



## Disparities in Healthcare Access

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### Abstract

Access to quality healthcare has presented significant challenges for African Americans and the ongoing mistrust has embedded itself into the psyche of generations of African Americans [1-12]. The purpose of this qualitative phenomenological study was to identify ways to increase access to healthcare for African Americans and to answer the research question: How do informed African Americans with insurance coverage experience distrust and reduced levels of access to healthcare systems in the state of Illinois? This study and the interview questions both utilized Michel Foucault's theory of power and knowledge [13]. The findings suggest that power and knowledge continue to impact access to healthcare based on the lived experiences of ten adult African American participants. The participants were selected because they met two criteria. Eligible participants had direct interactions with a healthcare provider in the past five years and had healthcare insurance. These individuals were recruited by posting the recruitment flyer and prescreening survey links to social media platforms. The participants completed a pre-screening and demographic survey and the Healthcare Systems Distrust Scale [14, 15]. During the data analysis, four themes emerged: education, experience, resources, and power. The results spoke to the connection between power and knowledge and accessing healthcare. The study also discussed the theoretical and practical implications of the findings.

**Keywords:** African American, Power and Knowledge, Michel Foucault, Healthcare, Qualitative, Phenomenological, Insurance, Access, Illinois, Distrust, Reduced, Mistrust

### Introduction

Access to quality healthcare has presented significant challenges for African Americans from the moment their enslaved ancestors were transported from Africa to the Americas to current day where there is this ongoing mistrust that has embedded itself into the psyche of generations of African Americans. This mistrust is not without merit as African Americans have been cast as the lowest class and has historically been subjected to medical experiments without consent and or knowledge. The following are examples; the Tuskegee Syphilis

Study and the case of Mrs. Henrietta Lacks, subpar medical care or no medical care, biases and misperceptions of pain tolerance, and covert and overt discriminatory practices which were on full display during the recent onset of the COVID-19 pandemic. James Marian Sims, a renowned gynecological surgeon, experimented and researched on enslaved African American women, often without consideration for their own modesty, without anesthesia, and forcibly restrained with no consideration for their vocalized screams of pain and discomfort [16]. The knowledge that came from these experiments did not go to the benefit of the enslaved women but to the White women of the time [11, 16]. These negative interactions and experiences have led to the perpetuation of distrust of the healthcare system among those in the African American community. This has resulted in many of the chronic conditions prevalent in the community, the lack of willingness to seek preventative care, and the dependence on reactive treatment. In coming to terms with this reality and seeking effective interventions, one must acknowledge the power dynamic at play between the healthcare system, politics, and the people in the African American community and how the concepts and ideals established over 400 years ago continue to influence treatment and care [11, 17, 18].

### Foucault's Theory of Power and Knowledge

Michel Foucault's theory of power and knowledge speaks to the overall treatment of the human body and how the medical field has become politicized over the years resulting in those with the power being able to decide who is worthy of receiving medical services, where the services are provided, and at what cost to the population. While Foucault does not identify a specific racial community, this concept is something the African American community continues to try and navigate. Foucault's theory speaks to the idea of the dominant group having and exerting power over the bodies of the non-dominant group and it is this power dynamic that Social Workers and other researchers should take into consideration along with the limitations it presents as they consider which interventions would be most effective in overcoming these barriers [19]. Foucault details how the treatment of the human body, and the later medical field has become politicized over the years to where it has now morphed into an

organization that has an enormous strong hold as to who is worthy of receiving medical services, where the services are provided, and at what cost to the population [20]. Foucault equates the healthcare system to that of a monarchial rule of power which has morphed into a capitalistic and political endeavor of ever-changing rules of knowledge that help the dominant class to “make it their business to involve themselves in other people’s lives, health, nutrition, housing [20]. Foucault [20] further offers examples of how knowledge and power play into offering a sense of legitimacy to those who hold political or institutional dominance which continues to perpetuate the idea that they have the constitutional right to regulate the bodies of those that are considered unworthy of knowledge and who hold no political power. He further expounds on this idea by presenting the idea of subjugated knowledge, which he defines as the knowledge and ideas of others that have been “disqualified as inadequate and to their task or insufficiently elaborated: naïve knowledge's, located low down on the hierarchy, beneath the required level of cognition or scientificity (sic)” [20]. Foucault [20] defines knowledge and power as being a form of repression, and by showing how knowledge and power have been politicized and used to exert control over those considered less worthy, it has stymied the voice and autonomy of many who do not fall into the dominant class, such as African Americans and has resulted in an increase in different social service programs and private institutions that benefit financially from this separation in power. Foucault compares this idea of the division of power to that of sovereignty over others which he defines as, “the displacement and appropriation on the part of power, not of time and labor, but of goods and wealth,” with the expectation of obedience from those who do not have the power and wealth and without the consideration of the intention of those who are in power [20]. Over time, this concept has resulted in a “society of normalization” in which these constructs have become deeply embedded into the societal structures, that it would take major discourse to separate them [20]. The medical community is another example that Foucault highlights as it embodies the ideas of dominance over the bodies and health of others like those who hold political power and the intersectionality of the two when making decisions for others.

