



Michael Mahany. *Red Fox and Sibling*. Photograph. Anchorage, Alaska.

*Factors that affect the willingness of black men to engage in prostate cancer screening are discussed.*

## Culture, Black Men, and Prostate Cancer: What Is Reality?

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**Background:** *The worldwide incidence of prostate cancer is higher among American black men than any other male group. In the United States, lack of participation in screening for prostate cancer by black men is influenced by several cultural factors, including knowledge, health beliefs, barriers, and relationships with primary healthcare providers.*

**Methods:** *We used the qualitative and paralleling descriptive quantitative findings of a mixed-method longitudinal study exploring prostate cancer screening behaviors among 277 black men.*

**Results:** *Five themes were identified as critical elements affecting men's screening for prostate cancer: lack of knowledge, communication, social support, quality of care, and sexuality. These themes were associated with a sense of disconnectedness by black men from the healthcare system and contributed to nonparticipation in prostate cancer early detection activities.*

**Conclusions:** *Lack of discussion about the decision to screen for prostate cancer and general lack of culturally appropriate communication with healthcare providers has engendered distrust, created fear, fostered disconnect, and increased the likelihood of nonparticipation in prostate cancer screening among black men.*

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*Abbreviations used in this paper: PSA = prostate-specific antigen, DRE = digital rectal examination.*

## Introduction

Prostate cancer is the leading cancer diagnosed among men in the United States. Black men in America continue to have the highest incidence rate of prostate cancer in the world — 180.6 per 100,000 population.<sup>1</sup> Between 1996 and 2000 in the United States, the age-adjusted death rate of prostate cancer among black men (73.0 per 100,000 population) was more than double that of non-Hispanic white men (30.2 per 100,000 population).<sup>2,3</sup> The causes of higher rates of prostate cancer among black men are largely unknown. However, higher mortality is associated with late detection.

Screening is the most common method for early detection of disease in asymptomatic populations. One problem with early detection in prostate cancer prevention is a lack of consensus regarding screening and early detection guidelines among medical professional groups.<sup>4</sup> Current guidelines of the American Cancer Society (ACS)<sup>5</sup> recommend that men at high-risk (eg, family history, black) should begin early detection with the prostate-specific antigen (PSA) blood test and the digital rectal examination (DRE) at 45 years of age. Furthermore, ACS guidelines suggest that the decision for high-risk men to be tested should be made within the doctor/patient relationship. The US Prevention Services Task Force recently concluded that there was insufficient evidence for or against routine screening for prostate cancer using PSA or DRE.<sup>6</sup> According to the Task Force, however, good evidence exists that PSA screening can detect early-stage prostate cancer, but it is unclear how early detection improves health outcomes.<sup>7</sup> The National Cancer Institute (NCI) has concluded that there is insufficient evidence that prostate cancer mortality can be reduced by early detection and screening methods.<sup>8</sup> It is not clear however, that studies on which these recommendations are based included sufficient numbers of black men, despite the fact that they have the highest disease burden of all ethnic and racial groups.

This confusion is complicated by the fact that men are less likely than women to seek assistance when health problems arise.<sup>9</sup> Furthermore, compared with women or with any other group of men, black men are less likely to seek care and participate in health-related activities. Such health activities are preventive and self-care practices, which places them at high risk for nonparticipation in prostate cancer early detection and screening.<sup>10</sup> Researchers attribute the lack of participation in prostate cancer prevention activities to economic limitations, low level of education, poor access to health care, lack of awareness about studies, past negative experiences, physicians' attitudes, and cultural and religious beliefs/attitudes.<sup>11,12</sup> In addition, some researchers have identified sexual dysfunction as a sensitive issue for black men, which discourages their involvement in prostate cancer screening and early detection activities.<sup>13,14</sup>

Braithwaite<sup>10</sup> discusses the concept of "stoicism" as a possible explanation of why black men are disconnected from the American healthcare system and are reluctant to participate in health-related activities. The theory of stoicism suggest that black men become "indifferent to pain or discomfort and do not seek healthcare services until absolutely necessary, and then most often in the emergency room."<sup>10</sup> Additional factors that contribute to their nonparticipation in screening include lack of adequate health insurance, traditional attitudes about male gender roles, fear of a poor prognosis, and distrust of the medical community. Difficulty in obtaining information about black health behavior is compounded by limited participation by this population in all forms of research.

