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RESEARCH ARTICLE

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Experiences of African American Adults on Healthcare Encounters: A Qualitative Study

Christopher S. Hairfield[1,*], Shannon Phillips[1] and Teresa J. Kelechi[1]

[1]*Medical University of South Carolina, College of Nursing, Room 324, 99 Jonathan Lucas St MSC 160 Charleston, SC 29425-1600, United States*

Abstract:

Aim: The goal of this research is to contribute to the current conversation about the experiences of African American individuals in the U.S. related to accessing and utilizing healthcare services.

Introduction: National healthcare quality goals in the U.S. aim to ensure equitable access and delivery of quality care to all, yet significant disparities persist, particularly among minority and underserved populations. African Americans face higher incidence rates and poorer disease outcomes, leading to a life expectancy of 5.5 years shorter than their White counterparts. Addressing these disparities requires multilevel interventions that consider the perceptions and experiences of African American healthcare recipients, as explored in this qualitative study conducted in a southeastern U.S. region.

Methods: This study utilized a qualitative descriptive design and semi-structured interviews. The recruitment utilized purposive sampling, and interviews were conducted with 7 participants between February and April of 2021. The data analysis was conducted using conventional content analysis methods. Study reporting follows the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines.

Results: Three major themes emerged from the data: Clear and Open Communication, Healthcare Mistrust, and Challenges with Access to Care. The findings highlight that clear communication, healthcare mistrust, and access to care challenges are critical factors impacting the perceived quality of healthcare encounters among African Americans in a southeastern U.S. region.

Conclusion: Recommendations for practice emphasize culturally competent care to address health disparities affecting African Americans. The findings highlight the importance of equitable care, more research on patient perceptions, and addressing medical mistrust through participatory research methods that include the African American community's input.

Keywords: African American adults, Healthcare encounters, Open communication, Healthcare mistrust, healthcare services, qualitative descriptive.

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*Address correspondence to this author at the Director of Interprofessional Initiatives and Instructor, Medical University of South Carolina, College of Nursing, Room 324, 99 Jonathan Lucas St MSC 160 Charleston, SC 29425-1600, United States; Tel: 843-323-7254; E-mail: hairfie@musc.edu

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1. INTRODUCTION

National healthcare quality goals in the United States (U.S.) require organizations and individual providers to address barriers to ensuring equity in access to and delivery of quality care to all healthcare recipients [1, 2]. However, glaring gaps in equitable, quality care persist, particularly among minority and underserved populations. As of 2020, approximately 12.4% of the U.S. population identified as Black/African American (AA), with a higher concentration in the southern U.S. at 18.6% [3, 4]. While healthcare advancements have improved overall life expectancy in the U.S., individuals in AA communities have higher incidence rates and disproportionately poorer disease outcomes [5], which contribute to an estimated life expectancy at birth that is 5. 5 years shorter than their White counterparts [6]. In a 2022 report released by the Pew Research Center (2022) on health outcomes for AA in the U.S., the majority of those surveyed (51%) believed outcomes for AA have stayed the same or gotten worse over recent years [7].

Factors associated with perceptions of the lack of improvement in outcomes are related to the quality of and access to care, including perceived discrimination, medical mistrust, and challenges in the provider–recipient relationship [8-10]. In a specific example of healthcare disparities, concerns of inequitable treatment and pain management practices are common themes among AA care recipients [10, 11]. Multilevel programs and interventions are needed to address factors related to disparities in care and improve health outcomes for AA in the U.S. Furthermore, to improve the likelihood of success, interventions and programs should consider and incorporate the perceptions and experiences of AA recipients of healthcare, particularly when healthcare encounters have been unfavorable. This study contributes to the literature in this area and augments the existing literature by focusing on a regional population residing in a southeastern state. Thus, the purpose of this study was to apply qualitative methods to explore the perceptions and experiences of healthcare encounters among AA individuals living in a 3-county region in a Southeastern state of the U.S.

