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It's a Matter of Trust: Older African Americans Speak About Their Health Care Encounters

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Abstract

Purpose—To examine perceptions of older African Americans' encounters with health care providers and ways to enhance trust.

Method—Transcribed semi-structured interviews with African American senior center members were analyzed, using Pattern Coding method.

Results—Four themes emerged: "Added Insult of Ageism," "Alternative Remedies," "Good Providers in a 'Broken' System," and "The Foundation of Trust Is Person Recognition." Provider behaviors leading to mistrust included erroneously assuming stereotypical preferences and competence, spending inadequate time listening to patients, disregarding patient preferences, and insufficiently explaining treatments.

Discussion—Of importance to improving trust among older African American patients is valuing individual histories and preferences by reallocating scarce time to person-centered listening, individualizing treatments, more completely explaining interventions, and assuring that patients understand and agree with treatment plans.

Keywords

health care provider; trust; health disparity; older adult

Introduction

Trust is a fundamental aspect of the patient–provider relationship, affecting every aspect of clinical exchanges and interventions from personal disclosure to adherence to treatment (LaVeist, Nickerson, & Bowie, 2000). Although trust is important for providers to be able to provide appropriate care to patients, there are a myriad challenges to establishing and maintaining trust in health care (Shore, 2007). Mistrust between provider and patient may occur for a number of reasons, including ageism, racism, or prior experiences with poor patient–provider communication (Kennedy, Mathis, & Woods, 2007; Lynn-sMcHale & Deatrick, 2000).

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The impact of ageism on the health care experiences of the general population of older adults has been well established in previous research. In an exploratory study, Greene, Adelman, Charon, and Hoffman (1986) observed that physicians often allowed younger patients to lead the encounter compared with older patients. In addition, physicians were more likely to “give permission” to younger patients to address psychosocial concerns but primarily focused on medical concerns with older patients. More recent research similarly has shown the effect of ageism on health care encounters and suggests that physicians continue to have negative perceptions of older adults, especially those in nursing homes and, to a slightly lesser extent, adults above the age of 85 years (Gunderson, Tomkowiak, Menachemi, & Brooks, 2005; Leung, LoGiudice, Schwarz, & Brand, 2009). This does not appear to be changing quickly, if at all, as physicians-in-training have also been found to hold these ageist perspectives before they even embark on a career in medicine (Higashi, Tillack, Steinman, Harper, & Johnston, 2012). These findings raise concern about the quality of the health care experience for older adults in general.

Mistrust of the health care system is also an issue of great concern for racial and ethnic minorities in the United States (Stone, 2012). This mistrust has formed an especially strong theme in the African American discourse. A strong historical context underlies this mistrust, stemming from a long history of abuses, including the infamous Tuskegee Syphilis experiments (Brandon, Isaac, & LaVeist, 2005; Kennedy et al., 2007; Suite, La Bril, Primm, & Harrison-Ross, 2007). Prior experiences with discrimination may help to explain some of the mistrust in the health care system (Armstrong et al., 2013); however, current research continues to show that African American patients report that they are less valued by health care providers, that providers consider their illnesses as less deserving of treatment, and that a lower standard of health care is routinely provided to them (LaVeist et al., 2000). This mistrust has profound implications for the acceptance of health care by older African Americans and is grounded in the reality of health care practices.

The system in which health care is provided in the United States may further worsen mistrust between health care providers and older African Americans. Research has demonstrated that older African Americans are less likely than their White counterparts to receive evidence-based guided treatments, that they are undertreated for various conditions including basic nursing care and depression, and that less time is spent in health care encounters with this group (Black, Gitlin, & Burke, 2011; Shellman, Granara, & Rosengarten, 2011; Smedley, Stith, & Nelson, 2009; Smith, Worts, & Smith, 2013). Health care providers frequently face substantial challenges balancing multiple professional responsibilities and systemic factors, such as the shortage of primary care providers and reimbursement fee structures, with the time spent in individual patient encounters. Many patients encounter time constraints in provider encounters; however, this may be most especially true for older African American patients.

