences didn’t carry over to adulthood.” For Celestine, time has not presented increased positive experiences. She continues to verbalize disappointing experiences utilizing health care systems over time.

Van Manen (1990) stated that lived time may appear long if one is anxious or having a boring experience and it may appear short if the experience is pleasurable. Erin experienced times when she would spend almost all day in clinics with her children. She would have to prepare lunch because she knew she would spend most of the day waiting. There was reorganization within the health care system, consequently, waiting time for Erin is approximately 15 minutes. Even when Erin spent long hours waiting for medical care, she did so with the expectation that things would be better for she or her children and the time did not seem to be a factor. Lived time has not changed very much for Celestine and Harry. Experiences of not feeling excepted continue as they continue to remain uninsured, even though their financial obligations are immediately met. Harry encountered many racial experiences while growing up. His coping strategy for these experiences was becoming militant. From a temporality perspective, Harry’s feelings of

anxiety extended over decades as health care systems were utilized to meet health care needs. Experiencing racial discrimination by Harry extended beyond utilizing health care systems to the utilization of other public services.

Conclusion

As data were analyzed, six barriers which impede health care utilization by African Americans were identified. The barriers include having to delay utilization because of cost and denial of health care services, fear, quality of care, distrust, racism, and waiting time. The magnitude of the barriers were relative to the era in which they occurred. For example, subjects whose early childhood years were prior to health care reform and the Civil Rights movement experienced barriers such as denial of health care services and the cost of health care services, both of which led to a delay in utilizing health care services. These experiences caused African Americans to seek alternative methods of meeting health needs, such as home remedies. It is important to know barriers experienced by subjects during this era. Knowing such can help to determine the extent to which cultural practices of delaying utilizing health care systems and utilizing alternative methods to meet health needs have been maintained among African Americans, even though the need to do such has been removed.

Consequently, attention will be given those barriers which subjects are currently experiencing. Also attention will be given to the degree to which delay in utilizing health care systems is influenced by cultural practice.

Some African Americans are fearful of utilizing health care systems because they are afraid of knowing of a problem. Some believe if you don't know, the problem may not happen.

There are times, even with our scientific approach and high technological capabilities for providing patient care, when the quality of care patients receive is unsatisfactory. This dissatisfaction has led some participants to delay utilizing health care systems.

There continue to remain levels of distrust among African Americans. Some distrust is cultural distrust, some is distrust associated with undesirable outcomes of health care services, some distrust is related to news reports of high incidence of deaths from physician and pharmaceutical errors and some is related to past experiences of discrimination. The theme of distrust represents multiple exemplars.

While some participants did not experience racism with their health care provider, others felt that discrimination would always exist. They viewed racism as a barrier to utilizing health care and felt there is a need for more African American doctors. Practices of racism can often be covert. It is the most difficult to recognize and respond to. In the health care system, racial bias could be practiced without a patient's knowledge. The practices could easily be in the form of treatment modalities, withholding information on treatment options, failure to provide education on disease and illness management, lack of respect, and lack of cultural sensitivity.

Most participants recognize the importance of utilizing health care services and are not inhibited because of negative experiences. They have been able to look beyond the negative experiences and 'understand man's inhumanity to man.' This researcher believes this demonstration of faith in man and faith in the health care providers has caused this subject to be able to describe subsequent health care experiences as having 'excellent relationships' and being treated with 'great respect.'

The extent to which delay in utilizing health care services is related to cultural practices is minimal among participants in this study. However, there continues to be delay in utilizing health care systems which could benefit from additional research studies. Two participants who had disappointing experiences, now actively seek alternative methods of meeting their health care needs. For these participants, the magnitude of the negative experiences has maintained throughout the temporality of their being-in-the-world.

Strategies for ameliorating noneconomic barriers include reducing cultural distrust by elevating educational levels, becoming culturally sensitive, acculturation, and a demonstration of respect for all mankind. One strategy utilized by parents of a subject was to promote self esteem. The parents would tell the children, "You are the E----- boys," meaning take pride in yourself. Self esteem is not developed primarily by what others give to you as much as by what you give to yourself and to others.

Relevance to Nursing

Because nursing education is based on nursing research, studies such as this can provide nursing knowledge which is specific to the needs of clients. Information directly related to client needs and ways to best serve clients is provided by potential (and often actual) clients, themselves. Consequently, nursing practice can directly address specific needs of clients.

