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Does Medical Racism Influence Medical Mistrust in the Black Community?

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DOES MEDICAL RACISM INFLUENCE MEDICAL MISTRUST IN THE BLACK COMMUNITY?

by

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ABSTRACT

Mistrust in the medical field can be generated through experiences of racism and discrimination during interactions with members of the medical community. Black and African American individuals find themselves facing increased rates of morbidity including heart disease, and diabetes, and increased rates of mortality as compared to White individuals yet are treated less frequently and to a lesser extent. This thesis examines the mistrust black people have towards the medical field, as well as differences within the black community in terms of experiences with medical racism. In order to collect this information, I created a survey that enquires about race and ethnicity and the types of encounters that individuals have had with medical professionals. I analyzed the responses and found that a majority of those surveyed believe that medical racism does exist. Although the production of medical mistrust is evident, it is a difficult task to eliminate it. Therefore, this thesis recommends that more emphasis be placed on the sociological aspects of medicine.

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INTRODUCTION

Medical racism is defined as medical interactions between Black and African American patients and non-Black physicians that result in less positive and productive interactions than same-race interactions (Penner et.al, 2010). There are racial disparities throughout the healthcare system. Unequal medical treatments for black individuals results in a greater percentage of morbidity and mortality. For example, black people are more likely than non-Hispanic whites to die of heart disease, strokes, cancers, liver disease, diabetes, childbirth, and tuberculosis (Hoberman 2007).

Throughout the medical system, race is often viewed as a biological construct and the sociological aspects of race are often overlooked (Gamble 1997). Because race is based on skin color and other physical features such as facial features and hair textures, all black individuals in the United States can be viewed as being the same. The classification of all black individuals in one racial category is problematic as it fails to distinguish between African Americans, Afro-Caribbeans, Afro-Latinos, and Africans and their social and genetic diversity. It is necessary for physicians to distinguish between these groups as understanding any medical issues, especially rare or unusual conditions, which may depend on specific geographic locations and cultural differences. Outside of the biological aspect, African Americans are typically stereotyped negatively, while Back immigrants are typically observed in a more positive light as harder working and less disruptive (Molina and James 2016). It is necessary to understand the racial bias in order to help reduce it and to create a normal distribution of healthcare and medical treatment for all individuals regardless of skin color.

During the times of slavery, black individuals in the United States were used for experiments by physicians. Even after the emancipation of enslaved individuals, black people were still the targets of unethical medical trials. In 1932, the Tuskegee Syphilis Study was conducted where 600 black men with Syphilis did not receive treatment once it became available resulting in the unnecessary pain and death (Gamble, 1997). The disregard for their health in this experiment among other examples has led to increased mistrust of medical institutions throughout black communities. This study examines the lingering effect of such atrocities by addressing the research question, does medical racism lead to medical mistrust among black individuals?

While most research views all black people as members of one homogeneous group, the data collected in this study can be utilized to understand medical racism experienced among diverse black and African American individuals and to analyze the levels of mistrust displayed towards physicians based on these experiences. It helps to identify differences in medical experiences between African Americans, Afro-Caribbeans, Afro-Latinos, and Africans in the United States. Note: Throughout this study, the term "black" will be used to refer to the racial category of all African Americans, Afro-Caribbeans, Afro-Latinos, and Africans, while the term African American refers to Black Americans with total or partial ancestry tracing to black racial groups of Africa.

LITERATURE REVIEW

RACIAL MEDICAL DIFFERENCES ATTRIBUTED TO BIOLOGY

Racial differences in healthcare have been viewed and emphasized as solely biological with a lack of focus on the sociological aspect of medicine (Dennis 2012). The disregard for sociological aspects results in unequal or differential treatments between minority and majority Americans. According to Dennis (2012), residual racism has resulted in differences and inequities throughout medical training and decisions, as well as medical practice, research, and the environment these inequities take place in. Hoberman (2007) states that racially motivated medical occurrences are disguised under the terms of "racial disparities" and "ethnic differences."

Racial disparities in health are differences in the ability of populations to receive quality care for injuries, disease, and other clinical necessities. The lack of a quality care disproportionately affects minority groups such as black populations. Terminology attributing race to biological differences results in the dehumanization and depersonalization of individuals as it disrupts the reality of people's lived experiences. This attribution devalues the shock and disturbance towards black individuals dying at a higher rate of heart disease, strokes, cancers, liver disease, diabetes, childbirth, and tuberculosis (Hoberman 2007).