Fortunately, patient–provider trust, despite the pressures providers face, can be restored and increased with greater empathetic provider communication and increased person-centered care (Fiscella et al., 2004). Person-centered care allows and accounts for individual preferences, approaches, and contexts in health care (Ekman et al., 2011) and requires that providers and patients reach health care decisions together (Barry & Edgman-Levitan, 2012). Numerous studies have found that better patient outcomes are associated with person-centered care, as well as greater provider empathy and patient–provider trust (Del Canale et al., 2012; Derksen, Bensing, & Lagro-Janssen, 2013; Farin, Gramm, & Schmidt, 2013; Hojat et al., 2011). A number of interventions have been developed that have been shown to increase person-centered care in providers; however, more research is needed to understand exactly how patient outcomes change as a proximal result of these interventions (Dwamena et al., 2012). Nonetheless, it is clear that it is important for health care providers to be aware of the impact that the patient–provider relationship has on health outcomes, especially for the most vulnerable and marginalized patients.

Purpose and Research Questions

This study is a secondary analysis of semi-structured, face-to-face interviews collected as part of a larger descriptive, exploratory study of older African Americans' strategies for adapting to the challenges of aging. The interview focused on health, well-being, neighborhood safety, understanding of depression, adaptation to aging, and interactions with health care professionals. This study focuses on the latter section of the interview and involved four specific questions:

> **Research Question 1:** How would you describe your relationship with your doctor/s?
>
> **Research Question 2:** Can you describe a recent experience with a health professional, either your primary care physician, a specialist, or other health professional? What was it like? What would you have liked to occur differently? What was good about it?
>
> **Research Question 3:** How do you think the health care you receive is affected by your race, ethnicity, age, gender, or any other way?
>
> **Research Question 4:** What do you think health professionals need to know to effectively work with/help African American older adults like yourself?

Method

Design and Data Collection

A total of 60 participants were recruited from an urban senior center in a Northeastern city primarily serving African American elders and 53 of those are included in this study. Study participants were 55 years of age or older, members of the participating senior center, and willing to participate in a 2-hr interview. Data were collected from October 2006 through March 2007 in interviews conducted at times and places convenient to participants, such as their homes or the senior center.

Interviewer Characteristics

All 60 participants were interviewed by one of four trained interviewers. Interviewer training included simulated interviews among peers (other study personnel), practicing interviews with the principal investigator (PI) and then receiving feedback, and observing others conducting the interviews. Interviewers kept field notes for interviews and interviewer consistency in conducting interviews was checked by the PI or project manager on an ongoing basis. Only 53 interviews were available at the time for these analyses, although all interviews had been transcribed verbatim. Although the remaining 7 were subsequently made available, given the high level of saturation achieved in the themes identified for the 53 interviews, it was determined that further analyses of the additional 7 interviews was not necessary.

Ethical Considerations

Human participants procedures for the “In-Touch” project were reviewed and approved by Thomas Jefferson University’s Institutional Review Board where the data were originally collected, as previously reported elsewhere (Black et al., 2011). All informed consent procedures were conducted as approved; participant confidentiality was protected; and data, both tapes and transcriptions, were stored in secure cabinets accessible only by project team members. Only de-identified (stripped of identifiable personal information and variables) data were obtained for this secondary analysis by permission of the PI (L.N.G.).

Data Analysis

The transcripts were analyzed using thematic analysis. All 53 available transcripts were read, with close attention to the participants’ responses to the four questions described above. The text was independently coded by the first and second authors using MAXQDA 10 qualitative software (VERBI Software-Consult-Sozialforschung GmbH, 1989–2012). During the first phase of analysis using the process described by Saldaña (2009), both authors created codes using a priori categories from the questions asked across interviewers. Next, a process of thematic coding was performed and the respective coding schemes were jointly reviewed and reconciled during a joint discussion. Trustworthiness of the analysis was addressed through regular meetings to share coding notes and to reconcile discrepancies. Discussions continued until consensus was reached. To assess inter-rater reliability of the coding schema, intra-class correlation coefficients (ICC) were computed using a two-way ANOVA; ICCs ranged from .83 to .95, indicating very high inter-rater reliability. Themes began emerging during further iterative coding, which was done collaboratively using the Pattern Coding method (Miles & Huberman, 1994).

