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Understanding the factors that influence risk tolerance among minority women: A qualitative study

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Abstract

Objective—The objective of our study was to explore the factors that influence risk tolerance among women from different racial/ethnic groups.

Methods—In-depth individual interviews of Non-Hispanic Black, Non-Hispanic White, and Hispanic women aged 20–45 were conducted by a trained interviewer (S.B.) using a semi-structured interview guide to elicit the factors that influence risk tolerance among minority women. The interviews were audiotaped and professionally transcribed with a final sample size of 36 determined by thematic saturation. The members of the research team used open coding to review and develop a list of codes which was modified as new codes emerged. A final list of 35 codes was applied to the transcripts and combined into broader themes.

Results—Participants were 30.6% Non-Hispanic Blacks, 33.3% Non-Hispanic Whites and 36.1% Hispanics, with a mean (SD) age of 34.8 (6.8) years. Several major themes explaining risk aversion among minority women emerged: discrepancies in quality of healthcare, perceived prejudice, lack of knowledge and education, medication beliefs, risk perception, and constrained resources. The latter was discussed most frequently.

Conclusion—While our results point out several concerns that may be addressed through medical providers implementing more effective communication strategies, they also highlight that disparities are strongly influenced by the complex ways financial and social constraints influence minority women's healthcare decisions.

Disparities in the delivery of healthcare across racial and ethnic minority groups have been extensively documented (1). Limitations due to access have long been blamed for these disparities; however, differences in patients' preferences also contribute (2,3). For example, some studies have found that minority patients are less willing to undergo knee replacement

compared to their Caucasian counterparts despite having as or a greater level of pain and disability (4). In an experimental study, we previously found that minority women were more worried about a rare dreaded adverse event (AE) and were less willing to take a medication associated with this AE, compared to White women (5). Similarly, Constantinescu et al (6) found that African American patients with active rheumatoid arthritis were less likely to choose to escalate their care compared to White patients even after adjusting for sociodemographic factors. These results were due to a relative overweighting of rare adverse events and underweighting of benefits (7). Distrust in the healthcare system and race discordance between providers and patients have been suggested as reasons underlying differences in preferences (8–10). However, these factors are not consistently associated with treatment preference, and the reasons underlying a greater reluctance to accept risk among minorities remain poorly understood.

The objective of this study was to further explore the factors that influence risk tolerance among different racial/ethnic groups, particularly those that may contribute to risk aversion among minority women. Risk averse individuals tend to reduce uncertainty when faced with decisions and prefer to choose outcomes with lower returns than take a chance on uncertain outcomes with potentially equal or greater returns (11).

METHODS

Study Design

We elected to conduct the study using qualitative methods, which are particularly suitable to generate new ideas to improve our understanding of the factors influencing unwarranted variability in care. (12). We chose to interview Non-Hispanic Black, Non-Hispanic White, and Hispanic women between the ages of 20 and 45. We restricted the study population to eliminate the known effects of gender (13,14) and age (15) on risk perceptions. We chose to focus our study on young women in order to better understand the beliefs and attitudes of a population in which racial/ethnic disparities in treatment preference have been shown to significantly impact health outcomes. A notable example is systemic lupus erythematosus, in which African American and Hispanic women have been known to have more severe disease at a younger age and worse outcomes (16). Because the objective of this study was to explore the factors that influence risk tolerance among minority women, this study utilized the classic Grounded Theory Method using an inductive approach, as recommended by Glaser (17).

Participants and Recruitment

Participants were women receiving treatment at a large academic hospital either while inpatient or in an infusion center. Women were considered eligible if they were between the ages of 20 and 45 years; able to speak English or Spanish and self-identified as Non-Hispanic Black, Non-Hispanic White or Hispanic. Eligibility was not based on a specific disease or treatment. Women were purposely recruited to ensure representation of all three groups. Participants did not receive any monetary or non-monetary incentive. Our final sample size of 36 women was determined by thematic saturation, at a point when no new

themes emerged from successive interviews (18–20). The study duration was March 2013–2014. The research protocol was approved by the Institutional Review Board.