BIOLOGICAL RESEARCH ON GENETIC DIVERSITY

The concept of race as a biological concept versus a sociological concept persists, as researchers debate how genetic variation in the human population should be categorized (Foster and Sharp 2000). Conducted biological research has provided evidence to support the concept

that diversity cannot be separated into distinct racial genetic categories, and that the concept of race should not solely be applied to determine health. Through the utilization of genetic data from blood group and serum proteins, as well as red blood cell enzymes, it was discovered by geneticist Richard Lewontin that eighty-five percent of genetic variation resides within racial groups rather than between them (Braun 2002). This finding of genetic variation was later confirmed by Barbujani et al. (2007), who discovered that 84.4% of genetic variation was found within the same race, rather than between the races by observing the polymorphic sequences and the microsatellite loci of 16 different populations to illustrate human diversity. Although a section of the biomedical community has acknowledged the sociological aspect of race, the concept that human population variation is divided into strict biological categories is still rooted in biomedicine (Braun 2002).

Race as a biological concept has been emphasized through the ascription of diseases to a specific race or ethnicity. These diseases include, but are not limited to, sickle cell anemia and type 2 diabetes mellitus. According to Rotimi (2004), sickle cell anemia has been labeled the "black disease," and even though it has been more frequently observed in the black population, it also frequents the Hispanic population, as well as the northwestern Indian, and the Mediterranean population. The label eliminates the view of the disease in other populations forcing focus on specific geographic locations, resulting in a lack of knowledge of other areas with this disease. For example, Orchomenos in Greece contains twice the rate of sickle cell anemia than that of black people, a town that does not share in the phenotype of them. A disease attributed to race also does not explain why South Africans do not have an extremely low incidence of the sickle cell anemia trait as well (Rotimi 2004).

When observing the pattern of diabetes in black communities, other social and risk factors should be considered outside of the aforementioned concept of biology. Risk factors include obesity and lack of physical activity which disproportionately affect members of the black community (Marshall 2005). Also included in this consideration are housing inequalities, opportunities for employment, and the difficulty in obtaining abundant wealth, which are all factors that contribute to health disparities regardless of race. According to Jones and Hall (2006), the definitions of race and ethnicity were defined historically as genetic, but having race solely dependent on a biological standpoint is problematic, especially for those with a complex ancestry. A complex ancestry with a location difficult to pinpoint results in inaccuracies among diagnoses and treatment, when an individual's skin color and physical traits are not as evident. In the United States, African American, African Caribbean, Afro-Latinos, and Africans all fall under the umbrella term of Black or African American. Using race as a biological category does not account for the differences between all the ethnicities or the complex ancestries. Employing both racial and ethnic categories is better utilized to help predict genetic variation, however, social categories aid in the understanding of biological relatedness and the social factors that occur in the different subgroups of populations and human genetics (Foster and Sharp 2002). According to Smedley (2003), it is necessary to distinguish between racial and ethnic categories in regard to the medical field, but it should be coupled with an understanding of environmental, cultural, and the behavioral influences of human variation.

HISTORICAL CONTRIBUTIONS TO RACISM IN MEDICINE

Racial disparity and mistrust of physicians caused by instances of unequal access to healthcare and differences in treatment are deeply rooted in the history of African Americans.

Throughout the nineteenth century, differences between races were emphasized to be biological in order to exemplify the superiority of the white race and to justify policies that negatively affect African Americans (Bhopal 1998). The history has been directly affected by slavery as well as the Jim Crow laws that enforced racial segregation. After the emancipation of enslaved people, physicians sought to label African American individuals as diseased and inferior. Physicians would draw on evolution and natural selection to attribute the susceptibility and predisposition of disease to African Americans, in order to mark the group as deserving of their inferior social status, and predicted the extinction of the African American race (Braun 2002).

SLAVERY'S CONTRIBUTION TO RACISM IN MEDICINE

Throughout the time of slavery, physicians were not "wasted" on enslaved African Americans, and even if owners were willing to get medical care for them, it was difficult to find physicians who were willing to treat them. Enslaved individuals were also a source for physicians to enhance their medical education through medical experiments and demonstrations, and if they were reluctant to submit, punishment or death would ensue. This oppression resulted in a reluctance by African Americans to report any illnesses, establishing a mistrust towards physicians. Physicians would also not take adequate care of people who were enslaved. Physicians genuinely believed that African Americans had lower sensitivity to pain, as well as different reactions to medication, which resulted in them receiving differential and inadequate treatment. In the 1840s during the time of slavery, a southern white physician accentuated a difference between the white and black communities by stating that medical treatment administered to benefit a white man, would have an adverse effect on the black man to either maim or harm him. (Charatz-Litt 1992). Byrd and Clayton (2003), similarly stated that after the

emancipation of enslaved people, the health of African Americans fluctuated greatly and biostatisticians and other medical professionals predicted the extinction of the African American race.

