EXPERTISE IN THE CARE OF LATINOS: AN INTERPRETIVE STUDY OF CULTURALLY CONGRUENT NURSING PRACTICES IN THE EMERGENCY DEPARTMENT

By

Regina Eileen Ruskamp Nailon

A Dissertation

Presented to

Oregon Health & Science University
School of Nursing

in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy

May 4, 2004

APPROVED:

[redacted]

Christine A. Tanner RN, PhD, FAAN
Professor, Oregon Health & Science University School of Nursing
Research Advisor

[redacted]

Sheila Kodadek PhD, RN
Professor, Oregon Health & Science University School of Nursing
Committee Member

[redacted]

Marie Napolitano RN, PhD
Associate Professor, Oregon Health & Science University School of Nursing
Committee Member

[redacted]

Kathleen Potempa, DNSc, RN, FAAN
Dean, Oregon Health & Science University School of Nursing

Acknowledgement

I would like to acknowledge the financial support that enabled me to complete this research. This research was supported by the Northwest Health Foundation and the Washington State Nurses Foundation.

Acknowledgements

This study would not have been possible were it not for the contributions of many. First I would like to acknowledge my appreciation for the nurses and Latino patients and families who participated in this study. I am honored that they trusted me with their experiences. I would like to thank and acknowledge Dr. Christine Tanner, Dr. Sheila Kodadek, and Dr. Marie Napolitano for their expertise in critically reviewing my work in a positive and encouraging environment. Each brought a unique perspective to my study that enriched it in many ways. These women taught me volumes about the art of directing one's passion so as to make positive differences in nursing practices. To my colleagues who offered critical reviews of my work and along the way offered tea, coffee, mindless chatter and laughter, I thank you. I would also like to thank and acknowledge my partner in this life, my husband, Jim, whose confidence in my abilities has never faltered. His contribution to the success of this endeavor will forever be appreciated. Lastly, I wish to acknowledge my dearest friends Susan Brookhart and Helen Kuebel for supporting me in achieving this reality. I am forever grateful for their limitless love and support.

ABSTRACT

TITLE: Expertise in the Care of Latinos: An Interpretive Study of Culturally Congruent Nursing Practices in the Emergency Department

AUTHOR: Regina E. Nailon, RN, MS

APPROVED: [redacted]

Christine A. Tanner, RN, PhD

The purposes of this study were twofold: 1) to describe concerns directing care of Latinos by nurses identified by their peers as expert in the care of Latinos in the ED to explicate the knowledge guiding their practice, and 2) to determine if expert nursing practices were congruent with concerns brought to clinical encounters by Latino patients and could therefore be considered culturally competent. Fifteen nurses who worked in the emergency departments of four hospitals were interviewed about their experiences of caring for Latino patients. Four of these nurses were identified by their peers as expert, and eleven were not. Observations of selected nurses' practices enabled descriptions of the everyday, often taken-for-granted context within which care occurred; including the environment, resources used by nurses, and events of clinical situations as they unfolded. Twenty-two Latino patients participated by allowing the investigator to observe the care they received from selected nurse participants. Ten Latino patients and/or their family members were interviewed following care received to elicit their concerns brought to the health care encounter and their perceptions of nursing care received. An interpretive, phenomenological design was utilized, and data were analyzed through thematic analysis. Exemplars and paradigm cases were selected that captured concerns embedded in nurses' and Latino informants' experiences.

Expertise was found in the practices of nurses who were identified as experts by their peers and those who were not. Wanting to connect with patients and provide particularized care was requisite to providing expert and culturally competent care. Contextually embedded concerns focus expert nurses' efforts toward providing concernful and compassionate care that is uniquely planned relative to the Latino patient's ethnicity. Nurses whose practices manifested expertise connected in meaningful ways and provided particularized care to Latino patients through the use of non-verbal gestures, interpreters, and the Spanish language. Additionally, expertise was manifested when nurses adapted the environment to accommodate family presence and involvement in the patient's care. Care was culturally congruent, and therefore, determined to be culturally competent, when nurses attended to patients' concerns related to communication and information needs, family involvement, and the need to feel cared about and valued—which included being provided personable care that offered validation, comfort, and reassurance.

Limitations of the study include an inadequate representation of emergency department nurses who provide care to Latino patients, and the potential effect that being observed may have had on nurses' caring behaviors. This study broadens nursing's knowledge base and enhances nurses' abilities with providing culturally competent care by revealing the contextually embedded concerns that direct culturally congruent, expert care, and the facets of nurses' work environments that enhance or impede nurses' efforts. Emergency department administrators must foster culturally congruent nursing care by providing nurses resources necessary to this end. Latino patients must be included in care evaluation to determine if cultural competence was achieved.

TABLE OF CONTENTS

Table of Appendices

List of Figures

CHAPTER I: INTRODUCTION

In 2000, there were 32.8 million Latinos in the United States (U.S.), representing 12.5% of the population (Therrien & Ramirez, 2000). It is estimated that by the year 2009, the Latino population in the U.S. will exceed 40 million, making it the country's largest minority population (Council of Economic Advisors, 1998). In this discussion, the term "Latino" is used as an ethnic label, not to denote a race but, rather, to indicate a group that shares collective values that are manifested through group-specific behaviors (Marín & Marín, 1991). Latinos may have come from one of the 19 Spanish-speaking countries in the Americas, from Puerto Rico, or from Spain (Marín & Marín, 1991), and may claim indigenous, as well as Spanish origin (Sandstrom, 1991). Latinos are a heterogeneous group, representing a wide variety of ethnic subgroups.

According to the 2000 census, 39.1% of the Latino population in the U.S. was foreign born (Therrien & Ramirez, 2000). This would account for approximately 12.8 million people. The majority (43%) of these individuals entered the U.S. in the 1990s, approximately 30% came in the 1980s and the remainder entered before 1980 (Therrien & Ramirez, 2000). In 2000, approximately 79% of Latinos in the U.S. spoke a language other than English at home. Of the Latinos who spoke Spanish at home, about 19% indicated they did not speak English well and about 11% indicated they did not speak English at all (U.S. Census Bureau, 2000a). Twenty-four percent of Latinos in the U.S. live in linguistically isolated households, in which all members 14 years old and over have at least some difficulty with the English language (U.S. Census Bureau, 2000a). Language acquisition, influenced by age and education level, is one of the most significant factors for acculturation and integration into the host society (Lipson &

Meleis, 1999). Individuals who do not speak the language of the host society have increased risks for adverse health outcomes (Hornberger et al., 1996; Hu, Keller & Fleming, 1989; Kirkman-Liff & Mondragon, 1991; Taira, 1999; Vega, Warheit, Buhl-Auth & Meinhardt, 1984).

Wide disparities exist in health insurance coverage and overall health status across this nation's minority populations (Council of Economic Advisors, 1998), and Latinos have been found to be more susceptible to adverse health outcomes than all other populations in the U.S. (Council on Scientific Affairs, 1991; Meleis, 1995; Zambrana, 1995). There is a growing sense of urgency among health care professionals and policy makers in this country to eradicate health disparities in culturally and ethnically diverse populations (CED) (Council of Economic Advisors, 1998; Department of Health & Human Services (DHHS), 2000; Fortier, Convissor & Pacheco, 1999; Department of Health & Human Services, Office of Minority Health [DHHS-OMH, 2000]). Efforts made by governmental agencies to address health disparities (DHHS-OMH, 2000) provide direction to health care providers seeking to minimize disparate outcomes. In particular, the standards for culturally and linguistically appropriate services (CLAS) in health care, developed for the Office of Minority Health, emphasize the need for and importance of delivering culturally competent health care to diverse patient populations (DHHS-OMH, 2000). "Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations" (Fortier et al., 1999, p. 11). The CLAS standards offer mandates, guidelines, and recommendations to health care providers to inform, guide, and facilitate health care practices (DHHS-OMH, 2000).

It is envisaged that cultural competence will become manifest through health care providers and health care organizations understanding and responding in effective ways to the cultural, including linguistic, needs brought by patients to the health care encounter.

Culture encompasses values and beliefs that are manifested through group-specific behaviors (e.g., communication, customs and habits) within any given society (Helman, 1994). Increasingly, nurses within this pluralistic society are becoming more aware of the importance of attending to patients' cultural needs (Meleis, 1995; Villarruel, Porter & Kane, 1999). The need for nurses to be sensitive to and aware of Latino cultural values, needs and health care practices brought to care encounters by Latinos has been emphasized (Torres, 1996). Recognizing and attending to the cultural values and concerns brought by Latino patients to health care encounters are imperative in providing culturally competent care (Torres, 1996; Villarruel & Leininger, 1995).

Cultural competence is manifested through the provision of care that is congruent with values, beliefs, and behaviors of culturally diverse patients (Cross, Bazron, Dennis & Isaacs, 1989). With experience, study and reflection on numerous clinical situations with Latino patients, it is assumed some nurses have become expert at caring for this population. In this discussion, "expert" describes the perceived quality of care provided by certain nurses in the emergency department. Use of the term is not meant to indicate that a particular nurse is considered expert in every aspect of practice (Benner, Hooper-Kyriakidis & Stannard, 1999), but rather, is indicative of those nurses to whom other nurses turn for guidance and assistance in providing care to Latino patients. Little is known about the knowledge that guides expert nursing practice in the care of Latino

patients in the emergency department (ED).

The purpose of this research was to describe the experiences of nurses who have been identified as expert in providing care to Latino patients in the ED in order to explicate the knowledge and concerns that guide their practice. To address the gap in knowledge about the experiences of nurses identified as expert in the care of Latinos and the degree to which expert nursing care in the ED is provided in a culturally congruent manner, this study was guided by the following research questions:

1. What are the everyday concerns, habits and practices embedded in the care given to Latino patients by emergency department nurses who have been identified by their peers as expert in the care of Latinos?
2. To what extent do the concerns embedded in the care given to Latinos by these nurses match the needs and concerns brought to clinical encounters by Latino patients?

To address these questions the study employed an interpretive phenomenological design. Through rich, descriptive narratives the context, including the spatial, temporal and cultural aspects that influenced nurses' care experiences with Latino patients and families, and the meaning attached to those experiences was made known. Together with previous studies that examined expertise in nursing practice (Benner, 1984; Benner Tanner & Chesla, 1996; Benner et al., 1999) the current study can inform clinicians caring for Latino patients, and has the potential to positively impact patient outcomes.

This study is a first step in a program of research that will explore the concept of cultural competence in nursing practice and generate and test culturally relevant nursing assessment, intervention, and evaluation strategies in order to improve the health of culturally and ethnically diverse patients.

CHAPTER II: REVIEW OF THE LITERATURE

The study of nursing practices in the care of Latinos requires a comprehensive understanding of what extant research literature reveals about cultural competence in nursing practice and its influence on care interactions and outcomes with Latino patients. In addition, the literature informs our knowledge of expert nursing practice; specifically, in how nurses develop expertise and manifest it in their caring practices. The following is a critical review of extant research literature related to cultural competence in the nursing care of Latino patients, and expertise in nursing practice.

Cultural Competence in Nursing Practice

Attention to ethnic and cultural diversity in patient populations has surged within the nursing literature over the past decade in response to the increasing pluralism found in American society. Several nursing organizations including the American Academy of Nursing (Davis et al., 1992), the American Nurses' Association (1991), and the Emergency Nurses Association (2001a) have emphasized the importance of nurses recognizing and embracing diversity in cultural practices and beliefs, and providing care that is attentive to and congruent with culture-based needs and concerns.

Culturally sensitive, *culturally appropriate*, and *culturally competent* are examples of concepts that are used in the literature to direct providers toward interventions that consider the influence of ethnicity and culture on patient beliefs and behaviors. Oftentimes these concepts are used interchangeably, causing confusion among practitioners who struggle to operationalize them in the practice setting. What does cultural competence mean? How is it conceptualized and operationalized in the research literature so that it can be transferred to the health care setting? Are there substantial

differences between *cultural competence* and *cultural sensitivity*? Do both subsume *cultural appropriateness*? What is the evidence that interventions based on these concepts make a difference in patient outcomes?

Developing culturally competent practice requires that nurses attend to unique and shared cultural characteristics of the individual they are working with. A patient's culture affects the experience and expression of symptoms, and must be an inherent part of diagnostic and therapeutic interventions of nurses (Blumhagen, 1982; Good & Good, 1981; Kleinman, 1988; Kleinman, Eisenberg & Good, 1978). An individual's illness and health beliefs influence behaviors related to how and when treatment should be sought, and present challenges to health care providers in determining appropriate treatment interventions (Blumhagen, 1982; Good & Good, 1981; Kleinman, 1988; Kleinman et al., 1978).

Models of Cultural Competence in Nursing Practice

Several models and theories of cultural competence discussed in the literature can guide nurses in their delivery of care to culturally and ethnically diverse populations (Brach, & Fraser, 2000; Campinha-Bacote, 1998; Giger & Davidhizar, 1999; Leininger, 1991; Spector, 2000). Some authors have conceptualized cultural competence as a continuum (Campinha-Bacote, 1998; Cross et al., 1989; Giger & Davidhizar, 1999; Spector, 2000). Viewed as a process, rather than an end point, the continuum of cultural competence allows for growth; movement along the continuum is relative to the cultural group with which one is working. At any given time, a nurse may find him/herself more, or less, competent with one group than with other groups.

The theories and models of cultural competence found in the literature share similar

features that can be useful to nurses in developing cultural competence in their care of Latino patients. First, the importance of understanding the patient's cultural worldview and lifeways, including beliefs, values, and behaviors has been emphasized (Andrews & Boyle, 2003; Campinha-Bacote, 1998; Giger & Davidhizar, 1999; Leininger, 1991; Spector, 2000). Understanding the patient's cultural background and meanings associated with values, beliefs, and behaviors is imperative to the nurse's abilities to deliver care that is congruent with the culture-based needs and concerns of the patient. Second, nurses must develop skills in obtaining appropriate culture-related data from patients that can be incorporated into the patient's particularized care. Several authors have described frameworks for obtaining cultural assessments (Andrews & Boyle, 2003; Campinha-Bacote, 1998; Giger & Davidhizar, 1999; Leininger, 1991; Spector, 2000). Third, in order to become culturally competent, nurses must develop an awareness of their own cultural background (Spector, 2000), and the attitudes and potential biases they hold toward culturally diverse patients (Andrews & Boyle, 2003; Campinha-Bacote, 1998; 2002; Giger & Davidhizar, 1999; Spector, 2000). Cultural sensitivity develops out of self awareness and enables the nurse to move beyond ethnocentrism and provide care that addresses the patient's cultural needs in a particularized manner that maintains respect for the patient's cultural worldview. Fourth, it is through multiple encounters with CED individuals and families that nurses are able to move toward cultural competence in their provision of care. As has been discussed by several authors, there is more variation within a cultural group than across cultural groups (Andrews & Boyle, 2003; Campinha-Bacote, 1998); therefore, multiple interactions with individuals and families from similar cultural groups are necessary in order to broaden the nurse's cultural knowledge base

relative to caring for a specific cultural group.

A major assumption underlying this study is that cultural values, beliefs, and behaviors are unique to, and manifest themselves relative to the cultural group a nurse is working with—a concept well supported in the literature (Gordon, 1994; Kleinman, 1988; Kleinman et al., 1978; Leininger, 1970). Medical anthropology and nursing research literature are replete with information about culture and its influence on Latinos' perceptions of health, illness, and health seeking behaviors (Clark, 1970; Giger & Davidhizar, 1999; Good & Good, 1981; Heinrich, 1997; Helman, 1994; Kleinman et al., 1978; Leininger, 1970; Loustaunau & Sobo, 1997; Singer & Baer, 1995; Zambrana, 1995). Several investigators have emphasized the importance of eliciting the meaning of the illness episode from the patient, for without this understanding providers risk imposing narrow biomedical models of care that have little relevance to the patient's culturally constructed reality (Benner & Wrubel, 1989; Good & Good, 1981; Kleinman, 1988; Kleinman et al., 1978). When the patient is not involved as a therapeutic ally in the provision of care (Kleinman et al., 1978), issues and concerns brought to the clinical encounter by the patient are not attended to, and care that is provided is not culturally congruent or competent. Obtaining an understanding of cultural values and behaviors, and experiencing multiple interactions with individuals and families from Latino cultural groups are necessary if nurses are to develop culturally competent practice with Latino patients.

The discussion now turns to a review of nursing research literature that focuses on nurses' and Latino patients' care experiences in order to understand the current knowledge base informing nursing care of Latino patients. A brief discussion of

findings from these studies is provided, followed by a critique of their methodological strengths and limitations and identification of gaps in knowledge that provides justification for this study.

Qualities of Culturally Appropriate Care of Latino Patients

Several investigators have explored patients' and/or nurses' and other health care providers' perceptions of culturally appropriate care of Latino individuals and families (Baldonado et al., 1998; Berry, 1999; Niska, 1999; Stasiak, 1991; Warda, 2000; Zoucha, 1998). Cultural values that were perceived as being important elements in nursing care have been described, and are related to four major areas: spirituality, health beliefs and behaviors, family, and communication.

Spirituality

Components of spirituality described in the literature include belief in the omnipotence of God (Stasiak, 1991), the importance of faith and prayer (Berry, 1999; Stasiak, 1991; Warda, 2000), and use of religious rituals and symbols in patient care (Baldonado et al., 1998; Berry, 1999; Stasiak, 1991). Allowing use of folk healers (Lipton, Losey, Giachello, Mendez & Girotti, 1998; Stasiak, 1991), and incorporating folk practices into the care of Latinos have been emphasized (Baldonado et al., 1998; Berry, 1999; Stasiak, 1991; Warda, 2000; Zoucha, 1998).

Health Beliefs and Behaviors

In addition to use of folk healers (Stasiak, 1991; Warda, 2000) and indigenous folk rituals (Stasiak, 1991), several studies revealed specific cultural practices believed to be beneficial to patients' well-being. For instance, the use of roots and herbs believed to have pharmacologic and psychocultural benefits has been described (Gordon, 1994;

Lipton et al., 1998; Stasiak, 1991). Berry (1999) described the importance of nurses reaffirming cultural behaviors practiced by pregnant Mexican American women that were congruent with professional care practices, such as light exercise, and avoidance of heavy lifting, alcohol, tobacco, and illicit drugs. Being sensitive to cultural beliefs related to the hot-cold theory in the postpartum period and accommodating related needs was also emphasized by Berry (1999).

Family

Incorporating the patient's family into the plan of care was viewed as an essential component of providing culturally appropriate nursing care of Latinos (Baldonado et al., 1998; Berry, 1999; Bollenbacher et al., 2000; Lipton et al., 1998; Stasiak, 1991; Warda, 2000). Some Mexican Americans viewed nurses as outsiders while emphasizing the importance of maintaining tight family boundaries (Niska, 1999). Zoucha (1998) found that Latino patients' sense of security and connectedness was promoted when family members accompanied them when seeking nursing care.