Interview Guide

We developed a semi-structured interview guide including an introductory question and prompts. In the opening question, all participants were asked why they thought minority women tend to be more risk averse (Appendix). Verification of responses was performed throughout the interviews using talk back to ensure that the interview accurately interpreted participants' responses. Demographic characteristics were collected after the qualitative interview. In-depth interviews were conducted by a single trained interviewer (S.B.). The interviewer was a female medical resident from India who had a distinct cultural background and medical experience from the target population and did not feel more or less comfortable or familiar with any of the racial/ethnic groups recruited for this study. The interview lasted an average of 45 minutes. Interviews were audiotaped and subsequently transcribed verbatim by a professional transcribing service.

Analysis

We created an audit trail by audio recording each interview. Recordings were transcribed verbatim. The transcripts were independently evaluated and substantive codes identified and labeled line-by-line by three members of the research team (S.B., K.M., and L.F.) with varying expertise (in clinical research, clinical rheumatology, medical decision making and qualitative research methods), thus fulfilling the requirements of investigator triangulation (using perspectives from varying investigators in qualitative research). A constant comparative approach was used to develop codes among research team members. All coders met at regular intervals to review, compare, and resolve discrepancies in their codes. Codes were re-defined, and a final coding list of 35 codes was then applied to the transcripts (Appendix). The resulting substantive codes with similar meanings were clustered together, leading to the emergence of concepts, which were further sorted into broader categories that defined emerging themes across the three racial/ethnic groups. Throughout the process of data analysis, emerging substantive codes, concepts, and broad categories were continuously compared to the data to ensure the “grounded” nature of the analysis.

RESULTS

Demographic characteristics by race and ethnicity are summarized in Table 1. The participants were 30.6% Non-Hispanic Blacks, 33.3% Non-Hispanic Whites and 36.1% Hispanics. The mean (SD) age was 34.8 (6.8) years. Most (66.7%) had a college education or higher; 58.3% had an annual income of \$40,000 or more; 41.7% were employed full-time, and 55.6% were married.

At the onset, participants acknowledged differences in risk tolerance between Non-Hispanic White and minority ethnic groups:

[Caucasian women] are really risk takers whereas we got so much to lose if we make decisions like them. (Non-Hispanic Black woman)

Black people are not willing to take the risk. They feel as though that risk is much too much. (Non-Hispanic Black woman)

Hispanics we are not that daring, the Hispanic race just does not like to take risks. If you talk about business, yeah we would take the risk, but when it is about health issues, better not. (Hispanic woman)

Upon analyzing the data, several major themes explaining risk aversion among minority women emerged: 1) constrained resources 2) discrepancies in quality of healthcare 3) perceived prejudice 4) lack of knowledge and education 5) medication beliefs and 6) risk perception. These themes with supportive quotes are described below. Additional quotes are included in Table 2.

Constrained Resources

The pervasive impact of constrained resources on treatment preferences was the theme most commonly discussed, and participants described several mechanisms by which limited resources influenced their decision making. Black women described having less bandwidth to deal with health-related decisions because of the amount of stress they contend with.

It is hard for us as Black women to make decisions because we have to think about everything, like everything. We are so concerned with our families, economic status and just how we are going to get by for the next days. (Non-Hispanic Black woman)

Participants highlighted low income status as the cause of inability to think of their own health before absolute necessities were covered.

You know, you may need to pay your rent or your mortgage or your electricity first because that is more important to you than maybe feeling better. (Non-Hispanic Black woman)

Many minority women self-identified as being the primary or sole breadwinner in the family and/or the primary caretaker in the family. Both minority and Non-Hispanic White women explained that minority women were less likely to seek healthcare compared to Non-Hispanic White women because of their inability to be absent from work and/or their familial responsibilities.