SEGREGATION'S CONTRIBUTION TO RACISM IN MEDICINE

After the Civil War, the black health experience for emancipated individuals changed from individual issues to deep systemic, issues including structural and environmental racism. Funding was refused for black health facilities and white physicians would not treat black individuals unless the treatment was paid for in cash. Throughout the era of Jim Crow, the action of segregation resulted in poor housing, poor working conditions, and poor medical treatment for the black community, where they would be blamed for their own poor health as it was considered a direct consequence of their own diet and the fact that their skin tone was darker than whites (Charatz-Litt 1992). The effects of the health deficit brought from the time period of slavery resulted in unequal treatment, unfavorable policies, and desertion of black individuals by the current health care system through consistent racial discrimination (Braun 2002). Examples of the differences in care were evident through the decline infectious diseases and mortality, as well as the increase in the life expectancy rate found throughout the white population but not seen in the minority population. Minority groups were excluded from elements of social progress such as the improvements among sanitation, diet, hygiene, and better housing developments, resulting in an isolation from the increasingly beneficial mainstream health care system (Byrd and Clayton 2003).

Racial residential segregation has determined to be a major detriment of racial health disparities. The Civil Rights Act of 1968 made the discrimination of housing sales in the United

States illegal, but both subtle and explicit discrimination still occurs today. The 2000 Census indicated that black and white segregation still remains distinctive and in order to completely eliminate segregation, 66% of the total black population would have to move. Segregation results in differences in the quality of neighborhoods, where there is unequal access of necessary services in black neighborhoods. Political leaders are also more likely to cut funding in these neighborhoods resulting in less economic resources, as well as a decline in the physical environment, and the quality of life (Williams and Collins 2001). These funding cuts result in a socioeconomic disadvantage for those residing in these neighborhoods as a concentration of poverty persists. Examples of racial segregation and structural racism also include placing bus garages and toxic waste sites mainly near the areas where black individuals reside, as well as the Flint, Michigan drinking water crisis where the government failed to prevent lead from poisoning the water supply (Bailey et. al 2017). Another influence on health disparities is clearly evident in that black individuals are more likely to pay higher costs for goods and services but their segregated neighborhoods have less access to quality food, resulting in poorer nutrition (Williams and Collins 2001). Black individuals are still found to occupy lower-quality neighborhoods with lower-quality schools and jobs, where they are likely to be paid less for the same work as their white counterparts (Bailey et. al 2017). Segregation also has an adverse effect on medical treatment and typically results in less access to quality healthcare for black individuals. According to Williams and Collins (2001), pharmacies in minority neighborhoods are less likely to have adequate medication to treat severe symptoms of pain, and black individuals are less likely to receive the proper medical treatment even after receiving medical care.

PHYSICIAN IMPLICIT RACIAL BIAS

Implicit bias refers to the unconscious attitudes and stereotypes that affect actions and understandings in race, gender, and sexuality categories (Maine e. al 2018). Implicit racial bias is different than blatant racism or discrimination. It is the unconscious mind causing individuals to act in discriminatory ways based on race, from biased perceptions and their experiences. Implicit racial bias is deeply ingrained in the culture of the United States and it is found in television programs, books, and newspapers, and manifests itself in every day actions (Maine et. al 2018). It is necessary to acknowledge the presence of implicit racial bias in medicine as it leads to discriminatory behavior towards black individuals throughout medical treatment. If a physician has a judgmental or discriminatory attitude towards a black patient and a notion that the patient will not comply with a strict regimen, that will reflect in treatment and also fuel medical mistrust. In order to progress and acknowledge implicit racial bias, the Implicit Association Test was created. The Implicit Association Test records implicit bias through a series of tests that measures an individual's decisions of automatic associations of certain concepts, turning implicit bias into a tangible model (Maine et. al 2018). An administered Implicit Association Test found a stereotype of "implicit perceived compliance and race," similar to a study that concluded with a result of implicit bias when black patients were considered to be less cooperative than white patients (Sabin et. al 2003). According to Ashton et. al (2003), there are three different possibilities as to why racial and ethnic disparities occur in medicine, including physician racial bias, preferences of the patient, and poor communication.

