

# Health Decision-Making Preferences Among African American Men Recruited From Urban Barbershops

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**Financial Support:** This work was supported by a grant (MRS-GT-04-209-01- CPPB) from the American Cancer Society.

**Objective:** To examine general health decision-making roles among African American men ages 40 to 70 recruited in barbershops in the Richmond, Virginia, metropolitan area.

**Methods:** We adapted the 1-item Control Preference scale to study the associations between health decision-making role preferences and demographic variables. Forty African-American men were recruited from barbershops to complete a self-administered survey. After performing descriptive statistics, we dichotomized our outcome into active vs nonactive (collaborative or passive) decision makers. Data were then analyzed using  $\chi^2$ , Wilcoxon-Mann-Whitney rank sum, and multiple logistic regression.

**Results:** Fifteen subjects responded that they engaged in active decision making, 20 in collaborative, and 5 in passive decision making. Almost all (86.7%) active decision makers were home owners, vs 41.7% of nonactive decision makers. Among active decision makers, 46.7% had incomes of more than \$70,000, vs 12.5% of nonactive decision makers. The active group reported health status that was good to excellent, while 20.8% of those in the nonactive group reported poor/fair health.

**Conclusion:** African American male barbershop clients preferred an active or collaborative health decision-making role with their physician, rather than a passive role. The relationship among home ownership, income, and decision style may best be understood by considering the historical and cultural influences on gender role socialization among African American males. More comprehensive assessment of decision styles is necessary to better understand health decision making among African American male patients.

**Keywords:** patient-physician relationship ■ African Americans ■ men's health

*J Natl Med Assoc.* 2009;101:684-689

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## INTRODUCTION

Patient preferences in health decision making have been explored increasingly over recent decades.<sup>1,2</sup> Including patients in the decision-making process is a shift from the paternalistic paradigm that has been the predominant model of the patient-physician medical encounter.<sup>1-3</sup> Under the paternalistic model physicians assume an authoritarian role during medical encounters and make the treatment decisions.<sup>1-3</sup> Existing data suggest that patients who are knowledgeable about their conditions,<sup>4</sup> active participants in their own care,<sup>4</sup> or at least involved in decision making for their care fare better in their health outcomes.<sup>4</sup> These data may explain why patients increasingly are being encouraged to become more involved with their health care and in their health care decisions.<sup>2,5</sup> Efforts to increase patient involvement in health decisions are particularly important given the projected impact of health care costs at individual and government levels.<sup>6</sup> Therefore, it is imperative that factors that might promote better health care be identified, explored, and implemented into processes that may help reduce or buffer the multilevel economic strain of health care costs.

Shifting the traditional paradigm in health decision-making roles is a topic of interest in the United States and abroad. For example, in Europe, the World Health Organization emphasized the importance of involving patients in the development and delivery of health care services.<sup>7</sup> The Institute of Medicine in the United States has been a strong proponent of patients exercising control in their health decisions when it is appropriate and possible.<sup>8</sup> Recently, the Agency for Healthcare Research and Quality developed a public awareness campaign to encourage patients to become more active in their health care.<sup>9</sup> The informed/shared decision-making paradigm<sup>10,11</sup> requires that the physician share pertinent information with the patient, enabling the patient to participate in making medical decisions with the physician. It

assumes that it is normative and desirable for patients to have active or collaborative decision-making styles. This assumed normality may apply to some patients more than others and may be moderated by ethnic, gender, and demographic factors. For example, education and socioeconomic status (SES) generally predict positive health practices and health outcomes.<sup>12</sup> Such findings may help explain ambiguities in patient preferences for health decision making.