Historically, researchers have studied the impact of culture on health-seeking behaviors among many ethnic groups such as Asian, Native Americans, and Latinos to better understand the role of culture in health-related behaviors.<sup>15-17</sup> In contrast, little is known about the effect of culture in health-seeking behaviors and disconnectedness among black men.<sup>18-21</sup> One problem has been a focus on blacks as a race rather than as an ethnic group with unique cultural traits.<sup>22</sup> The National Institutes of Health (NIH) 2000 enrollment of non-Hispanic black men and women in extramural research was 11.3%; male participation was 4.5%.<sup>23-25</sup> The syphilis experiments conducted at Tuskegee, Alabama, have left a legacy of distrust and profound fear among blacks for research participation.<sup>26-28</sup> Distrust and fear are strong deterrents for black men to engage the healthcare system.

A goal of Healthy People 2010 is to eliminate racial health disparities.<sup>29</sup> Black men suffer a disproportionately higher burden of disease than any other ethnic and racial group.<sup>3,30</sup> Black men in particular have been labeled an "endangered species"<sup>10</sup> due to health, sociopolitical, and psychological issues affecting this group. To achieve the Healthy People 2010 goals of decreasing health disparities, innovative strategies must be used to overcome this barrier of distrust and create mechanisms to engage, support, and reinforce black men to make healthy choices.<sup>31</sup>

This study explores how culture and communication with healthcare providers influence black men's knowledge, health beliefs, and practices regarding prostate cancer screening. We utilized a mixed-method research approach to investigate these issues in a cohort of 277 black men and 94 primary care providers. In this article, we present the qualitative results of the black participants in our study. Quantitative data are used to show that the qualitative findings were verified in the subsequent survey work.

## Methods

### Study Design

A mixed-methods longitudinal cohort study was conducted to explore (at baseline and 6-month follow-up) general

and screening-related health behaviors in a convenience sample of black men. Since little is known about prevention-related attitudes and behaviors of this group, we utilized a sequential exploratory approach in two phases. We used phase I to collect and analyze qualitative data, and we used these data to develop our quantitative phase II survey, a 160-question self-administered questionnaire.

The study was conducted between March 2002 and September 2003 in a Southern California county of 1.8 million people with an ethnic/racial distribution of non-Hispanic whites (44.0%), Hispanics (39.2%), and blacks (8.8%).<sup>32</sup> Three major health systems collaborated on this study — a university-associated private medical center, a large regional county medical center, and a Veterans' Administration medical facility — as well as the American Cancer Society in Atlanta, Ga, and 100 Black Men of America, Inc (Atlanta, Ga). A purposive convenience sample of black men was selected for both the qualitative and quantitative phases of the study from healthcare providers and community groups. The study was approved by the Loma Linda University Institutional Review Board (IRB) and the IRBs of all collaborating partners. Participants provided informed consent before qualitative or quantitative interviews. An ethnically matched trained interviewer either administered the survey or interviewed the participants with literacy concerns. All interviews were conducted at the point of contact (ie, clinic waiting room) unless the participant preferred a private appointment. Appointments were arranged for home, office, and clinic visits, at community meetings, or at the Loma Linda University Evaluation Research Unit.

### Sample

Eligibility selection criteria included being a non-Hispanic black American man, being at least 40 years of age, having no diagnosis or symptoms of prostate cancer, and having no evidence of mental illness.

### Qualitative Data Collection

Phase I consisted of formative qualitative data collection around beliefs about prostate cancer prevention issues. Key informant interviews were conducted with 15 black men in the target age range, as well as 7 physicians and 2 nurses. Based on the existing literature and health behavior theory, we developed a key informant guide around four topics: prostate cancer knowledge, doctor/patient relationship, healthcare concerns, and barriers to participating in prostate cancer screening. All participants were interviewed in private settings of their choice (home, clinic, or worksite). All interviews were confidential. A \$15.00 cash incentive was offered to each participant. To validate our key informant findings, two focus groups (N = 22) were conducted with black men from the target community. The focus groups were located in community centers well known by the men. Health center staff meetings were utilized to obtain healthcare provider focus group

perspectives. All interviews and focus groups were recorded on audiotape and transcribed verbatim to allow in-depth qualitative analysis.