PHYSICIAN BIAS THEORY

The theory of physician racial bias results in physicians not offering the same services for black individuals as they do their white counterparts. Physicians who have high implicit bias are more likely to have poorer interactions in their clinical encounters. In a 1996-1997 research study on implicit racial bias, physicians were less likely to refer black women for a cardiac catheterization procedure, than they were to refer white women, white men, and black men. Not only did these black women experience implicit racism, they also experienced implicit sexism resulting in greater disproportionate rates of disease. Other findings depict that black patients are less likely to receive invasive diagnostic procedures (LaViest et. al 2000). Black patients receive less bypass surgery, cancer treatments, or renal transplants compared to their white counterparts who matched them in income, education, age and disease severity (Geiger 2001). These findings establish that both skin color and gender can implicitly affect diagnoses and test-ordering. (Ashton et. al, 2003).

PATIENT PREFERENCES AND PATIENT COMMUNICATION THEORY

The preferences hypothesis refers to the idea that black people are more likely to refuse certain services and benefits because of values in their race and culture (Ashton et. al 2003). However, it has been found that patient preferences are not the driving force for racial disparities in medicine (Ashton et. al 2003). Research findings have indicated that black individuals do not seek out fewer medical services, but rather twice as many seek out help for depression and end-of-life care as compared to white individuals. In order to follow physician recommendations, effective communication needs to occur between physician and patient. This communication may be difficult for black people and physicians, as physicians typically have poorer

interpersonal skills, provide less information, and use a less-participatory decision-making style when interacting with black individuals. Findings throughout the patient communication study suggest that black individuals view their visits with their physicians as one-sided and non-participatory, more than white individuals, as physicians utilize a narrow communication pattern with them (Ashton et. al 2003). The results suggest that physician racial bias plays a role in patients' mistrust in the healthcare system, through beliefs that prejudice and discrimination will lessen the quality of their care (Greiger 2001).

DEFINING THE TERM "BLACK"

The racial category "black" encompasses all the ethnicities of African American, Afro-Caribbean, Afro-Latino, and African groups. African Americans who experience the aftermath of slavery have been negatively stereotyped throughout the United States and misrepresented, while Afro-Caribbean, and Afro-Latinos, and Africans who immigrated to the United States have suffered similar fates due to their shared skin color. However, when ethnicity is coupled with race, findings show that Afro-Caribbeans and other black immigrants are shown to be more positively stereotyped by white Americans, including being considered to be more hardworking and less likely to cause "trouble." Differences between stereotypes and discriminatory approaches towards African Americans and black immigrants may also be apparent in the medical field and influence health attitudes towards physicians in dissimilar ways (Molina and James 2016).

THEORETICAL FRAMEWORK

CRITICAL RACE THEORY

Critical race theory can be used to explain the medical racism observed in black communities today as race as racism continues to explain the inequities that occur throughout the United States. Critical race theory posits that legislation and institutions are racist, and that the ascription of race as a biological feature is solely utilized by the white population to reduce the advancement of minority groups. Race is a social construct created to benefit the own administrative and economic interests of the white community. Critical race theory insinuates that minority groups, especially black and African American individuals, have less access to opportunities, and in the case of medicine, access to healthcare.

Structural, environmental, and medical racism exist and result in healthcare disparities. Medical racism, including physician implicit bias is found throughout healthcare and can result in lesser treatment for the black/African American individual. White privilege is another concept discussed in critical race theory and is defined as the ability of white people to gain advantages economically and politically, as well as easier access to power, education, and social status. White individuals find themselves with lesser rates of mortality and morbidity compared to their black counterparts, may be less likely to feel discriminated against throughout healthcare encounters, and may be more comfortable communicating with and visiting their physician. The lack of funding within black communities for health and healthcare necessities also affects the inequity between white and black communities. Microaggressions are also a product of implicit bias as prejudices and discriminatory attitudes manifest themselves in treatment, thus potentially

resulting in negative healthcare experiences for black and African Americans, in turn resulting in the medical mistrust of the black/African American community. (Dixson 2018).

INTERSECTIONALITY

Another important theoretical consideration to this study is intersectionality. Intersectionality rests on the idea that power relations in a given society surrounding factors such as class, race, and gender are not mutually exclusive but rather intertwined and work together (Collins and Blige 2020). In regard to medicine, intersectionality is significant when comparing the experiences of black women to black men and white women. These differences are evident in the maternal morbidity and mortality rates where black women are disproportionately negatively affected, as the intersectional oppression of sexism and racism limits the ability of healthcare access for black women. Black men experience racism, white women experience sexism, and black women experience racism and sexism causing a disproportionate mortality and morbidity rate (Mijal 2019).