They [minority women] don't have transportation; how are they going to arrange to get to the doctors or who is going to watch the children when they go to the doctor. Maybe they can't get off of work ... They don't want to be sitting, lying around somewhere recovering. They want to be able to go to work and pay their bills, take care of their families. (Non-Hispanic Black woman)

Some underscored how cost limited their ability to consider specific treatment attributes:

The person is thinking of the cost they are not thinking about the percentage of how they would be cured... because cost is the number one concern. (Non-Hispanic Black woman)

In addition to the cost of receiving treatment, several women worried about their inability to pay for possible treatment-related complications.

We are more worried about the side effects because it is more costly to us. So if I barely have enough to pay for that medication what makes you think I am going to have enough if one of those side effects tends to come to me. (Hispanic woman)

Minority women viewed their personal healthcare needs within the context of their family's needs. Their accounts illustrate the complexity and amount of effort required for them to be able to add to their already full lives. Non-Hispanic White women also described their extensive responsibilities. However, in contrast to Black women who focused on the risks of the medications, they highlighted the potential benefits of treatment in order to ensure that they would be able to uphold their obligations.

My life is so busy with work, school, three children....I can't sit and worry all day about if there is going to be a risk. If I have something that is going to help me to continue with my life and keep up the pace that I want to be at then I want to try it. (Non-Hispanic White woman)

Discrepancies in Quality of Healthcare

Participants spoke about their personal experiences receiving poor quality of care. They alluded to differences between "private practices" and "public clinics":

A lot of times we get passed over. Our health care physicians in minority neighborhoods are much different than the ones in a higher income neighborhoods, there is a big difference and most people don't notice that until you go to another hospital and see the differences and you feel kind of passed over. (Non-Hispanic Black woman)

Others further noted how poor communication between patients and physicians could negatively influence their decision making. They described being dissatisfied with both the amount of information physicians disclose and the way they communicate.

They have to be more expressive when they talk about the medications. They sometimes give you the script but don't even tell you why. They have to explain the treatment better. (Hispanic woman)

In addition to lower quality associated with settings and providers, one woman eluded to minority women receiving lower quality medications. She expressed concern that, because of their insurance, they were being prescribed generic medications, which they felt were inferior to brand name drugs.

We have the Medicaid and they pay for the generic, a downgrade one then the actual one that you need. (Hispanic woman)

Perceived Prejudice

Minority women further expressed concern about dealing with prejudice and alleged bias from treating physicians.

[Black women] have not gotten out of that racist mentality so they think that someone is out to get them. "Oh I am not going to come out of the surgery"—they think someone is going to do harm to them. (Non-Hispanic Black woman)

But because I was talking in Spanish they started looking at me in a bad way. They did not treat me. They just sent me home. Just because you are Hispanic, doctors treat you different. (Hispanic woman)

Some expressed apprehension about being able to relate to their physicians, who may not share the same race or ethnicity. They also questioned if the physicians were always acting in their best interest.

Usually people go with other people of the same race or the same culture on purpose because you feel more comfortable with them and if you are a minority going to a health care provider or an establishment that is not of your race you kind of feel not as safe as you would around your own people. So you are more distrusting, like I said because of history and kind of what is going on now. (Non-Hispanic Black woman)

One participant identified how an inherent fear of being treated differently as a minority influenced her decision-making; she recognized that the need to always adopt a “defensive” stance might have impacted her health negatively.