Research has shown mixed results regarding patients' desired levels of involvement in health decision making<sup>1,13,14</sup> and certainly has not shown that active decision-making styles predominate among patients. Studies have suggested that some patients want to play an active role in their health care decisions, while others prefer to leave final health care decisions to their physicians.<sup>1,4</sup> One observational study of patients with chronic diseases<sup>15</sup> found that 69% of the patients preferred to leave their medical decisions to their doctors. Preferences varied significantly by patient characteristics, such as the severity of the disease, demographics, and lifestyle characteristics. For example, patients with severe diabetes were less likely to prefer an active decision-making role than patients with "unsevere" hypertension. Also, younger patients and those with more education preferred a more active decision-making role. Another study, perhaps the most representative national sample of desired roles in health decision making, found that women were more likely than men to prefer an active role in health decision making.<sup>4</sup> This finding is consistent with research that has reported that women have higher levels of health information seeking than men.<sup>16</sup> Higher levels of health information seeking may suggest higher levels of active or collaborative decision-making preferences.<sup>4</sup> Furthermore, Levinson et al reported that African Americans were more likely to prefer a more passive role in their health decision making.<sup>4</sup> Results of comparisons of demographic variables with decision making styles in Levinson's study suggested that other vulnerability, including poorer health and older age, was associated with less active decision-making styles. The issue of the relationship of decision-making style to racial and ethnic health disparities was considered complex and worthy of more study.

Emerging research has focused on African Americans and their role preferences in health decision making. Studies have emerged about preferences for involvement in general decision making,<sup>17,18</sup> use of advanced directives and hospice care,<sup>19,20</sup> organ donation decision making,<sup>21</sup> diabetes treatment decision making,<sup>22</sup> and mammography screening decision making.<sup>23</sup> At least 2 studies have focused on African American men's decision-making preferences in the context of prostate cancer screening.<sup>24,25</sup> However, we found no studies that have examined general health care decision-making preferences exclusively among African American men.

We conducted a brief pilot study of African American men recruited from urban barbershops to explore their preferred levels of involvement in health care decisions with a physician or health care provider. We sought insight into possible factors that might explain our anecdotal experience that some African American men choose to play an active or collaborative role in their health decision making with physicians or health care providers, while others chose to play a passive role. This pilot study was intended both to serve as a basis of an intervention to help these men make more informed decisions, and to inform the design of further studies which compare and explain African American men's decision-making styles vs those of other groups.

## METHODS

### Participants

**Barbershops.** We recruited barbershops in the Richmond, Virginia, metropolitan area that serve a high percentage of African American men ages 40 to 70. The details of our sampling frame development and recruitment procedures have been described elsewhere.<sup>26</sup> In brief, the sampling frame was initially developed by obtaining a list of barbershops from the Department of Professional and Occupational Regulation. A geographical information system was used to narrow the geographical locations of barbershops in metro Richmond (including Henrico and Chesterfield) based on zip codes/census tracts that were believed to be predominantly African American. To help identify other African American barbershops, we searched a copy of Black Pages obtained from the Richmond Metropolitan Business League. Finally, we obtained information about other barbershops in the metro Richmond area by talking with barbershop proprietors, community referents, our Barbershops Advisory Council (described in detail elsewhere),<sup>26</sup> and by using a sampling technique known as "snowballing."

**Barbershop clients.** Participants were approached in person by the project research assistant, screened for eligibility, and asked to participate in an individual qualitative interview that focused on multiple health-related topics. All potential interview participants were offered a stipend of \$50. Men who agreed to participate were asked to choose a convenient date for the interview. The interviews were conducted at sites most convenient for the participants (eg, barbershops, Center for Culture Experiences in Prevention Research Center, or participant's home). Due to the personal nature of the topic, an African American male (principal investigator and research assistant) conducted all the interviews. The interviews lasted approximately 1 hour. During the qualitative interview, each participant was asked, "What role does your doctor play or other regular health care provider play in your health decisions?" Participants were then asked to select 1 option from the Degner Control

Preference scale.<sup>27</sup> The options were read to the participants. At the completion of the qualitative portion of the session, participants were asked to complete a brief self-administered demographic survey.