Results

Participant Characteristics

Twenty-five men and 28 women ($N = 53$), aged 55 years and above who fit 1 of 3 self-described functional categories (having no to few functional difficulties, some difficulties with 2–3 self-care activities, major difficulties with >4 activities) were enrolled (Table 1). The functional difficulty criteria assured variation in health status, chronicity, and exposure to health providers. The mean participant age was 73 years (range 60–88) with the majority reporting at least a high school education (89%), which was considerably higher than the national average (U.S. Administration on Aging, 2010).

Themes

The overarching concept of "Person-centered care" emerged as key to the promotion of trust in the patient–provider relationship. For these participants, "person-centered care" refers to health care providers' recognition of and appreciation for the participants' unique contribution to their own health care. Four major themes emerged within the concept of "person-centered care" and included "The Added Insult of Ageism," referring to how ageism emerged in health care encounters; "Alternative Remedies to Health Care," referring to importance to participants of alternative, nonpharmacologic approaches; "Good Providers in a 'Broken' System," referring to participants' recognition of systemic challenges constricting provider interactions; and "The Foundation of Trust Is Person Recognition," referring to participants' wish that providers recognize their life histories and perspectives to form a trusting relationship.

The added insult of ageism—The most common theme that emerged was the concept of being made to feel "less than" because of one's age. One participant drew a sharp contrast between racial and age discrimination by stating,

> Older people tend to be poor and don't hear as well and they may become a little impatient at times with the person. But, basically, I don't feel that it is because of the color because I've seen them treat their own color the same way. I have never encountered any discrimination in any way, except my age. (Ms. S, 88)

This statement illustrates that ageism cuts across other sociocultural and racial divisions, to become the preeminent defining barrier to health care communication as perceived by this group.

Participants also identified a sense of being prejudged because of age, especially about health beliefs and the ability to self-manage, as exemplified by one participant, stating, "I think they need to recognize that … age doesn't necessarily mean that you're not thinking clearly and that you are not aware of the importance of your health" (Mr. M, 79). The perception of a lack of respect for the older adult's ethical right to autonomy, or "self-determination," is profound in this statement.

Alternative remedies to health care—Alternative remedies were a central and consistent part of how these study participants self-managed their health. The participants reported using alternative approaches such as herbal remedies (e.g., Saw Palmetto for prostate health, Hawthorne berries for hypertension) and viewed these as viable forms of treatment. Participants also reported a strong reliance on alternative, nonmedical health providers and music as their first choice of treatments to promote their health and well-being.

Alternative providers: Participants commonly reported greater comfort with the use of alternative health care providers, particularly Chinese medicine providers and herbalists when compared with traditional approaches to health care. One participant described the personal impact of using such a provider:

> … Doc Green cured what medical science couldn't. But you see, there are very few people training in the use of herbs and things to the degree that Doc Green was today … He does Chinese medicine and he has this wellness center at his office there, has acupuncturists and a chiropractor and he does Chinese medicine as well as western medicine. He does Chi Gong and I'm like oh, god, I'm at the right place. I was so happy until I cried … I was so happy until I cried. (Mr. J, 69)

Music: One sub-theme that emerged from the data was the importance of music in participants' lives for their sense of well-being. One participant stated, "Life is a symphony, which is you know, music and all. It is a symphony. And you, you can live it. You've got choices" (Ms. J, 71). Music was described as an important component of self-care that promoted quality of life and a connection to historical, cultural African American traditions. Another participant expanded on her understanding of how music was an integral part of every part of her life, including in health care settings:

> Keeping the music alive and increasing the awareness of the general public that it is a part of our cultural heritage, I find myself singing all the time. Because that's me, that is what God has given me to do it, and that is what I do. His Music, I sing it at the supermarket, I sing in the doctor's office, I sing in the hallways, people will say Miss X I give them a song. I sing over at Senator Park all the time, yeah. Music is me. (Ms. J, 71)

Good providers in a "broken" system—Participants frequently noted that the medical providers were caught up in a system that forced them to demonstrate behaviors the participants did not like. For example, patients reported that providers had little time for patients, rushing them through appointments while not providing patients with adequate time for the expression of health care needs. One participant expressed, "These people don't have a lot of time to sit and [coddle] a person along" (Mr. S, 88).