Foucault further explores this intersectionality in his book, *The Birth of the Clinic* [19]. Foucault details the simple origins of medicine with its crude and archaic practices where doctors relied on the patient to tell them what ailed them to transitioning to where the doctors told the patient what was wrong [19, 21, 22]. This was the start of doctors establishing power over the patient’s body [19, 21, 22]. Foucault details four principles of the configuration of disease, with these principles establishing which and whose knowledge about disease and the treatment of it are considered correct, which is that of the doctor [19, 21, 22]. One who has been treated by any medical professional agrees that it is important for a doctor to be knowledgeable in the area in which they are treating, but as Foucault points out, the doctors gaze often bypass that of seeing the patient as a whole and not just the presenting ailment, “If one wishes to know the illness from which he is suffering, one must subtract the individual, with his particular qualities” [19]. As time progressed, the medical field established schools and societies to further research health ailments and establish treatment methods that could be used to benefit all. This established a sense of legitimacy to the field and placed them at odds, the old way of treating disease against modern thinking. Foucault details an incident taking place during an epidemic in which the Royal Society of Medicine became in conflict with the university faculty over the best mode of treatment when faced with an epidemic [19, 21, 22]. The outcome of this conflict has had long-term effects on the medical field as the result was that of the modern, politically connected group being elevated as the sole source of correct information and the other forced to comply or be pushed aside [19, 21, 22].

## Research Question

The purpose of this qualitative study is to increase access to healthcare for African Americans. It looks to answer the proposed research question: How do informed African Americans with insurance coverage experience distrust and reduced levels of access to healthcare systems in the state of Illinois? Realistically, we know that we are unable to completely dismantle an institution that has been in existence for hundreds of years, yet we continue to pursue meaningful changes to these systems and structures that negatively affect the overall well-being of certain members of the population. As a society, we continue to conform to the idea that politics and capitalism take precedence over the general well-being of members of society who are in need. The idea of racial capitalism, in which the racial exploitation of others has resulted in capital gain factored greatly into the disparities that were witnessed during COVID-19 [23-26]. For generations, the dominant culture has financially benefited from the oppression of others through acts of enslavement, colonization, racial segregation, oppression, and the establishment of systems that have been proven to be disparaging to the less dominant culture [7, 24-28]. This has resulted in African Americans and other people of color disproportionately relegated to low-wage or higher health risk jobs [23-26].

## Materials and Methods

The present study will accomplish the following: (1) identify factors that contribute to distrust, mistrust, and reduced levels of access to healthcare; (2) seek to explore the connection between power and knowledge and its impact on access to healthcare for African Americans; and (3) contribute to empirical literature by sharing the results from the study. This qualitative, non- experimental research, phenomenological study is exploratory in nature and seeks to provide areas of need for future research. Demographic information such as gender, race, age, education level, and income will also be examined. By using a qualitative phenomenological research design, this study sought to identify the themes that factor into the distrust and mistrust of the healthcare system by African Americans and the impact that it has on access to care. This study explored the lived experiences of African Americans particularly situations that have garnered a lack of trust with the healthcare system. A qualitative phenomenological research design will allow the researcher to engage directly with the participants [29, 30]. These participants were chosen based on having had direct interaction with any healthcare provider in the past five years and having health insurance. These individuals were recruited through posting the screening survey link to social media platforms, chain referral sampling, and email blasts.