And your health suffers from it. Your trust is not there. You think everyone is fake or not real. You automatically put on that “she is out to get me or what is she up to”. You don’t want to really do that but you are always on the defense. (Non-Hispanic Black woman)

Some minority women interviewed also recognized that their fear of prejudice resulted in unfounded generalizations:

If anything at all goes wrong I think Black people feel like “see what I am talking about, see we always get treated worse or lesser then”. I think White people tend to think like “oh that’s just an accident”. We feel more like that was an accident aimed at us. (Non-Hispanic Black woman)

A White participant also described differences in causal attributions:

If you talk to her and she is African American and she will say “My grandfather was in a physician’s care and he died on the table” but my father was under a physician’s care too and he passed away too but he passed away because it was his time. (Non-Hispanic White woman)

Several minority women perceived themselves as having a greater risk of being used as experimental subjects. In addition, they felt that minorities, as a whole, were more vulnerable to be considered as subjects for the initial more harmful phases of drug trials.

We as Hispanics are always the guinea pigs. There are a lot of experimental medications used in Hispanics. (Hispanic woman)

You know after the drug trial is over and they start giving out the medicine I think that they would give it to more Black people first as like another trial ... just to see what would happen. (Non-Hispanic Black woman)

Lack of Knowledge and Education

Minority women also identified a general lack of understanding of medical conditions among Hispanic and Black women as having a negative impact on the quality of their decision making. They described racial differences in general education, initiative to research and inquire about potential treatment options, as well as preferences for being informed.

Being a Black women I can honestly say a lot of Black people in our community they don't take the time to educate themselves on a lot of things and White people they research stuff. (Non-Hispanic Black woman)

Some participants felt that learning about the conditions and treatments empowered patients, enabling them to “take control” of their medical management.

If you are not educated or you are not willing to speak up and do your research and ask your doctor questions than I think that you are really doing yourself a disservice. (Non-Hispanic Black woman)

A Black participant further reflected that some of her family members would rather be unaware of their actual medical condition in order to avoid facing a “diagnosis”.

People in my family and they would just rather not go to the doctor then to go to the doctor and find out all these things are wrong with them. It is a fear of death or a fear of decline in life. (Non-Hispanic Black woman)

In comparison, minority women felt that White women have more advanced education and initiative to research medical questions, which they believed ultimately led to making “better” healthcare choices.

White people take more control over their health and may be more educated and do the research to find out that the likelihood that something bad is going to happen to you is very small. I think maybe Caucasians will say “Well if I am fearful of dying maybe I can prevent it by going to the doctor.” Where Black people sometimes they are just like “I just don't want to know”. (Non-Hispanic Black woman)

Medication Beliefs

A number of minority women described having a general aversion for medications.

If you are fixing something but instead you give me side effects why would it be worth taking the medication? If you are spoiling something else in my body or you are giving me another disease. (Hispanic woman)

Others recounted past experiences with natural or home remedies, stating they would continue to implement these remedies as first-line treatment for a number of illnesses.

Like your grandmother use to give you these old remedies to try instead of going to the doctor. I grew up on that. (Non-Hispanic Black woman)

I think that it is cultural, their [minority women] reliance more on family, traditions and remedies that are not traditional medicine. (Non-Hispanic White woman)

Many minority women felt that natural or home remedies were unlikely to cause any side effects. As these remedies were handed down over multiple family generations, they were regarded as safe and effective.

My grandma used roses and honey for diabetes and bees for arthritis because the bee stings you and the pain goes away. They used to give her 20 pills and none of them worked. But she looked for one to get stung and the pain improved. I think these things [natural remedies] was better, without side effects. (Hispanic woman)

Risk Perception

Several women felt that Black women were more likely to experience side effects. One Black participant identified Black women as those more likely to fall within the “one in a hundred thousand” category.

Just seems like Black women would be the ones that are the one in a hundred thousand. We’d be more likely to get it. (Non-Hispanic Black woman)

Some felt that inaccurate risk perceptions were influenced by the media portraying minorities as being at higher risk for certain illnesses.