Nursing Research

Hermeneutic phenomenology focuses on being-in-the-world as an ontological way of gaining knowledge of phenomena. Being is to know of lived experiences and the meaning of those experiences. Being-in-the-world includes

the entire landscape of the existentials of one's lived experience. It is a four dimension of one's being-in-the-world and the lived experience.

Benner (1994) defined world as the meaningful set of relationships, practices, and language that we have by virtue of being born into a culture (p. 46). To interpret experiences of being-in-the-world, there must be connection with social interest. Thompson (1990) stated hermeneutic philosophy emphasizes the social and the historical nature of inquiry and argues that understanding cannot be separated from the social interests and standpoints which we assume.

Hermeneutic phenomenology allows for knowledge to be gained on the intermediate phenomena rather than providing quick explanations for reasons for phenomena. Benner (1994) asserted that if we see phenomena as being rational and explain them by assigning a reason or see phenomena as being irrational and explain them by assigning a cause, we miss all the intermediate phenomena which are particularly important to nursing and medicine. An example from this study is Celestine and her seeking medical advice from her friends at 47th street rather than utilizing health care systems. Without looking at Celestine's experience of being-in-the-world, different reasons would likely be given to explain her behavior. This is because the reasons for Celestine's behavior would be based on whether she is perceived as rational or irrational. However, if intermediate information was considered, there would be greater consensus on the reasons given to explain her behavior.

Another example is Harry's tendency to be defensive when seeking health care. Harry's behavior could be interpreted as a dislike for people or anger.

However, the reality is that Harry has encountered so many experiences of discrimination that he is expecting yet additional experiences. Because he is unsure of the source or form in which it will come, he braces himself by becoming defensive.

These are examples of the extent to which interpretive inquiries gain insight into phenomena. It is examining being-in-the-world from the four existentials of corporeality, spatiality, relationality, and temporality that phenomena can be interpreted and given meaning.

Van Manen (1990) stated that phenomenology, unlike some other sciences, attempts to look for conditions and commonalties which create distinction and differences in phenomena. Through interpretive research, conditions which have facilitated differences and made distinctions in utilizing health care systems can be identified. Strategies for changing or managing these conditions can be developed in nursing research, disseminated through nursing education, and operationalized in nursing practice. Additional types of research are needed in order to recognize the extent to which barriers such as distrust, fear, and racism exist in health care systems.

Nursing Education

The knowledge gained from nursing research can be disseminated throughout nursing education. As a result, the curriculum of nursing education can include techniques to utilize during the provision of care to clients. Techniques for initial patient interview can be managed so that relationships are not dwarfed and clients do not feel they are being viewed through critical eyes.

Nursing Practice

Patient assessment is a starting point at which nursing practice can make changes. Some changes in nursing practice include interviewing techniques. Clients can be asked open ended questions and the interviewer listen to the client's answers without attaching personal biases to the answers. Upon admission, patients can be asked, "What are some previous experiences you have had while utilizing health care systems that you would like to be different?" Answers to such questions can provide insight on specific patient needs and allow nurses to respond to these specific needs.

Health care providers can continue practicing good communication skills by listening, restating, and clarifying unclear messages during patient interactions. Approaching people with a focus on commonalities helps to minimize perceptions of differences which impede relationships.

Patient education is an area that can be affected by nurses making attempts to increase the knowledge level of illness and disease management. Some specific activities include having patients verbalize what they know about their illness and disease and how they manage them. The need to educate patients on managing medication, including side effects is an ongoing need. Another method to influence patient education is to provide patients with appropriate and easy-to-read literature.

More specifically, nursing can benefit two ways from hermeneutic phenomenology. First, as contextual knowledge is gained on the intermediate component of a phenomenon, nurses can adjust practice approaches based on

scientific knowledge. Second, when nurses experience a phenomenon and recognize that knowledge of the intermediate component is unknown, this can be reported to nurse researchers, who can then conduct research to gain contextual knowledge on the intermediate component of the phenomenon. The process then becomes cyclical, continuously improving the effectiveness of nursing practice. Since it is impossible to know the intermediate component of all phenomena, and since there is a strong tendency for persons to retain their cultural values and practices rather than acculturate, another approach must be considered. This approach is demonstrating respect for humanity. Such an approach will contribute to optimizing the experience of gaining access to and the utilization of health care for all persons.