### Qualitative Data Analysis

Our final qualitative data set consisted of 27 transcripts and field notes. Grounded theory methods were used to analyze the resulting data. Grounded theory is a well-established approach where the researcher attempts to

**Table 1. — Sociodemographic Characteristics of Black Male Study Participants (N = 277)**

Characteristics	No. of Participants <sup>a</sup> (%) <sup>b</sup>
<b>Age (mean = 53 years)</b>	
30–39	11 (4.0)
40–49	98 (35.4)
50–59	104 (37.5)
60–69	46 (16.6)
>70	18 (6.5)
<b>Marital Status</b>	
Married	148 (54.2)
Single	118 (43.3)
Part of an unmarried couple	7 (2.6)
<b>Education</b>	
<11th grade	39 (14.0)
High school graduate	86 (31.0)
1–4 years of college	114 (41.2)
Graduate/professional school	38 (13.7)
<b>Annual Household Income</b>	
<\$9,999	72 (27.9)
\$10,000–\$29,999	60 (23.2)
\$30,000–\$49,999	55 (21.3)
\$50,000–\$69,999	31 (12.1)
>\$70,000	40 (15.5)
<b>Work Situation in Last 12 Months</b>	
Unemployed	31 (11.5)
Work >35 hours per week	104 (38.5)
Work <35 hours per week	22 (8.1)
Retired	51 (18.9)
Disabled	47 (17.4)
Other	15 (5.6)
<b>Type of Health Coverage<sup>c</sup></b>	
None	54 (19.7)
Health maintenance organization	61 (22.0)
Medicare/Medicaid	60 (21.7)
Private	98 (5.8)
Veterans' Administration	42 (15.2)
Other	42 (15.2)
<b>PSA Done</b>	
Yes	127 (45.8)
No	113 (40.8)
<b>DRE Done</b>	
Yes	170 (61.4)
No	102 (36.8)

<sup>a</sup> Missing data accounts for totals not equaling 277.  
<sup>b</sup> Percentages are based on the total number of responses.  
<sup>c</sup> Totals exceed 277 because some respondents had more than one insurance type.  
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document a general process, action, or interaction systematically by gathering and analyzing data from the views of participants.<sup>33</sup> Emergent themes on how culture influenced language, attitudes, beliefs, and practices were grouped into subcategories.

### Quantitative Data Analysis

Phase II data on knowledge, attitudes, beliefs, practices, culture, and personal characteristics were entered and analyzed using predictive analytics software technology (SPSS Inc, Chicago, Ill). For this paper, however, only descriptive frequencies of participants' responses to questions matching our qualitative themes were selected to show that our qualitative findings were validated in the quantitative phase of the study.

## Results

We approached 498 black men over a 5-month period, and 277 participated. Of the 221 men who did not participate, 67 were not eligible, 75 made appointments but did not complete the questionnaire, 31 were too busy, 28 did not respond to a written invitation, and 20 refused to be a part of the study. Of those who completed the questionnaire, 53.1% were from the community, and 46.9% were from healthcare settings. Mean age was 53 years, with 4% under age 40. Responses indicated 80.3% had health coverage, and 86% were educated beyond the 12th grade. Annual household income was <\$29,999 for 51% and >\$50,000 for almost 30%; 49.6% reported having a job. Table 1 shows the group's sociodemographic characteristics.

Five themes emerged on how culture influences attitudes, beliefs, and practices regarding decision-making about prostate cancer prevention. These themes were lack of knowledge, communication, social support, quality care, and sexuality. Table 2 summarizes qualitative quotes within each theme. Table 3 presents how quantitative responses to questions paralleling the qualitative themes validated our original findings. Findings are presented by emergent theme using qualitative results, quotes, and quantitative frequencies of matching survey items from phase II of the study.

### Lack of Knowledge

When asked about their risk for developing prostate cancer, 48.7% of the respondents answered they were not certain of their risk. Nearly half (44.8%) were not aware of the PSA, and approximately 27% had not heard of the DRE. Almost unanimously, respondents stated prostate cancer was a topic that was not discussed because:

*"These are things black men don't normally talk about ... It's because we don't know ... we are not aware."*  
 — 45-year-old participant in Community Focus Group #1

*"Black people think that it is taboo to talk about it ... because, we don't want to hear nothing bad."*  
 — 54-year-old participant in Masonic Lodge Focus Group

However, actual knowledge levels were high, with 81% answering the signs and symptoms questions correctly. Participants attributed a lack of knowledge to not having culturally appropriate health information and health messages. "Only Anglo-type magazines, literature,