Nurses have modified their practice to meet the various roles of family members and the cultural value of including them in the patient's care (Baldonado et al., 1998). Modified care included nurses showing respect for intergenerational roles (Berry, 1999; Niska, 1999) and male authority in decision-making (Baldonado et al., 1998; Berry, 1999) within families. Brown & Hanis (1999) achieved improved outcomes in diabetic Mexican Americans' glycosylated hemoglobin and fasting blood glucose levels when family members were involved in treatment interventions that were being tested. These investigators also attributed the success of the treatment regimen to the fact that interventions were designed specifically for a bilingual setting and involved culturally

acceptable lifestyle recommendations made by Mexican Americans (Brown & Hanis, 1999).

Communication

Components of communication discussed in the literature regarding the care of Latinos focused on interpersonal aspects that were found to be important in care encounters, such as the importance of conveying respect (Berry, 1999; Stasiak, 1991; Warda, 2000; Zoucha, 1998), and kindness and sensitivity (Warda, 2000; Zoucha, 1998) when interacting with Latino patients. Actions such as addressing the patient by his/her formal name (Berry, 1999; Stasiak, 1991), spending extra time with the patient (Berry, 1999; Stasiak, 1991; Warda, 2000; Zoucha, 1998), making general conversation before beginning care (Berry, 1999), displaying empathy (Warda, 2000), and concern and personal attention toward the patient (Berry, 1999; Lipton et al., 1998; Warda, 2000; Zoucha, 1998) enhanced treatment adherence (Lipton et al., 1998) and the patient's confidence in the nurse's abilities (Stasiak, 1991; Warda, 2000; Zoucha, 1998).

The importance of having bilingual staff available to care for Spanish-speaking patients has been identified (Baldonado et al., 1998; Bollenbacher et al., 2000; Johnson, Noble, Matthews & Aguilar, 1998), and the need for nurses to be able to communicate in Spanish with non-English-speaking (NES) Latino patients has been emphasized (Berry, 1999; Brown & Hanis, 1999; Stasiak, 1991; Warda, 2000; Zoucha, 1998). Inability of providers to speak Spanish was cited as a factor that reduced health access (Warda, 2000). Linguistic differences evoked a sense of powerlessness in patients, and also made them feel less able to gain knowledge that would help them to follow medical instructions and make informed health care choices (Warda, 2000). Patients' recall of and satisfaction

with care interactions was enhanced when nurses were able to communicate in Spanish (Warda, 2000). Even feeble attempts by nurses at speaking Spanish have been perceived as caring by Latino patients (Zoucha, 1998).

Nurses have described their lack of Spanish language fluency as disadvantageous to their practice, and have indicated a desire to learn the Spanish language if classes were made available to them (Bollenbacher et al., 2000). Zoucha (1998) recommended that institutions encourage and promote nurses' abilities to provide culturally congruent care by providing nurses the opportunities to learn Spanish.

Several investigators have discussed the need for nurses to use medically trained interpreters when nurses themselves did not know the Spanish language (Baldonado et al., 1998; Zoucha, 1998). However, research revealed nurses do not consistently use appropriate medical interpreters in patient care situations due to a lack of qualified bilingual staff (Baldonado et al., 1998; Bollenbacher et al., 2000). As a result of inadequate resources, nurses have described using children as interpreters during patient situations (Baldonado et al., 1998; Bollenbacher et al., 2000), and have voiced discomfort doing so (Baldonado et al., 1998). Nurses have also described situations when interpreters were not used, and the nurse relied solely on non-verbal communication; however, the success of these nurse-patient interactions was not reported (Baldonado et al., 1998).

Although not empirically tested for its efficacy, utilizing the expertise of nurses who are certified in transcultural nursing and who are knowledgeable about the Mexican American culture was identified by Zoucha (1998) as a strategy for providing culturally appropriate care and promoting the cultural knowledge and abilities of other nurses.

However, since it is unlikely that all acute care settings have certified transcultural nurses, and due to a lack of research that has explored whether or not a difference exists in the perceived quality of care relative to a nurse's certification in transcultural nursing, it is important to investigate in what other ways nurses are learning to provide culturally appropriate care to Latino patients. It is also important to explore how institutions provide an environment that is conducive to or acts as a barrier against the provision of culturally competent nursing care in order to better understand the context in which expert nursing care is being provided to Latino patients.

Qualities of Culturally Inappropriate Care of Latino Patients

Investigators have explored what Latino patients perceived as culturally inappropriate care (Warda, 2000; Zoucha, 1998). Culturally incongruent practices included system barriers such as long waits, as well as linguistic differences, inadequate cultural knowledge, lack of humane care, inadequate patient education, illness-based care, and dissonant verbal and non-verbal communication (Warda, 2000). Discounting, or failing to acknowledge the patient's perception of the health care situation, and blaming the patient for his/her or a family member's health status were also viewed as culturally incongruent practices (Warda, 2000).

Latinos viewed nurses as noncaring if they did not combine Mexican American folk care practices and values with professional nursing care practices (Zoucha, 1998). Noncaring nurses were those who rushed through procedures or were inattentive and displayed a lack of concern, did not communicate in Spanish while giving care, or who displayed disrespectful behaviors or made disrespectful statements about Mexican Americans (Zoucha, 1998).

Despite the rich amount of knowledge that can inform nursing care of Latino patients, there have been no studies that have explored the everyday experiences and knowledge of nurses identified as expert in the care of Latino patients; nor have Latino patients' perceptions of such care been examined. In light of this apparent gap in knowledge, strengths and limitations of the research studies reviewed herein strengthened the methodological decisions and provided additional justification for this study.

Strengths and Limitations of Research Literature

Several investigators were able to include NES Latinos in their investigations either because of their own fluency with the Spanish language (Niska, 1999; Stasiak, 1991; Warda, 2000), or through the assistance of bilingual individuals knowledgeable in the content area of the study (Berry, 1999). Given the lack of English-speaking abilities of Latino individuals residing in the U.S. who access health care (U.S. Census Bureau, 2000A), the paucity of research involving NES Latino individuals (Frayne, Burns, Hardt, Rosen & Moskowitz, 1996), and the need for fairness in the distribution of benefits and burdens associated with research participation (Department of Health, Education, and Welfare, 1979), the need exists for inclusion of NES Latino individuals in research investigations that explore nursing care provided to this population. Although the integrity of such studies can be enhanced through the use of a separate individual to verify translations of interview transcripts, as was done by Niska (1999), and was done in this study, this practice was not consistently reported in the literature (Berry, 1999; Stasiak, 1991; Warda, 2000).

Several studies elicited nurses' and other health care providers' and patients' perceptions of culturally competent care (Berry, 1999; Warda, 2000; Zoucha, 1998). In

the study conducted by Zoucha (1998), the inclusion of patient perceptions of cultural competence revealed how nursing actions such as the ability to speak some Spanish, allowing family members to stay with the patient, and spending extra time with Mexican American patients influenced patients' health-related behaviors. Although Zoucha (1998) indicated that non-Mexican American nurses participated in the study as general informants, he did not specify what the data from these nurse informants revealed. The majority of registered nurses in the U.S. are of non-Latino ethnicity (Bureau of Health Professions, 2001). Describing non-Latino nurses' care experiences involving Latino patients, as was done in this study, provided valuable insights into non-Latino nurses' understandings of Latino cultures, revealed where nurses obtained this knowledge, and illustrated how nurses' practices were influenced by these experiences.

In a study conducted by Baldonado et al. (1998) respondents were asked to estimate how frequently they had provided care to a specific cultural group, assessed culturally related factors, and modified their nursing care to meet patient needs (p. 17). Additionally, respondents were asked to rate their level of confidence in providing culturally-specific care. The researchers acknowledged the limitations inherent in their inability to assess the trustworthiness of respondents' self-reports (Baldonado et al., 1998). What was not assessed in the study was the influence on patient outcomes that resulted from care modifications described by respondents.

Zoucha (1998) elicited perceptions of culturally competent care from family members or friends who accompanied Mexican American patients to care encounters. Although this information could prove helpful to nurses, given the possibility that these individuals could one day become patients themselves, the inclusion of non-patient

perceptions of the care that was provided to family members/friends did little to verify whether a nurse's actions were congruent with the patient's needs and concerns. Concerns and issues brought by Latino patients to the clinical encounter must be examined and compared to the knowledge guiding nurses' practices in order to determine the extent to which nurses provided care that was relevant to and congruent with the patient's needs.

In several studies, rather than eliciting perceptions of cultural competence in actual care that was received, participants were asked to provide general abstractions of what *would* constitute culturally competent care (Berry, 1999; Stasiak, 1991; Warda, 2000). In these studies, interview guides elicited descriptions from participants of what culturally competent practices would look like. A similar limitation in understanding the rich context of care experiences was found in the study conducted by Niska (1999). In this study acontextual descriptions of potential nursing interventions, written on 5 x 7 cards, were given to participants, and participants were asked to indicate whether or not the interventions would be considered culturally appropriate if they were to happen (Niska, 1999). Even though the rationale was elicited from participants as to why the potential interventions were considered culturally unacceptable (Niska, 1999), and in lieu of the fact that the findings from these studies (Berry, 1999; Niska, 1999; Stasiak, 1991; Warda, 2000) have the ability to inform culturally congruent nursing care, application of findings from these studies is limited by their inability in capturing salient interventions from actual nurse-patient care encounters in which culturally competent care *was* provided.

Although research literature offers valuable information to nurses caring for Latino patients, many of the studies reviewed herein failed to provide evidence that

differentiates *culturally competent* nursing care of Latino patients from *competent* nursing care for *any* patient. Several studies identified the importance of treating the patient with respect (Berry, 1999; Stasiak, 1991; Warda, 2000; Zoucha, 1998), displaying sensitivity and kindness (Warda, 2000; Zoucha, 1998), incorporating the family (Baldonado et al., 1998; Berry, 1999; Bollenbacher et al., 2000; Lipton et al., 1998; Stasiak, 1991; Warda, 2000), and including the patient's religious beliefs into the plan of care (Baldonado et al., 1998; Berry, 1999; Stasiak, 1991). One could easily argue that these should be inherent qualities of nursing care for *all* patients, regardless of the patient's ethnicity. However, only one study reviewed herein identified culturally distinctive characteristics of Latinos that could be incorporated into care delivery in order for that care to be culturally congruent. Brown & Hanis (1999) attributed the success of their strategies at lowering diabetic Mexican Americans' glycosylated hemoglobin and fasting blood glucose levels to the fact that they were designed specifically for a bilingual setting for Mexican Americans, and they involved culturally acceptable lifestyle recommendations. No other studies reviewed herein offered empirical evidence that the recommendations offered in their findings were empirically tested for their cultural appropriateness or for any differences they made with regard to patient outcomes.

The literature related to nursing care of Latinos reveals aspects of nurse-patient encounters that are culturally based and have the potential to influence patient outcomes. However, absent from this literature are studies that dwell in the everyday world of nurses caring for Latino patients in the ED. If cultural competence in nursing care of Latino patients is to be described and promoted, then it is crucial to determine in what ways such nursing care is uniquely planned and provided relative to the patient's Latino

ethnicity. Are there specific interventions that nurses in the ED use when working with Latino patients that would make the care culturally competent? What are the everyday concerns, habits and practices that direct the practice of nurses identified as expert in the care of Latino patients in the ED? Do concerns that guide expert nursing care of Latinos match the needs and concerns brought to clinical encounters by Latino patients?

The discussion now turns to the process of how nurses develop expertise in their practice. Although there have been no studies that have examined how nurses develop expertise in caring for Latino patients, components of the development of expertise in nursing practice as described in the extant literature can be extended to our understanding of this phenomenon.

Development of Expertise in Nursing Practice

The process by which nurses develop expertise in practice is complex and multifaceted. Review of the literature revealed several widely accepted studies that focused on this phenomenon (Benner, 1984; Benner et al., 1996; Benner et al., 1999). Although it is noted that this body of research may be criticized because expertise in practice has not been validated or confirmed by patients' perceptions, or for lack of evidence that supports any difference that expert practice may make on patient outcomes, there have been no studies that have convincingly refuted these findings.

Benner (1984) made explicit the limitations of formal rules in guiding nurses' clinical judgments, and expounded on the discretionary judgment used by expert critical care nurses. As described by Benner (1984), expertise is manifested in a nurse's ability to intuitively grasp the salient aspects of a clinical situation and intervene in a skilled manner based on the situated meaning ascribed to the particular patient situation. Benner

et al. (1996) extended this research and found that extensive practical experience with particular patient populations is requisite to developing expertise because this skill level depended on "a perceptual grasp of qualitative distinctions, which can only be acquired by seeing and contrasting many similar and distinct situations as they evolve over time" (p. 114). Benner et al. (1999) incorporated other critical care areas, including emergency department nursing practice, in their aims to delineate the practical knowledge embedded in expert practice, to identify institutional barriers and resources for the development of expertise in nursing practice, and to identify educational strategies that encourage the development of expertise (p. 6).

The knowledge gleaned from literature focusing on expertise in critical care nursing practice can be extended to how nurses develop expertise in the context of caring for Latino patients in the ED. Nurses approach clinical situations with some background understanding about patients and their culture. Repeated exposure to clinical situations involving patients enables the experienced nurse to identify new instances of certain things s/he already knew; not only in relation to physiological symptomatology and illness trajectories, but also to culture-based knowledge and distinctions made between patients (Benner et al, 1996; Benner et al, 1999). As the experienced nurse draws from knowledge previously acquired, meanings and patterns emerge in the present situation that enable the nurse to delineate its sense and to discern its nuances and saliencies, and thus, direct the nurse to an appropriate course of action on the patient's behalf. Research has demonstrated that as a nurse develops expertise, the nurse's internalized patterns of meaning and behaviors that guide performance in clinical situations serve to organize the clinical surroundings, and are perfected through a process of trial and error in subsequent

situations as interventions which have worked in the past are tested for their current applicability (Benner et al, 1996; Benner et al, 1999).

Theoretical and practical knowledge become embodied (Polanyi, 1962) as a result of repeated exposure to and engagement in many clinical situations. Investigators have discovered that meanings ascribed to thoughts and actions become taken-for-granted as the nurse who practices in an expert manner becomes engaged with the clinical surroundings (Benner, 1984; Benner et al., 1996; Benner et al., 1999). Schon (1983) explored facets of expertise, and described a knowing-in-action—a kind of knowing that is inherent in intelligent action. "Skillful action often reveals knowing more than [the nurse] can say" (Schon, 1983, p. 51). Hence, nurses' expert knowing is implicit in their patterns of action in clinical situations with patients (Benner & Wrubel, 1989). The knowing-in-action that guides skillful performance often leaves experts unable to fully explicate what they know. Thus, a tacit way of knowing (Polanyi, 1962; Schon, 1983) directs interventions and enables nurses who practice in an expert manner to recognize nuances within situations that require a modified course of action.

As a nurse gains clinical expertise, s/he begins to organize and deliver care in relation to the patient's responses (Benner, 1984; Benner et al., 1996). Nurses who practice in an expert manner come to understand the particulars of a situation only within the context of that situation. Skillful involvement requires that the nurse be attuned to the context of the clinical situation in relation to the patient's response to therapies, and how the illness episode affects the patient and his or her family (Benner, 1984; Benner & Wrubel, 1989; Benner et al., 1996).

Several authors have examined the personal meaning of illness in the context of the

patient's life (Blumhagen, 1982; Good & Good, 1981; Kleinman, 1988; Kleinman et al., 1978; Benner & Wrubel, 1989). The lived experience of illness in the clinical situation is filled with issues that are significant to the patient as well as to the nurse. Patients examine an illness episode in relation to how it affects their past, present, and future (Kleinman, 1988), and it is this situated meaning that the nurse must understand in order to provide effective care that is sensitive to the Latino patient's grasp of possibilities (Benner et al., 1996; Benner & Wrubel, 1989). Connecting with the patient and his/her concerns "enables the nurse to understand and respond to what is salient in the situation" (Benner et al., 1996, p. 116). Emotional, skilled involvement with patients promotes "engaged reasoning, perceptual acuity, and…connecting with patients/families in healing and therapeutic ways" (Benner et al., 1996, p. 110). Through skilled involvement, nurses who practice in an expert manner provide particularized care that supports and empowers the Latino patient and family.

Analysis of expert clinical knowledge discloses patterns of meaning and behavior in nurses' practices that hitherto were practiced tacitly (Polanyi, 1962; Schon, 1983). The purpose of the present study was to reveal the extent to which nurses' practices were directed by internalized meanings of Latino patients' cultures and culture-based needs, and how these internalized meanings were developed and tested over time. Interpretive descriptions of nurses' narrative accounts and observations of care encounters with Latino patients in the ED can provide a model of involvement from which other nurses can learn by revealing the contextually embedded ways of knowing the patient that directed expert nursing practice, and the concerns that influenced nurses' actions throughout the clinical situation. Interpretive descriptions of Latino patients' narratives of

their nursing care experiences validates the cultural competence of particularized care that emerged from nurses' concernful and engaged involvement in the clinical situation.

The discussion now turns to the philosophical framework underlying this study. Epistemological and ontological assumptions supported the chosen methodology that facilitated examination of nurses' and patients' everyday care experiences. Examining nurses' and Latino patients' experiences made possible the explication of the contextually embedded concerns and meanings that oriented participants to the world in which they lived and in the clinical situations in which they participated.

Philosophical Framework

This study was designed to understand the everyday concerns, habits and practices that directed the care given to Latino patients by nurses who were identified as expert in the care of Latino patients in the ED. Because little is known about this phenomenon, an interpretive phenomenological design was used to study nurses' lived experiences as a way of uncovering and understanding the practical knowing (VanManen, 1990) that guided their actions, and to uncover commonalities and differences in the meanings ascribed to nurses' and Latino patients' experiences (Benner, 1994). An interpretive phenomenological method served to uncover the meaning hidden in taken-for-granted experiences and expose the possibilities of what can occur in practice that may not have been seen otherwise (Benner, 1984).

Philosophical Origins and Assumptions of Interpretive Phenomenology

The phenomenological methodology that guided this study derives from an interpretivist philosophical paradigm informed by Martin Heidegger (Heidegger, 1962) and Maurice Merleau-Ponty (Mallin, 1979; Moran, 2000). Reacting against the positivist

notions of Cartesian duality, Heidegger did not believe that the world existed through cognitive representations separate from human experience (Dreyfus, 1997). Rather, he believed that persons were *in* the world, constituting while at the same time being constituted by their world (Heidegger, 1962). Humans are born into a world of shared meaning, pre-understanding, language, and customs, and these influence one's interpretation of one's world throughout one's life (Heidegger, 1962). Humans are self-interpreting beings that make sense out of their experiences in relation to their background and culture, and the historical context in which they occur (Leonard, 1994). Heidegger emphasized ontology over epistemology, and believed that it is through interpreting one's involvement in their world that things can be known at all (Heidegger, 1962).