References

- Adler, N. E., Boyce, W. T., Chesney, M. A., Folkman, S., & Syme, S. L. (1993). Socioeconomic inequalities in health. No easy solution. Journal of American Medical Association, 269 (24), 3140-3145.
- Alston, R. J., & Bell, T. J. (1996). Cultural mistrust and the rehabilitation enigma for African Americans. Journal of Rehabilitation, 62 (2), 16-20 (35 ref.).
- American Heritage Dictionary. (1994). New York: Dell Publishing.
- Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? Journal of Health and Social Behavior, 36, 1-10.
- Anderson, R. N., Kochanek, K. D., & Murphy, S. L. (1997). Report of final mortality statistics, 1995. Monthly Vital Statistics Report, 45 (11): (supp. 2), Hyattsville, MD: National Center for Health Statistics.
- Baker, C., Wuest, J., & Stern, P. N. (1992). Method slurring: The grounded theory phenomenology example. Journal of Advanced Nursing, 17, 1355-1360.
- Benner, P. (1994). The tradition and skill of interpretive phenomenology in studying health, illness, and caring practices. In P. Benner (Ed.), Interpretive phenomenology (pp. 99-127). Thousand Oaks: Sage Publications.
- Benson, V., & Marano, M. A. (1994). Current estimates from the National Health Interview Survey, 1993. National Center for Health Statistics. Vital Health Statistics, 10 (190), 106-116.
- Berger, J. T. (1998). Culture and ethnicity in clinical care. Archives of Internal Medicine, 158, 2085-2089.

Berk, M. L., & Schur, C. L. (1998). Measuring access to care: Improving information for policy makers. Health Affairs, 17 (1), 180-186.

Blendon, R. J., Aiken, L. H., Freeman, H. E., & Corey, C. R. (1989). Access to medical care for Black and White Americans. Journal of the American Medical Association, 261 (2), 278-281.

Bloom, B., Simpson, G., Cohen, R. A., & Parsons, P. E. (1997). Access to health care. Part 2: Working-age adults. Vital Health Statistics, 197, 1-46.

Cary, A. H., Goldberg, B. W., Jobe, A. C., McCann, T., Skupien, M. B., Troxel, T. M., & Williams, D. R. (1995). If we fund it, will they come? Researching non-financial barriers to primary health care. Family Community Health, 18 (1), 69-74.

Cohen, M. (1987). A historical view of the phenomenologic movement. Image, 19 (1), 31-34.

Daley, W. M., Price, L., & Fransworth, M., (1997). U S Bureau of the Census, Statistical Abstract of the United States, 1997. The National Data Book. (117th Edition) Austin TX: Hoover's Business Press.

Erikson, E. (1963). Childhood and Society. New York: Norton.

Fang, J., Madhavan, S., & Alderman, M. H. (1996). The association between birthplace and mortality from cardiovascular causes among Black and White residents of New York City. The New England Journal of Medicine, 335 (21), 1545-1551.

Fingerhut, L. A., & Warner, M. (1997). Injury chart book. Health, United States, 1996-1997. Hyattsville, MD: National Center for Health Statistics. 1997.

Franklin, A. J. (1992). Therapy with African American men. Families in Society, 73 (6), 350-55.

Frey, J. H., & Fontana, A. (1993). The group interview in social research. In D. L. Morgan (Ed.), Successful focus groups. (pp. 20-34). Newbury Park, CA: Sage.

Gordon, A. K. (1995). Deterrents to access and service for Blacks and Hispanics: The Medicare hospice benefit, healthcare utilization, and cultural barriers. Hospice Journal, 10 (2), 65-83.

Gornick, M. E., Eggers, P. W., Reilly, T. W., Mentnech, M. S., Fitterman, L. K., Kucken, L. E., & Vladeck, B. C. (1996). Effects of race and income on mortality and use of systems among Medicare beneficiaries. The New England Journal of Medicine, 335 (11), 791-799.

Grant-Thompson, S. K., & Atkinson, D. R. (1997). Cross-cultural mentor effectiveness and African American male students. Journal of Black Psychology, 23 (2), 120-133.

Green, B. L., Maisiak, R., Wang, M. Q., Britt, M. F., & Ebeling, N. (1997). Participation in health education, health promotion, and health research by African Americans: Effects of the Tuskegee Syphilis Experiment. Journal of Health Education, 28 (4), 196-204.

Grier, W., & Cobbs, P. (1968). Black Rage. New York: Bantam.