METHODS

The data for this study was collected through an anonymous online survey in order to determine and compare any medical mistrust among the diverse African American, Afro-Caribbean, Afro-Latino, and African communities as well as the white community. The Qualtrics system was used to send a voluntary survey to participants over the age of 18, through email, text, and the online platform systems, Instagram and Facebook. After the data was collected, statistical analysis was conducted.

The demographic variables age, gender, race, and ethnicity were measured. For race and ethnicity, individuals were asked to select either African American, Afro-Caribbean, Afro-Latino, African, American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, non-White Hispanic or Latino, White Hispanic or Latino, or White/Caucasian. Socioeconomic variables including education and employment status were also measured. How often an individual seeks out a physician and the likelihood of attending annual checkups was measured using a least likely to most likely 5-point scale. Microagressions and implicit bias was measured through questions that inquire about subtle racism. Physician communication towards the participants about their health was measured, as well as how comfortable the individual is visiting a doctor. Personal experiences were also measured in relation to the participant or their family members through questions that inquire about past diagnoses and treatments for medical conditions.

RESULTS

DEMOGRAPHICS

This sample consisted of fifty-two (n = 52) participants. The demographics of the sample are shown below (Table 1).

Table 1. Demographics (N=49)

Race	
Black	40.4
White or Caucasian	30.8
African American	15.4
Non-white Latino or Hispanic	11.5
Other	9.6
American Indian or Alaska Native	0.0
Native Hawaiian or Pacific Islander	0.0
Black/African American	
Caribbean	32.7
African American	21.2
African	3.8
Hispanic or Latino	1.9
Gender	
Female	69.4
Male	30.6
Education Level	
Less than High School	2.0
High School Graduate	12.2
Some College	34.7
2 Year Degree	8.2
4 Year Degree	28.6
Professional/Graduate Degree	14.3
Current Employment Status	
Employed Full Time	12.2
Employed Part Time	22.4
Unemployed Looking for Work	10.2

Unemployed Not Looking for Work	4.1
Student	51.0
Annual Household Income	
Less than $25,000	24.5
$25,000 - $50,000	18.4
$50,001 - $100,000	22.4
$100,001 - $200,000	26.5
More than $200,000	8.2

PRIMARY CARE PHYSICIAN EXPERIENCES

Participants were asked how often they visit a physician and the results indicated that most of the participants, regardless of race visit a primary care physician at least once a year. In regard to Black/African American ethnicities, Caribbeans were the most likely group to visit their primary care doctor more than once a year. The frequency of all races is shown below (Table 2). The frequency of physician visit among Black/African American ethnicities is shown below (Table 3).

Table 2. Physician Visit Frequency (N=49)

	White or Caucasian	African American	Black	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Non-white Latino Or Hispanic	Other
More Than Once a Year	43.8	25	23.8	0	0	6	5
Once a Year	37.5	62.5	47.6	0	0	66.7	40
Every 2 Years	6.3	0	9.5	0	0	0	40
Every 3-5 Years	12.5	0	4.8	0	0	16.7	20
I Have Not Seen a Physician in Over 5 Years	0	12.5	14.3	0	0	16.7	0

Table 3. Physician Visit Frequency with Black/African American Ethnicities Specified (N=31)

	Caribbean	African	Hispanic or Latino	African American
More Than Once a Year	17.6	0	0	36.4
Once a Year	64.7	50	0	45.5
Every 2 Years	5.9	0	0	9.1
Every 3-5 Years	5.9	0	0	0
I Have Not Seen a Physician in Over 5 Years	5.9	50	100	9.1

The last experience that the participants had was measured through a 7-point scale ranging from extremely positive to extremely negative. A majority of the participants, regardless of race felt that they had either a slightly, moderate, or extremely positive experience. See Table 4 below.) There was also not a great difference within the ethnicities of last physician experience. The last physician experience among Black/African American ethnicities is shown below (Table 5).