Whereas Heidegger did not address the corporeal nature of human existence, Merleau-Ponty, another European phenomenologist and a contemporary of Heidegger, posited that humans are united with their surroundings (Mallin, 1979), and make sense of situations and come to understand their world through the body and its sensory and motor capacities (Mallin, 1979; Moran, 2000). Merleau-Ponty posited that it is through sensory capacities that humans subjectively perceive their surroundings, interpret their world, and ascribe meaning to situations that involve them (Mallin, 1979; Moran, 2000).

Concern and Involvement

A person is a being for whom things matter. And because things matter, people become involved in their world. Heidegger (1962) calls this way of being involved "concern". Humans are intentional, concernful beings who have personal and practical concerns that engage them in the everyday world (Heidegger, 1962; Mallin, 1979).

Human beings care about others, and this caring and concern is manifested through intervening on another's behalf (Heidegger, 1962). It is through their concern that humans are constituted by and solicited by their worlds, and, thus, always involved in a context (Benner & Wrubel, 1989).

Contextual Embeddedness of Human Experience

Human behavior cannot be understood out of the context in which it occurs (Heidegger, 1962). Context describes the ways a person is connected to and involved in the world (Benner & Wrubel, 1989). Temporality, background meaning, and concern are embedded in context in such a way that the person is defined by the situation while at the same time defining the situation (Benner & Wrubel, 1989). Humans, united with their surroundings, construct meaning in relation to their world and in the situations in which they participate. As humans interact with their world, their sensory perceptions allow them to attribute meanings and develop patterns of familiarity through repeated exposure to environments that over time become familiar to them (Mallin, 1979).

Interpretivism and Nursing Practice

It is this researcher's position that the philosophical assumptions of Heideggerian phenomenology can extend to our understanding of nurses caring for Latino patients in the ED. Nurses, situated in a world of shared meanings with patients, bring their concernful and caring practices to clinical situations (Benner & Wrubel, 1989). Nurses involve themselves in the world with their patients, are actively engaged as participants in the clinical situation through concernful, and caring relationships (Benner, 1984; Benner et al., 1996; Benner et al., 1999), and derive meaning from the caring relationships that develop (Benner & Wrubel, 1989). The outcome of a nurse's concernful involvement is

that her world is understood in light of that concern (Benner & Wrubel, 1989), and this meaning influences the nurse's actions in clinical situations involving Latino patients.

The clinical knowledge expert nurses acquire over time, which is influenced by personal and professional history and meaning, is based on previous experiences with a series of clinical situations (Benner, 1984; Benner et al., 1996; Benner et al., 1999) with Latino patients. Through repeated exposure to clinical encounters involving Latino patients, expert nurses acquire patterns of meaning and behaviors that allow them to discern the saliencies and nuances that must be attended to in particularized patient situations; they are then able to deliver effective interventions that promote optimal patient outcomes.

Interpretive Phenomenology as a Foundation for Qualitative Inquiry

Interpretive phenomenology as a philosophic and methodologic foundation for research has much to offer to the science of nursing. Unlike scientists within the positivist tradition, who through objective methodologies aspire to explain or predict human phenomena and seek to discover evidence that describes an ultimate truth in the phenomena of human existence (Allen, Benner & Diekelmann, 1986; Bernstein, 1983), interpretive phenomenologists embrace the lived experiences of humans, and seek to interpret (describe or understand) these multiple experiences or realities through qualitative methodologies. Within the interpretivist paradigm, "truth is viewed as a composite of individuals' perceived realities and is conceptualized as changing and context-dependent rather than as fixed and inviolate" (Dzurec & Abraham, 1986, p. 58). An enhanced understanding of the person is desired that invokes "context, wholeness,

and the irreducible connectedness between observer and observed to address questions about the meaning and structure of lived experience" (Bent, 1999, p. 79).

Interpretive phenomenology as a research methodology emphasizes and respects the social and cultural nature of being human (Benner, 1994). Although humans "do not all experience or live in the same worlds, these worlds can be described, talked about, and discovered" (Benner, 1994, p. 117). And it is because of our social and cultural nature that humans can have shared meanings and can understand the other's experiences. This research method has an intersubjective character to it, because it "always addresses any phenomenon as a *possible human experience*" (Van Manen, 1990, p. 58). This intersubjectivity enables the researcher to develop a dialogic relationship with participants who have experienced the phenomenon (Van Manen, 1990). "Researcher and research participant are viewed as sharing common practices, skills, interpretations, and everyday practical understanding by virtue of their common culture and language" (Leonard, 1994, p. 55). Interpretive phenomenology is both subjective—in that narrative accounts of lived experiences are elicited from participants—and objective—in that "skills, practices, and meanings are … shared and therefore verifiable with both research participants and colleagues" (Leonard, 1994, p. 58).

Rationale for Interpretive Phenomenological Methodology

Interpretive phenomenology was chosen as the philosophical and methodological framework for this study for several reasons. First, interpretive phenomenology is concerned with obtaining a deep understanding of the nature of an individual's everyday experiences (Van Manen, 1990). In phenomenological inquiry, "what is important to know is what people experience and how they interpret the world" (Patton, 2002, p. 106).

Second, the methodology rests on the assumption that individuals bring their background understandings (history, culture, values, beliefs) with them to every situation (Heidegger, 1962), including encounters where Latino patients seek care and nurses deliver care. Each nurse's background understanding as well as his/her values and beliefs inherent in nursing practices influence his/her interpretation of and reaction to clinical situations involving Latino patients and thus, plays a large role in the development of expertise in clinical knowledge. Third, phenomenology provides the philosophical foundation for qualitative inquiry, which is a research method that aims to capture lived experiences of study participants and allow those experiences to present themselves as they would in their everydayness (Benner, 1994). This methodology has been widely used by nurse researchers and others (Benner, 1984; Benner, 1994; Benner & Wrubel, 1989; Benner et al., 1996; Benner et al., 1999; Chesla, 1995; Darbyshire, 2004; Freda, Devine & Semelsberger, 2003; Gullickson, 1993; Racher, 2003; Rankin & Monahan, 1991; SmithBattle, 1995; Van Manen, 1990) to understand the concerns and experiences presented by participant narratives and situated actions. Interpretive phenomenology allows the researcher to dwell in the everyday existence of nurses considered expert in the care of Latino patients to discover and understand the knowledge and concerns that guide their practices, and to explore the congruency of this care to the concerns brought to clinical encounters by Latino patients and families.

Significance of Interpretive Accounts Beyond Sensitization

Narrative inquiry shows us what can occur in practice that may not otherwise be seen (Benner, 1984). It accomplishes this by uncovering the meaning that is hidden in the taken-for-granted, everyday experiences of nurses caring for Latino patients in the ED,

and the Latino patients who receive that care. Theories that emerge from objective scientific methodologies do not consider the context in which humans experience and interpret their world. Decontextualized propositions and laws do little to further our understanding of nurse and Latino patient clinical encounters, for they disregard the contextual richness of participants' everyday experiences. By conducting an interpretive, phenomenological study, this investigator was able to explore and interpret nurses' experiences while caring for Latino patients so that commonalities in the nurses' everyday meanings, skills, practices, and embodied experiences could be uncovered, understood, and described. Exploring and interpreting the experiences of Latino patients enabled the explication of meanings they ascribed to health concerns and care interventions, thus, enhancing our understanding of culturally competent nursing practices in the ED.

"Narratives of actual practice must be made public, because in the narrative lies the possibility of describing the knowledge embedded in the particular, historical, clinical relationship" (Tanner, Benner, Chesla & Gordon, 1993, p. 279). Understanding the knowledge that guides expert nursing practices adds to the knowledge base that informs culturally competent nursing care of Latino patients. Nurses must recognize how their understanding of the Latino patient's cultural needs influences their nursing actions and care. Through narrative accounts, interpretations of nurses' everyday experiences can provide insights into the significance of the phenomenon of caring for Latino patients in the ED; those interpretations can also sensitize nurses so that they are able to approach similar patient situations with the knowledge, sensitivity and tactfulness necessary to intervene in a culturally congruent manner (Van Manen, 1990).

Investigator's Background Understandings of the Phenomenon

"In drawing up personal descriptions of lived experiences, the phenomenologist knows that one's own experiences are also the possible experiences of others" (Van Manen, 1990, p. 54). As a nurse who has provided care to Latino patients in an acute care setting and observed other nurses do so as well, I entered this study with some background knowledge—a pre-understanding—of the care experiences of nurses as well as facets of the work environments that might either enhance or act as barriers to the nurses providing culturally competent care to Latino patients.

My background as an Anglo nurse and my experiences with providing care and observing other nurses as they provided care to Latino patients shaped the research questions that were asked and formed the basis of analysis from which my interpretations of the participants' narrative accounts was carried out. My being Caucasian and monolingual presented challenges to my efforts to form connections with non-English-speaking Latino patients and families and to provide care that addressed their concerns and needs. My concern for the well-being of Latino individuals and families in those situations, highlighted my inability to provide quality care because of a lack of knowledge. Thus, the situations presented problems to solve. As Mallin (1979) indicated, "We are pulled into situations and feel the need to become involved in the solution of the problems they present because we have concerns we always carry with us" (p. 12). Experiencing and observing care encounters in which cultural differences existed fueled my desire to explore nursing care of Latinos and influenced my decision to examine the experiences of nurses and patients to uncover the issues and concerns that direct actions in culturally competent care of Latinos.

Chapter III: RESEARCH DESIGN AND METHODS

Methodology in Relation to Research Questions

Question 1. **What are the everyday concerns, habits and practices embedded in the care given to Latino patients by emergency department nurses who have been identified by their peers as expert in the care of Latinos?** This qualitative study describes the knowledge that guides expert nurses (i.e., expert in caring for Latino patients) in their everyday practice of caring for Latino patients in the ED. Interpretation of nurses' narratives and observations of care experiences reveal the concerns, habits and practices that guide expert care of Latino patients, including nuances and salient features these nurses attend to in these clinical situations.

Question 2. **To what extent do the concerns embedded in the care given to Latinos by these nurses match the needs and concerns brought to clinical encounters by Latino patients?** In addition to nurses' narratives and observations of care experiences, Latino patients who received care from nurses participating in this study describe their care experiences as well as the concerns that brought them to the clinical encounter. Interpretation of nurses' and patients' narratives and observations of care experiences revealed the extent to which expert nursing care was congruent with the Latino patients' needs and concerns.

This study was designed to: (a) understand the everyday concerns, habits and practices embedded in the care given to Latino patients by nurses who were identified as expert in the care of Latino patients in the ED; and (b) determine the degree to which this nursing care is congruent with the needs and concerns brought by Latino patients to clinical encounters, and thus, considered culturally competent. An interpretive

phenomenological design was used to study the nurses' and patients' lived experiences as a way of understanding the meanings ascribed to those experiences (Benner, 1994).

Setting

Four hospitals in a state in the northwestern U.S. were chosen as the settings for this study. Each is located in a county selected because of its large Latino population comprised of immigrants from Mexico and other Latin American countries (U.S. Department of Commerce, 2002). The selected counties either ranked among the top three in that state with the highest percentage of Latino population, or whose Latino population was at least 25% of the total population (U.S. Census Bureau, 2000b). The nursing practice area examined by this research was the emergency department (ED) of each hospital. The facilities in the geographical areas where this study took place do not collect data that reflects the use of health care services in hospital settings based on cultural/ethnic groups. However, other research findings do indicate that people who have neither medical insurance nor a regular health care provider access the ED as their primary source of medical care (Chavez, 1998; Warda, 2000). The investigator obtained approval to conduct the study from the Institutional Review Board of Oregon Health & Science University and in each affiliated hospital before nurses or Latino patients were contacted.

Sample

The study participants included nurses who worked in the ED of affiliated hospitals and Latino patients who received care from these nurses in those departments. (See Figure 1 for sampling procedures.) Additional details about the participant sampling can be found in the Procedures section of this chapter.

Nurse Participants

The expert and non-expert nurse participants were recruited using purposive and convenience sampling techniques. The narratives of non-expert nurses served as contrast cases (Patton, 2002) that helped illuminate and confirm patterns that emerged in the practice of expert nurses; they also provided boundaries for what was considered expert practice and what was not. Fifteen nurses who worked in the ED of the affiliated hospitals were selected to participate in this study; 4 were identified by their peers as expert in the care of Latino patients, and 11 were not.

Nurse participants demonstrated diversity in gender, ethnicity, experience, and educational attainment. The majority of nurse participants indicated their ethnicity as "White" (67%, $\underline{n} = 10$), while 1 indicated "American Indian" (6%), and 4 indicated "Hispanic or Latino" (27%). Nine of the nurses in the sample (60%) reported their highest degree earned was an Associate's Degree in Nursing; 27% had earned a Bachelor's Degree in Nursing; and 13% ($\underline{n} = 2$) had earned a Master's degree (one in Arts and one in Social Work). The nurse sample consisted of 4 males and 11 females. Their years of experience in the ED ranged from less than 1 year to greater than 16. No correlation was found between years of experience in the ED and expertise in practice. One of the nurses identified as expert had over 16 years of experience; however, narratives and observed practices from this nurse did not exhibit expertise. Another nurse who had less than 1 year experience in the ED and who was not identified as expert, manifested expertise in his nursing practice.

Latino Patient Participants

As part of data collection in this study, the practices of selected expert and non-

expert nurses were observed to further examine and describe the everyday concerns, habits and practices that influenced their actions and guided the care they provided to Latino patients. Latino patients who presented for care during the times when a selected nurse's practice was being observed were asked to participate by allowing the investigator to observe the nursing care they received in the ED (see Figure 1 for sampling procedures). A total of 22 Latino patients who received care in the EDs of affiliated hospitals participated in this study. This sample consisted of 8 males and 14 females. The patient participants were also asked to take part in an interview about the care they received following their care episode in the ED. A total of 10 interviews were done with Latino participants; 6 were done with the parent of a child seen in the ED, and 4 were done with the patient.

By allowing the Latino patients to participate, this study was strengthened in several ways. First, it enabled the disclosure of concerns that were significant in the patient's illness experience and that influenced their interactions with nurses during the care encounter. Second, it enabled Latino patients' concerns to be compared with the actions of expert and non-expert nurses to examine the cultural congruence of the care. Previous research on expertise lacked the patient perspective. Consequently, what nurses described as "making a difference" was not examined against the perceptions held by recipients of their care (Benner, 1984; Benner et al., 1996; Benner et al., 1999).

Because of the need to establish trust and rapport with Latino participants (Marín & Marín, 1991), and because the investigator is non-Latina and monolingual, a bilingual Latina research assistant (RA) was contracted by the investigator to recruit and interview Latino patient participants. The RA was recruited based on the following criteria: (a) she

was bicultural (self-identified as being of Latino/a ethnicity); (b) she was bilingual (self-identified as being proficient in Spanish and English); and, (c) she had previous experience as an RA working with Latino bilingual, bicultural individuals.

Before any Latino patients were recruited, the primary investigator fully apprised the RA of the study's purposes. This was done to ensure the RA was trained in the study protocols, and understood the importance of maintaining the integrity of the study and of protecting the confidentiality of the participants for the duration of the study. The additional training that was done with the RA regarding study protocols is discussed in the Data Collection section of this chapter.

The RA was present in the ED while the investigator observed a selected nurse's practice, and sat in the patient waiting area after being introduced to triage and registration personnel by the investigator. Following a script that had been translated into Spanish (see Appendix A), triage and/or registration personnel informed Latino patients (or, if a minor, patient's parent) who presented for care that a study was being conducted in the ED. They were then asked if the RA could talk to them about the study while they waited to be seen by care providers. If the patient or parent did not speak Spanish, the conversation took place in English, and the triage and/or registration personnel followed an English language version of the same script (see Appendix B). Patients who were emergently ill or in need of immediate care were not told about the study. Whenever a patient (or his/her parent) agreed to be approached about the study, triage and/or registration personnel notified the RA, gave her the patient's (or parent's) signed permission form, and pointed out where the patient/family was sitting in the ED waiting area.

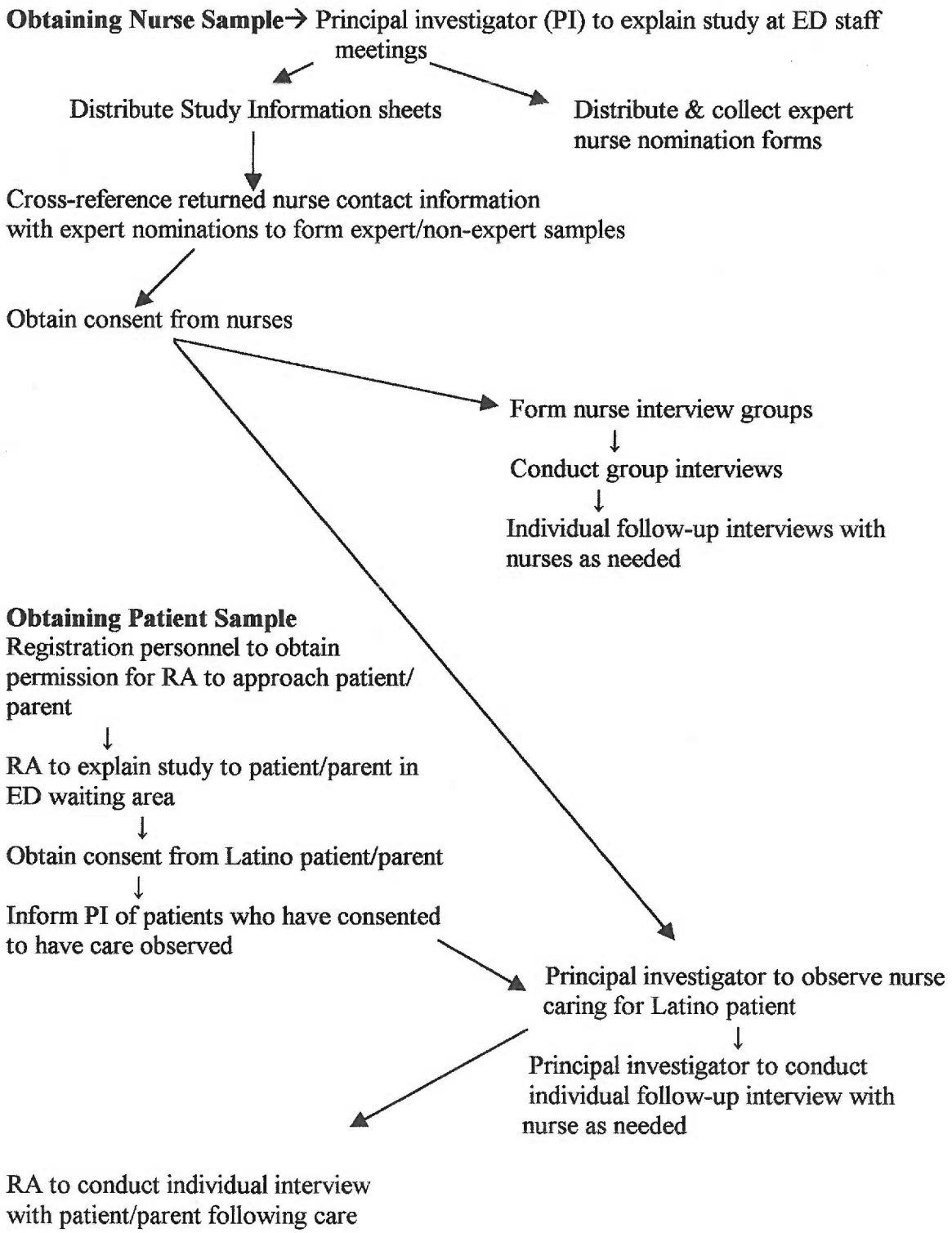


Figure 1. Sampling and data collection procedures.