The theme of time and its perceived scarcity in the patient/health care provider relationship arose frequently. One participant described his perception of manipulative behaviors that led to adverse experiences with a health care professional:

> I quit my other doctor because … he would come in his office, to the waiting room, where we were, and … when he walked in the door he would look at his wristwatch. And then if you stayed past five minutes or ten minutes, whatever his time was with you, his nurse would call him on the phone and say, "You have an important phone call." (Ms. G, 68)

Another participant expressed a similar perspective and emphasized constraints imposed by the health care system:

> … it's this production line doc. It's … a big clinical office. It's the 50 patients you've got to see so I guess you've got to spend so much time with this guy, so much time with this guy, so much time with that guy … I don't really care for that but I think that's how it is these days, isn't it man? Yeah. They've got so much time to spend with you. I don't particularly care for that but that's the way it is though. (Mr. W, 68)

This participant's perception was that the system itself put providers in a difficult position and that the health care experience he had was a result of providers trying to do the best they can within a high-pressure, time-scarce environment.

These experiences, however, may be situational. For example, in contrast, other participants described having the opposite experience. They recognized the time constraints but felt their health provider managed it positively. One participant described such a health care encounter:

> My primary doctor [is] good, reason I say that, he comes in … the room and he sits and listens to what you [say], asks you questions and takes the time with you. He's not looking at his watch to get to the next person. (Mr. C, 88)

The sense of being important enough that all other obligations or demands are set aside for that time that the health care professional was with this participant seemed to be paramount. The point of reference for this participant, however, implicitly appears to be other situations in which she found providers checking their watch, which was a behavior that most participants remarked on and found disturbing. To this participant, not looking at the clock, having eye contact, and giving space for her to talk were highly valued and the primary defining features of a "good" health care provider and encounter. Another participant delineated this distinction even more succinctly and forcefully, stating, "And he's very good in that he takes time to talk to you, he's not in and rush right out" (Mr. L, 80).

The older adults in this study appeared to define positive health care provider encounters based on the active verbal and nonverbal demonstration of respect, active listening, and the amount of time spent. What made health care providers most desirable and trustworthy was not ability, training, or knowledge, but rather the way in which they conducted themselves in even brief encounters.

The foundation of trust is person recognition—Participants provided a wide range of advice as to how health care providers could improve the encounter. One participant's advice demonstrated an awareness of the potential for prejudice and discrimination but provided a path forward to achieving positive interactions between patients and health care professionals:

> … if you have those two things in place, understand where I'm coming from culturally … and what's happening to me, where I am … in my aging process. I think if you got those two pieces together that then you'd have … the foundation for a beginning relationship. (Ms. Y, 71)

The provider's empathy and genuine interest in the patient were important enough to be considered "the foundation for a beginning relationship." This would seem to indicate that before any relationship can even begin to form, the health care professional must already bring an openness and willingness to learn from the patient. For clinicians, this advice can be interpreted to mean that no other health promotion activity can even be instigated until the patient is satisfied that the clinician understands and respects where the patient is coming from in his or her experience.

The participants were clear that providers should seek to know the person and his or her family as individuals and communicate with them based on that knowledge. During this part of the interview, the concept of personhood and respect for personhood was explicit. As one participant stated directly, “Treat each person as an individual person, with an individual personality and individual health problems” (Mr. C, 88).