**Measures**

**Preference for control in decision making.** To assess the degree of control an individual desired in the decision-making process, we adapted the 1-item Control Preference scale.<sup>26</sup> Participants were asked, "What role does your doctor play or other regular health care provider play in your health decisions?" Individuals were asked to select from the following response options: (a) "I prefer to leave all decisions regarding my health care to a doctor or health care provider;" (b) "I prefer that a doctor or health care provider makes the final decision about my health care but seriously consider my opinion;" (c) "I prefer that a doctor or health care provider and I share responsibility for deciding what health care is best for me;" (d) "I prefer to make the final selection of my health care after seriously considering a doctor's or health

care provider's opinion;" and (e) "I prefer to make the final selection about what health care I will receive." In analyses, responses were collapsed to reflect passive decision-making styles (options a and b), collaborative styles (option c), and active styles (options d and e).

**Demographic survey.** The demographic survey asked basic questions regarding age, education, and income.

**Data Analysis**

Descriptive statistics summarized participant responses, particularly their decision-making preferences (active, collaborative, or passive). Since the sample size was small, and there were only a few subjects with passive decision making, we dichotomized our outcome into active vs nonactive (collaborative or passive) decision makers. Association between active decision making and other variables used  $\chi^2$  tests or Fisher's exact test (when expected cell sizes were <5) for categorical measures and the Wilcoxon–Mann-Whitney rank sum test for ordinal or continuous data (age, education, occupation, and income). While health status was an ordinal

**Table.** Comparison of Active and Nonactive Decision Makers<sup>a</sup>

Variable	Active (n = 15)	Nonactive (N = 25)	P Value
Age <sup>b</sup> (mean)	52.5 (7.8)	49.4 (6.5)	.263
Education <sup>b</sup>			.254
High school graduate	5 (27.8)	13 (72.2)	
Some college	7 (43.8)	9 (56.2)	
College graduate	3 (50.0)	3 (50.0)	
Marital status <sup>c</sup>			.061
Married/living with partner	12 (50.0)	12 (50.0)	
Single, widowed, or divorced	3 (20.0)	12 (80.0)	
Home ownership <sup>c</sup>			.005
Yes	13 (56.5)	10 (43.5)	
No	2 (12.5)	14 (87.5)	
Employment <sup>d</sup>			1.000
Full or part time/self-employed	13 (38.2)	21 (61.8)	
Retired/not employed	2 (40.0)	3 (60.0)	
Occupation <sup>b</sup>			.053
Managerial/professional	6 (54.5)	5 (45.5)	
Service/technical	6 (46.1)	7 (53.9)	
Operator/laborer	3 (25.0)	9 (75.0)	
Income <sup>b</sup>			.021
<\$15 000	0 (0.0)	1 (100.0)	
\$15 000–\$30 000	2 (22.2)	7 (77.8)	
\$31 000–\$50 000	3 (27.3)	8 (72.7)	
\$51 000–\$70 000	3 (37.5)	5 (62.5)	
>\$70 000	7 (70.0)	3 (30.0)	
Health <sup>d</sup>			.042
Poor/fair	0 ( 0.0)	5 (100.0)	
Good	8 (61.5)	5 (28.5)	
Very good/excellent	7 (33.3)	14 (66.7)	

<sup>a</sup> Columns may not total to sample size due to missing data.

<sup>b</sup> Wilcoxon rank sum test for ordinal variables.

<sup>c</sup> Pearson  $\chi^2$  for categorical variables.

<sup>d</sup> Fisher's exact test for categorical variables when expected values are <5.

variable, the response pattern was not ordinal, so categorical methods were used. If more than 1 variable was found to be significantly related to decision making, multiple logistic regression was considered to determine if variables were independently predictive of being an active decision maker. A significance level of .05 was considered significant. Because of the small sample size, we also note marginal significance when  $.05 < p < .10$ .

## RESULTS

### Barbershop Client Survey

Sixty barbershop clients were approached to participate in this study. Forty African-American men completed self-administered surveys (response rate 67%).