Table 2. — Selected Responses by Black Men to Emergent Themes (N = 277)

Themes	Responses
Knowledge	It's a deadly curse. That's the only thing I know about it. You are reluctant to go get checked. We don't know ... we just simply don't have a clue about this prostate stuff.
Communication	A lot of men wouldn't go because number one, they feel like no one is going to care. You find very few doctors that have a caring nature about them ... the receptionist, the nurses, the doctors ... so you are kind of uncomfortable with that. When you find a doctor who takes the time to explain stuff I have more respect for him, believe it or not. Just the fact that he's explaining to me puts me at ease with whatever the procedure happens to be or whatever the situations — he's letting me know "this is where we're at, and this is what we got to do." It's not about "me doctor, you patient, you sit on table and be quiet, me do work" type of thing.
Social Support	We have a tendency to gravitate to a familiar environment. You have walk-in clinics in every neighborhood ... The problems are once again the environment is not one that they [black Americans] can feel comfortable. I think it is worth it for all of us to be aware and know; that way, in talking with some of our friends, we can make them aware also.
Quality Care	Most minorities don't get a chance to see the doctor like the other populations. It's a trust thing ... if he doesn't know what he is doing ... I want a doctor who knows what he is doing, or else I'm not going. He didn't understand ... he had no clue. You see this is a problem. African American-blacks want go to the doctor because of his [the doctor's] training, or logic, or whatever. I want the trust.
Sexuality	Well, all I know is when you mess around with the "booty" ... I don't play that. I have one flaw [laugh] ... you don't mess with the booty. The big thing is having sex. We want to keep having sex.

and pictures [are in] the waiting room ... [There are] no media campaigns with black men talking about this prostate problem.”

Men also indicated that their physicians or healthcare providers did not discuss prostate cancer information “in a way that is understandable.” Respondents reported that completing the questionnaire had increased their personal knowledge and believed that by participating, they did something to “learn about prostate cancer.” They viewed the survey as an “attractive, colorful, Afrocentric questionnaire that appears to be professional and legitimate.” Respondents said they wanted to take the questionnaire because “that brother [referring to another participant] is doing it; I figure it’s OK. It looks legit.” Others indicated that they participated because they “were asked” and because it was important to them to know more about prostate cancer prevention since they knew too little.

### Complex Communication Issues

Of the 277 participants, 127 respondents (45.8%) had the PSA. Within this group, nearly half (47.4%) reported that the doctor/healthcare provider did not explain the benefits or risk of the PSA, and 43.4% were not told why they should have the PSA (43.4%). Over half of the respondents (53.4%) indicated that the doctor had never told them they needed a PSA. Of those who had a DRE (61.4%), 58.3% reported the doctor/healthcare provider had not

explained the reasons for having the DRE, and 63.2% were not told of the benefits and risk of having the DRE. Despite these relatively low levels of testing, more than two thirds (69.2%) of the men reported they thought that prostate cancer screening was a routine part of medical care. The age group below 49 years of age comprised highest number of men (17.9%) who had no PSA or DRE. However, there were men in all age categories who stated they had never had a PSA or DRE.

Verbal and nonverbal messages communicated from the healthcare providers engendered negative feelings.

*“You walk into a waiting room, you very seldom see anything but Anglo-type magazines and literature ... You are kinda uncomfortable with that ... and you want [will not] go to the doctor.” — 54-year-old key informant*

Inappropriate references by the healthcare provider to symbolic representations of cultural practices reportedly were insulting, resulting in aversion behavior by black men.

*“He [the doctor] said, ‘You people use a hot comb to press your hair. That’s why your hair is falling out.’ He didn’t understand ... He left medicine and went into culture ... He had no clue. You see this is a problem ... Blacks want [will not] go to the doctor because of ... his logic, or whatever.” — 55-year-old key informant discussing his and his wife’s experience*

Table 3. — Quantitative Findings on Qualitative Data of Emergent Themes (N = 277)