Table 4. Last Physician Experience (N=49)

	White or Caucasian	African American	Black	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Non-white Latino Or Hispanic	Other
Extremely Positive	50	12.5	28.6	0	0	16.7	50
Moderately Positive	31.3	62.5	42.9	0	0	50	50
Slightly Positive	12.5	12.5	0	0	0	0	0
Neither Positive nor Negative	6.3	12.5	23.8	0	0	16.7	0
Slightly Negative	0	0	4.8	0	0	16.7	0
Moderately Negative	0	0	0	0	0	0	0
Extremely Negative	0	0	0	0	0	0	0

Table 5: Last Physician Experience with Black/African American Ethnicity Specified (N=31)

	Caribbean	African	Hispanic or Latino	African American
Extremely Positive	23.5	0	0	27.3
Moderately Positive	47.1	100	0	36.4
Slightly Positive	5.9	0	0	9.1
Neither Positive nor Negative	17.6	0	100	27.3
Slightly Negative	5.9	0	0	0
Moderately Negative	0	0	0	0
Extremely Negative	0	0	0	0

Participants were asked to indicate how well their physician typically communicates with them about their health. Most participants believe their physician communicates well to them, however only individuals who identify as Black indicated that they believe that their physician does not communicate well at all. The results are shown in Table 6 below.

Table 6. Physician Level of Communication (N=49)

	White or Caucasian	African American	Black	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Non-white Latino Or Hispanic	Other
Extremely Well	18.8	12.5	23.8	0	0	33.3	25
Very Well	37.5	25	23.8	0	0	16.7	50
Moderately Well	37.5	62.5	33.3	0	0	50	25
Slightly Well	6.3	0	9.5	0	0	0	0
Not Well at All	0	0	9.5	0	0	0	0

TRUST AND DISCRIMINATION EXPERIENCES

Participants indicated the level of which they agree or disagree with discrimination being present in medicine. Most of the participants regardless of race believe that there is discrimination in medicine. However, a small amount of those who identify as African American and Black, disagreed or strongly disagreed that there is discrimination in medicine, shown in (Table 7) below.

Table 7. Belief of Discrimination in Medicine (N=49)

	White or Caucasian	African American	Black	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Non-white Latino Or Hispanic	Other
Strongly Agree	43.8	25	61.9	0	0	80	75
Agree	43.8	50	19	0	0	20	25
Neither Agree nor Disagree	12.5	12.5	9.5	0	0	0	0
Disagree	0	12.5	0	0	0	0	0
Strongly Disagree	0	0	9.5	0	0	0	0

Participants were asked if they had ever experienced being talked down to by a doctor. No individual who identified as White or Caucasian strongly agreed that this have ever occurred. Participants who identify as African American, Black, and Non-white Latino or Hispanic strongly agreed and all races agreed that this has occurred. The results are shown in (Table 8) below.

Table 8. Experienced Being Talked Down to By a Doctor (N=49)

	White or Caucasian	African American	Black	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Non-white Latino Or Hispanic	Other
Strongly Agree	0	12.5	14.3	0	0	20	0
Agree	37.5	25	28.6	0	0	20	25
Neither Agree nor Disagree	18.8	0	9.5	0	0	40	0
Disagree	31.3	50	38.1	0	0	0	25
Strongly Disagree	12.5	12.5	9.5	0	0	20	25

The level of trust of which participants had that doctors make the best decisions for their health was measured. A small portion of participants who identify as Black was the only group to strongly disagree that they trust that doctors make the best decision for their health. Most of the participants who identify as White or Caucasian indicated that they trust the doctors and their decisions. Results are shown in the table below (Table 9).

Table 9. Trust That Doctors Make the Best Decisions for Their Health (N=49)

	White or Caucasian	African American	Black	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Non-white Latino Or Hispanic	Other
Strongly Agree	18.8	0	0	0	0	0	0
Agree	56.3	12.5	28.6	0	0	50	75
Neither Agree nor Disagree	0	62.5	42.9	0	0	50	25
Disagree	25	25	19	0	0	0	0
Strongly Disagree	0	0	9.5	0	0	0	0

Participants indicated how comfortable they are with visiting a doctor. Only individuals who identify as Black strongly disagreed that they feel comfortable. In regard to the other selections, the distribution was similar among the races. Results shown below (Table 10).