## Research Design

This study utilizes a qualitative approach which is defined as a way to explore and understand “the meaning individuals or groups ascribe to a social or human problem [29].” Utilizing a phenomenological design for this study will assist in identifying the unknown factors that impact access to healthcare for African American adults with insurance. These interviews were conducted face-to-face via videoconferencing and utilized questions from the Revised Health Care Systems Distrust Scale (HCSDS) along with additional questions formulated by the researcher with a total of no more than nine to fifteen questions. The researcher utilized an interview protocol which was used to interview each participant in which each interview consisted of the following key components: 1) basic interview information such as the time, date, and location 2) an introduction in which the interviewer explained the interview process and structure as well as addressed any initial questions that the participant had, 3) question and answer section in which the research questions were asked of the participants, 4) closing instructions in which the interviewer ended the interview and provided answers to any final questions that the participants had while also assuring them again of the confidentiality of the information they have provided as

well as their personal information [29]. All interviews were recorded with the participant's consent as well as handwritten notes taken by the researcher in the event that there was an issue with the recording process [29].

### Target Population and Sample

This study utilized a nonprobability sample of ten adult African Americans who were willing, available, and met the predetermined criteria [29]. The study used Criterion Sampling. Inclusion criteria were the participants had to reside in the state of Illinois of all identified genders. They had to be 18 years of age and older with healthcare insurance of any kind and they must have engaged with a healthcare provider of any kind in the past five years. The study also used a single-stage sampling design to access potential participants directly as opposed to engaging organizations or list services [29]. This study utilized a non-probability sample as these individuals were recruited through posting the screening survey link to social media platforms, chain referral sampling, and email blasts and were chosen based on their availability, willingness to participate, and meeting the identified criteria [29, 30].

### Data Collection

The study began after securing IRB approval from Aurora University's Human Subjects Committee. The researcher recruited participants in the state of Illinois by posting the screening survey link to social media platforms, chain referral sampling, and email blasts. The full study consisted of ten African American adults living in the state of Illinois. Consent forms detailing the research study were provided both electronically and a paper copy was included as a part of the pre-screening survey that was used to recruit the participants. Consent forms were provided again at the time of the interview detailing to the participants that their participation in the study was voluntary, and that they had the right to decline participation at any time, as well as explaining that there could be risks associated with their participation.

Once the participants had been recruited and consent forms obtained, the researcher reached out to each participant individually via their preferred communication method to schedule the 60-minute interview. These interviews were held during the month of January 2023 and were conducted via video conferencing to accommodate for travel limitations and COVID restrictions. Prior to the start of each interview, each participant received a copy of the consent form to again review and confirm their willingness to participate. The researcher also reviewed the interview protocol and addressed any initial questions or concerns from the participants. The interview was conducted by the researcher via the Zoom platform and was recorded to the Zoom cloud in order to transcribe and analyze upon completion of each interview and as a whole.

### Instruments

This qualitative phenomenological research study was conducted using the following instruments: the Revised Health Care System Distrust Scale, the researcher's questionnaire, and a demographic survey. The Revised Health Care System Distrust Scale is based on the Medical Mistrust Index (MMI) which is a Likert structured scale, comprised of nine questions, with a Cronbach's  $\alpha = 0.75$  reliability, and was used to gauge how the participants identify medical distrust in healthcare systems [2, 14, 15, 31]. This study also utilized a power and knowledge questionnaire consisting of ten open-ended questions seeking to garner insight on the participants' experience with accessing healthcare. These questions are based on Foucault's theory of Power and Knowledge and were administered during the 60-minute virtual interview. Additionally, perceptions of how each participant communicated verbally and responded emotionally to each question were observed and noted in correlation to their self-reported experience.

### Validity and Reliability

The researcher assessed for qualitative validity and reliability to

ensure that the findings are accurate and that the findings are based on the trustworthiness and authenticity of the participants and can be duplicated [29]. The researcher utilized triangulation to compare the data from the interview responses against the observed body language and emotional responses of each participant. The researcher compared this data to the final four themes and the results were found to be consistent with what the research questions sought to uncover and were consistent with the responses provided by the participants. To ensure accuracy, the researcher asked probing and clarifying questions during the interviews and the responses were documented verbatim and, in the context, they were given during the interview. The researcher also compared the transcripts from each participant interview against the video recordings to ensure that the Zoom platform transcribed the responses correctly. To ensure reliability researchers created and adhered to a specific process for each interview in which the same amount of time was allowed, consent to participation and right to withdraw were reviewed, and the same questions were asked of each participant in the same order without deviation.