Although some effort was made to include an equal number of Latino men and women as participants, the random nature of who sought care in the ED on the occasions when the investigator and RA were there made this element of patient demographics difficult to control. The goal of each observation session was for the investigator to observe the care of two Latino patients, one of whom would be interviewed after receiving care in the ED. After the RA conducted an interview with one patient (or parent) who had consented to be interviewed, the RA proceeded to recruit a patient who agreed to only have his or her nursing care observed. (For a full review of sampling procedures used to recruit Latin participants, refer to the Procedures section of this chapter.)

The following protocol was followed by the RA for recruiting Latino patient participants:

1. The RA approached patient (or patient's parent) in Spanish and continued the conversation in Spanish if the patient (or parent) responded in Spanish. The RA followed a script that had been translated into Spanish that informed the patient (or parent) of the purpose of the study and the extent of their participation should they agree to participate (see Appendix C). If the patient's (or parent's) response revealed that they did not speak Spanish, the conversation took place in English, and the RA followed an English language version of the same script (see Appendix D).
2. The RA asked each patient (or parent) who agreed to participate in the study to sign a written informed consent (in the appropriate language) to acknowledge a willingness to have his/her (or the child's) nursing care observed (see

Appendices E and F) or to have his/her (or the child's) care observed and then be interviewed (see Appendices G and H).

3. Each patient (or parent) who agreed only to have their nursing care observed was informed that they would not receive any compensation for participating. Each patient (or parent) who agreed to have his/her care observed and to be interviewed were informed that they would receive $20 cash at the completion of the interview.
4. Out of respect for participants who could not read and to avoid any discomfort associated with asking them about their literacy abilities, the RA read the informed consent to all participants. Reading the consent form also ensured that all information was conveyed to the participant before the form was signed.
5. After the RA had obtained a written informed consent, she gave a copy of the consent form to the patient (parent) and placed the original in a locked bag kept in her possession during each observation session the investigator was in the ED. The RA told the investigator the name of each participant who agreed to have his/her care observed, so that the investigator could arrange for the nurse being observed to be assigned to that patient. The investigator was not told which patient (parent) agreed to be interviewed.
6. The RA told patients (or parents) who agreed to have their nursing care observed that their participation ended once they received care in the ED. Patients (parents) who agreed to have their nursing care observed and also agreed to be interviewed were instructed to meet the RA in the ED waiting area upon completion of their care. When the Latino patients (or parents) returned to the

waiting area after receiving care, the RA accompanied them to a room located outside the ED that allowed for privacy during the interview.

Data Collection

Three types of data collection were incorporated into this study: (a) written questionnaire to obtain demographic data; (b) in-depth individual and group interviews; and (c) participant observation. Demographic data were collected from all nurses who participated in the study and from the Latino patients who were interviewed. No demographic data were collected from the Latino patients who were not interviewed.

In-depth, unstructured group and individual interviews were employed to uncover concerns, habits, and practices embedded within expert and non-expert nursing care. An interview guide with open-ended questions was used to elicit nurses' narratives of care experiences. The researcher's goal was to describe expert nurses' practical experiences with providing care to Latino patients. "Narratives communicate aspects of the human experience … and provide access to specific experience rather than to abstract or general constructions about that experience" (Benner et al., 1996, p. 354). Stories are told by nurses in such a way that central concerns, or themes, emerge. Through interpretive analysis of nurses' experiential descriptions and reflections on their experiences, we are able to "come to an understanding of the deeper meaning of an aspect of human experience" (Van Manen, 1990, p. 62) in the context of the whole of nurses living this experience.

Because research has demonstrated that experts cannot fully articulate all they know (Polanyi, 1962; Schon, 1983), and because experts understand the particulars of a situation only within the context of that situation (Benner, 1984; Benner et al., 1996;

Benner et al., 1999; Polanyi, 1962), direct observations of expert and non-expert nurses' practice were incorporated into data collection to further reveal concerns, habits and practices embedded in nurses' care of Latino patients. Individual interviews with Latino patients following observed care encounters uncovered issues and concerns brought to clinical situations by Latino patients and their family members. (See Figure 1 for data collection procedures.)

Nurse Interviews

Before meeting for the first interview, the investigator met with the nurses individually mutually acceptable locations over coffee to obtain consent and to have them complete demographic questionnaires. The informed consent form (see Appendix I) was read to nurses, and they were allowed time to ask any questions they had about the study or its procedures. The process for obtaining consent allowed nurses to choose whether or not they would agree to have their practice observed should the investigator find them to be good informants during group and individual interviews. Nurses who agreed to participate in the study were asked to complete a demographic questionnaire (see Appendix J) that the investigator collected during this meeting; they were also given pre-interview instructions (Benner et al., 1996) that directed them to reflect on their care of Latino patients and to recall at least one particular patient situation that stood out as poignant for them (see Appendix K). Probes inserted into these instructions served to stimulate reflection. Nurses were instructed to bring any notes they might take while reflecting on their practice to the first interview session during which they would be asked to share their stories.

Effort was made to arrange the nurse participants into expert or non-expert groups

based on their level of expertise (as identified by their peers) in the care of Latino patients in the ED. Four groups of nurses were formed consisting of 3 to 4 nurses each. Due to a delay in receiving responses from nurses at one of the participating facilities, some groups included both expert and non-expert nurses. Each group was interviewed twice to obtain several instances of practice and to allow nurses to present instances from their practice that became salient in the course of the study as they listened to each other's narratives. In previous studies that examined expertise in nursing care, this strategy was found to be effective in gathering meaningful qualitative data from nurses about their practice (Benner et al., 1996). Multiple interviews allowed the investigator to clarify issues and concerns left unexamined in the prior interview (Benner, 1994; Benner et al., 1996).

Group and individual interviews were conducted to gather narrative accounts about nurses' care experiences. Narrative accounts point to what is perceived and noticed, as well as to what concerns the storyteller (Benner, 1994). They also provide rich descriptions of the everyday realities of study participants that give "access to specific experience rather than to abstract or general constructions about that experience" (Benner et al., 1996, p. 354). Such rich descriptions of experiences cannot be gathered when one stands outside of the experience and describes it in abstract terms.

Benner's (1994) guidelines for small group interviewing were followed during data collection. These guidelines included: (a) creating a natural communicative context for telling stories; (b) encouraging participants to converse naturally to engage the storytelling process; (c) promoting an environment conducive to eliciting narrative accounts of events, situations, feelings, and actions from participants; (d) being an active

listener; (e) probing participants to fill in unclear aspects or details of their story; and (f) confirming and clarifying initial understanding of stories with participants (Benner, 1994). Nurses' narrative descriptions of practice were obtained through small group interviews.

Group interviews allowed for more flexibility in the interviewing process, permitted considerable probing (Frey & Fontana, 1993), and created an atmosphere that encouraged mutual sharing of similar and dissimilar experiences, feelings, and actions (Benner, 1994). Careful attention was given to setting an informal tone during the group interviews. A relaxed, informal environment enhanced the participants' active engagement in the process of sharing stories from their practices (Benner, 1994; Benner et al., 1996; Benner et al., 1999). An unstructured interview guide consisting of open-ended questions with probes to further clarify or fill in the discussion was used during group interviews (see Appendix L). Open-ended questions, adapted from an interview guide used in previous studies of expertise in nurses' practices (Benner et al., 1996) guided the storytelling.

The investigator began each interview by asking nurses to recall patient care experiences that stood out in their memories as being significant in how they had gone really well, or not very well at all. The investigator limited her attempts at structuring the participants' narratives so that interviewees could shape the stories and actions that were conveyed (Benner, 1994). Probes inserted into the interview guide allowed the investigator to gather detailed accounts of the concerns that nurses had during the experiences they recalled, as well as influences of other providers and resources in the work environments that directed their attention and focused their actions. Probes also

allowed the investigator to elicit clarifications of nurses' accounts. Nurses, who were identified and identified each other during interviews by code names assigned to them by the investigator, were encouraged to use everyday language as they took turns presenting stories. Nurses were also encouraged to ask each other questions to clarify their understanding of stories (Benner et al., 1996). Each nurse varied in the amount and clarity of stories he or she recalled from their practice. Many nurses took on active roles during the group interviewers and asked each other for clarification or further details about care experiences. Stories told by nurses prompted others in the group to recall similar or dissimilar care experiences.

Data collection continued until data saturation, or redundancy of themes, occurred (Lincoln & Guba, 1985). The investigator conducted, audio-recorded and transcribed all interviews with nurse participants, and took detailed notes during the interviews. A list linking nurse identities with code names was kept in a secure location away from any data during the course of the study.

Latino Patient Interviews

Before any data were collected from Latino patients, the primary investigator fully apprised the RA of the study's purposes (refer to the discussion about informed consent procedures in the Sample section of this chapter). This was done to ensure that the RA was trained in the study protocols, and understood the importance of maintaining the integrity of the study and of protecting participant confidentiality for the duration of the study. The investigator and one of her dissertation committee members, who is fluent in Spanish and who has trained assistants for previous research studies with Latinos, trained the RA in interview techniques. Training included teaching the RA: (a) how to elicit

detailed stories from patients about their care experiences, (b) how to keep patients on track when they told their stories, (c) how to take detailed field notes during interviews, and (d) how to debrief with the patient following the interview.

The following protocol was followed for collecting data from all Latino participants who consented to be interviewed after receiving care in the ED:

1. During recruitment efforts, patients who agreed to have their nursing care observed and to be interviewed were instructed to meet the RA in the ED waiting area after they had received care. When they did, the RA accompanied the patient (or parent) to a room located outside of the ED that allowed for privacy during the interview.
2. In the interview room, before any data were collected from Latino patients, the RA obtained permission from the patient (or parent) to audio-record the interview. Interviews were conducted in the language preferred by the patient (or parent). The RA followed an unstructured interview guide with open-ended questions and probes to stimulate further discussion (see Appendix M). The interview guide was marked with a pre-assigned code number used to conceal the patient's identity, and the RA referred to the patient in any field notes by this code number only.
3. After the patient (parent) had finished narrating his/her care experiences, the RA turned off the tape recorder, debriefed with the patient about the interview experience, and collected demographic data by following questions included on the patient interview guide (see Appendix M).

4. Once the interview was completed, the RA paid the participant $20 cash. All notes and interview tapes were placed in a locked bag that was kept in the possession of the RA until the bag was given to the investigator at the end of each observation session.

During each observation session, individual interviews were conducted with the first Latino patient who agreed to have his/her care observed *and* who agreed to be interviewed after receiving care. Although the goal was to observe one nurse care encounter that correlated with one patient interview (during each of two observation sessions), this was not always realized. In several instances, patients who had consented to be interviewed were admitted to the hospital or had received too much of a sedative medication to allow them to be interviewed. In another instance, scheduling or patient load conflicts emerged in the nurse's practice that kept the nurse from being assigned a particular patient even though that patient had already consented to have their care observed and to be interviewed. When these situations arose, the RA made every effort to recruit another participant to be observed and interviewed during that nurse's observation session.

A total of 10 interviews were conducted with Latino patients or their parents following the care they received in the ED. Nine of the 10 participants indicated they were first generation immigrants, having been born in Mexico. The length of time participants indicated they had lived near the hospital where they had received care ranged from 5 to 30 years, with an average of 11.7 years. Nine of the 10 interviews were conducted in Spanish. Six of the 10 interviews were conducted with the parent of a child seen in the ED; 1 with the father of a child, and the remaining 5 with the mother. The

remaining 4 interviews were conducted with the patients themselves. Eight of the interviewees were women.

Transcription and Translation of Spanish Language Data

Because the study included interviews conducted in Spanish, and because the investigator is monolingual and relied upon bilingual individuals to accurately and comprehensively translate the data into English, a brief discussion of how the investigator established this is warranted. A bilingual Latina individual other than the RA and the individual who translated the Spanish language informed consent forms was contracted by the investigator to transcribe Latino patient interviews verbatim and then translate those into English. This transcriptionist was born in Mexico; she also had previous experience with transcription and translation in a job she held for a governmental agency that served a migrant Latino population. After transcribing the first interview, another bilingual individual who was a second-generation Latina whose primary language was Spanish, listened to the audio-taped patient interview and compared the transcription with the interview dialogue. This was done to confirm the accuracy of the transcript. This individual then marked minor changes in writing on the interview transcript to ensure its accuracy before it was translated into English.

The investigator made all the corrections to the Spanish language interview transcripts. After corrections were made and the transcripts' accuracy had been established, the transcriptionist then translated the interview transcript into English and dictated the English translation into a tape recorder. The investigator transcribed the taped English translations. A member of the investigator's dissertation committee who is fluent in Spanish reviewed the English transcript with the original Spanish transcript of

the first Latino patient interview in its entirety to ensure accuracy in the content of the translated interview. Upon establishing the accuracy of the translated account, the same dissertation committee member reviewed randomly selected pages from subsequent Latino patient interviews All subsequent Latino patient interviews conducted in Spanish were transcribed, verified (i.e., accuracy confirmed) and then translated in the same manner by the same individuals.

Observational Data

Because experts cannot fully articulate all that they know, and because they understand the particulars of a situation only within the context of that situation, direct observations of nurses' practice were incorporated into data collection to reveal knowledge embedded in nurses' care of Latino patients. The aim of observing nurses "is to further articulate the practices that nurses describe in the group interview narratives" (Benner et al., 1996, p. 358). Direct observations allowed the investigator to enter the everyday world (Van Manen, 1990) of nurses and access knowledge implicit in patterns of action (Schon, 1983). Observations enabled direct access to the taken-for-granted and oftentimes transparent context of the clinical situation—including the environment, the equipment used by the nurse, and the events of a clinical situation as they unfold (Benner et al., 1996).

During the process of obtaining informed consent at the start of the study, nurses were asked to indicate whether or not they would agree to have their practice observed by the investigator. Those who agreed to this additional data collection were invited to participate in observation sessions after the investigator had determined they were good informants during interviews, or if they demonstrated a range of experiences in their

interview narratives (Benner et al., 1996). Like their narrative descriptions, observations of non-expert nurses served as contrast cases to help the investigator discern differences in the concerns, habits and practices between non-expert and expert nurses.

The investigator attempted to observe 3 expert and 3 non-expert nurses on two occasions each, with each session concluding after the investigator had observed the nurse provide care to two Latino patients (i.e., a goal of 24 observation sessions total). Because of scheduling conflicts that arose during the course of data collection, one of the selected nurses was only observed on one occasion; however, three patient care encounters were observed during that session. Due to scheduling conflicts that arose with the RA during an observation session, only one patient encounter was observed during a particular session.

To guide data collection during observation sessions, the investigator referred to specific categories of interpersonal behavior that included the nurse's use of touch, verbal and non-verbal communication, and resources (equipment, interpreter, educational materials). All dialogue between the investigator and nurse during observation sessions was tape recorded, and only the nurse's code name was used. To enhance candidness and to ensure privacy, all dialogue took place outside of patient rooms and where no one else was within earshot. During participant observations, the investigator recorded detailed written field notes, once again identifying the nurse only by his/her code name. One follow-up interview was conducted with two nurses whose practice was observed to further explicate or clarify salient aspects of practice that were revealed in the nurses' patterns of action.

Observations of nursing care practices and nurse narratives during these patient

interactions were compared with the Latino patients' (parents') narratives during data analysis to determine the extent to which nurses attended to issues and concerns brought to care encounters by the Latino patients (parents). The investigator recorded the patient's name in the participant observation field notes and cross-referenced this information with demographic data gathered during the interview with the patient. This allowed the investigator to compare observation field notes with the patient interview data. All field notes containing patient-identifying information were stored in a locked file cabinet in the investigator's home; once data analysis was completed, that material was destroyed.

A total of 22 interactions between nurses and Latino patients were observed; 14 involved female patients, and 8 involved males. Those patients ranged in age from 2 months to 71 years and included 14 children. All but 4 of the 22 observed care encounters occurred in Spanish, with or without assistance from an interpreter.

Procedures

Sampling Procedures

Sampling of Nurse Participants

The principal investigator attended ED nursing staff meetings to explain the purpose of the study and to invite all nurses in attendance to participate in the study (see Figure 1). Each nurse and nurse supervisor in attendance was given a form on which they were asked to write the names of co-workers whom they considered "expert nurses." (For purposes of this research, "expert nurse" was defined as those to whom others turn for guidance and assistance when providing care to Latino patients in the ED. See Appendix N) This description provided the definition of what was meant by "expert". None of the supervisors who attended the staff meetings completed the form.

A study information sheet (see Appendix O) was given to each nurse in attendance. Any nurse who wanted to participate in the study was asked to complete and return the bottom portion of the form, which elicited the nurse's contact information. Each nurse supervisor was also given study information sheets, but only for the purpose of placing them in the mailboxes of nurses not in attendance at staff meetings. The investigator attached a self-addressed, stamped envelope to each study information sheet. A total of 15 nurses were selected to participate in this study; 4 were identified as expert by their peers, and 11 were not.

Expert nurse sample.

To identify the expert nurse sample, the investigator cross-referenced expert nurse nominations with the contact information supplied by each nurse. A total of 4 nurses who were identified as expert by their peers agreed to participate in this study.

Non-expert nurse sample.