U.S Department of Health and Human Services. Healthy People 2010 (Conference Edition, in Two Volumes). Washington, DC: January 2000 .

Hennessy, C. H., Moriarty, D. G., Zack, M. M., Scherr, P. A., & Brackbill, R. (1994). Measuring health-related quality of life for public health surveillance. Public Health Reports, 109 (5), 665-671.

Herek, G. M., & Capitanio, J. P. (1994). Conspiracies, contagion, and compassion: Trust and public reactions to AIDS. AIDS Education and Prevention, 6 (4), 365-375.

Herek, G. M., Gillis, J. R., Glunt, E. K., Lewis, J., Welton, D., & Capitanio, J. P. (1998). Culturally sensitive AIDS educational videos for African American audiences: Effects of source, message, receiver, and context. American Journal of Community Psychology, 26 (5), 705-741.

Hoyert, D., Kochanek, K., & Murphy, S. (1999). National Statistics Report, 47 (19), June 30, 1999.

Jennings, K. M. (1997). Getting a pap smear: Focus group responses of African American and Latino Women. Oncology Nursing Forum, 24 (5), 827-834.

Kawachi, I., Kennedy, B. P., Lochner, K., & Prothrow-Stith, D. (1997). Social capital, income inequality, and mortality. American Journal of Public Health, 87 (9), 1491-1498.

Kim, J., Bramlett, M. H., Wright, L. K., & Poon, L. W. (1998). Racial differences in health status and health behaviors of older adults. Nursing Research, 47 (4), 243-49.

Klonoff, E. A., & Landrine, H. (1997). Distrust of Whites, acculturation, and AIDS knowledge among African Americans. Journal of Black Psychology, 23 (1), 50-57.

Leonard, V. W. (1994). A Heideggerian phenomenological perspective on the concept of person. In P. Benner (Ed.), Interpretive phenomenology (pp. 43-62). Thousand Oaks: Sage Publication.

Liao, Y., & Cooper, R. S. (1995). Continued adverse trends in coronary heart disease mortality among Blacks. Public Health Reports September, 110, 572-579.

Lieu, T. A., Newacheck, P. W., & McManus, M. A. (1993). Race, ethnicity, and access to ambulatory care among US adolescents. American Journal of Public Health, 83 (7), 960-965.

Livingston, I. L. (1994). Hand Book of Black American Health: The Mosaic of Conditions, Issues, Policies and Prospects. West Port CT: Greenwood Press.

Millman, M. (1993). Access to Health Care in America. Washington, D. C.: National Academy Press.

Newacheck, P. W., Hughes, D. C., & Stoddard, J. J. (1995). Children's access to primary care: Differences by race, income, and insurance status. Pediatrics (ISSN 0031 4005) p. 26-32.

Nickerson, K. J., Helms, J. E., & Terrell, F. (1994). Cultural mistrust, opinions about mental illness, and Black students' attitude toward seeking

psychological help from White counselors. Journal of Counseling Psychology, 41, 378-385.

Omery, A. (1983). Phenomenology; a method for nursing research. Advanced Nursing Science, 5 (2), 49-63.

Pamuk, E., Makuc, D., Heck, K., Reuben, C., & Lochner, K. (1998). Socioeconomic status and health chartbook. Health, United States, 1998. Hyattsville, MD: National Center for Health Statistics.

Perry, M., Tasheff, J., Magnet, P., Miller, C., Potsic, S., & Pezzino, G. (1996). Factors associated with self-perceived excellent and very good health among Blacks. Morbidity and Mortality Weekly Report, 45 (42), 906-11.

Pichert, J. W., & Brisco, V. J. (1997). A questionnaire for assessing barriers to healthcare utilization. The Diabetic Educator, 23 (2), 181-191.

Plager, K. A. (1994). Hermeneutic phenomenology. In P. Benner (Ed.), Interpretive phenomenology. Thousand Oaks: Sage Publication.

Powell, I. J. (1997). Prostate cancer and African American men. Oncology, 11 (5), 599-605.

Quinn, S. C. (1997). Belief in AIDS as a form of Genocide: Implications for HIV Prevention Programs For African Americans. Journal of Health Education, 28 (5), 6-10.