Table 10. Comfortable Going to the Doctor (N=49)

	White or Caucasian	African American	Black	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Non-white Latino Or Hispanic	Other
Strongly Agree	18.8	0	14.3	0	0	33.3	20
Agree	43.8	37.5	14.3	0	0	0	60
Neither Agree nor Disagree	18.8	25	28.6	0	0	16.7	0
Disagree	18.8	37.5	28.6	0	0	33.3	0
Strongly Disagree	0	0	9.5	0	0	0	0

The likelihood of participants receiving the Covid-19 vaccine was measured. Participants who identify as Black or African American indicated that they were extremely likely and somewhat likely to get the vaccine, however they were also the group that made up most of the somewhat unlikely/ extremely unlikely category. A majority of participants who identify as White/Caucasian selected that they were extremely and somewhat likely to get the vaccine. The results are shown in the table below (Table 11).

Table 11. Likelihood of Receiving the Covid-19 Vaccine (N=49)

	White or Caucasian	African American	Black	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Non-white Latino Or Hispanic	Other
Extremely Likely	50	25	38.1	0	0	60	75
Somewhat Likely	6.3	37.5	19	0	0	0	0
Neither Likely or Unlikely	0	0	4.8	0	0	0	0
Somewhat Unlikely	12.5	25	14.3	0	0	0	0
Extremely Unlikely	0	0	4.8	0	0	0	0
I Have Already Been Vaccinated	25	0	14.3	0	0	40	25
I Have Not Yet Decided	6.3	12.5	4.8	0	0	0	0

DISCUSSION

The research conducted here focused on the relationship between discrimination and medical racism with the medical mistrust of the Black/African community. It has also attempted to discern a difference within the Black/African American race of healthcare treatment. Based on the results, it can be inferred that there is minimal difference between any of the races in regard to physician visits. The participants regardless of race do not appear to visit their physician more frequently than the other. It was found that Black/African Americans equally agree and disagree that they have been talked down to by a physician. However, it was found that Black/African Americans were the least comfortable group seeing a physician, as well as the only group that had participants believe that their physician does not communicate well to them about their health. In regard to trusting the judgement of healthcare professionals, it was also found that Black/African American participants were less likely to agree that they trusted the decisions compared to their White/Caucasian counterparts. A majority of participants regardless of race do believe that discrimination in medicine does exist. Although it has been observed that there is medical mistrust among the black community, a strong correlation between healthcare experiences and medical treatment with medical mistrust was not evident throughout this study. All the participants, regardless of race are willing to get the Covid-19 vaccine at the same rate. It was found that a sizable portion of individuals of color trust the healthcare that the field provides to them, there is also a significant percentage of individuals who do not trust the healthcare field. There were also not any significant differences between the way that Africans, African Americans, Afro-Latinos, and Caribbeans view the healthcare system, however a small sample

size was utilized. Examining factors and correcting medial racism and discrimination that lead to mistrust in the medical field are necessary to eliminate issues in the health of the Black/African American community. It is also necessary to define what the term "black" means in health because African Americans, Afro-Latinos, Caribbeans, and Africans are all from different regions around the world, thus leading to different health issues, where they should not be grouped under one term.

LIMITATIONS

This research could prove useful when coupled with methods to reduce mistrust in the medical field. The study however, did have its limitations. The sample size of (n=52) was small in regard to the necessary comparisons needed between Non-White participants and White/Caucasian participants, as well as the differences between African, Afro-Latino, African American, and Caribbean. The sample only included 17 Caribbeans, 11 African Americans, 2 Africans, and 1 Afro-Latino. Due to the limited sample size, a chi-squared analysis could not be run. In future studies, I would increase the sample size and include a greater area of Florida. Also, there were no replies in the sections that needed a description of why a participant may have had a negative experience. Additionally, the results may be subject to change if I were to increase the scope of the demographics. The plurality of people who make less than $25,0000 a year are students. The results may vary among those if individuals who make less than $25,000 a year are not students.

CONCLUSION

Many of the results indicated that there were differences between physician experiences between white and black Americans. However, due to the small sample size the differences seemed insignificant. In the future, expanding on those differences and truly understanding how large the gap is in healthcare and treatment between white and black individuals could eventually reduce morbidity and mortality rates in the black community with the correct policies in place. Implementing programs beginning at the medical school level could help to reduce some of the negative experiences that black Americans face within the healthcare, allowing physicians to fully acknowledge their implicit racial bias. Future research could focus on differences between white and black physicians and their patient interactions as well in order to discover the best method to overcome any patient discomfort. Delving more into themes that cause issues in health such as environmental and public health issues, as well as discovering the differences between the lifestyles, interactions, and health among African Americans, Afro-Caribbeans, Afro-Latinos, and Africans who all fall under the umbrella term “black”, could prove effective in reducing health disparities.

APPENDIX A: SURVEY

SURVEY

Q2 Are you 18 years or older?