A subsample of ED nurses who were not identified by their peers as expert in the care of Latino patients was included in this study to assess commonalities and differences between the care provided to Latino patients by expert nurses and care provided by non-expert nurses. A total of 11 nurses who were not identified as experts in their work setting returned contact information to the investigator indicating their interest in participating. All agreed to and did participate in this study.

Sampling for Observations of Latino Participants

A convenience sample was obtained of Latino patients who presented to the ED for care during the times that the investigator was observing the practices of selected nurses. A total of 25 Latino patients (or parents) were approached about the study; 23 agreed to

have their nursing care interactions in the ED observed by the investigator. More than half of these participants (n = 13) were parents of a child brought to the ED for medical care.

Sampling for Interviews of Latino Participants

Convenience sampling techniques were followed to obtain a subsample of Latino patients. Those patients (or parents) were interviewed after they had received care in the ED: (a) to elicit narratives of their care experiences, and (b) to describe the issues and concerns they brought to the clinical encounter. Since linguistic differences have been shown to influence provision of health care (Kirkman-Liff & Mondragon, 1991; Hu et al., 1989), the study sample included both English-speaking and NES Latino patients in the sample. Consequently, the results yielded a variety of in-depth descriptions of experiences and perceptions of care. A total of 13 Latino patients (or parents) agreed to be interviewed after they had received care in the ED.

Protection of Human Subjects

The design of the study ensured that human subjects were protected during the course of the research. All nurse participants were given the option of returning contact information to the investigator as an indicator of their interest in participating. All Latino participants were first asked for permission to have someone approach them about the study, and then signed a form acknowledging their willingness to be approached by the RA. The RA kept these forms in a locked bag that she kept in her possession until it was turned over to the investigator at the end of each observation session.

All participants were informed of the purpose of the research before being asked to

participate. A written, informed consent was obtained from all participants before any data were collected, and all participants were informed that they could withdraw from the study at any time without any consequence to them. Patient-identifying information was kept in a locked cabinet in the investigator's home, separate from the data and bearing only a code name or number to link it to the data. All patient-identifying information was destroyed upon completion of the study. All persons with access to participants' identities (i.e., investigator, and RA) followed procedures that would ensure confidentiality and security of data including securing any documents that identified participants.

Before any data were collected from Latino patients, the investigator had the following study-related scripts and forms translated into Spanish: (a) the script used for gaining permission from patients for someone to approach them about the study, (b) the script used for approaching patients, (c) the informed consent form for observing a patient's care, (d) the informed consent form for observing a patient's care and for interviewing the patient, and (e) the interview guide. The informed consent forms were also back-translated into English in an effort to establish accuracy of translator abilities and to ensure accuracy in meaning and intent (Marín & Marín, 1991).

Because the majority of Latino individuals living in the U.S. have immigrated from Mexico (Immigration and Naturalization Services, 1997; U.S. Department of Commerce, 2002), a bilingual individual who was born in Mexico and whose primary language was Spanish translated the consent forms into Spanish. A second bilingual individual who was also born in Mexico and whose primary language was Spanish, back-translated the Spanish-translated versions of the consent forms into English. Both translators had experience working as translators on previous research and/or scholastic projects. A

member of the investigator's dissertation committee who is fluent in Spanish compared each original consent form with its back-translated version to ensure accuracy in meaning and intent. Revisions to the Spanish language versions of the consent forms were minimal, and were made to ensure that consistency in meaning and intent were was obtained between the English- and Spanish-language versions. Given the accuracy in meaning and intent with the first translation/back-translation process involving the consent forms, the investigator had the first bilingual individual translate the remaining data collection instruments, and did not repeat the back-translation process.

All interviews were audio taped with the participants' prior consent. Interview tapes were destroyed upon completion of the study. All interview transcripts, reflective memos, and computer disks containing interview data and analytic progress notes were kept in a locked cabinet in the investigator's home during the course of the study. Those items will remain there for up to two years, during which time secondary analysis may be performed. After two years, all this material will be destroyed.

Risks and Benefits to Participants

Although no assurances were made to the participants regarding benefits they might experience as a result of participating in the study, there were several actual and potential benefits. By participating in group interviews, the narratives of nurses revealed insights into the care of Latino patients by some nurses that other nurses may not have thought about before and could now incorporate into their practices. These care modifications could prove to be beneficial to Latino patients that these nurses care for in the future. Mutual sharing of personal reflections on practice may also enhance a nurse's confidence in his/her own nursing abilities. Another benefit to nurses was the monetary incentive of

$25 cash per hour that each received following their participation in group and individual interviews.

Latino participants may have realized that their involvement in the study could help to improve nursing care provided to future Latino patients. Another benefit to the Latino patient participants who were interviewed was the monetary incentive of $20 in cash that each received at the completion of their individual interview.

This study involved risks related to the legal reporting requirement in the event any incidences of patient abuse had been revealed during participant observation or during nurse or Latino patient interviews. All participants were apprised of this risk during the process of obtaining informed consent. Although it was unlikely that the subject matter of this study would involve other risks to participants, it was remotely possible that the participants could experience slight psychological discomfort in recalling personal experiences if those experiences involved highly sensitive information about their health status (Latino patient participants) or their perceived lack of confidence or quality of care given to Latino patients (nurse participants). The amount of time allotted for interviews allowed interviewees to debrief from the experiences they recalled and to share any feelings they may have had about the interview process and the feelings that were evoked. These debriefing sessions were not tape recorded. Although referrals could have been given for appropriate follow-up to any participant who indicated a need for further assistance in handling the emotions evoked during the interview, none were needed.

Gender and Minority Inclusion

Latino Patient Sample

Twenty-three Latino individuals were recruited to participate in this study so that the

investigator could observe the care they received from selected expert and non-expert nurse participants. Thirteen Latino individuals whose care was observed consented to participate in one interview following their care so that the research could determine the extent to which the concerns, habits and practices that guided nurses' care were congruent with the concerns brought to care encounters by these Latino patients. Efforts were made to include a balanced representation of Latino men and women to obtain a variety of care experiences. Since linguistic differences may influence the provision of nursing care and the experiences of the patient involved, efforts were made to include both English-speaking and NES Latino patients in observation sessions as well as in interviews. This study included Latino individuals who were at least 18 years old. Since Latino children younger than 18 years of age were brought to the ED for care by their parents, parents of children who were seen in the ED were included in this study so that the research could examine the child's care and elicit from the parents descriptions of the child's and family's care experience and the concerns they brought to the care encounter.

The following scripts and documents were translated into Spanish for NES participants and read to the participants: (a) the script for obtaining patient permission for the RA to approach Latino patients about the study (see Appendix A); (b) the script for the RA to approach patients about the study (see Appendix C); (c) consent forms (i.e., to observe care only and to observe care and be interviewed) (see Appendices E, G); and (d) interview guidelines, including demographic questionnaires (see Appendix M). Latino patients who expressed an interest in having their care observed and then being interviewed were told that they would receive a payment of $20 in cash at the completion of their interview as an incentive for their participation. Due to the nature of the ED

setting and the variety of health problems that warrant emergency treatment, patients with life-threatening conditions were not approached for inclusion in this study. Having triage personnel in participating facilities identify for the RA those Latino patients who were appropriate for potential inclusion in the study and who provided permission for the RA to approach them ensured that appropriate assessments were made before any patients were approached.

Registered Nurse Sample

Every effort was made to obtain a sample of nurses that was diverse with regard to ethnicity and gender. However, since the nature of the study sample relied solely on supervisor and peer recognition of nursing abilities and on each nurse's interest in participating in the study, this could not be guaranteed. (See the Sample section of this chapter for a description of the gender and ethnicity of nurse participants.) The age range of the nurses who participated in this study was between 25 and 54 years.

Data Analysis

The intent of the data analysis for this study was to describe the concerns, habits and practices embedded in and guiding the everyday practices of expert nurses caring for Latino patients in the ED, and to determine if the care provided by nurses who practiced in an expert manner matched the concerns brought to clinical encounters by Latino patients. A deep understanding of the experiences of study participants was the focus of interpretive data analysis. This interpretive approach, also called hermeneutics, involved an interpretation, by the researcher, of the stories told by study participants. "In hermeneutics, the primary source of knowledge is everyday practical activity. Human behavior becomes a text analogue that is studied and interpreted in order to discover the

hidden or obscured meaning" (Leonard, 1994, p. 58). The goal of data analysis in interpretive research is to present findings that are plausible and that accurately reflect the intents and meanings embedded in participants' realities (Packer & Addison, 1989). Verbatim transcripts of the narrative accounts of lived experiences by nurse and Latino patient participants became the text that was interpreted to uncover concerns and practices embedded in nurses' caring actions, and the meanings attached to the care received by Latino patients and families.

Data analysis occurred simultaneously with data collection and was continuously refined as additional interview and observational data were collected. Interpretive data analysis strategies, as described by Benner (1994), were used in this study and included: (a) thematic analysis, (b) paradigm cases, and (c) exemplars. Through data analysis, the researcher aimed to provide the reader with opportunities for vicarious experience so that shared meanings could be learned from nurses' and patients' narrative accounts and observations of clinical situations.

The researcher analyzed transcripts from 8 nurse group interviews, 2 individual nurse interviews, 10 Latino patient interviews, and 11 participant observation data sessions—including detailed, or thick, descriptions of a total of 22 care encounters within the context of the ED as well as dialogue with each of the nurses that occurred during participant observation sessions.

Thematic Analysis

The following presents the process by which data in this study were interpreted and analyzed, and through which significant findings emerged that captured the essence of participants' lived experiences. First, transcripts of interviews and dialogue from

observation sessions were read in their entirety to grasp a global understanding of the participants' stories. As narratives were read, meaningful patterns, stances, or concerns emerged that directed the researcher's attention (Benner, 1994). Open coding was done using paper and pencil in order to track initial impressions of the meaning embedded in the narratives. Topics, issues, or concerns (rather than specific words or phrases) were selected for a more detailed interpretation (Benner, 1994).

The interpretive process was circular (Leonard, 1994), moving back and forth between part and whole of the narratives, and between initial understandings and what was being revealed in the data. Analysis and interpretation of nurses' and patients' narratives was an iterative process, moving forward and backward from early understandings within the text to evolving understandings that represented a deeper reflection upon meanings embedded in participants' lived experiences. "Shifting between texts and between parts and wholes of the text allows the interpreter to confront and develop new interpretive questions" (Benner, 1994, p. 115). A reflective journal tracked the researcher's initial impressions and those formed in transition, as she stayed engaged with the participants' narratives and descriptions of nurses' practices. False starts captured in this journal illuminated the investigator's taken-for-granted background (Benner, 1994) that influenced her interpretation of participants' lived experiences. As a result, new lines of inquiry emerged that allowed for a deeper, clearer understanding of the concerns and meanings that constituted participants' experiences.

While moving back and forth between parts of the text and portions of analysis, inconsistencies within the text drew the researcher's attention to similarities and differences between participants' stories and experiences and allowed themes to surface

(Benner, 1994). Themes that emerged identified differences and similarities in expert and non-expert nursing practice, as well as differences and similarities among experiences of Latino patients and the concerns that guided the actions of the nurses who cared for them. Open coding resulted in a list of 91 preliminary codes that were further explored and verified in subsequent interviews with nurse participants. These categories were subsequently condensed to 13 themes that were further condensed and expanded as the investigator went from parts of narratives to the whole of narratives in order to grasp meanings ascribed by informants to particular actions and concerns situated in clinical encounters. Throughout the process of data analysis, N5 software (Qualitative Solutions & Research Pty Ltd., 2000) was used as a data organizing system. This system enabled the investigator to import preliminary codes along with the narratives in order that continued revisions to data analysis and interpretation could occur.

Paradigm Cases

Data analysis resulted in the emergence of three over-arching categories of concerns guiding nurses' practices. These were: (a) nursing care in the presence of a language barrier, (b) the involvement of family in patient care, and (c) cultural nuances such as patients' health and illness-related beliefs and behaviors. In each of these categories, themes and sub-themes emerged that further elucidated nurses' and patients' concerns and experiences in the context of care provided in the ED.

Paradigm cases were used to present data in each of the categories listed above to illustrate striking examples of nurses' practices in a way that could enhance the reader's understanding of the totality of concerns and meanings embedded in the nurses' narratives about their care experiences. Paradigm cases are strong instances of practice or

experience that are selected because they enhance understanding of experiences; they do this by affording the reader the opportunity to engage in the everyday world of the participant (Benner, 1994). Paradigm cases were selected based on the story's ability to convey a powerful picture of the themes they represented in expertise in nurses' practices. The selection of paradigm cases for this research was based on how the stories were able to capture commonalities embedded in nurses' narratives or illustrate important differences in nurses' practices.

Exemplars

Exemplars substitute for operational definitions in interpretive research, because they allow the researcher to demonstrate intents and concerns within contexts and situations in which the objective attributes of the situation might be quite different (Benner, 1994, p. 117). Exemplars were identified that "embody the meanings of everyday practices … in such a way that they are not destroyed, distorted, decontextualized, trivialized, or sentimentalized" (Leonard, 1994, p. 56). They were chosen on the basis of how best they represented nurses' and patients' concerns and experiences. Once over-arching categories and themes were identified in nurses' and patients' narratives, exemplars were identified from the text that provided powerful illustrations of each theme and sub-theme in an effort to clearly illustrate concerns that attracted the attention of participants during clinical encounters and the meanings that were ascribed to care experiences.

Ensuring Credibility of Data and Interpretation

Although interpretive research makes no claim to an ultimate and objective truth, evaluating the credibility of narratives involved determining the likelihood that

participants offered their narratives honestly, accurately and completely (to the extent that they remembered their experiences). Data analysis in the interpretivist paradigm offers significant challenges in that the researcher must accurately interpret the data to present a correct representation of the participant's reality. Because the researcher's personal history, values, experiences, and preconceptions about the phenomenon influenced the interpretation of participants' narrative accounts, it was important to maintain methodological rigor (Sandelowski, 1993) and establish trustworthiness of the interpretive process (Lincoln & Guba, 1985) to produce an accurate representation of participants' realities and not simply the researcher's personal opinion.

Trustworthiness of the data analytic process was established through application of evaluative procedures discussed by Creswell (1998). Credibility of the data and findings were enhanced through incorporating the following strategies: (a) prolonged engagement, (b) persistent observation, (c) triangulation, (d) peer debriefing, and (e) rich, thick descriptions (Creswell, 1998). Additionally, the investigator kept a detailed reflective journal during the analytic process that served as an external audit trail to enhance methodologic rigor (Koch, 1994; Smith, 1999). Each of these will be briefly discussed.

Ensuring Credibility of Data

The credibility of narrative accounts was enhanced by prolonged engagement and persistent observation with the participants. In the field, it includes "building trust with participants, learning the culture, and checking for misinformation that stems from distortions introduced by the researcher or informants" (Creswell, 1998, p. 201). Prolonged engagement was realized in this study in several ways. Nurses participated in two group interviews that were no more than 2 months apart. Selected nurses participated

in one individual interview following observations of their practice in the ED. Multiple interactions with nurse participants assisted in building trust and rapport between the researcher and nurse participants and offered opportunities for clarification and further exploration of themes and concerns that emerged from data analysis. Multiple interactions with nurse participants also allowed the investigator to clarify any potential misinformation from previous encounters during follow-up interviews.

Being able to directly observing the practice of selected nurses on two separate occasions (each for a period that allowed the investigator to observe their care of 2 Latino patients) exposed the researcher to nurses' everyday practices in the ED setting and assisted the researcher with identifying saliencies in the clinical setting that were relevant to the purposes of the study and incorporated into ongoing interviews (Creswell, 1998). Having a bilingual, bicultural RA enhanced trust with Latino informants and lessened the discomfort that may have arisen had a non-Latina RA conducted the interviews. Credibility of data was enhanced when interviews were conducted with Latinos in their preferred language.

Ensuring Credibility of Interpretation

Triangulation is achieved when multiple sources of data are collected to corroborate findings (Creswell, 1998; Lincoln & Guba, 1985). Triangulation of findings from narratives from nurses who practiced in an expert manner was achieved through group and individual interviews with nurses, direct observation of these nurses' practices, and the inclusion of narratives from Latino patients who received care from these nurses. Multiple interviews with nurses allowed the investigator to confirm and clarify initial understanding of participants' stories. Direct observation of nurses' practices further

articulated and verified themes described by nurses in group and individual interviews. Narratives of Latino patients that revealed issues and concerns brought to clinical encounters were analyzed and compared with narratives and observations of expert nursing practices to determine the congruence of concerns guiding expert nursing practices.

Peer debriefing provided an external check on the research process (Creswell, 1998). The investigator's dissertation committee served as peer reviewers of the interpretation of narratives. Each of these doctoral-prepared experts discussed the research process with the investigator and acted as an external check on the appropriateness of data analysis as it progressed by challenging the investigator's biases, exploring meanings, and clarifying interpretations (Lincoln & Guba, 1985). In addition, two selected nurses with a vast background of experience in the ED (one, a predoctoral trainee), as well as other predoctoral trainees, provided peer review of the investigator's interpretations, further enhancing the trustworthiness of the data analytic process.

Rich, thick descriptions allow readers to decide the transferability of findings (Creswell, 1998). Detailed descriptions of expert and non-expert nursing practices and Latino patients' experiences allowed the context in which these experiences took place to emerge. In-depth, contextual narratives illustrated through paradigm cases and exemplars allow readers to identify shared characteristics within nursing practices and to determine the appropriateness of transferring this information to other practice settings.

Reflective journaling lent external support for the trustworthiness of findings by providing a detailed account of the investigator's thoughts, actions, and decisions during data collection and analysis. A reflective journal considered the influence of the

investigator's feelings, values, and beliefs on decisions made when interpreting the participants' narratives, and has been found to enhance the credibility of findings; it does this by increasing the researcher's self awareness of his/her role in the interpretive process (Koch, 1994; Smith, 1999). Throughout the course of the study, including the data analysis phase, the investigator recorded in a journal her impressions of participants' stories, noting topics, issues, or concerns that surfaced as the texts were read and as practices were observed. In addition, reflective memos were recorded throughout the period when data was being collected and analyzed to track changes in interpretations and overall impressions gleaned from the data. This audit trail enhances confidence in study findings, as it enables readers to examine the events, influences, and actions of the researcher.

investigator's feelings, values, and beliefs on decisions made when interpreting the participants' narratives, and has been found to enhance the credibility of findings; it does this by increasing the researcher's self awareness of his/her role in the interpretive process (Koch, 1994; Smith, 1999). Throughout the course of the study, including the data analysis phase, the investigator recorded in a journal her impressions of participants' stories, noting topics, issues, or concerns that surfaced as the texts were read and as practices were observed. In addition, reflective memos were recorded throughout the period when data was being collected and analyzed to track changes in interpretations and overall impressions gleaned from the data. This audit trail enhances confidence in study findings, as it enables readers to examine the events, influences, and actions of the researcher.