Another participant provides an elaboration on this theme:

> No matter what we’re not that damn friendly. Okay? That’s the first thing. But I don’t think they should be calling me honey child. You know. This is kind of condescending. I don’t want that either. There must be a happy medium. Like, “Do you understand what I said? Do you really understand what I’m talking about?” Because sometimes I don’t understand what he is talking about, but he can make it so I can understand it, you know. (Ms. G, 68)

The participant’s struggle to find “a happy medium” seems to be reflected throughout the interviews. This older adult’s objection to condescension is again a reference to the desire to feel respected and valued as a person. The statement, “… we’re not that damn friendly,” seems to refer not to the participant’s general disposition, life outlook, or mood but rather to a desire for others to see her as a person, with all the nuances that accompany the ebb and flow of individuality on a given day.

While participants desired that providers recognize and acknowledge the importance of individuality, they also asserted that it is important for providers to recognize the impact that a shared culture can have on the choices patients make regarding health care. One participant described how such awareness could affect an older African American patient’s health care experience:

> I think the background of the race of people, different races of people, study their background, their culture, their diet, what they’re pretty used to eating, like we’re used to eating certain things … I would think that doctors who are non-Black should learn about the Black cultures because I think it would be more in-tune to our problems … If he did. He would also sort of—if he knew about Black culture, he would also put in almost the same thinking mood, almost and I say that with—thinking mood as a black person would think. (Mr. L, 80)

Provider identification of unique individual characteristics of each patient, blended with an understanding of cultural influences, may help to inform how to build a strong patient–provider relationship.

Discussion

This exploratory, qualitative study revealed important nuances in the experiences of older African Americans in their interactions with health care providers. Participants in our study uniformly believed that effective communication could only occur when health providers seek to understand them as a person with unique experiences, cultural backgrounds, and preferences that may reside outside traditional medical practices and viewpoints.

The interviews also suggest that ageism, rather than racism, is the primary concern of this group consistent with other studies indicating that ageism continues to exist and permeate such encounters (Palmore, 2001; Palmore & Manton, 1973). Racism is an attitude and set of behaviors that these participants routinely confronted throughout their lifetime and for which they developed coping mechanisms. Also, participants were keenly aware that race concordance in health care is not realistic or necessary. In contrast, ageism is an attitude that is not encountered personally until aging occurs in the latter years of a life course. This may help to explain why encountering ageism in the health care system was so troublesome to these participants than the encounter of and concern with racism. Although individuals may not define themselves according to their age, there is awareness that as one becomes older, age becomes the characteristic by which one is most identified by society. What makes this characteristic different than all others on which discrimination is based is that every person who lives long enough will eventually find himself or herself having the same characteristic of advanced age.

Nonetheless, it should be noted that older adults who are members of a minority community may experience additional discrimination, beyond that of ageism. Studies examining primary care physician practices found that they were more dominant, less patient-centered, and less positive toward African American patients compared with White patients, and African American patients rated their visits as less participatory (Cooper-Patrick et al., 1999; Johnson, Roter, Powe, & Cooper, 2004). Health care providers may need additional training to understand the way in which cultural context informs how patients perceive or receive health care interventions. Supporting this approach, a recent report from the Institute of Medicine emphasized that cultural competencies needed to be taught to health care providers to improve the relationship between provider and patient to, in turn, reduce health disparities (Board on Population Health and Public Health Practice, Institute of Medicine, 2012). It is clear that although some progress has been made, many health care providers continue to have difficulty navigating the complexities of interacting with and treating patients from diverse cultural backgrounds and more research is needed in determining best teaching practices to improve health provider facileness and sensitivities to cultural differences among their patients (Truong, Paradies, & Priest, 2014).

The reliance on alternative health care providers was an important theme worthy of further exploration. African Americans are higher users of complementary and alternative treatments for health and mental health problems. This preference is deemed to reflect long-standing African American cultural traditions rooted in African culture and slavery, reinforced in part by the systematic exclusion of African Americans from mainstream health care institutions (Fahie, 1998), but there is scant literature on the use of alternative remedies in this population. Several clinic-based studies found that alternative therapies were used to treat anxiety and depression (Davidson et al., 1998; Elder, Gillcrist, & Minz, 1997) or to treat health problems that occur in conjunction with mental health problems (Druss & Rosenheck, 2000). One nationally representative survey indicated that African Americans held more favorable views toward use of alternative or folk remedies than did Whites (Snowden, Libby, & Thomas, 1997). Recent research suggests that for publicly insured, and especially minority individuals, complementary and alternative treatments may represent a response to disenfranchisement in conventional medical settings and resulting distrust (Shippee et al., 2013).