2. METHODS

2.1. Design

This study was conducted using a qualitative descriptive design [12] and semi-structured interviews. Interviews were completed between January and March 2021. Study procedures were approved by the Institutional Review Board for Walden University (02-19-21-0744031) prior to data collection. Study reporting follows the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines [13].

2.2. Participants and Recruitment

The eligible participants were adults (> 18 years of age) who identified as African American, resided in one of three counties in a state in the Southeast US, and had any prior or current interaction with the healthcare system. All interactions with healthcare were considered, including personal encounters as well as those encounters as a visitor or family member. A purposive sampling strategy was applied to identify participants with a range of experiences with the healthcare system. Variation was sought in interactions with provider or healthcare staff types (*i.e.*, physicians, nurses, office personnel) and location of care (*i.e.*, primary care offices, outpatient clinics, acute care). Participants were recruited in community settings such as bus stops, hair salons, and public libraries through in-person distribution or public posting of flyers. Potential participants expressed interest through emailing or texting the investigator *via* the contact information on the flyer. The targeted sample size was up to 10 participants. Written consent was obtained from each participant prior to the commencement of the interview. All interested participants agreed to participate during the consent process.

2.3. Data Collection

Interview guide development was informed by a literature review with a focus on the experiences of African Americans with healthcare system encounters. The interview guide consisted of open-ended questions with probes to use as needed and was pilot-tested with three African American adults to assess clarity and flow. Data from pilot testing were not included in the findings. Investigator C. H., a male masters-prepared nurse and PhD student with training in qualitative methods and experience in healthcare delivery across settings and with various populations, conducted interviews. All interviews were completed by telephone, with the interviewer in a private setting and participants in a private location in their own homes. The interviewer had no prior relationship with the participants; participants were given information about the study and the interviewer’s background prior to data collection. Relevant participant demographics related to this study were limited to identifying as AA, being at least 18 years of age, and having had interactions with healthcare delivery. Participants were not asked to identify specific age, sex, gender, orientation, or socioeconomic status. Participants received a $25 Amazon gift card as compensation upon completion of the interview. Interviews were audio recorded using a handheld digital device and transcribed by C.H. The mean interview duration was 29 minutes, with a range of 20 to 45 minutes. Field notes were recorded during and following interviews, and an audit trail was maintained for reflexivity. Data saturation was reached at the seventh participant. No repeat interviews were conducted, transcripts were not returned to participants for review, and participant feedback on findings was not requested.

2.4. Data Analysis

Data analysis was conducted by C.H. using conventional content analysis as described by Hsieh and Shannon [14]. Data immersion was conducted by listening to interview recordings and reviewing transcripts multiple times, resulting in the emergence of insights from the data and gaining a sense of the whole. Inductive coding was conducted with constant comparison to identify codes that emerged from the data. Labels for codes were identified from the data, and codes were organized into meaningful clusters. Coding followed a hierarchical structure with codes and subcodes, and definitions for each code and subcode were developed. One or more exemplars were identified for each code. Walden PhD Program faculty actively participated in the analysis of the data. The manuscript writing team, SP and TK, reviewed the data analysis results for consensus.

2.5. Methodological Rigor

Methods for credibility, transferability, dependability, and confirmability were applied to confirm data correctness [15]. Credibility was maintained by including all data during coding and by recording field notes during interviews. In addition, eligibility criteria were structured to recruit participants with experiences appropriate to the study purpose. In addition to age criteria, participants were asked if they identified as African American. Transferability was maintained through thick, rich descriptions of data, keeping an accurate audit trail of study procedures and processes, and maintenance and review of field notes. Dependability was maintained through electronic storage of records and data for review. Confirmability was supported through reflexivity, including investigator bracketing of beliefs and ideas, and documented *via* field notes.