### Ethical Considerations

Many of the questions asked in this study are sensitive in nature and pose the risk of triggering memories of adverse past experiences related to negative interactions that the participant or loved one of a participant may have experienced when attempting to access healthcare. The participants were informed that if they were to experience emotional distress and/or discomfort during the interview process, they could withdraw from the study without penalty. The participants were provided with a list of mental health resources if they needed to speak with someone for additional support. This list was provided as an attachment with information regarding the study and when informed consent was provided and explained to the participants prior to the start of the study either electronically or as a paper copy.

The participants were informed during the recruitment process, when scheduling the interview, in all written documents provided to each participant, and again prior to the start of the interview that their participation in this study was voluntary and they had the right to decline participation at any point in the process without penalty.

## Results

### Description of the Sample

There was a total of ten participants, which included eight women and two men, who identified as African American or Black and reside in Illinois. The average age range of the participants was 30-49, and the participants had either employee or government-provided healthcare insurance. All the participants had encountered a healthcare provider in the past five years and self-reported having a negative experience during that timeframe. The participants were recruited through several sources including posting the recruitment flyer on Facebook, Instagram, and LinkedIn. Those who encountered the recruitment flyer shared it on their social media pages and via email and text. The participants also shared the study information themselves after completing their interviews. Potential participants completed a pre-screening and demographic survey and the Health Care System Distrust Scale via Survey Monkey which allowed this researcher to narrow down to ten participants. Once identified, this researcher scheduled Zoom interviews with each participant.

### Data Analysis

Upon completion of all ten interviews, the video, audio, and written transcript was retrieved from the Zoom cloud compiled into one source, and then uploaded into the Nvivo12 software to identify themes and conduct coding. The NVivo12 software included opportunities to organize, code, and analyze the collected data. The software allowed for the identification of themes, word searches, and suggested methods for sharing the data from this study [32]. The researcher used both inductive and deductive analysis to narrow



down themes which included open coding via a word search of the top one thousand words with a minimum of five letters and a word cloud created. Once the main themes were identified, the researcher was able to code the correlating responses of the participants. The researcher took into consideration the meaning and context in which each participant responded to ensure their responses were accurately represented in the results. To protect the confidentiality of each participant, their actual names were removed and replaced with random names selected by this researcher and were coded individually based on these pseudonyms.

### Emerging Themes and Participant Responses

During the analysis phase, four main themes emerged within the Nvivo12 software beginning with the word frequency query which produced a list of the top one thousand words derived from the interviews in this study. The four main themes revealed by the query are: Theme 1: Knowledge, Theme 2: Experience, Theme 3: Resources, Theme 4: Power.

#### Theme 1: Education

The responses from the participants indicate that education and knowledge were key factors in accessing healthcare and appeared in the word search in various forms including the words knowledgeable, information, understand, questions, research, and define. This was expressed during the interviews in which the participants detailed how they obtained information about medical diagnoses or unknown ailments or researched information that was provided by their healthcare provider by asking family and friends, asking additional questions, and researching online as shared by Imani who stated, "As I've aged and certain things have happened, I noticed that I put more research into it. and not just taking what the health care professional says is." There was discussion of how the level of education one has may come into play with asking questions, knowing which questions to ask, and understanding the information that was provided. Tiana shared how increasing her education level changed her perspective but felt that having a thorough healthcare provider who holds her accountable is also a key factor:

I think my health care provider has a lot to do with it. She's very thorough, and so she forces me to be thorough, and I know it's the accountability aspect. If she asks me a question, I'm prepared to respond to her question, and just wanting to know my own body and doing my own research, I had conversations with my health care Provider, that will oftentimes say, you know we'll put you on this medication. But just so, you know, this is what we see among African American women, and they often throw that out there just as a statistic besides me accent. But I think it's like their go to now, like Well, statistics, say African American women, so you really should consider doing this because of that. Having a level of education that I have not only allows me the ability to have access to different types of research, but it expands my understanding. I feel like someone who does not have a higher level of education, lacks certain knowledge and privileges that other people have of knowing your rights when it comes to certain things, and just not being in a position where you feel like you must accept something just because you didn't know that you have the right to request a different doctor. You have the right to request different access to different things, so you have the right to refuse that you have the right to request to have your declaration of benefits. Sometimes you don't see that stuff because you're not in a position where you have health insurance that often sends that out or tells you.