Given the stock of folk and alternative remedies in many African American communities, mutual trust is essential for older African American patients to believe that a provider has accurately perceived and properly negotiated with them the nature of their disorder and the treatment needed. In addition, the patient must have faith in the healing abilities of the provider. Several hypotheses have been posited to explain the use of alternative remedies in race/ethnic minority elders. The “economic hardship” hypothesis argues that use of alternative remedies such as herbs and home remedies is one way that race/ethnic minority elders stretch their limited financial resources (Grzywacz et al., 2006). The “health inequalities” hypothesis argues that minority older adults may seek additional approaches to treatment to manage the relatively greater burden of their chronic condition such as arthritis for which conventional medical care offers little relief (Brach & Fraserirector, 2000). These hypotheses underscore the need for research that contributes to a deeper understanding of the factors that influence alternative approaches to health care in African American elders.

Despite known differences in how men and women experience and express their health concerns, both men and women expressed similar perspectives concerning their health care encounters (Sellers, Cherepanov, Hanmer, Fryback, & Palta, 2013; Thorpe et al., 2011; Warner & Brown, 2011). We could find no substantial differences between men and women as it concerns the four themes explicated.

The most poignant stories that emerged from these interviews were about the participants’ understanding of the challenges imposed by a broken health care system. These participants appear to be open to a trusting relationship with their providers, and a basis for that relationship existed in some cases but not all. However, participants were acutely aware that the system in which health care was being delivered to them prevented a satisfactory health care–seeking experience. Yet, they sought that health providers actively work to overcome these structural constraints. The pressure on providers to limit the time spent with patients was particularly noteworthy to participants. Those providers who successfully managed that pressure by portraying a relaxed, open consultation environment provided the counterpoint to the rest of the system. One way for individual health care providers to potentially improve patient–provider interactions is to optimize the limited time that providers have with their patients by building trust, using verbal and nonverbal communication approaches (Stepanikova, Zhang, Wieland, Eleazer, & Stewart, 2012). As trust increases, both patients and providers may find that their time together is more productive with greater benefit derived.

Limitations

As a secondary analysis, the data for this study were limited to participant responses to the parent study’s original interview questions. While additional probes and queries emerged from the analysis of transcripts, the potential for follow-up with and clarification by participants was not possible. In addition, nonverbal communication with health care providers was not possible to evaluate although this form of communication is an important aspect of the diagnostic and therapeutic process and all patient–provider encounters

(Stepanikova et al., 2012). Future research is warranted to capture verbal and nonverbal behavioral components of encounters and how they shape patient perceptions and health outcomes.

Participants in this study were, on average, better educated than the national average among their peers. This may influence this study both in the manner with which participants were able to communicate and the perspectives they held on their interactions with health care providers. Although having a higher education is not directly related to a higher health literacy rate, they are highly correlated (Baker, Williams, Parker, Gazmararian, & Nurss, 1999). This may affect how comfortable these participants were in the health care environment when compared with their less-well-educated peers, and thus their perceptions of health care providers.

As is common in qualitative research, generalizability was not as much the purpose of this study as it was to understand these particular participants' experiences, to explore a phenomenon that is not well-understood for one particular group, low-income urban older African Americans (Glesne, 2010). Thus, application to other settings and persons should be undertaken with caution.