### Respondent Characteristics

The average age of participants was 50.6 (SD, 7.1) years. Six participants had a college degree, and almost half ( $n = 18$ ) reported completing high school or having received a GED. The majority of participants were married or living with a partner ( $n = 24$ ).

### Decision Control Preference

Fifteen subjects responded that they engaged in active decision making, 20 in collaborative decision making, and 5 in passive decision making. The outcome was dichotomized as active ( $n = 15$ ) or nonactive ( $n = 25$ ) because the sample size was small and few subjects engaged in passive decision making (Table). Mean age was 52.5 for subjects in the active group vs 49.4 in the nonactive group. Twenty-seven percent of subjects who completed high school were active decision makers. The number of participants who preferred active decision making increased to 43.8% for those with some college and 50% for college graduates. However, the trend was not statistically significant ( $p = .254$ ). One-half of the subjects married or living with a partner were active decision makers. This was marginally higher ( $p = .061$ ) than the 20% of active decision makers among subjects single, separated, or divorced. There was a significant difference in decision-making style according to home ownership. Fifty-six percent of those who owned homes were active decision makers, while only 12.5% of those who did not own homes were active decision makers ( $p = .005$ ). Thirty-four subjects were employed. There was a trend ( $p = .053$ ) for those with managerial/professional or service/technical jobs to be active decision makers (54.5%, 46.1% respectively), while laborers tended to be non active decision makers (75%). Similarly, there was association between income and decision making ( $p = .021$ ). As income increased, subjects were more likely to be active decision makers. While only 2 subjects with incomes less than \$30 000 were active decision makers, 70% of subjects making greater than \$70 000 classified themselves as active decision makers. Finally, health

status was significantly associated with decision-making style ( $p = .042$ ), although tendency to be an active decision maker did not increase with increasing health. No subjects who reported poor health were active decision makers, while 61.5% of those with good health were active decision makers, but only 33.3% of those reporting very good or excellent health were active decision makers. In a multiple logistic regression none of the variables found to be significant in univariate analysis were independently predictive of active decision making, in the presence of the other (table not shown).

## DISCUSSION

We found in this sample of African American barbershop customers that they preferred a collaborative (50%) or an active role (37.5%) in health decision making with their physician, rather than a passive role. Only 5 (12.5%) of the 40 subjects chose a passive decision-making role. In comparison, 52% of subjects in Levinson's nationally representative sample preferred to leave final decisions to their physicians.<sup>4</sup> The demographics of our sample were solely African American males, and therefore far different than Levinson's representative study in which African Americans were more likely passive in their health decision making with physicians. Although Levinson did not differentiate between African American men and women, Levinson noted that more women, in general, preferred an active role compared to men.<sup>4</sup> However, our results are similar to those reported by Williams et al in a study involving 286 African American men aged 40 to 70. Using a version of the Degner Control Preference scale<sup>27</sup> to explore prostate cancer screening decision making, Williams et al also found more men who preferred a collaborative (57%) or an active role (36%), rather than a passive role (7%).<sup>24</sup> Our study further adds to the literature by examining general health care decision-making preferences among African American men and provides a broader context and insight for physicians and health care providers serving African American men.

We examined demographic characteristics to further describe our sample of African American men and their preferred health decision-making roles. Decision-making styles were more often active among our sample of African American men if they owned homes, had managerial/professional jobs, had incomes greater than \$70 000, or reported good to excellent health. Interestingly, a large percentage of men in the nonactive (collaborative and passive) group reported being in poor/fair health. Similarly, Levinson et al noted that subjects with poorer health were more likely to prefer a passive role in health decision making with their physicians.<sup>4</sup> As previously noted, the active decision-making group in our study reported higher incomes compared to the nonactive decision-making group. Therefore, it is possible that men in the active decision-making group reported