There were responses from all ten participants regarding education, many of which shared similar thoughts and responses to those shared above. Most participants felt that while a higher level of education afforded them the confidence to know which questions to ask, it was important for everyone to be willing to ask questions about their health. There was also a consensus that most participants did

not rely solely on the information that was given to them by their healthcare provider, but they also did their research on the topic by asking family and friends.

#### Theme 2: Experience

The concept of experience appeared in the word search in various forms and was identifiable based on the responses from the actual interviews. This included the terms experience, family, issues, better, negative, study, and treatment. The responses from the participants indicate that their own experience and the experience of loved ones were key factors in their overall trust in their healthcare providers and impacted how and when they accessed healthcare. Some participants felt that their providers took their concerns seriously as shared by Neveah, who felt that you have to be willing to express your concerns, "I think if you have concerns, and you don't express them, that is when you're not taken seriously. I think that there are assumptions made of the times about people before the doctor actually gets to know them." Some participants did not feel they were taken seriously, such as Tiana, "They gave the impression that my concerns were being addressed, but in reality, they were not paying attention at all."

When discussing experiences, some participants identified generational trauma and past treatment of the African American community as factors. For example, Gabrielle shared how she was taught to engage with White people in authority roles such as healthcare professional, she stated:

Growing up, you know, if you want to get ahead, you were told you gotta keep your head down. Don't act a certain way. Don't speak a certain way or dress a certain way. Yes, ma'am, no sir, to get where you want it to be. Our history with being enslaved. That's a traumatic experience that continues to play out through generations and generations, and how we respond to things, and how we have been taught to respond to certain things. It just goes back to one of those things, you know some events that's still within my parents' lifetime, so you can't sit here and tell me that that has all ceased when there are people that was fighting for us and fighting for those equalities. There are people still alive who we have taught the others the hate that we have been trying to overcome you know. So, it's embedded in our system. It's embedded in every day and in our housing and our education.

#### Theme 3: Resources

The word search query indicated that resources were another factor that impacted accessing healthcare and included the terms provider, doctor, hospital, community, services, access, and things. During the interview process, the participants expressed concern over the lack of access to quality care in their communities and the need for qualified providers who were willing to engage in their communities. Kiara discussed her frustration with having to travel outside of her neighborhood for quality healthcare, "Healthcare options in our neighborhoods should be equal to those outside our neighborhoods because it shouldn't be that we have to travel so far just to get good health care."

Naveah spoke of the ongoing distrust between African Americans and the medical field and suggested how to address it:

There's so much distrust for the medical field as a whole among people of color. They need to put people in the communities too, you know, to kind of gain that trust. Kind of like this community policing and stuff. Send these vans out that are gonna take blood pressure, or you know things like that, just something, communicate with churches and these different community organizations.

#### Theme 4: Power

The final theme that emerged from the word search was power which was identified by the terms insurance, money, influence,

political, system, and control. Throughout the interview process, the participants expressed concern with out-of-pocket costs and the changes in the political climate impacting their ability to have access to certain treatment options.

Kiara, who has government-provided insurance, discussed how politics impact her insurance coverage and the services she is offered:

The political scene determines my healthcare coverage, and it determines the limitations to what my healthcare coverage will allow me to get in terms of medicines and treatments and different things like that. So, my healthcare team must work around that. So, I think that if those parameters weren't in place, then my health care would possibly change because they could do more freely, and they could offer me more services freely. I think that the only reason I'm lacking out is because I just happen to be in a good hospital system, but I do think that they would be able to offer me more, if not for those.

## Discussion

### Review of Findings

The findings from this study indicate that the participants of this study hold education and knowledge as the key to having power and control over their care, allowing them autonomy when engaging with a profession that has not always held their best interest. The participants recognize that there is a power play at hand when it comes to accessing healthcare in the African American community and that the politicization of services through insurance, limitations of accessible resources, and lack of power to influence change, have resulted in the participants delaying or avoiding treatment.