CHAPTER IV

FINDINGS AND DISCUSSION: NURSES' CONCERNS AND PRACTICES IN THE CARE OF LATINO PATIENTS IN THE EMERGENCY DEPARTMENT

The overall goal of this study was to identify the everyday concerns and practices embedded in the care given to Latino patients in the ED by nurses identified as expert in their care in order for the purpose of explicating the knowledge that guides their practices. A second aim was to determine the extent to which expert nursing practices were congruent with issues and concerns brought to clinical encounters by Latino patients and could therefore be considered culturally competent. The following findings are comprised of evidence of expertise and cultural congruence in nurses' practices derived from the investigator's interpretation of informant narratives and observations of nurse-patient care episodes.

Four of the 15 nurses who participated in this study were identified by their peers as experts in the care of Latino patients in the ED. However, data analysis revealed: (a) that expertise was not evident in the care provided by all of the nurses identified as experts by their peers, and (b) that, if present, expertise was not consistently demonstrated in all of a particular expert nurse's narratives of care encounters with Latino patients. Illustrations of expertise in the nursing care of Latino patients in the ED presented in these findings include practice narratives from nurses who were identified as expert in the care of Latinos, and from those who were not but whose practice clearly manifested expertise in this context. Contrast cases of nurse practices that did not exhibit expertise interspersed throughout the findings illuminate and confirm patterns that emerged in expert practices as well as provide boundaries for what did and what did not demonstrate expertise in

nurses' practices.

In the following discussion, narrative texts are presented to illustrate nurses' concerns in the care of Latinos that show the contextual embeddedness of meanings ascribed to patient situations as well as the everyday practices that nurses developed to address those concerns and to provide culturally congruent care. Narratives from Latino patients and/or family members infused throughout the findings verify the congruence of concerns directing expertise in nurses' practices with issues and concerns brought by these informants to clinical encounters.

The findings and discussion are presented in Chapters V-VII. Each one will include illustrations of practices that nurses developed in response to concerns that surfaced as meaningful and became the focus of their attention during Latino patient care encounters. This chapter includes a description of nurses' concerns regarding the context of the ED. Additional discussion in this chapter illustrates nurses' concerns with establishing and maintaining involved connections with Latino patients. Three major themes that surfaced in the practices that nurses developed in response to these concerns will be briefly addressed here, then more fully explicated in the three chapters that follow. This chapter ends with the presentation of a paradigm case that exemplifies the deep and meaningful connections that nurses who practiced in an expert manner were able to establish and maintain with Latino patients and their families despite the presence of a language barrier.

In Chapter V, concerns and practices unique to nurses' abilities to provide care and maintain connections with patients in the presence of a language barrier will be further explicated and described. Particular attention will be given to describing nurses' concerns

with and skillful practices in the use of interpreters and in the use of Spanish during patient care encounters. Chapter VI will address nurses' background understandings of family within the Latino patient's cultural context. The practices that nurses developed to involve family in the patient's care—which emerged from these background understandings—will be illustrated and described. In Chapter VII, nurses' concerns and practices related to cultural nuances beyond language and family will be explicated and described in relationship to the nurses' overall lack of preparedness and ability to provide culturally congruent care in response to those concerns.

In addition to paradigm cases, exemplars will illustrate concerns brought to clinical encounters by nurses and patients to further elucidate the knowledge and practices needed by nurses to provide culturally congruent care to Latino patients in the ED. Additional findings and discussion included in each of the following three chapters highlight enhancers and barriers to the ability of nurses to provide culturally congruent care. Further discussion incorporates extant research literature related to nursing practice in the ED, expertise in nursing practice, and cultural competence in nursing care of Latino patients.

Nurses' Concerns Regarding the Context of the Emergency Department and Establishing Connections with Latino Patients

Concerns that surfaced throughout the narratives of nurses in relationship to caring for Latino patients focused on the context of the ED and on the desire of nurses to establish and maintain meaningful connections with patients and their families. The ED is the context for the everyday and oftentimes transparent background that shapes nurses' concerns and the setting from which the nurses' practices emerge. Three concerns

(disclosed during the interviews) related to the ED that solicited the attention of nurses and influenced their everyday practices included: (a) time constraints, (b) balancing competing demands, and (c) the lack of consistently available resources. Additional concerns that surfaced in the nurses' narratives and directed their practices focused on the nurses' desires to establish and maintain meaningful connections with the patients and their families. These additional concerns included: (a) obtaining accurate triage and assessment data in order to understand the whole picture of a clinical situation and plan appropriate care that addresses the patient's needs; and (b) communicating care requirements clearly, accurately, and comprehensively. These five concerns often overlapped and were interrelated as nurses endeavored to meet the needs of Latino patients and to provide care in a culturally congruent manner.

Balancing Competing Demands amid Time Constraints

The care episode in the ED begins with the patient's presentation of a chief complaint and ends with the patient's discharge from the unit, either with the patient being admitted or transferred to another facility or being sent home with instructions for follow-up care. Analysis and interpretation of data from this study revealed that nurses' practices during care episodes centered around three distinct arenas of concern that solicited their attention and influenced their practices: the triage encounter, the care encounter—in which the nurse attended to the patient's needs in a patient room within the department—and the patient's discharge from the unit. Narratives revealed nurses' concerns with time constraints and competing demands in each of these segments of a patient's care episode.

Time Constraints

Nurses in this study unanimously expressed concerns with coordinating care and moving patients through the ED in a timely fashion. Their concerns regarding time allocation and competing demands are not unique to the care of Latino patients. However, as evidenced in observed encounters and in the majority of nurses' narratives, the care of Latino patients frequently involved a language barrier, which posed additional challenges that heightened the nurses' awareness of time concerns within the context of the ED. Specifically, many nurses verbalized concerns related to timeliness of care and delays inherent in caring for NES patients when interpreters were not readily available to assist them. As one nurse indicated,

> And where I work there's maybe only <u>one</u> [interpreter] for the whole hospital sometimes. And if you're just bustling a bunch of Spanish people in and out, you got a doctor that wants them, you have a nurse that wants them, a triage nurse that wants them, and the guy up on 4th floor has a nurse that wants them. . . . And it's really a difficult thing to work with. <u>And you gotta wait</u>. So there's a longer waiting time in the ER for the Spanish-speaking folks <u>because</u> you're waiting for an interpreter. [1]

Because of the unpredictability of the ED environment, where patient census and acuity often increase with little, if any, advance warning, nurses in this study described how they made the most of every moment as they coordinated care for several patients simultaneously. When interpreters were not readily available, nurses occupied themselves by attending to needs of other patients being cared for in the ED.

---

[1] The quotations from nurses presented in this document were taken from transcripts of oral tape recordings; underlined words reflect the nurse's emphasis in the oral recording.

Competing Demands

Nurses' practices were often directed by competing demands as they juggled multiple tasks while moving patients in and out of the department. Upon receiving discharge orders for any given patient, nurses were quick to complete the care encounter and dismiss the patient from the unit, especially when the ED was extremely busy with many patients waiting to be seen. Several nurses acknowledged that competing demands heightened their awareness of time constraints and the need to quickly discharge patients from the unit. The following comments from one nurse exemplify tensions verbalized by many nurses regarding how competing demands amid time constraints influenced their practices, particularly in relation to time spent reviewing discharge instructions with Latino patients:

> It's on a night when you have patients waiting in the aisles and no chairs left. You go in and basically, out of rote memory, give them the instructions, get their signature and get them gone. I mean, other nights I'll explain over and over and over what they need, and I'll ask if they have any questions. And all the time, I think, it's driven out of how many patients are waiting to be seen. And I don't know what's in room 1, and it might be cardiac . . . . Even if you ask them if they have questions, on a busy, busy night, you really don't want them to start pouring out a bunch of questions.

As evidenced in the nurse's comments above, amidst a chaotic and ever-changing environment, many nurses in this study felt pressure to move patients through the ED in an expedient manner by hurrying through the discharge portion of the care encounter so they could attend to the more urgent needs of other patients. The practices that nurses

developed in response to concerns with time constraints and competing demands associated with interpreter availability will be discussed in Chapter V.

Lack of Consistently Available Resources

Since the majority of nurses' narratives focused on their experiences with caring for NES Latino patients, nurses' concerns regarding resource availability were primarily centered on interpretation services. In all of the EDs at the facilities where this study took place, registration personnel also served as interpreters for doctors and nurses. Only two of the four facilities employed on-site medical interpreters who did not also serve as registration personnel. However, those interpreters were assigned to the ED for a limited number of hours, working the remainder of their shifts throughout the hospital setting. In many instances, these medically certified interpreters were not readily available to nurses in the ED, necessitating that registration personnel, who may or may not have had any formal training in providing interpretation services, be called to assist with patient care.

A few nurses in the study recognized how the linguistic needs of NES patients elsewhere in the hospital were compromised when interpreters were paged to the ED for emergent cases. One nurse shared his concerns with interpreter workload and scarcity, and how those issues influenced the quality of care provided throughout the hospital:

> Often we'll pull an interpreter for somebody who severely needs interpretation. You know, a child is sick, we need to know what meds were given <u>now</u> kind of situation. So we will pull the interpreter. But pulling that interpreter means that doctor in room 2 who was in the middle of an assessment, or [the] nurse on floor 4 who is trying to console the family and take care of the family's needs 'cause the patient is down in ICU on a ventilator has that interpreter just pulled because we need him now, in the

> ER. So there's that flux of what's going on within the hospital, and the quality of care. Not just to the patient, but to the family members that need the services too.

Several nurses described concerns with over-utilizing interpretation services in the ED and endeavored to be more conservative in their use of this resource. The scarcity of this resource had direct implications for the nurses' practices; these will be described in Chapter V.

Nurses described concerns not only with being unable to access interpretation services in a timely manner, but with being able to have the interpreter present during the entire time the patient was being treated. The lack of readily available interpreters was most problematic in situations involving patients admitted to the ED with traumatic injuries or high acuity presentations that commanded a nurse's vigilance. As one nurse lamented, "In situations like that . . . you can't and you shouldn't have to find the interpreter because it's a one-on-one situation . . . . How can you be a one-on-one nurse when you're taking out the language part of it?" Several nurses verbalized their concerns about the fact that when faced with the need to intervene on behalf of a NES patient, their first intervention was to leave the patient's presence to locate an interpreter. Many nurses were especially concerned with how, as a result, patients might feel abandoned and/or less valued or important. The following nurse's comments exemplify the concerns and frustrations voiced by several nurses in this study when interpreters were not readily accessible:

> You're sort of saying, "Just a minute, I know you want to tell me something. I will be back." And they don't know what you're saying. You can't even say, "You're

> important to me. Let me find an interpreter so we can talk." It happens all the time. And I don't think that they always trust that you'll be back. They worry that, "Oh, there she goes." And you can't convey to them that, "Well, I will be back. I just need an interpreter so we can find out what's going on."

Emergency department nurses are continually assessing and monitoring patient needs and the effectiveness of treatment interventions throughout the patient's stay. Data analysis in this study revealed that nurses often had only a few moments in which to assess and provide interventions appropriate to the particularized needs and concerns called for. A busy shift, the need to attend to the needs of other patients, and an increased demand for interpreters hindered the efforts of Non-Spanish speaking (NSS) nurses with directly assisting patients. In many cases, and despite their best efforts, nurses were caught in a dilemma—unable to convey their concern and to assure patients that they would return, while simultaneously realizing that the patient may attribute the nurse's absence to their being ignored. As the nurse quoted directly above stated:

> A lot of times . . . in the emergency department you walk out of the room expecting to be back, something happens. Things you have no control over. And that's just how, unfortunately, it is . . . And it is frustrating.

Several nurses in this study indicated that the language barrier, along with the lack of available interpreters, resulted in their spending less time with the patient than they felt the patient needed. The nurses' awareness of these nuances in clinical situations signified a deep sense of loss that reflected their concernful engagement in NES patient care encounters. Short of employing one's own Spanish skills, (a resource not available to

every nurse, and one that will be discussed further in the next chapter), nurses relied on the interpreter's presence and assistance to foster and sustain the connection with the nurse. Interpreter availability allowed nurses to remain present and to convey their care and interest in the patient. The following comments made by a nurse during a group interview illustrates the concerns that nurses in this study had with interpreter unavailability and how it affected the patient's impression of the nurse's interest in him or her:

> Say if I'm doing pain management or something like that and I want to take an interpreter in with me. . . . If I have to page an interpreter every 5 minutes or every 15 minutes to go in there, it's just a pain in the ya ya versus if it was an English-speaking patient I could walk in there every 30 seconds if I wanted to and say, "How are ya doin? Oh, you're still pukin?" or, "You're still hurtin?" . . . . So I have to sometimes base my reassessments on the availability of the interpreter. And that cuts into showing how much I'm trying to make them feel better. Say if the interpreter has to go to the cath lab for a half hour and then my guy in 2-right [room in ED] is saying, "Well this guy hasn't come in here for a darn half hour. He really cares, doesn't he? He's really doing a good job for me tonight."

Nurses in this study who viewed the interpreters as their only means of maintaining connections with patients realized that when interpreters were not available, connections with patients could not be established or maintained in the concernful manner that nurses desired for their practice. As a result, patients were not able to benefit from the nurse's care when it was delayed or when a nurse's presence with the patient was shortened. The inability to manifest concernful engagement through on-going assessments and presence

with patients further aggravated the sense that nurses had of not being involved to the degree that situations demanded, the patients deserved, and the nurses desired in their practices.

Connecting and maintaining concernful involvement with Latino patients in the ED was predicated upon a nurse's ability to attend to the three contextually embedded concerns described thus far in this chapter. Connecting with patients and providing particularized care also required nurses to obtain accurate triage and assessment data so that they would fully understand the patient's needs. In addition, meeting patient's communication needs and communicating care requirements throughout the patient's stay in the ED were foundational to the maintenance of involved connections.

Obtaining Accurate Triage and Assessment Data

Emergency department nurses are immediately drawn into patient presentations and can quickly grasp their acuity by observing and listening to patient and family interactions during triage and care encounters. Concernful involvement begins when the nurse first encounters the patient. Experienced ED nurses develop a pre-understanding of the care that a particular situation will require based on knowledge gained from previous experiences with caring for patients with a variety of illness and injury conditions. Nurses draw from their background understandings of similar patient situations as they develop initial clinical impressions of patient presentations and begin to plan appropriate care.

Nurses' narratives revealed that planning and providing appropriate patient care was dependent upon the nurses getting the patient's story and understanding the whole clinical picture through accurate assessment data obtained during patient triage and care encounters. Nurses routinely read triage notes before escorting patients to an exam room

to determine what a patient's care needs might involve. For example, triage notes influenced actions regarding how quickly the nurses would escort a patient to an exam room, whether or not a patient is placed in a specific room because of their presenting health concern, whether or not the patient is asked to change into a hospital gown, and whether or not to proceed by first obtaining laboratory tests such as a urine analysis.

Findings from this study revealed that forming an accurate clinical impression through the retrieval of accurate assessment data, establishing a connection, and planning and providing appropriate care were more difficult for nurses when a language barrier existed between themselves and patients. Nurses' concerns regarding obtaining accurate triage and assessment data focused on the patient's linguistic needs and the necessity of an interpreter. Without first addressing these concerns, getting the patient's story and understanding the clinical situation was not possible. The practices that nurses developed as a result of their concerns regarding the retrieval of accurate assessment data are described in Chapter V.

Communicating Care Requirements

The provision of appropriate and comprehensive care and the maintenance of meaningful connections with patients in the ED depend on accurate communication between the providers and patients. Continuous communication throughout the patient's visit to the ED is necessary for nurses to continually assess patients' needs and their responses to care. In addition, nurses must clearly, accurately, and comprehensively inform patients about the care they are receiving and provide them with information about their care requirements until their discharge from the unit.

In their narratives, nurses repeatedly expressed concern related to their abilities to

maintain open lines of communication with patients through which care requirements could be communicated and connections could be sustained. Despite the fact that nurses were sometimes able to proceed with patient care because of the patient's ability to speak some English and the nurse's ability to speak some Spanish, the majority of nurses in this study had minimal, if any, Spanish-speaking ability. As a result, concerns that directed nurses' practices were primarily related to their reliance upon interpreters to maintain connections with patients and to communicate care requirements. As one nurse, who spoke very little Spanish indicated, "Obviously it's a lot easier for me to do, right off the bat, with my English-speaking patients. I establish that relationship, just talking. And it's a little bit harder getting it third person, or through an interpreter."

Nurses' Concerns with Relying on Interpreters to Communicate Care Requirements

Nurses' narratives highlighted the importance of providing care that was planned appropriately and according to the patient's presentation, and most nurses recognized the pivotal role that interpreters held in their nursing practice when NES Latino patients presented for care. Many nurses in this study described the trust they had to have in the interpreter's ability to accurately relay information to and from patients and families; this was especially the case for nurses who spoke little or no Spanish and, therefore, could not verify what the interpreter was saying.

Various styles of communication and behaviors displayed by interpreters focused the attention of nurses and either helped or hindered their efforts to communicate care requirements and secure trust that the intended messages were being accurately conveyed. The following quote from one nurse illustrates the extent to which nurses in this study paid attention to what the interpreter said, how it was said, and how patients

responded:

> I've worked with two styles of interpreters. One interpreter style would be they would repeat verbatim what you've said, you know, word for word. And then another style would be if they just paraphrase, or I'm not sure what they're doing [laughs] 'cause I don't understand Spanish. But they are putting it in to more phrasal context that the patient would understand. But then sometimes I'm not getting the real answer that I'm searching for, by them doing that. And so sometimes I'll say, "Now back up a minute. I want you to say ' . . . .' And then they will."

Nurse narrative accounts and practice observations revealed how NSS nurses, unable to verify the accuracy of the relayed messages, watched patient responses, both verbal and non-verbal, for cues that would reflect the patient's understanding. As indicated by one nurse's comments, discrepancies in expected reactions or answers often led nurses to seek clarification or to reemphasize messages that had been given to the patient through the interpreter: "I can just kind of tell from the emotion of the patient, or their reaction as to, What? Why would she be asking me? And then I can just kind of sense that and say, 'No, no, no. I didn't mean that, I meant this.'" Reactions and responses expected from NES patients were based on the nurse's impression of the particular patient's presentation and clinical situation. Data in this study revealed how the context of the patient's presentation and clinical situation set up expectations for the nurse that, when not realized, alerted the nurse to the possibility that the message was inaccurately conveyed. And as a result, the nurse's attention focused on the performance of the interpreter.