Themes	Items	%
Knowledge	Examining my prostate is the same as examining my testes (yes).	38.2
	Prostate enlargement is a common part of aging and nothing to worry about (agree or not certain).	31.3
	Prostate cancer is only found in men who have a close relative (father, brother or uncle) with the disease (agree or not certain).	32.0
Communication	I have considered talking with my doctor/healthcare provider about prostate cancer screening (agree).	77.6
	At each regular checkup, my doctor/healthcare provider discusses prostate cancer screening with me (disagree or not certain).	52.4
	During your last visit, did your doctor/healthcare provider discuss why you did not want to have the:	
	PSA test (no)?	89.9
	DRE (no)?	84.3
	During your last visit, did your doctor/healthcare provider give you any additional information (brochures) about the:	
	PSA test (no)?	80.9
DRE (no)?	84.3	
Social Support	I would get screened for prostate cancer if:	
	My doctor/healthcare provider recommends it (agree).	85.6
	Significant others asked me too (agree).	75.1
	Someone I knew died of it (agree).	68.3
Quality	Prostate cancer screening should be a routine part of medical care (agree).	87.1
	Men who have a high chance of getting prostate cancer should be screened more than once a year (agree).	85.3
	African American men should be screened for prostate cancer before age 50 (agree).	87.8
Sexuality	African American men in general are:	
	Uncomfortable with rectal examinations (yes).	78.8
	Afraid of the possible sexual side effects of cancer treatment (yes).	83.6
	Afraid that after prostate cancer surgery, “I will not be able to perform sexually” (agree or not certain).	54.4
Afraid prostate cancer would affect their sexuality (somewhat to large amount).	82.6	

### **Social Support: A Bridge to Reconnect**

Black men provided support by talking to each other, sharing experiences and serving as an example. Most men felt a personal responsibility to share correct prostate cancer information. Additionally, older men were perceived as role models.

*"I am trying to communicate with other black men about prostate cancer because it is a very serious disease ... so they can go to the doctor." — 45-year-old participant, Masonic Lodge Focus Group*

*"I talked to my cousin before he passed ... that scared me, but I wanted to get checked out because of my cousin's situation." — 60-year-old key informant*

Significant others who accompanied the respondents to the clinic encouraged them to participate in the study because "we could learn more about prostate cancer." Over 75% of the respondents reported they would get screened if asked by a significant other.

*"If some of us older guys would talk to some of the younger guys, it might help." — 65-year-old participant, Masonic Lodge Focus Group*

*"When my father went in, it was too late. He said if he had known about this prostate stuff earlier, he would have done something about it. Since my father was diagnosed, I went to the doctor and requested the test. He did the test. I think all men need to know this and get something done." — 50-year-old participant, Masonic Lodge Focus Group*

### **CQC: Competence, Quality, Caring**

When respondents were asked about quality services, nearly 40% felt the healthcare system is not designed to help African American men. Our respondents felt that black men did not have prostate cancer screening because they are not aware they should be screened (79.5%), they believed they are not at risk (78.4%), or the doctor never mentioned it (66.7%). Additionally, 62.8% felt they were treated badly because of their race, and 45.2% believed they received poor quality of health care due to their race.

*"I know that in areas where people are underserved ... the attitude of the people giving the service is superiority. 'If you don't like it, leave.' I have bad insurance forever, and no one's talked to me about prostate cancer." — 50-year-old key informant*

When the men in our study were asked what they believed would affect the quality of healthcare they receive, 58.6% reported that their race/ethnicity influenced the quality of care they received. They expressed a strong interest in prevention of prostate cancer and expected the same level of caring about their health from the healthcare provider. Nearly 94% of the respondents believed that early detection of prostate cancer would improve their chances of living longer, and 85.3% felt that

black men care about not getting prostate cancer. Similarly, 87.8% stated if they were told they had prostate cancer, they would do something about it. A 52-year-old respondent stated, "I asked my physician for prostate cancer screening test for the last couple of years and was told, I was not old enough yet." Virtually all respondents agreed with the comment that "I'm going to ... go where they understand me." "Quality of care" is judged by men as providing care in collaboration with them and respect for them.

*"Minorities, because they don't get a chance to see the doctor like the other populations, ... have the trust thing. If he doesn't talk right to you, if you don't get the idea that he's concerned with you enough, then you go to another doctor." — 62-year-old participant in Community Focus Group #2*

### **Sexuality**

In response to questions about prostate cancer, erectile dysfunctions, and intercourse, concerns included uncertainty about the effect of prostate cancer on the ability to have a normal erection and intercourse (42.2%), a weak erection (44.5%), and an erection of insufficient strength for vaginal penetration (46.2%). Half reported uncertainty of being able to have an erection. Nearly all of the participants (91.9%) felt that functioning well sexually was important.