The findings implicated a wide range of concerns which included provider treatment, lack of quality care in African American communities, dependency on political changes that impact insurance coverage or lack of funding for healthcare facilities in the community. Through data analysis, four themes emerged: education, experience, resources, and power.

#### Theme 1: Education

The participants were asked questions related to knowledge during the interview process, so it was not unlikely that education would be identified as one of the main themes that emerged during the word search. The participant's responses focused on the overall education of themselves and those in the African American community, research and information, and the ability to ask questions and understand what is being conveyed to them by healthcare providers. The participants shared how they have and will obtain information from their healthcare providers but will then do their research or seek out second opinions from other providers or family and friends before making a final decision on their plan of care. The resounding response from all the participants was that they tend to ask family and friends about medical ailments and how they have gone about treatment for themselves before deciding. The participants expressed that they felt that their level of education factored into what questions they asked, how they researched health topics, and their expectations of services. They felt that their level of education provided them with a level of confidence to question their treatment and not just accept what was being conveyed to them by the healthcare provider.

#### Theme 2: Experience

The participants were open to sharing their own experiences and those of family members and indicated that they have experienced at least one negative experience while accessing healthcare. All identified race as a key factor. Some participants identified generational trauma and how this factored into how they initially engaged with healthcare providers before learning to advocate for themselves. One participant alluded to the Tuskegee Syphilis Study unprompted when discussing his hesitancy with getting the COVID-19 vaccination, echoing many other voices in the African American communities. Many of the participants felt that most providers were unaware of the specific

healthcare needs of African Americans and expressed having their concerns minimized or dismissed. One thing that stood out to this researcher was that while all ten participants preferred an African American/Black healthcare provider, it was not a deterrent from engaging in healthcare. The participants felt that having a provider who cared, took the time to learn, listen, and take their concerns seriously was more important than the race of the provider.

#### Theme 3: Resources

The lack of resources in African American communities was identified as the third theme. The participants collectively expressed frustration at the lack of healthcare and mental health facilities and quality clinics, crisis centers, and hospitals in the community. The fact that they had to travel out of their communities to access quality care impacted how and when they sought care and due to concerns with transportation and costs, many delayed or avoided care. Many of the participants expressed the desire to have a "one-stop-shop" in which there would be multiple medical centers in the community that would provide access to general doctors, dentists, pediatricians, specialists, and patient advocates. Another concern was funding and support for services as they felt that marginalized communities were the first to have healthcare services eliminated and funding was deferred to other areas.

#### Theme 4: Power

Throughout the interview process, the participants expressed concerns with insurance coverage and out-of-pocket costs and how the current political climate impacts their ability to access healthcare. There were a few participants with government provided insurance and they expressed concern that politicians are constantly seeking to limit or discontinue Medicaid/Medicare benefits. They shared the frustration of having limitations on what services were provided, choices of medication, and choices of providers. These same concerns were shared by those with employee-provided insurance as they expressed concern with the out-of-pocket costs. The female identifying participants acknowledged the current political climates impact on women's healthcare choices but felt that it was not a top concern now with them living in the state of Illinois. They are concerned that what is taking place in other states will eventually impact them on a federal level.

#### Implications for Social Work Education

The amount of rich information that was garnered from this small sample of African American adults provided insightful factors that impact access to healthcare. This study has shown that African Americans are willing to seek care despite past negative experiences and generational trauma, but that access is often limited based on education, experiences, resources, and power. This study found that there is still the need for those in healthcare, including Social Work, to take into consideration the specific needs and experiences of those in the African American community when providing services. The idea of cultural competency in Social Work calls for those in the field to be "more aware or sensitive to the cultural dynamics of people of color and adapting their practice to provide culturally competent and sensitive services [33]." The current political climate has seen an increase in advocacy focused on addressing the many social injustices that continue to arise and impact the community, however, there is an ongoing need for advocacy on the macro, mezzo, and micro levels to ensure policies that would effect change and bring resources to the community are passed and existing resources remain. There is a strong need to advocate for policies that address the economic disparities that were highlighted during this study. Clinical interventions are also needed to address adverse healthcare experiences, generational trauma, and the trauma responses that it has produced within the African American community leading to the delay or avoidance of seeking care.