“good” to “excellent” health because they could afford better health care coverage. Surprisingly, preferences for control in decision-making did not vary by age or educational attainment among our participants. Both Levinson et al and Williams et al reported that younger participants were more likely than older participants to prefer active decision-making roles.<sup>4,24</sup>

Active and collaborative decision styles among our sample may be a result of having received psychological validation along a number of areas—ethnic identity, racial socialization, and spirituality—which have been associated with a wide range of self-efficacies among African American populations.<sup>28-30</sup> However, the relationship between home ownership, income, and decision style among these active decision makers may best be understood by considering the influence of historical and cultural influences upon gender role socialization and gender role expectations among African American males. Although America has become a much more egalitarian society, there remains a persistent social pressure for males to meet traditional male gender role expectations.<sup>11</sup> The results of our study suggest that perhaps African American males who were homeowners met a societal and cultural gender role expectation that can be associated with other dimensions of male gender role socialization, especially autonomy.<sup>11</sup> This autonomy dimension of male gender role socialization implies that males are expected to rely upon themselves and their resources for decision making and economic viability. Thus, home ownership can be considered as an index of male gender role fulfillment and associated positive psychological effects, particularly decision-making self-efficacy. However, more research needs to be conducted to determine if there is variation among indices of male gender role fulfillment among males of minority and nonminority ethnic groups. It is possible that home ownership may be especially salient among African American and other minority males, given a cultural recognition of the systemic and structural inequities that generally produce lower levels of home ownership, and other socioeconomic indicators, among these populations.

The present study has several limitations. First, the sample of African American men recruited from the metro Richmond area may not be representative of African American barbershop clients located in other regions of the United States. For example, the 2005 Current Population Survey<sup>31</sup> reported that 48.2% of African Americans were home owners, while home ownership in this sample was 57.5%. Secondly, the men in this study might not be representative of the surrounding populations of the urban barbershops enrolled in our study. Relative to the demographic characteristics of the population surrounding the urban barbershops participating in the study,<sup>26</sup> the men in the current study were middle-aged to elderly men, more often married or partnered, better educated, and had higher incomes. The apparent

selection bias toward men with the aforementioned characteristics in our sample may be explained by the age of our sample of African American men. It is possible that older African American men have more socioeconomic stability compared to younger men. Also, regularity and costs of haircuts may be another SES indicator among this sample. Most clientele aged 40 to 70 years get at least 2 haircuts a month<sup>26</sup> at costs ranging from \$10 to \$15 per haircut in this region. Therefore, the barbershop clients in our study may be individuals who have higher levels of discretionary income than other populations. Thirdly, in addition to not being population based, the small sample size limited our power to detect some differences that might truly exist, as well or to perform more detailed analyses.

Despite the limitations described above, we believe the results of the present study should encourage more research exploring health decision-making preferences among African American men. In order to better understand health decision making among African American male patients, more comprehensive assessment of African American male decision styles is necessary, including research using white comparison group(s) and comparing different demographic segments of African American males.

Furthermore, the African American barbershop is an important institution in the African American community. The neighborhood barbershop in the African American community is often more than a place for haircuts and shaves. Traditionally, it has been a place where African American men, both young and old, have come together to hang out and socialize. In his book, *Do Bald Men Get Half-Price Haircuts?*, Staten says, “When you talk about black barbershops, you talk about community.”<sup>32</sup> Also, barbershops patronized by African American men have been emotional safe havens where the conversations are as varied as the patrons that frequent them.<sup>33</sup> In this fraternal environment African American men discuss topics ranging from sports and local current events to personal subjects such as religion and family issues. Staten proposes that there is an openness in the black barbershops that is not found anywhere else.<sup>32</sup> We propose that the openness of this environment is favorable for conducting research among men who could be potentially excluded from clinical recruitment processes due to lack of routine health care for various reasons.<sup>34</sup> Therefore, more research is needed in urban barbershops, both regionally and nationally, to better describe this population of African American males for future public health research, education, and interventions.

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