*"Your 'manhood' doesn't even get up. It's a macho thing; it's embarrassing." — 40-year-old key informant*

*"My great uncle was 85 years old, and his first question was whether he was still going to have sex. The doctors told him, 'We are going to save your life — we don't care if you have sex.' He was never the same again. He was a broken man after that." — 45-year-old participant, Community Focus Group #1*

### **Discussion**

Lack of knowledge centered on black men not having basic information about the prostate gland, prostate problems, consequences of prostate cancer, and recognition of the need to have the prostate checked by a healthcare provider. Our results are similar to those of Weinrich et al,<sup>34</sup> who cited knowledge as a predisposing factor to prostate cancer screening. Respondents were unsure about signs and symptoms of prostate problems. Although the participants fared well with respect to knowledge, they indicated that they were not sure questions were answered correctly and stated they guessed at most of the answers. Several men took a long time to complete the questionnaire and said they wanted to make sure all answers were to the best of their knowledge since this was "so important." Time needed to complete the questionnaire varied from 20 minutes to 2½ hours. Many men attributed the uncertainty about prostate cancer to not

having access to professional information that is culturally appropriate and understandable, and they also noted that healthcare providers do not take the time to meaningfully talk with them. Collectively, these responses indicate that credible information is an important determinant for black men when making decisions about cancer screening.

Lack of culturally appropriate linguistic and symbolic information is a barrier to appropriate communication with black men. The participants expressed a desire to communicate with their provider. However, they felt verbal and nonverbal communications, either in general or regarding prostate cancer, were discouraging to them. Lack of sufficient and respectful interaction with healthcare providers, health facility staff, and the professional health community emerged as a significant determinant of men's preventive health action. A lack of overt communicated health messages tailored toward black men sent the message that they did not need to be concerned about prostate cancer prevention.

Most men (all of them in the target risk range) trusted that if prostate cancer was indeed a potential problem for them, their healthcare providers would explain the seriousness of this to them. However, few providers had done so. Our respondents equated poor provider-patient communication with a lack of understanding and respect of their culture. Furthermore, such a lack of provider competence is thought to be synonymous with poor-quality health care. Interestingly, healthcare providers who are black are not automatically perceived to be culturally competent.<sup>35</sup> For instance, if black providers do not comfortably identify with the population and if they are not perceived to be caring or dedicated, barriers are immediately erected regardless of the racial match. If the black man perceives a lack of appreciation of the uniqueness of black culture, attempts to communicate with him about prostate cancer early detection and screening will have limited success.

Our participants view cultural competence as a sign of acceptance of black values and an openness of having blacks engaged in meaningful and respectful ways in the system. Lack of discussion by the physician about prostate cancer sends the message that prostate cancer is not an important issue affecting black men or that there is a strong cultural barrier that precludes quality care. Communication that is personally presented, one-on-one, and touches the real life experiences of black men is more readily received and acted on. When the black man is engaged, he is in most cases willing to participate in a meaningful discussion about prostate cancer prevention.

Traditional barriers to communication with blacks have been associated with factors such as economics, education, and insurance status. In our study, however, most of the participants were highly educated, had a personal physician, and had insurance coverage. Our findings are consistent with the recent Institute of Medicine report on healthcare access.<sup>36</sup> The report provided overwhelming

evidence that blacks and other minorities receive inferior health care compared with whites across a range of health conditions and procedures, even when insurance status, income, age, and severity of condition are comparable.

Our survey findings indicated that male physicians were not responsive to black men's inquiries about prostate cancer issues. The black male sex image positively portrayed in our study materials (poster and brochure) was often seen as problematic by certain staff. Some white male physicians, other (white) male patients, and clinic staff exhibited inappropriate behaviors and made negative comments about our materials. When we revisited the sites where our posters were displayed, some had been altered to make the black picture look humorous. Additionally, at clinics where we had displayed posters announcing information on survey enrollment, our posters had been removed and/or substituted with traditional materials featuring white men. Some of our posters were placed in the back of the clinic on the floor or against the wall. Conversely, our respondents were appreciative of the positive portrayal of the black man, and we received many unsolicited comments about the attractiveness of our posters and materials that "caught their eye."

Our participants believed that non-black physicians felt intimidated when asked questions about prostate cancer and its potential impact on life. Most of our respondents felt this reaction was a reflection of a global negative view of the black man. Our participants reported that physicians often responded to their request by discouraging them from testing. Others ignored the question entirely, further alienating the men. Such responses from physicians reinforced the distrust in the healthcare system felt by our black respondents.