Because they are in the news as that percentage. So they are going to think “I am that one.” It really is all in your upbringing and what you perceive in the news; what you read in the papers that make those insecurities. News media influences a lot of people and it is sad because it is not fair because they might not be that one. (Non-Hispanic White woman)

DISCUSSION

In this study, we performed in-depth interviews to elucidate the factors that influence risk tolerance across different racial/ethnic groups, particularly to improve understanding of risk aversion among minority women. In concordance with the existing literature (4–7), participants in this study acknowledged a discrepancy in risk tolerance across races/ethnicities and offered several possible contributing reasons. While participants described factors that could influence risk tolerance, they also described pervasive barriers to care that were independent of risk attitude.

Of all the issues discussed, the impact of constrained resources was raised most frequently. Women described multiple pathways by which financial stress and limited resources could impact decision making: the inability to consider any new expense related to medical care before taking care of basic requirements (e.g. food and electricity); the mandatory fulfillment of obligations at home and work prior to the consideration of seeking medical care; insufficient financial means to pay for recommended medications or procedures; and the lack of social and financial support required to accept the possible risk of treatment-related complications. As minority women do not have the capacity to mitigate the strain of any additional hardships, the risk of complications appears to be factored more heavily in their decision-making.

In addition to acting as a logistical barrier, limited resources may also influence preferences by affecting the cognitive mechanisms underlying decision making. Pocheptsova et al (21) found that participants randomized to perform more difficult tasks known to deplete cognitive resources required for higher order executive functions, were less able to engage in effortful and deliberative processing, relied on more on simple and intuitive strategies, and made poorer decisions compared to those randomized to tasks which were not resource depleting. Mani et al (22) describe similar results under real life stressors. Specifically, farmers in India had poorer cognitive functioning during times of financial stress (pre-harvest) as compared to when they were not as stressed financially (post-harvest). Thus, the financial stress and familial responsibilities that minority women face may deplete the resources needed for high quality decision-making—resulting in a default towards making decisions based on heuristics rather than careful deliberation.

In this study, Black women noted that they were at higher risk for more severe disease. This conclusion is factual as Black Americans have a higher risk for kidney failure, stroke, diabetes (23), and the worst cancer-related outcomes (24). It appears that subjects extrapolated their increased risk of disease severity to a generalized increased risk of suffering treatment-related complications. Home remedies, often passed down to the participants when they were children, continue to be a significant component of health self-management among African Americans, particularly among those who experienced barriers to care or discrimination with the healthcare system in the past (25). These results underscore the importance of ensuring that patients are adequately informed prior to engaging in decision making, which requires efficacious communication in the patient-physician relationship.

Minority women also acknowledged that concerns regarding discrepancies of care, perceived racism, apprehension toward physicians of dissimilar races/ethnicities, and fear of medical experimentation influenced their decisions. Several responses alluded to the impact of stereotypes. Burgess et al (26) describe how stereotype threat may contribute to healthcare disparities by prompting multiple physiological and psychological processes that have harmful consequences for behavior, including treatment noncompliance, ineffective communication, discounting feedback, and disengagement. Strategies aimed at minimizing stereotype threat include encouraging providers to draw on patients' values and strengths as well as provide assurance that diversity is respected, which may help decrease the likelihood of these behaviors (26). As perceived prejudice persists, and given recent events may actually increase (27), physicians must actively address these concerns because recurrent exposures to stereotype threats may perpetuate a vicious cycle that negatively impacts patients' health.

The women interviewed in our study also highlighted concerns regarding discrepancies in quality of care, drawing clear distinctions between medical/community clinics versus private offices. Poor experiences at medical clinics may tarnish perceptions of the medical system, laying the foundation for distrust and a trend towards more risk averse medical decision making. The value of trust is described extensively in the published literature as the cornerstone of the patient-physician relationship; patients with trust in their healthcare providers have been shown to have better medical outcomes (28–30). Physicians may build

trust early on in the patient-physician relationship by providing reassurance, encouraging patients to ask questions, explaining lab results, avoiding judgmental behavior and/or language, and eliciting patients' preferences (31). A 2014 Cochrane Database Systematic Review of ten randomized controlled trials involving 11,063 patients found insufficient evidence to recommend any single intervention to improve patients' trust in their physicians, underscoring a lack of evidence-based practices available to effectively address this issue (32).