#### Conclusion

This study was proposed and conducted in an effort to identify unknown barriers that were preventing African Americans from

accessing healthcare and if these barriers were impacted by the concept of knowledge and power. The idea was to hear the voices of the those in the community who were living the experience. The researcher wanted to focus on those who were not impacted by previously identified barriers such as lack of healthcare insurance, dependency on a parent to engage them in care, and who were informed about current healthcare issues. The participants of this study reiterated concerns that have been expressed repeatedly by those in the African American community such as the lack of healthcare resources within the community, limited knowledge on medical conditions and treatment, the history of negative experiences, and feeling powerless and at the mercy of insurance companies and politicians. These concerns have been expressed each time a healthcare facility or mental health agency was closed and moved from the community. If there is to be improvement in ensuring access to healthcare for African Americans, it should be addressed based on the needs expressed by those in the community and not based on political decisions from those outside of the community. The participants expressed concern for the debates that are taking place now with both federal and state politicians on who has the power to determine what knowledge is right and who should have access to it through anti-CRT and anti-woke rhetoric and legislation, the banning of certain types of books, and the restructuring and limitations placed on educational curriculum. Give those in the community back the power to effect changes for themselves. These communities need sustainable, long-term solutions which could be started by looking at the four themes that emerged from this study.

Begin with increasing health literacy in the community in a way that allows those in the community to ask questions without ridicule or feeling dismissed. Explain medical terms and the top diseases that impact the community in a way that resonates and is impactful. Educate those in the community on what to expect and what rights they had when engaging with healthcare providers. Healthcare providers and Social Workers should take into consideration the power dynamic between themselves and the patient and practice cultural humility when engaging with African American patients. Ensure that they educate themselves on specific diseases and mental health concerns that impact the community. Healthcare providers and Social Workers should make time to answer questions or ensure that the patient has access to patient advocates who can further assist the patient after an appointment or for follow-up questions. Healthcare providers and Social Workers should provide advocacy and implementation of programs to address the lack of healthcare resources in the community. Social Workers should continue to advocate on the macro level to ensure policies that negatively impact access to healthcare are defeated and those that would be beneficial, are passed. Lastly, and most importantly, healthcare providers and Social Workers should remind themselves that they are engaging with living, feeling, breathing individuals who are seeking to be treated with dignity and respect. It is this personal relationship and interaction that will allow for trust to increase and ultimately lead to an increase in access to healthcare.

**Conflicts of Interest:** The authors declare no conflict of interest.

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**Appendix A**

Participant	Age Range	Gender	Control over Health	Negative Experience	Education Level
Ebony	30-49	Female	Yes	Yes	Master's
Gabrielle	30-49	Female	Yes	Yes	Master's
Imani	30-49	Female	No	Yes	Master's
Jada	30-49	Female	Yes	Yes	Bachelor's
Jadyn	30-49	Male	No	Yes	Master's
Laila	70+	Female	Yes	Yes	Bachelor's
Kiara	30-49	Female	Yes	Yes	Bachelor's
Nevach	50-69	Female	Yes	Yes	Bachelor's
Tiana	30-49	Female	Yes	Yes	Master's
Joseph	30-49	Male	Yes	Yes	High School

Table 1 Participant Demographic Details

**Appendix B**

Word	Length	Count	Weighted Percentage (%)
Health	6	267	0.75
Think	5	136	0.38
Knowledge	9	96	0.27
Things	6	86	0.24
Right	5	85	0.24
Going	5	78	0.22
People	6	76	0.21
Questions	9	73	0.20
Doctor	6	72	0.20
African	7	71	0.20
Power	5	60	0.17
Really	6	60	0.17
Medical	7	57	0.16
Insurance	9	52	0.15
Something	9	49	0.14
Anything	8	45	0.13
Different	9	45	0.13
Knowledgeable	13	44	0.12
Understand	10	43	0.12
American	8	42	0.12
Better	6	42	0.12
Research	8	40	0.11
Stuff	5	40	0.11
Provider	8	39	0.11
Doctors	7	38	0.11
Actually	8	33	0.09
Little	6	33	0.09
Access	6	32	0.09
Services	8	32	0.09
Still	5	32	0.09
Thing	5	32	0.09
Education	9	31	0.09
Experience	10	31	0.00
Community	9	30	0.08

Table 2: Word Frequency Table (35 of 1000 words)