3. RESULTS

Three major themes emerged from the data: Clear and Open Communication, Healthcare Mistrust, and Challenges with Access to Care. Subthemes that emerged are described below in the context of the major theme.

3.1. Clear and Open Communication

This theme was defined as perceptions of the quality of verbal and nonverbal information exchange between the provider or individual delivering healthcare and the patient or recipient of healthcare. Findings in this theme illustrated the importance of high-quality communication and skills in communicating with patients to drive satisfaction with care and ensure a positive experience. Subthemes within this major theme included active and engaged communication and honest information delivery and receipt.

The subtheme of active and engaged communication was mentioned by participants as important to feeling comfortable with a provider and included overt methods of communication and non-verbal cues. Participants described feeling a greater sense of caring and respect when healthcare professionals exhibit strategies such as active listening and eye contact during encounters. Illustrating the importance of active listening and non-verbal cues, Participant 1 stated: “She talked to me... not like, like a physician. She sat down and crossed her legs like she was talking to one of her girlfriends.” Another participant described the importance of eye contact in ensuring high-quality communication and a sense of caring. Participant 5 reported: “The fact that if I am talking that the doctor is actually looking at me directly, of course doctor write notes. But doctors looking at me back and forth as I am talking, and actually responding as we’re having a conversation or as I’m explaining my situation.”

Honest information delivery and receipt was another subtheme and key component of high-quality communication. Participants described honest communication as a bidirectional concept and highlighted the importance of honest communication to and from healthcare professionals to improve health outcomes. Participant 4 described the importance of genuine information delivery from a provider in facilitating their comfort, stating: “It definitely put me at ease. It was very nice just to know that the person who I was interacting with and was going to stick something in me was not trying to rush through the experience was not trying to rush through this.” To illustrate the role of bidirectional honest communication, another participant described the importance of a patient disclosing information after previous negative expe- riences: “... the point is this physician has to have all of the information to make a true assessment. If they’re going to, if the physician is going to do his or her job, the physician must have all of the information” (Participant 5).

Healthcare Mistrust was a theme defined as a lack of confidence in the beneficence, equity, and quality of the care delivered by the healthcare system and/or individual healthcare professionals. Participants reported experiencing healthcare mistrust on the systems and provider levels. Factors pertaining to systems-level mistrust included experiencing stereotypes (commonly perceived as unfounded), and perceptions of being offered or given unnecessary and costly treatments. Participant 7 described a stereotype often assigned to AA women: “We tend to think that black women can take a lot of pain and it’s not that we can, we just do.” Participant 4 described their perceptions of the root of being given unnecessary treatments, stating: “A lot of people, especially AA people, both male and female, don’t trust the system because they feel like all it’s doing is trying to suck you dry.” Similarly, some participants noted a history of mistrust in the AA community that included perceptions of unnecessary treatment, but also of being unwittingly included in experiments. Participant 3 shared an experience with their mother: “Because my mom would tell you this first thing when it came down to her... she has diabetes. She wanted to stay on, um, just taking a diabetes pill. The same doctor I had issues with my dad, did not fill my mom’s prescription or her pills... But then sent her out to have the insulin... So, the needle insulin. So, my mom thinking this is an experiment. She’s thinking that the clinics are experimenting for the drugs that’s passing through. So, this is this is, this is her mind frame. So, I think what doctors need to be more aware of it .” In terms of provider-level mistrust, in some cases, participants described an outcome of general mistrust; Participant 3 stated: “I need to be focused more on, um, just getting that person comfortable with actually coming to the doctor, knowing that... it’s so much that, because African Americans are not comfortable [with] doctors... For some apparent reason.” Some participants related this mistrust to perceived dishonesty in communication. Participant 7 described a situation where her medical situation was clarified at a later visit with a different provider reviewing her medical record. This experience compounded already existing and recurrent medical mistrust. The participant stated that it was “Another situation where I, I feel like he was spoon feeding me information and not giving me everything that I needed to know.” Along the same lines, participants described situations in which effective communication led to increased trust with providers and the system: “We signed all the paperwork. We knew that there was a possibility that certain things could happen. Uhm, but he’s having the surgery and the doctor was very, very specific as to. Uhm, just making us feel good then he’s gonna be OK. He’s gonna come out of this. Uh... You know not to worry. Uh, but we, you know we did a lot of research on him as well to make sure that he was the right fit for this type of surgery” (Participant 1).