- ○ Yes (1)
- ○ No (2)

Q3 Do you consent to participate in this survey?

- ○ Yes (1)
- ○ No (2)

Q4 Please choose the race(s) you identify as: (Select all that apply)

- ☐ White or Caucasian (1)
- ☐ African American (2)
- ☐ Black (3)
- ☐ American Indian or Alaska Native (4)
- ☐ Native Hawaiian or Pacific Islander (5)
- ☐ Non-white Latino or Hispanic (6)
- ☐ Other (7) _____

Q5 Choose what you identify as:

- [ ] Caribbean (1)
- [ ] African (2)
- [ ] Hispanic or Latino (3)
- [ ] African American (4)

Q6 How often do you visit a primary care physician?

- ○ More than once a year (1)
- ○ Once a year (2)
- ○ Every 2 years (3)
- ○ Every 3-5 years (4)
- ○ I have not seen a primary care physician in over 5 years (5)

Q7 What is the main reason that you do not visit a primary care physician more often?

_____

Q8 What was your last experience with a physician like?

- ○ Extremely positive (6)
- ○ Moderately positive (7)
- ○ Slightly positive (8)
- ○ Neither positive nor negative (9)
- ○ Slightly negative (10)
- ○ Moderately negative (11)
- ○ Extremely negative (12)

Q9 What made the experience a negative one for you?

_____

Q10 How well do physicians normally communicate with you about your health?

- ○ Extremely well (1)
- ○ Very well (2)
- ○ Moderately well (3)
- ○ Slightly well (4)
- ○ Not well at all (5)

	Strongly Agree (1)	Agree (2)	Neither Agree nor Disagree (3)	Disagree (4)	Strongly Disagree (5)
I typically go to a doctor who is the same race/ethnicity as me. (1)	○	○	○	○	○
I typically go to a doctor who is the same gender as me. (2)	○	○	○	○	○
I am always comfortable going to see a doctor. (3)	○	○	○	○	○
I have difficulty finding a doctor who treats me with respect. (4)	○	○	○	○	○
I have been treated unfairly by a physician because of my race/ethnicity. (5)	○	○	○	○	○
I believe there is discrimination throughout medical treatment. (6)	○	○	○	○	○

I have experienced discrimination during a medical treatment. (7)	○	○	○	○	○
I have been talked down to by a doctor. (8)	○	○	○	○	○
Doctors typically blame my health on genetics. (9)	○	○	○	○	○
I trust that doctors always choose the best course of action for me. (10)	○	○	○	○	○
I trust the healthcare system to provide the best options for me. (11)	○	○	○	○	○

Q12 How likely are you to get the Covid-19 vaccine?

- ○ Extremely likely (1)
- ○ Somewhat likely (2)
- ○ Neither likely nor unlikely (3)
- ○ Somewhat unlikely (4)
- ○ Extremely unlikely (5)
- ○ I have already been vaccinated (6)
- ○ I have not yet decided (7)
- ○ Other (8) _____

Q13 Why do you think you will not get the vaccine?

- ○ Do not trust the development of the vaccine (1)
- ○ Not at risk of catching the virus (2)
- ○ Concerned about the side effects (3)
- ○ Do not trust the healthcare system and its delivery of the vaccine (4)
- ○ Other (5) _____

Now just a few demographic questions and the survey will be complete.

Q15 How old are you?

_____

Q16 Please choose the gender you identify as:

- ○ Male (1)
- ○ Female (2)
- ○ Non-binary / third gender (3)
- ○ Other gender identity (4) _____

Q17 What is the highest level of education you have completed?

- ○ Less than high school (1)
- ○ High school graduate (2)
- ○ Some college (3)
- ○ 2 year degree (4)
- ○ 4 year degree (5)
- ○ Professional/graduate degree (6)

Q18 What is your marital status?

- ○ Married (1)
- ○ Widowed (2)
- ○ Divorced (3)
- ○ Separated (4)
- ○ Never married (5)

Q19 What is your annual household income?

- ○ Less than $25,000 (1)
- ○ $25,000-$50,000 (2)
- ○ $50,001-$100,000 (3)
- ○ $100,001-$200,000 (4)
- ○ More than $200,000 (5)

Q20 What is your current employment status?

- ○ Employed full time (1)
- ○ Employed part time (2)
- ○ Unemployed looking for work (3)
- ○ Unemployed not looking for work (4)
- ○ Retired (5)
- ○ Student (6)
- ○ Disabled (7)

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