In order to quell concerns about being uninformed regarding side effects, worry about being exploited as experimental subjects and fear that personal values are being ignored or compromised, physicians must adopt effective communication strategies to actively engage patients in shared-decision making and create a treatment plan to deliver high quality care that is aligned with patients' personal beliefs—with the goal of ensuring sufficient subjective knowledge, i.e. patients' perception of their own knowledge. Ensuring that patients feel informed is particularly important as low subjective knowledge is associated with increased risk aversion (33).

Our study has several limitations. Participants were recruited irrespective of their underlying diagnosis. While there are no data to suggest that the factors that influence risk tolerance should differ between women with rheumatic conditions versus other chronic illnesses, we did not explore how their different diagnoses may play a role in their perception of disease and risk (34–36). Though we tried to minimize the influence of the interviewer on participants' responses by using a standardized interview guide, an interviewer not belonging to any of the three targeted racial/ethnic groups, and talk back to clarify respondents' answers, it is possible that social approval bias (the desire of being perceived in a particular role to the interviewer) may have contributed to the participants' answers (37,38). Other culturally specific factors such as the importance of taking care of family before oneself or the disapproval of treatment by family members, although not mentioned by participants, may also influence willingness to accept treatment. Furthermore, although participants did discuss the influence of culture specific illness perceptions (such as the efficacy of complementary techniques), we did not prompt participants to discuss all illness perception domains.

While not all possible factors were prompted, nor did the possible impact of cultural specific values and/or illness perceptions on willingness to accept treatment among minority women emerge during the interviews, our results highlight several actionable findings. Additional efforts are clearly needed to improve experiences in clinics, foster high quality patient-physician relationships, improve communication, and ensure that patients feel informed. More difficult to address is the pervasive impact of financial and social constraints on decision making and access to care. Innovative approaches acknowledging the myriad of mechanisms by which limited resources influence decision making are clearly needed to improve health outcomes in this vulnerable population.

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Appendix

Interview Guide

“Please think back to a time when a doctor might have discussed starting a new medication with you. What kind of information would you have expected to receive from the doctor during that conversation? As it turns out, some studies show that White women and minority women feel differently about the risks and benefits related to medications—and we don’t understand why these differences exist. Why do you think this might happen?”

Prompts included: “How do you think a woman’s background, culture, and experiences influence how she thinks about medications and side effects? Some studies have shown that minority patients don’t want certain surgeries like knee surgery and back surgery as often as White patients. What do you think are the reasons for this difference?”

List of Codes

- Risk aversion
- Decisional regret
- Lack of knowledge (or information)
- Limited means (Income/wealth)
- Race based perceptions
- Income and decision making
- Risk perception
- Role of family
- Perceived social role
- Responsibilities (work or family)
- Social capital
- Access to type of care
- Relationship with doctors
- Doctor- Patient relationship
- Perceived susceptibility
- Illness perceptions (treatment/causal/consequences)
- Passed down in families
- Empowerment
- Personal responsibility (to becoming informed as a patient)

Ignorance is bliss

Expectations

Education

Limited cushion/bandwidth

Experience with healthcare

Fear of treatment related factors

Short vs long-term thinking

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Significance and Innovations

- Several major themes explaining risk aversion among minority women emerged, with an emphasis on the issue of constrained resources.
- Women described multiple pathways by which financial stress and limited resources could impact decision making.
- Innovative approaches acknowledging how limited resources influence patient decision making are needed to improve health outcomes.