Ries, P., & Brown, S. (1991). Disability and health: Characteristics of persons by limitation of activity and assessed health status, United States, 1984-88. In National Center for Health Statistics. Advance data from vital and health

statistics: Numbers 191-200. National Center for Health Statistics. Vital and Health Statistics, 16 (20). 1995

Schappert, S. M. National Ambulatory Medical Care Survey: 1994 Summary. Advance data from vital and health statistics; No 273. Hyattsville, MD: National Center for Health Statistics. 1996

Seccombe, K., & Amey, C. (1995). Playing by the rules and losing: Health insurance and the working poor. Journal of Health and Social Behavior, 36 June, 168-181.

Shapiro, R. J., Holmes, J. F., Huther, B. R., Potak, N. A., & McKay, M. S. (1998). United States Bureau of the Census, Statistical Abstract of the United States: (118th edition) Washington, DC.

Shea, D. G., Miles, T., & Hayward, M. (1996). The health-wealth connection: Racial differences. The Gerontologist, 36 (3), 342-49.

Singh, G. K., & Yu, S. M. (1996). US childhood mortality, 1950 through 1993: Trends and socioeconomic differentials. American Journal of Public Health, 86 (4), 505-511.

Terrell, F., & Terrell, S. (1981). An inventory to measure cultural mistrust among Blacks. The Western Journal of Black Studies, 5, 180-185.

Thompson, J. L., (1990). Hermeneutic inquiry. In L. E. Moody (Ed.), Advancing nursing science through research (pp. 223-281). Newbury Park: Sage.

Van Manen, M. (1990). Researching Lived Experiences. State University of New York Press.

Wulbern, J. H. (1963). Standard College Dictionary. New York:
Harcourt, Brace, & World, Inc.

Appendix A: Human Subjects Approval Forms

University of San Diego

Committee on the Protection of Human Subjects

Name4/24/00

Date

Dear Researcher/Faculty Advisor:

Enclosed is a copy of your proposal approved by the Committee for Protection of Human Subjects. This research project is approved for a period of one year. At the conclusion of the research, the researcher must complete a brief summary report. (Please see CPHS policy in the Policy and Procedures Manual.) A copy of the summary report form is enclosed.

If you continue your research beyond the one-year approval period, you must submit this report along with Forms A and, for expedited reviews, Form B. Please note that you must submit this request one to two months before the anniversary date of the original approval so that we can renew our approval before it expires.

We will send you a letter during the tenth month of your research project approval period requesting your summary report or continuation approval request.

Also enclosed is a Change of Address form you may use to keep us informed of changes in the address of either the researcher or the faculty advisor.

We appreciate your cooperation in these matters. Thank you.

Sincerely,

Jane Georges, Chair
Committee for Protection of Human Subjects

Appendix B: Consent Form

Consent Form

This study is being conducted by Johnnie Mae Tarver, a student in the Doctor of Philosophy in Nursing Program at the Hahn School of Nursing and Health Science, University of San Diego. The purpose of this study is to increase knowledge of noneconomic barriers to health care access and utilization by African Americans.

I understand that participants of this study will be interviewed at least once, and maybe twice, for an average of one hour each interview at a location agreeable to me. The interview will focus on my experiences obtaining health care services and the meaning of these experiences.

I understand the interview will be audio taped and notes will be taken. Tapes will be transcribed and all data will be analyzed to identify common themes. At some time, the findings of this study may be published. Even though these findings may be published, my confidentiality will be maintained. I will never be identified as a participant in this study and my name will not be used. I may be quoted, but the quote will not be associated with my identification. Only the investigator will have access to the original tapes and notes, which will be stored in a locked file in her office. All tapes and notes will be destroyed within five years of completion of the study.

I understand that risks associated with my participation in this study may include minor fatigue after the interview(s). My participation in this study is totally voluntary. I may withdraw from the study without consequences. Should I need to contact the researcher, I may do so by calling (619)265-2592.

The above information is clear and fully understood by myself. I voluntarily give my consent to participate in the study.

Participant _____	Date _____
Investigator _____	Date _____

Appendix C: Demographic Form

Demographic

ID # _____ (please do not sign your name to this form)

Age 18 - 44 _____ 45 -65 _____ 66 and over _____

Race African American _____ Asian _____ Caucasian _____

Hispanic _____ Native American _____ Other _____

Sex Female _____ Male _____

Annual Income \$35,000 - 45,999 _____ \$46,000 - 55,000 _____

\$56,000 - 75,999 _____ \$76,000 and above _____

Education Below 12th grade _____ Completed 12th grade _____

1 -2 years College/Vocation _____ Post Graduate _____

Masters Degree _____ Doctoral Degree _____