Nurses' narratives revealed the importance of nurses remaining attuned to interpreter performance during patient care encounters to ensure that connections and

communication with NES patients were not jeopardized. Nurses described several areas of concern with regard to their reliance on interpreter performance. These included (a) interpreter stance, emotional engagement, and discomfort with content being relayed; and (b) interpreter accuracy. The way these concerns focused the nurses' attention will now be described. In the next chapter, these concerns are revisited in relationship to how they influenced nurses' practices as the nurses attempted to maintain concernful involvement with patients.

Interpreter Stance, Emotional Engagement and Discomfort

The demeanor exhibited by interpreters during patient encounters influenced the level of confidence nurses had in the interpreter's comfort with what was happening in the setting, and the interpreter's emotional engagement in the interaction. Several nurses in this study described experiences during which they noticed interpreter discomfort with what was happening within the patient's immediate surroundings, during situations when the environment was frenzied and rather chaotic, such as when the patient had sustained traumatic injuries or required resuscitative efforts. One nurse described observing some interpreters experiencing difficulty at seeing the patients' injuries and handling all that was occurring around them, which, in turn affected the interpreter's performance and engagement in the situation:

> And she sees all this stuff that we're doing to this patient and it's probably freaking her out a little bit. And a lot of them don't like to see all that stuff, but they have to be right there and they have to do what you say. And then they get kind of non-focused.

The following comments from one nurse illustrate concerns verbalized by several nurses regarding interpreter stance and how it can hinder efforts to sustain the quality of communication and concernful involvement nurses desire during patient care encounters:

> Well I know that one of the interpreters will come into a code situation and she'll pull the curtain if it's not already pulled. And she'll stand behind the curtain and try and talk through the curtain [laughs] to the patient, to the family, and me. And it doesn't work for me 'cause . . . she's yelling at the family to make sure they hear her. And they can't see her, but she doesn't want to see what's going on. . . . And then the family will answer them back, and they don't necessarily hear what the family said 'cause there's so much other stuff going on.

Nurses voiced dissatisfaction when interpreters stood out of view from the patient, his/her family members and the nurse, and were concerned about the impression the interpreter's disengagement may have had on the patients' and family members' perceptions of feeling respected and cared for. As one nurse stated:

> I know it wouldn't make me feel like, you know, if I went somewhere and people were talking to me through a curtain or a wall or whatever, that it really mattered what I was saying anyway 'cause they weren't really paying attention. That could give you a bad feeling.

Some of the nurses in this study expressed concern with interpreters who were not engaged or emotionally involved in the patient situation, and thus, jeopardized the nurse's ability to convey care and to sustain concernful involvement. Nuances in interpreters'

behaviors led nurses to believe that a less than caring attitude was being relayed to patients and family members when interpreters were not emotionally involved or invested in the clinical situation. Nurses' narratives revealed that that the patient and his/her family members mattered to them, and many accounts of care episodes reflected the moral and ethical import of providing more than spoken words through a disengaged presence. Nurses were concerned and saddened when they sensed that patients did not realize the emotional investment the nurse had in their care because of attitudes or disengagement on the part of the interpreter, as evidenced in the following nurses' comments:

> Certain ones . . . have poor attitudes and they don't want to interpret. They feel like everybody should speak English when they come in, and it makes them upset that they have to be the one that goes in and interprets. So they have a chip on their shoulder . . . which worries me that the patient then feels [less than cared for].

The nurses in this study realized how much power interpreters had in altering the care atmosphere when they did not conceal their negative attitudes about patient presentations. Nurses discussed how interpreters were often preoccupied with other duties during patient encounters, and noted how the interpreter's disengagement focused the nurse's attention on less-than-caring impressions that could be relayed to patients. As one nurse indicated:

> Sometimes I will say something to an interpreter, and she'll be doing four other things and trying to talk to these people at the same time. . . . And I don't want the family to think they don't matter or that they're not being focused on.

Although interpreters are not nurses, and do not necessarily have the same goals to connect with and involve themselves in patient situations in the same way as nurses may want them to, many nurses in this study noticed and reacted to the stance taken by interpreters during patient encounters. As will be further illustrated in Chapter V, some nurses described their efforts at keeping the interpreter engaged, and maintaining some level of engagement with patients and family members by maintaining eye contact and directing their communication at the patient rather than at the interpreter. However, other nurses recognized the impressions that may have been relayed to patients as a result of the interpreter's disengagement and felt helpless to do much about them.

Interpreter Accuracy

Nurses voiced concern with the comprehensiveness and accuracy of messages being relayed by interpreters to patients and family members. Although the nurses in this study who knew some Spanish were able to more easily discern the accuracy of an interpreter's relayed messages, NSS nurses described nuances in interpreter behaviors that focused their attention and alerted them to potential inaccuracies. For instance, the nurses paid close attention when the length of verbal messages relayed from the nurse to the patient were considerably shorter than what was initially spoken by the nurse or patient. One nurse shared his observations of this phenomenon:

> What I would say in a small sentence, they're saying the same thing with a whole paragraph . . . . And when I finally get an interpreter that understands what they're trying to say, the interpreter basically says to me in a small sentence what she [the patient] just said in a paragraph to him.

Nurses realized the paramount role that accuracy in communicating care requirements had on patient outcomes and the problems inherent in situations where the accuracy of the interpreter's performance could not be evaluated. As one nurse stated:

> In terms of emergency nursing, they play a key role in making sure patients get the information that we're trying to give to them . . . . And that with my limited Spanish sometimes, I'm pretty clear there's certain interpreters, I know they're not getting the message to the patient that I'm trying to give. And I have to go over and over and over it. And I can imagine what happens when you don't even know a little Spanish. And I think that there's a lot of room for error in communication. And that, in the end, affects care of Hispanics.

Nurses described how interpreters often lacked medical terminology and other health related knowledge. Even nurses who claimed to know very little Spanish were able to, with extensive experience, notice when routinely used words were not being accurately conveyed by interpreters. As one nurse indicated, "So you kind of lose it with some of the specific body parts … pretty soon you just get stomach instead of appendix or gallbladder or liver. … So it stinks. It doesn't make the hospital or the ER or anybody look good."

Whereas some nurses were more concerned with how inadequate interpreter performance reflected poorly on the image of the nurse, the ED, and the hospital, others were attuned to how it affected patient care and, ultimately, patient outcomes, especially when the nurse involved did not know Spanish and could not verify the information relayed by the interpreter. As another nurse lamented:

> They [nurses] think the interpreter is getting the right message to the patient, but in fact, they aren't. And so the patient goes away either frustrated or questioning, or actually having misinformation about what's going on. And we get that a lot from patients that come from other settings, too, where they've gotten misinformation at other settings. And you wonder how much really is related to the interpreter services.

During an interview following the observation of a nurse's practice, the nurse described the problems with accurate communication inherent in working with ancillary staff who had not had any formal training in medical interpretation. Although the facility in which the nurse was employed did have medically certified interpreters available on an on-call basis, the nurse described how hospital administrators frowned upon the costly utilization of this resource:

> In this particular hospital we have interpreters on call. But the hospital administration has frowned upon us calling them in if we have people in house that speak Spanish. And they [administrators] don't really understand that it's not the admitting girl's job to be an interpreter. It's her job to be admitting clerk. But they [administrators] would be like, "Well, you just gotta get by, or call somebody from medical" [other unit in hospital]. 'Cause it would cost them money to have the interpreters come in. [Observation interview]

Nurses' narratives and observed care encounters in this study revealed the deep level of concern that nurses had for providing quality care to Latino patients. This was reflected in their desire to maintain the connection they establish with the patient and family at the onset of the care episode, to be present in a concernful manner and to

maintain open lines of communication with the patient until he or she was dismissed from the unit. Several nurses in this study described financial and emotional burdens that ED visits had on the patient and family. In light of this, nurses felt even more compelled to provide effective and comprehensive care in a compassionate manner, and realized that less-than-optimal interpreter performance compromised the nurses' good intentions.

During one group interview, a nurse described a patient experience that captured several of the concerns voiced by nurses and discussed in this research regarding the quality of interpreter performance and how it can influence the degree to which nurses are able to maintain involved connections and to communicate care requirements accurately, clearly, and comprehensively. The nurse recalled a situation in which he had provided care to a 5-year-old child who came into the ED severely dehydrated; doctors considered admitting the child to the hospital, but then decided to discharge the boy from the ED with careful instructions to the parents for follow-up observation and care. The nurse described nuances in his interaction with the interpreter and parents that led the nurse to believe that the discharge information he was giving them was not being relayed as comprehensively as the nurse wanted it to be:

> I wanted to be very clear on, "If this gets worse at home—vomiting, diarrhea, fever, anything else that's worsening—he needs to come back to be admitted." So in the translation, that took me a good, I don't know how many seconds to just spit out. But then when you have an interpretation of that that takes half of that, you're kind of wondering, you know, maybe they were just told, "Well if you get worse, come back." No. I want, "If you have diarrhea, if you have vomiting, and fever that's not going away, I want you back here. Or, at the very least, give us a call." And when

> you say that [give those instructions to the interpreter] you expect, I know what vomito sounds like . . . and when you don't hear that . . . if all you're hearing is, "If you're getting worse, come back." No, that's not what I said. This is what I said. . . . This is specific things to watch for, and if they happen, then the guy needs to come back. That's how much we care, and that's how sharp we're watching this fella!

The nurse's past experiences with providing discharge instructions during similar patient situations led to his pre-understanding and expectations for how long it should take the interpreter to accurately relay the information to the parents. Additionally, the nurse's experiences with caring for Spanish-speaking patients and with hearing what interpreters said during similar patient interactions familiarized him with commonly used words, and helped to develop the nurse's expectations of what he should have heard the interpreter say. He continued:

> You hear those things over and over and you're just kind of used to how long they last. . . . And I'm not very fluent in Spanish, but I know when what I said just didn't get transferred over to the patient. And then if you have, say, like an upset mother or father, probably because they have to be to work in an hour or so, and they're chapped because you just did a blood cultures times two, a little mini cath UA [urine analysis], and then the x-rays, lumbar puncture. They're chapped. They're out big bucks. They're late for work. And plus their little one doesn't feel very well. So you want this to go right.

This nurse's narrative reflected the deep concern for the patient and family that was illustrative of the quality of care the nurses in this study hoped to provide. His frustrations

stemmed from his awareness that the interpreter was not adequately invested in the process; the interpreter did not appreciate the gravity of the child's condition nor how imperative it was that the parents clearly understood what to watch for. This nurse's experience with caring for similar children informed his understanding of the possibilities that existed in the child's future after being discharged home and the likelihood of the child being hospitalized for more extensive care. The fact that the interpreter took less time and used fewer words, and did not use words the nurse anticipated hearing, led the nurse to doubt the accuracy and depth of the information being conveyed by the interpreter to the parents. The nurse's desire for wanting the situation to go right evidenced the deep concern he felt for the patient and his family, and his desire to maintain an involved connection with them that accurately conveyed not only the care requirements but his concern for them as well. Unfortunately, in this clinical situation the interpreter's performance severely compromised the involved connection and the quality of care the nurse desired.

Nurses' Practices in the Care of Latino Patients in the Emergency Department

Data analysis revealed that nurses in this study developed practices to address the contextually embedded concerns that solicited their attention while caring for Latino patients. Nurse practices in the care of Latino patients centered around three major themes: (a) the language barrier and how nurses cope with challenges in communicating with NES patients, (b) the presence and involvement of family in the ED, and (c) cultural nuances such as Latino patients' illness- and health-related beliefs and behaviors. Although "language" and "family" are attributes of one's culture (Helman, 1994; Marín & Marín, 1991), and, therefore, could be considered cultural nuances, they will be

discussed separately as areas of concern that directed nurses' practices, because in this study they drew the attention of nurses and influenced nurses' practices in ways that were unique when compared to other cultural nuances present in care episodes.

Although all of the nurses in the study described care experiences that involved the culture-based beliefs and behaviors of patients, and the researcher anticipated finding examples of expertise in the nurses' recognition of and attendance to these cultural nuances, no examples of expertise were found in this area of concern that directed the care of Latino patients. Instead, nurses' narratives reflected a general inability, awkwardness or uncertainty about how to utilize the cultural knowledge that they had developed during their many experiences involving Latino patients with similar presentations and incorporate that knowledge into their care provision. This finding was surprising considering that the sampling of Latino informants revealed the length of time that at least one Latino family had lived in the area where the study was conducted exceeded 30 years, indicating that the nurses' lack of expertise was not for lack of exposure to Latino cultures.

What was uncovered in data analysis with regard to nurses' abilities to recognize and attend to cultural nuances, however, was that nurses in the study were at different points along the continuum of developing cultural competence (Campinha-Bacote, 1998; Giger & Davidhizar, 1999; Spector, 2000). Whereas several nurses' practices revealed some degree of cultural attunement and the desire to understand cultural nuances and how to incorporate them into patient care, other practices revealed an ignorance with regard to the significance of cultural influences on the patient's presentation and a disregard for incorporating cultural nuances into the provision of care.

Data analysis revealed that expertise was manifested in nurses' abilities with: (a) establishing and maintaining meaningful connections with patients despite the presence of a language barrier, and (b) involving family in the patient's care. The practices of nurses who exhibited expertise in their care of Latinos will be presented in this chapter, and in the following two chapters. The discussion of expertise in nurses' practices in the care of Latino patients as derived from data in this study begins with a brief review of how expertise in nursing care was conceptualized in this study. A paradigm case follows, which richly illustrates nurses' practices in establishing and maintaining meaningful connections despite contextually embedded concerns that focused nurses' attentions and posed obstacles to their efforts with providing expert and culturally congruent care.

Conceptualizing Expertise in Nursing Care of Latino Patients

Expertise in nursing care refers to the perceived quality of care provided by certain nurses in the ED. It is considered to be a facet of the context of the clinical situation, not an indication that a particular nurse is expert in every aspect of practice (Benner et al., 1996). Expertise is manifested in the nurse's involvement with and concernful engagement in the patient's clinical situation (Benner et al., 1996). This concernful and caring stance, as opposed to a more distanced orientation during the care episode, enhances the nurse's grasp of possibilities that exist in the clinical situation (Benner & Wrubel, 1989).

Nurses who practice in an expert manner maintain an awareness of and openness to possibilities in the care encounter that require a perceptual acuity that stems not only from the nurse's recognition of and attendance to cues within the environment—a skill developed from extensive practical experience with particular patient populations—but

also from the nurse's realization of how the illness episode affects the patient's past, present, and future (Benner et al., 1996). Concernful involvement is related to the nurse coming to know the individual patient and family as the clinical situation unfolds (Tanner et al., 1993), and providing care that is contextually based and particularized to the individual patient and family. Narratives from nurses in this study whose practices exhibited expertise revealed the nurses' desires to connect in meaningful ways with Latino patients and their families and to provide particularized care that comprehensively and appropriately addressed the patients' needs. Nurses whose practices exhibited expertise maintained a watchful presence with their patients and demonstrated compassion and concern for the well-being of patients and their families.

Nurses' narratives revealed how contextually embedded concerns guided the development of expert practices that enabled them to establish and maintain meaningful connections within varying patient contexts despite having to deal with a language barrier. Concerns that directed nurses' actions toward establishing and maintaining those connections will now be discussed.

Expertise in Nurses' Abilities with Establishing and Maintaining Connections with Latino Patients Despite a Language Barrier

Many of the narratives from nurses revealed the challenges of providing care in the face of a language barrier. A paradigm case will now be presented that illustrates the complexities nurses face in providing care to NES patients, and in establishing and maintaining meaningful connections with patients and families amid contextual concerns in the ED that solicit the attention of nurses. The nurse's practices in the paradigm case exemplify expertise and illustrate how the nurse was able to move beyond the language

barrier and develop a mutually satisfying and meaningful connection with her patient—using charades and other non-verbal gestures of communication—during a very emotional and challenging ED visit.

Paradigm Case: Establishing and Maintaining a Meaningful Connection

During one group interview, one nurse relayed a care experience in which she and the patient had to rely on non-verbal communication throughout the majority of the ED visit. The situation involved a young woman who presented to the ED with significant pain. The nurse recalled how radiographic examination revealed the woman had cancer that had metastasized throughout her lungs and caused them to fill with fluid. In an effort to alleviate the woman's severe pain, the woman underwent a thoracentesis while in the ED to drain the fluid.

Establishing and Maintaining the Connection

The nurse described how linguistic differences between herself and the patient focused the nurse's attention and compromised the nurse's abilities to offer reassurances and communicate care requirements from the very start of the woman's visit:

> And she spoke absolutely no English. And with the limited Spanish that I have on board now, many of the things I needed to say to her were not within my vocabulary. So it was very challenging because this was a real emotional ER visit for her as well as for those of us caring for her, based on her youth and the seriousness and rapid progression of her disease.

The nurse indicated that an interpreter assisted with explaining the procedure and with obtaining the patient's consent before the procedure began but was unavailable for a

majority of the remainder of the patient's stay in the ED.

Maintaining a watchful presence.

Nuances in the patient's behavior that the nurse attributed to the patient's cultural background immediately drew the nurse's attention and helped the nurse to form a clinical impression of what the patient's care would entail. The nurse described the patient's demeanor and how it posed additional challenges to her plan of care and her ability to offer reassurances to the patient in the absence of the interpreter:

> She struck me as unique in that she obviously had a very strong personality with a lot of pride in hiding her pain. But clearly she was [pause] . . . . Anybody, I think, in her situation certainly would be in a great deal of pain. But she tried really hard not to express that, which was, I think, part of our communication block. Because had she just been frantic or anxious or pointing, it would have been pretty clear to me. But in her face, I could see that she obviously had a lot of physical pain. And that was our biggest issue right then and there, along with some of the emotional pieces. But number one was getting this physical pain under control.

The nurse's background knowledge and understanding of cancer, and the trajectory of the disease once it had metastasized to the lungs enabled her to quickly comprehend the significance of the patient's presentation and the immediacy of attending to the patient's physical as well as emotional discomfort. The nurse grasped the gestalt of the situation through her realization of the rapid progression of the disease and the seriousness of the clinical situation that required the patient to endure a painful procedure. The nurse's attention focused on the immediate need to provide pain control

and comfort measures, and her concern for monitoring the patient's pain and efficacy of comfort measures was made more challenging because of the linguistic and cultural differences between herself and the patient. As the nurse stated, "It's difficult enough in a time like that to try and be reassuring to a patient. But then trying to guess at your communication and cultural differences was additionally challenging."