Challenges with access to care were defined as the ability to obtain healthcare services for preventive care and treatment as desired by the individual. Participants described physical lack of access to healthcare services and limited choice in obtaining healthcare negatively impacted autonomy in seeking care. Lack of physical access to care was associated with geographic location and was predominantly described by rural-dwelling participants. Participant 1 mentioned the issues commonly faced by those in rural areas: “ Okay, I think one of the issues for me, even though I don’t live in the rural areas of (redacted). But I really feel that there are a lot of people that live out in the rural areas who lack getting a really good evaluation from a doctor.” This participant elaborated by describing opportunities for improving access to care in rural communities, and the importance of taking action on opportunities. They stated, “I wish that someplace like maybe (name of organization redacted) or (name of organization redacted) to take a... have a bus to go out there to treat the people. Because I think that they’re missing out on a lot. In the Black community, we have a lot of health issues. We have high blood pressure, we have a tendency for stroke, sugar diabetes, and the list. The list goes on. So, I think a lot of people out in the rural areas don’t get the kind of healthcare that they should.” Challenges in access to quality care pertaining to lack of healthcare choices were often driven by factors such as insurance, income, and employment. For instance, Provider 1 described the impact of income on healthcare in the rural AA community: “To me, it seems like the... the income, like this is a low-income clinic that’s out in the community. They lack every... I’ve had, um, doctors has been there that have really stepped it up when it comes down to my parents’ health, um, but recently I haven’t had that, but I take it... I’m thinking like maybe it’s because they’re on Medicaid, maybe because they are at this clinic.” This participant distinguished the influence of employment and insurance on access to quality care, stating: “Now, as far as I’m concerned, because I am employed and I’m working and I have healthcare coverage. It’s easy for me to get to a doctor, or call a doctor when I when I’m in need. That’s the difference.” Positive prior experiences with a provider mitigated challenges to access. In particular, Participant 5 described the benefit of a long-standing, positive relationship with their provider, stating: “It makes a huge difference. I can go any time I can go as a walk in. I do not even have to make an appointment if an emergency arises.”

4. DISCUSSION

Findings from this study illustrate the essential roles of clear communication, healthcare mistrust, and challenges with access to care as factors that influence the perceived quality of healthcare encounters among AA living in a southeast region of the U.S. These results were aligned with those from studies conducted nationally and in other regions of the U.S. and do not suggest substantial regional differences that would necessitate unique interventions or programs to improve healthcare encounters. Healthcare mistrust, either resulting directly from personal experience or derived from others’ experiences, was a key influential factor in perceptions of healthcare encounters in this study. This finding contributes to the current literature on mistrust and highlights opportunities for healthcare, on a systemic and individual level, to implement strategies to build trust with the AA community. Healthcare mistrust and ineffective patient-provider communication have been shown to negatively impact patient outcomes and disproportionately impact the AA community [9, 16]. In response, some healthcare systems have implemented a goal of providing culturally congruent care to improve the care of diverse communities [17]. However, cultural competence is not a one-size-fits-all solution and is shown to oversimplify culture and proliferate stereotypes about the patients intended to benefit from the strategy [18-20]. Furthermore, culturally competent care through the lens of the patient or family may not align with the intent of the concept and may perpetuate healthcare mistrust [21].