Implications for Health Care Providers

Effective communication between older African Americans and health care providers is critical for improved trust, satisfaction with care, and health outcomes. It is known that provider communication, increased empathy, and attention to patient preference are associated with improved health outcomes across a range of health conditions (Del Canale et al., 2012; Hojat et al., 2011; Thompson & McCabe, 2012). Although multiple pathways have been theorized between provider communication and improved health outcomes, more research must be done to understand the exact nature and components of these relationships (Street, 2013; Street, Elwyn, & Epstein, 2012; Street, Makoul, Arora, & Epstein, 2009). Nonetheless, literature in this area would suggest that the concepts of trust and communication between provider and patient are important to consider when seeking to improve patient outcomes.

Our study provides a basis for clinicians and researchers to reflect on how best to incorporate the concept of personhood into health care provider training and integrate this concept into practice. Carefully listening to the words of these participants suggests the importance of understanding each patient within the context of his or her personal and cultural history. Arising from that understanding, personal preferences regarding treatment decisions and lifestyle choices can begin to be more clearly identified and help inform a treatment plan and best ways of communicating that plan to patients. Regardless of whether the provider understands or supports such choices, however, respect for the patient in making health care and self-management choices must be communicated in the relationship.

These participants appeared open to establishing a trusting relationship with providers, even if the health care system does not allow for much time to establish one. This reflects in part the resilience of this group and their ability to be flexible as long as basic principles of respect and trust are upheld. Providers can consider using their limited time to first carefully listen to the patient because “rushing” can lead to missing vital information around alternative health choices. Also, adopting a behavioral stance that shows active listening, for example, making eye contact, not checking on time, or looking at a watch appears paramount. It is important to understand that lifestyle choices are grounded in and reflect a patients’ culture or worldview and may not easily be changed in advanced age (Gee, Walsemann, & Brondolo, 2012). Respecting the values and preferences of older African Americans has been demonstrated to be an important part of facilitating health promotion in this population (Waites, 2013). Health care decisions made in the absence of this knowledge may not adequately account for the effect that culture will have on patient adherence to any treatment regimen that is initiated by the provider.

Conclusion

The voices of these older African Americans indicate a desire to be an active participant in their health care. This group expects and desires that health care providers come to each encounter prepared to be open and to listen and to allow active participation by the patient. These are basic principles of the patient-centered movement, yet health providers appear to continue to have difficulty embracing this approach due in part to their lack of training and structural demands of their work and reimbursement environment. Thus, the health care system itself must also be restructured to enable providers to view patients as individuals and to respect their personhood.

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Biographies

Bryan R. Hansen, MSN, RN, is a PhD candidate at the Johns Hopkins University School of Nursing in Baltimore, Maryland, with specialties in gerontologic, psychiatric, and forensic nursing. The primary foci of his research interests include elder abuse detection and prevention and person-centered caregiver strategies to prevent, address, and reduce aggressive behaviors in persons with dementia.

Nancy A. Hodgson, PhD, RN, is an associate professor at the Johns Hopkins University School of Nursing in Baltimore, Maryland. She is committed to exploring how to incorporate evidence-based findings into geriatric nursing practice in meaningful ways. Her program of research emphasizes the examination of factors associated with health-related quality of life in chronically ill older adults and the enhancement of science-based nursing practice in older adults at the end of life.

Laura N. Gitlin, PhD, an applied research sociologist, is nationally and internationally recognized in the areas of nonpharmacologic approaches in dementia care, family caregiving, functional disability, mental health disparities, and aging in place. Her programs of behavioral intervention research apply a social ecological perspective to addressing unmet needs of older adults and their families in the community. She is also involved in translating and implementing evidence-based interventions for family caregivers, individuals with dementia, and older adults with functional difficulties and depressive symptoms.

Table 1

Participant Characteristics ($N = 53$).

Characteristic	***N***	**%**	***M***	***SD***	**Range**
Age			72.8	6.2	60–88
Gender					
Male	25	47.2			
Female	28	52.8			
Marital status					
Single, divorced, Widowed, or separated	30	56.6			
Married	23	43.4			
Education level					
<High school	6	11.3			
≥High school	47	88.7			
Health problems			2.8	1.2	0–5
Functional difficulties					
0 difficulties	21	39.6			
1–2 difficulties	17	32.0			
≥3 difficulties	15	28.3			