Historically, the dominant stereotypic perception of black men in American society as a "bad guy" (eg, thug, drug dealer) often limits the opportunity for a positive patient-physician relationship and black male engagement. The black men in our study prefer to be respected and have standard medical care provided by a competent physician and healthcare provider, regardless of race or ethnicity. They believe that a physician should provide positive support and encouragement when they attempt to be an active part of their healthcare decision-making. For the black man, active participation increases his desire to know about prostate cancer prevention, fosters trust, and decreases fears and concerns about prostate cancer. A trusting physician-patient relationship reassures the black man that he is receiving quality care.

A major concern for our respondents was the issue of testing. The DRE in particular was seen as problematic. In their view, the DRE was threatening to their sexuality. Even though our participants were willing to take the DRE, they did not like the examination, thought it was embarrassing, and felt it was associated with homosexual tendencies. Nevertheless, they stressed that it needed to be included since it is part of standard quality care. Inter-

estingly, while most men and physicians preferred the PSA to the DRE, the majority of men who had any screening reported having had a DRE as opposed to a PSA.

Another barrier related to sexuality is impotence. Prostate cancer is perceived as a threat to black manhood because of the fear of impotence. Vaginal intercourse is important to black men. The 1991 National Survey of Men indicated that 97% of black men prefer vaginal intercourse.<sup>37</sup> According to urologists, erectile dysfunction is the most common sexual dysfunction complaint among all men over 50 years of age.<sup>38</sup> Fear of impotence was a clear concern of our respondents, which is similar to other research findings regarding black men's attitudes about impotence.<sup>12,13</sup> Our respondents viewed sexual performance as an important natural function of healthy men of all ages and related it to physical, emotional, and psychological well-being.

Our participants reported that their family and friends provided the social support needed to make meaningful prostate cancer screening and early detection decisions. In the focus groups, it was mostly the trusted older men who initiated a deeper, more serious discussion and created an atmosphere where all men listened intently. The men shared highly personal experiences that engendered a sense of camaraderie, closeness, and respect. This created an atmosphere of trust among the men and led to our being invited back to share more information about prostate health with the group in the future.

A caring, trusting, social environment leads to an increased interest by the men and offers the potential to connect the black man into a positive, respectful relationship with his physician. Creating a positive relationship with the physician/healthcare provider strengthens the possibility of informed, shared decision-making regarding prostate cancer early detection and screening.

Social support gained through outreach using respected older men and family members validates trust, legitimizes prevention behavior, and encourages decision-making toward personal action. These findings are consistent with other researchers who have identified core black culture values and traits as respect for elders, reliance on familial networks, strong orientation toward black organizations for reliable information, respect for verbal communication skills, connection to ancestors and history, and preference for experience vs empiricism.<sup>20,39,40</sup>

By developing a trusting relationship with our participants through personal attention and by including them in the qualitative research process, we experienced an overwhelming recruitment response for phase II of the project.<sup>41</sup> Consequently, "word got out" about the importance of the issue and the respect with which our team approached men. Participants actually recruited other men to take the questionnaire. As a result, we were able to enroll 277 men into our study within a short time (<2.5 months) and in fact had to stop recruitment and turn potential participants away. Engaging black men in

research was not a problem we encountered; on the contrary, we found them to be committed, patient, appreciative, and motivated to participate.

## Conclusions

Black men's lack of engagement with the healthcare system in general and more specifically in prostate cancer screening occurs within a larger societal context. Black men have historically been dissuaded from active and meaningful participation as a partner in their own health care. Disconnectedness of black men from society has persisted for a long time, and healthcare is no exception. To improve the lagging health status of black men, health professionals must utilize strategies that reach, engage, and sustain relationships with this population.

To more effectively reach black men, we recommend a combination of culturally attractive materials, cultural sensitivity (including an acknowledgment of past negative experiences of this group with healthcare), and competent, person-oriented quality service delivery. Most important is the need for a "personal touch" — a relationship between the provider and the men. This personal touch will act as a bridge to decision-making. It meets the needs of the black man to be respected within a history of lack of respect, and it shows the provider's commitment to the process of building a trusting relationship with their black male patients. While somewhat time-consuming, this culturally sensitive approach earns trust of black men and allows for positive, safe decision-making. Consideration of their ethnic origin will enhance our ability to reach disenfranchised black men more effectively and will help to close the health disparity gap.

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