The themes revealed through the stories and experiences shared by the participants suggest that positive social change can be achieved by thoughtfully designing new approaches to education and training programs aimed at developing cultural competence among student nurses, practicing nurses, and other providers. Thus, further research is needed to better understand the span of healthcare mistrust and identify specific strategies to address mistrust on a systemic level using both individual- and population-based approaches. Quality communication and challenges in access to care also influenced perceptions of healthcare encounters, and in some cases, interactions with each other and/or with healthcare mistrust influence perceptions. Some participants described communication as a barrier to satisfaction with healthcare encounters; others attributed positive communication to satisfactory experiences.

These findings support the view that effective communication enhances the quality of patient–provider interactions by addressing other potential barriers to effective communication that enhance positive encounters. Access was described to include a total lack of access to healthcare services influenced by economic, educational, and social factors, and also as a lack of choice. Participants who described unfavorable healthcare experiences continued to experience a lack of access to their preferred healthcare provider or facility influenced by social and economic factors, including geographic location, employment, and insurance policy status. Further research into the experience of individuals and their perceptions of the care provided by healthcare is needed to inform strategies to improve the health and healthcare utilization of the larger AA community . In particular, studies that apply participatory research methods are needed and should include members of the AA community and provide them with the opportunity to tell researchers what is important to them [22]. The outcomes of these recommended studies can inform the development of programs and strategies that collaborate with researchers and the community they aim to support.

5. LIMITATIONS

Findings from this study should be interpreted in the context of limitations. First, data collection occurred during the COVID-19 pandemic, which may have influenced participants' perspectives of healthcare encounters, particularly because minority and underserved populations had a greater likelihood of experiencing significant negative outcomes and limitations in access to care [23]. Second, participants were recruited from a small geographical region of the U.S., which limits the transferability of findings; however, the purpose of this study was to explore perspectives within a specific region of the southeastern U.S. where health care disparities remain high. The demographic characteristics of participants were intentionally not collected to allow greater comfort during interviews and facilitate more open dialogue and rich,detailed descriptions of healthcare encounters. However, the lack of sample characteristics may limit the interpretability of findings. Finally, the sampling and recruitment methods of this study required participants to be proactive in contacting the investigator, which may have resulted in a biased participant pool.

CONCLUSION

Recommendations for practice emphasize culturally competent care to address health disparities affecting the AA community, though some experts advocate for cultural humility to avoid oversimplifying culture and reinforcing stereotypes [18-20]. Positive social change may be supported through thoughtful education and training programs. The findings highlight the need for more research on patients' perceptions of healthcare initiatives and healthcare mistrust, as current strategies often focus on the provider's perspective, neglecting the recipient's experience [16, 24-26]. Addressing medical mistrust on both individual and systemic levels is crucial, with participatory research methods recommended to include the AA community's input. Key themes identified include the need for clear and open communication, addressing healthcare mistrust, and focusing on challenges in accessing healthcare. These factors could significantly impact the healthcare experience for AA patients and highlight areas for ameliorating healthcare disparities.

AUTHORS' CONTRIBUTION

C.S.H.: Study conception and design; S.P.: Writing - Original Draft Preparation; T.J.K.: Writing - Reviewing and Editing. All authors reviewed the results and approved the final version of the manuscript.

ABBREVIATION

COREQ = Consolidated Criteria for Reporting Qualitative Research

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

The study procedures were approved by the Institutional Review Board for Walden University, Minnesota, United States (02-19-21-0744031).

HUMAN AND ANIMAL RIGHTS

All human research procedures followed were in accordance with the ethical standards of the committee responsible for human experimentation (institutional and national), and with the Helsinki Declaration of 1975, as revised in 2013.

CONSENT FOR PUBLICATION

Written consent was obtained from each participant prior to the interview commencement.

STANDARDS OF REPORTING

COREQ guidelines were followed.

AVAILABILITY OF DATA AND MATERIAL

All the data and supporting information are provided within the article.

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None.

CONFLICT OF INTEREST

The author(s) declare no conflict of interest, financial or otherwise.

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Declared none.

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