Table 1

Demographics Characteristics

Variable	Non-Hispanic White (n=12)	Non-Hispanic Black (n=11)	Hispanic (n=13)
Mean (SD) age in years	33.9 (6.6)	37 (4.9)	33.9 (8.4)
Marital status			
Single	3 (25%)	6 (54.4%)	5 (38.5%)
Married	9 (75%)	4 (36.3%)	7 (53.8%)
Divorced/Separated	NA	1 (9%)	1 (7.7%)
Education			
High school	1 (8.3%)	4 (36.4%)	7 (53.8%)
College +	11 (91.7%)	7 (63.6%)	6 (46.1%)
Income			
<\$39,000	1 (8.3%)	5 (45.4%)	7 (53.8%)
>\$40,000	10 (83.3%)	6 (54.5%)	5 (38.5%)
Unknown	1 (8.3%)	NA	1 (7.7%)
Occupation			
Full-time	7 (58.3%)	3 (27.3%)	6 (46.2%)
Part-time	2 (16.7%)	1 (9.1%)	3 (23.1%)
Student	0	0	1 (7.7%)
Unemployed	3 (25%)	2 (18.2%)	2 (15.4%)
Disability	0	5 (45.5%)	1 (7.7%)

Table 2

Quotes illustrative of each theme

Theme	Illustrative Quotes
Constrained Resources	<p><i>Most young minority women already have about four young children, so how are they supposed to take care of their families if they are sick. And if they have surgery they have to be out of work for a long time. (Hispanic woman)</i></p> <p><i>Realizing what it can do to their [minority women's] family and if that does happen to them then they would be out of work...so maybe they are more concerned about that and their long term financial stability. (Non-Hispanic White woman)</i></p> <p><i>It is the stress of not being able to have the money to fix things, not having resources. If I get another disease after taking a medication; what am I going to do then? (Non-Hispanic Black woman)</i></p>
Discrepancies in Quality of Healthcare	<p><i>They don't mention the side effects. They don't mention what could happen. It is after when patients come with different pains that things come out. How come my liver is damaged? Oh that was the medication you were taking. They should have said that from the beginning so patients are not caught by surprise and with so many problems. (Hispanic woman)</i></p> <p><i>Clinic doctors don't look you in the face...They don't mention the side effects. They don't mention what could happen. (Non-Hispanic Black woman)</i></p> <p><i>You know if you are treated as a number instead of a person it leaves a bad taste. I myself have been to a community health center and I didn't feel like an individual. I felt like a number. (Non-Hispanic White woman)</i></p>
Perceived Prejudice	<p><i>If I am from another country and I know for a fact that the doctors are going to do something that is bad for me and then I come here I am not going to be so trustworthy towards a doctor. (Hispanic woman)</i></p>
Lack of Knowledge and Education	<p><i>I also believe educational level is a huge factor. I have seen where the more educated you are the more likely that they are going to make a better choice for their health care. (Non-Hispanic Black woman)</i></p> <p><i>They don't go and do their own research or go and find out about this particular drug or the clinical trials that happened or how it could help them or hurt them. (Non-Hispanic Black woman)</i></p> <p><i>If I say something you should not go by what I say. There are studies and papers. I like to read and learn, you have to balance good and bad, positive and negative, so you weigh if surgery is the answer. (Hispanic woman)</i></p> <p><i>People don't know what they have. They don't take time to find out and read. (Hispanic woman)</i></p>
Medication Beliefs	<p><i>Sometimes you don't really have to take a lot of the medication that they give you. There is a lot of other ways to fix it or getting around it, I would try as well. I don't like to take medicine so if I can avoid not taking anything, if I can find another way of healing myself I would try it as well. (Non-Hispanic Black woman)</i></p> <p><i>Some African-American women will adopt a home remedy rather than taking medication. (Non-Hispanic Black woman)</i></p> <p><i>I will listen to my grandmother telling me what to take instead of the doctor. (Non-Hispanic Black woman)</i></p> <p><i>I know a few people, southern people. They grew up on these little folk remedies. A lot of medication is not good for you. Lot of different side effects... (Non-Hispanic Black woman)</i></p> <p><i>Homemade remedies don't give side effects. (Hispanic woman)</i></p>