The nurse indicated how, by paying careful attention to the patient's demeanor, she began to make sense of the patient's non-verbal communication and how her nursing care might be adjusted to meet the woman's particular needs. The nurse described how guessing at each other's non-verbal gestures throughout the care encounter helped to establish a connection between her and the patient, because of the concerted effort and attention each had to demonstrate in their attempts to communicate:

> And she was unable to tell me. I could certainly figure out where she was hurting, but I couldn't ask her, "Is this helping it, or making it worse? Well, what have you done in the past to help?" I couldn't get that kind of information from her. So it was all just kind of a lot of charades almost. And she was, even in her circumstances, was very good natured about it. She was almost kind of giggling with me. A couple times at me. [laughs] She was asking me for something, and I brought her a glass of water and she goes, "No, no, no." That wasn't it. I would show her, like if I was trying to get her to roll to one side, and I didn't know how to just say to her to do that. . . . I was rolling over onto my side to kind of show her. And then she would, "No, no, no" with her hands and shaking her head if it didn't work. But, I think a lot of effort went into it on both of our parts to communicate what should have been very simple, under trying circumstances for her, certainly. But at times I felt embarrassed and

> frustrated that I wasn't able to maybe do everything I wanted to do for her because I had this barrier in communicating with her.

Realizing her limited Spanish abilities inhibited verbal communication with the patient, the nurse watched the patient's body language for indications or cues as to how best to proceed with care. Based on her knowledge about metastatic cancer, and previous episodes with caring for patients experiencing pain, this nurse expected the patient to exhibit more obvious physical displays of pain symptoms. When this did not happen, the nurse became more attuned to the patient's non-verbal gestures. Searching for signs of discomfort, the nurse described how her attention was drawn to the patient's facial expressions, which helped her to know this patient's responses to pain and desire to hide what she was experiencing in the midst of all that was unfolding during her ED visit:

> When we were doing her thoracentesis, her facial grimacing was . . . she had a lot of physical features that led me to believe she was very uncomfortable. But, I mean, she didn't so much as . . . I think one tear rolled down her cheek, and she wiped it away quickly. She never shouted out. She never cried. She never asked for anything. . . . I was amazed that somebody could be in that position that she was in, receiving the news she got that day. Her whole family was in hysterics in the hallway, but she was just very, very poised and strong, and it was <u>amazing</u>. It was amazing.

Communicating Compassion and Concern

The nurse remained present at the patient's bedside throughout the thoracentesis, using non-verbal gestures to direct the patient's movements and to assess the patient's pain level. Although the nurse experienced some embarrassment with doing this, the

embarrassment had more to do with her perceptions of not doing enough for the patient than it had to do with self-consciousness. The nurse owned the communication barrier, seeing it as a deficiency on her part at being unable to speak the patient's language. The following excerpt from this nurse's interview illustrates how the nurse stayed attuned to the patient's non-verbal cues throughout the procedure and, as a result, was able to provide measures that lessened the patient's discomfort:

> **Nurse**: I sat with her a lot. I rubbed her back when she was saying she had some pain there. I held her hands through her thoracentesis 'cause she wanted to squeeze somebody's hands but her mother had to leave the room.
>
> **Int**: And what made you believe that those things were what she needed?
>
> **Nurse**: I think because she was receptive, you know. She was holding her mom's hand. And when her mother chose to leave the room and I offered her mine, she very quickly took my hands and squeezed, hard. She was not brushing me away or pushing me away. She would smile in response, too.

The nurse's compassionate actions, such as rubbing the patient's back and holding her hand, were natural and easy for her given the emotional involvement that she had developed in the patient situation. Her concernful engagement during the care encounter was centered on the patient's comfort and on the nurse's need to establish and maintain a connection with the patient from the very start of the clinical encounter without the assistance of an interpreter. Because of the nurse's desire for concernful involvement in the patient's care, she was able to establish a relationship with the patient without verbal communication. The nurse described how this relationship did not change even when an

interpreter became available after the procedure was underway:

> I don't think that my patient-nurse relationship changed at all. It expanded with some of the knowledge that we both gained [laughs] once she knew what it was that I was meaning to accomplish, or trying to do for her. And she was able to say what it was she needed from me, or give me more background information, or tell me where we were at with her pain control attempts. That kind of stuff obviously expands things. If anything it just aided us, but I don't think it changed the relationship so much that we had established.

From the start of the care encounter, the nurse realized the implications of the patient's metastatic cancer, and knew that the thoracentesis would be a palliative measure only. The patient's young age and the expected trajectory, that is, the terminal nature of the patient's illness, added to the clinical picture in meaningful ways that helped the nurse to provide care that was particularized to this patient. The nurse came to know the woman as more than a patient with cancer; she was a daughter and a younger sister to the family members present. The nurse grasped how the prognosis given to the patient that day affected the family as well as the patient; she described her interactions with the family members and how her concernful involvement extended to them as well during the care encounter:

> She came from a large family with a lot of sisters. And many of them were present, and I think older than her. And, you know, certainly very sad. Additionally, probably feeling kind of shocked. . . . I'm guessing at all this, 'cause we didn't really communicate with words at all. They were all very sad, and I offered a lot of hugs

> and Kleenex. . . They would come into the room and be with her for awhile, and then they would leave when they were becoming upset again. And so they were kind of in and out.

Despite not communicating "with words at all," the nurse noticed family members' interactions and non-verbal displays of emotion. Through her concernful involvement, the nurse developed a sense of what they may have been feeling in relation to the situation. The nurse's description of her involvement with the family reflected her comfort with being present for their suffering. The nurse offered her compassionate care to them in the form of tissues and hugs and by allowing them to determine for themselves the frequency and duration of their visits to the patient's room.

Verbal and non-verbal cues observed in the environment throughout the care episode influenced this nurse's actions without her knowing for certain in the moment if the care was effective, or how it was being perceived by the patient. Once an interpreter became available, the nurse described verbal feedback she received from the patient about the care that she had:

> But at the end of her ED stay, when we <u>did</u> have an interpreter available, she was telling me, through the interpreter, to keep up with my studies, that the little Spanish I knew was <u>wonderful</u> [laughs] and that she really appreciated the time I had spent with her that day, even though I may have at times been way off target with what she was trying to tell me.

Despite initial misgivings about the adequacy of her efforts, this nurse exhibited expertise in her care for the patient through her openness to seeing possibilities that

existed in the care environment. This openness enhanced the nurse's ability to connect and become emotionally involved with the patient and family despite the language barrier and the unavailability of an interpreter. Her concern for and efforts toward providing for their comfort and well-being took precedence over her inability to verbally communicate with them. Her grasp of the situation and her sense of what good nursing care should be, led to the provision of care that she, upon reflection, believed was appreciated by the patient:

> [Pause] I think she just struck me as a remarkable person. But the big thing for me when I went home that day was that, initially faced with the situation, I felt inadequate to be caring for her because I didn't understand her comments or requests. I couldn't. And until I could arrange an interpreter, we were kind of just guessing at things and stuff. And that left me feeling like I wasn't doing a good enough job. But in the end, she was highly impressed with the care that she received, and felt very appreciative and thankful for the time that I had given her. So that there was the impact on me. I realized that even though there's a lot of challenges and I might feel like I'm not doing enough, I think the effort is what was appreciated in there . . . maybe even more than some of my nursing skills [laughs] that I may or may not have been able to provide because I didn't know what she was looking for. Just the compassion, you know?

The concern and compassion exhibited by the nurse's actions enabled and maintained the meaningful connection she had established with the patient and family. Upon reflection, the nurse realized that the success of her efforts with conveying

compassion for the patient and with providing comfort and reassurance throughout the patient's difficult ED visit was not dependent upon verbal communication at all. Rather, the nurse realized the highly significant influence that her concernful stance had on the success of the patient care episode.

The research literature includes descriptions by nurses of patient situation in which interpreters were not used and the nurse relied solely on non-verbal communication (Baldonado et al., 1998). However, the success of these nurse-patient interactions was not reported (Baldonado et al., 1998). Kinesics is "the study of the nonverbal part of language, especially gestures and body language, as part of overall communication" (Landau, 2002, p. 396). Nonverbal cues such as the use of touch, body positions, movement of hands and arms, and facial expressions have been found to be effective in conveying across cultures similar emotions such as reassurance, compassion, understanding, and respect (Brooks, 1992). The nurse's ability to convey these emotions to the patient and her family was evident in the paradigm case presented above.

The appreciation verbalized by the patient in the paradigm case surprised the nurse, who initially felt her nursing care would be insufficient in meeting the patient's needs for comfort and reassurance in such a complex clinical situation. Through reflection, the nurse realized what a profound effect her efforts at conveying compassion had on the patient's care experience. Being present, rubbing the patient's back and holding the patient's hand during the painful procedure, as well as offering comfort to the family, were ways that the nurse demonstrated compassion without words, and these became her avenue for getting around the language barrier. Nursing care was provided in a seemingly effortless manner. The nurse established a relationship with the patient and family despite

using few spoken words, either directly or through an interpreter. The interpreter did not enable the connection the nurse had established with the patient, but rather was a conduit through which the nurse and patient could clarify initial efforts at communicating and maintain communication through the remainder of the patient's care episode.

Summary

This chapter has described five areas of concern that surfaced in nurses' narratives in relationship to how the context of the ED directed their practices in the care of Latino patients. The areas of concern were: (a) time constraints, (b) balancing competing demands, (c) the lack of consistently available resources, (d) obtaining accurate triage and assessment data, and (e) communicating care requirements. Connecting and maintaining involvement with patients was predicated upon a nurse's ability to attend to these contextually embedded concerns.

Narratives of care experiences from nurse participants revealed what was relevant to nurses during encounters with Latino patient and what drew their attention within the immediate care environment. Uncovering nurses' experiences provided evidence that highlighted the significance of the context in which care was provided to Latino patients by nurses, specifically in how the nurses made sense of the clinical situations, came to know the patients, and provided care that was attentive to nuances and salient aspects within the situation that drew the nurses' attention. Despite competing demands and time constraints, and in light of challenges inherent when care was provided in the presence of a language barrier, nurses in this study connected in meaningful ways with Latino patients and provided particularized care as a result of the meanings ascribed by nurses to clinical situations. In the next chapter, nurses' concerns and practices in relationship to

care provided in the presence of a language barrier will be further explicated and described, particularly in relation to nurses' use of interpreters and Spanish during patient care encounters.

CHAPTER V

FINDINGS AND DISCUSSION: NURSES' CONCERNS AND PRACTICES IN THE CARE OF LATINO PATIENTS IN THE PRESENCE OF A LANGUAGE BARRIER

In this chapter, nurses' concerns with providing care and maintaining connections with Latino patients in the presence of a language barrier will be explicated from nurses' narratives about their everyday clinical experiences. Skillful practices that nurses developed in relation to concerns regarding the language barrier, and the contextually embedded concerns discussed in Chapter IV will be illustrated. Two paradigm cases will be presented in this chapter to illustrate expertise and cultural congruence in nurses' practices as they provided care in the presence of a language barrier. The first paradigm case illustrates nurses' concerns and practices in connecting with patients, and sustaining that connection through the use of an interpreter during the patient's care episode. The second paradigm case illustrates a nurse's skillful use of Spanish as a means of providing concernful and involved care amidst the contextually embedded concerns in the ED.

Nurses' Concerns Regarding the Language Barrier

Nurses in this study varied in their perceptions of who had the language deficit: some nurses framed the language barrier as being a deficiency on the part of the patient, as in, "the patient didn't speak any English"; other nurses identified the barrier as a deficiency on their part, because they did not how to speak Spanish; and in some instances nurses described the barrier as linguistic inabilities on the part of both patient and nurse. Nurses described the language barrier as a "stumbling block," a "road block," or a "wall" that prevented them from performing caring actions they normally provide when they speak the same language as their Latino patients, and that they implied was evident in care

encounters with patients with whom they shared a similar language. Interestingly, only two of the 15 nurses who participated in the study recognized the language barrier as something experienced by both nurses and patients, rather than just nurses. These nurses verbalized their awareness of how the language barrier affected NES patients and prevented them from freely communicating with nurses during their stay in the ED. As one nurse stated,

> I don't think it's just us feeling like we can't talk to them. I think that's true for them. You see that they want to say something, and they look at you like, "You can't understand what I'm saying." And then they look at the interpreter. And it is a difficult thing to convey. They're frustrated too.

The nurse quoted above shared how her personal experiences fostered her sensitivity to the experiences of NES patients who were unable to freely communicate without the presence of an interpreter:

> Even before I probably was a nurse, just in my own personal feelings of being somewhere and having something important going on. Even if we may not think it's an emergency, it's important to them. And not being able to look at that person and talk to them, and have them talk back to you. How frustrating. That would be scary that you're not getting everything across.

Some nurses recognized behaviors exhibited by NES patients as disappointment and frustration with being unable to immediately verbalize their needs and concerns to providers in the ED. Nurses verbalized concerns related to how the language barrier

affected their practice in the ED, and the experiences of NES patients receiving nursing care. The following quote from one nurse with just over 1 year's experience in the ED, whose expert practices were illustrated in the paradigm case presented in Chapter IV, captures well the overriding concerns expressed by many nurses in this study regarding their provision of care to Latino patients and families in the presence of a language barrier:

> I guess I've always had a little bit of an extra concern for the patient that I cannot communicate directly with myself, and with the family members. I have a little added concern as to whether or not I'm really filling the whole piece of the nurse. 'Cause for me it's a very holistic thing. I definitely believe in the framework of nursing consisting of a lot more than just nursing skills in the medical setting. And so if I cannot personally communicate with a person, then that leaves a big chunk of that nursing piece out for me. And I need to for my patient's sake as well as for my own to make sure that they are well aware that there are opportunities for us to communicate. We'll do whatever we have to, whether we need to sit here and play charades, or draw pictures, or get another interpreter or more time with the interpreter, whatever the case may be. That I want both of us to have equal opportunity to communicate just like I would with the other patients, without a language barrier.

Nurses' Practices in Coping With the Language Barrier

Narrative accounts of nurses' care experiences revealed their attempts at overcoming the language barrier and developing meaningful connections with Latino patients and

families. Nurses developed practices in response to the language barrier that enabled them to address the concerns discussed in Chapter IV, particularly with regards to obtaining accurate triage and assessment data, and communicating care requirements. These practices included: (a) using interpreters, and (b) using the nurse's Spanish language abilities. Nurses also described using charades and other non-verbal means of communication, as was illustrated in the paradigm case in Chapter IV and will be briefly discussed in this chapter. In some care encounters, nurses utilized all three of these strategies as they strove to meet patient needs and to maintain engagement and involvement in the clinical situation.

Nurses in this study varied in their abilities to surmount obstacles posed by linguistic differences present in care encounters. For the majority of patient encounters, nurses with very limited Spanish abilities relied entirely upon interpreters to communicate with patients. Other nurses in this study saw mixed results when using their Spanish language abilities in patient situations, and more often than not required the use of an interpreter at some time during the care episode. None of the nurses claimed to be fluent in Spanish, although several considered themselves fairly knowledgeable and proceeded with patient care without the assistance of an interpreter. A few of the bilingual nurses acted as interpreters in their work setting. Despite being fairly well-versed in Spanish, however, the bilingual nurses in this study, at times, had to defer to someone more fluent in the care setting in order to accurately and comprehensively establish or maintain communication with patients.

Analysis and interpretation of nurses' narratives revealed that nurses unanimously began each patient encounter by assessing the patient's linguistic needs before

proceeding with care. The various ways that nurses in this study assessed patients' linguistic needs and proceeded with gathering assessment data and planning care will now be presented and will be followed by a discussion that explicates and illustrates the three practices listed above that nurses developed in coping with the language barrier.

Assessing Patients' Linguistic Needs

In all of the ED settings in which this study took place, bilingual ancillary staff persons—in most cases, registration personnel—were the first to interact with Latino patients who presented for care. These individuals recorded the patient's name and chief complaint on an admission form, and directed patients to a specific location where a triage nurse assessed and recorded on the same admission form pertinent history related to the patient's chief complaint. When NES Latino patients presented for care, registration personnel would flag the patient's admission form to indicate the need for an interpreter.

To expedite the flow of patients through the ED and to proceed with care amidst time constraints and competing demands, nurses often began the triage or care encounter by assessing the patient's linguistic needs, regardless of whether the patient's chart indicated the need for interpretation services. Determining the need for an interpreter during triage and care encounters involved a nurse's consideration of the English-speaking ability of the patient and his or her family members who were present, as well as the nurse's Spanish-speaking ability. Sometimes a combination of the nurse's/patient's/family's abilities led nurses to proceed with obtaining assessment data and initiating care without an interpreter. One nurse described how she determined the need for an interpreter when she approached the care of a Latino patient:

> Well, I always ask at the beginning, "Do you speak English?" And they usually will say no or yes, either way. Or they'll say, "A little." And then usually if they say, "A little," I figure I don't need an interpreter because between my limited Spanish and their limited English, we usually can get pretty much what needs to occur said.

Nurses' narratives revealed that even when patients were able to speak some English, nurses remained attuned to nuances in their patient's conversational abilities and sensed when an interpreter's presence was needed to obtain accurate assessment data. As another nurse indicated, "You'll have a patient that starts talking in English and it's broken. And you feel like you're missing part of it." Nurses described how they offered interpretation services to patients who were able to speak some English, just to ensure the patient's needs for communication were met. As another nurse explained:

> We have lots of Hispanics come in for minor things that I don't need an interpreter for. And many times I will ask them, 'Do you want an interpreter?' And sometimes they will say, "No, we're doing okay here." And other times they will say, "Yes." So I go get one, and we'll continue the conversation.

In addition to simply asking patients if they can speak English, determining linguistic abilities and the need for interpretation services involved the nurses' careful attention while watching verbal and non-verbal responses from patients for indications of their English proficiency and level of understanding. Nurses described non-verbal behaviors that focused their attention and cast doubt upon their perception of the patient's abilities and understanding. One nurse in the study was fairly knowledgeable about cultural nuances related to communication behaviors because of what he learned from reflection

upon his experiences with caring for Latino patients in the ED and several cultural immersions to Latin American countries that he had participated in. During one group interview, this nurse shared insights he had gained from these experiences that influenced his practice in determining a patient's English language proficiency:

> I know that I used to do it when I was in an area where I was the only Caucasian and everybody else around me was speaking Spanish. You would just say, "Uh-huh" [laughs] and nod your head to anything that's said, whether it's in the form of a question or a sentence. And I think that that's typical of the Latino patients because they don't want to feel like they're less, or like they don't understand what's going on. So asking questions in which they have to give you a detailed answer; not just a yes/no question.

Questions that required detailed answers enabled nurses to more confidently determine whether or not the patient's English-speaking abilities were adequate for the patient to communicate clearly his or her needs, and for the nurse to obtain the necessary assessment data for the patient's plan of care.

Assessing Family Members' Linguistic Abilities

Nurses in this study unanimously advocated proceeding with care based on the English-speaking abilities of family members who accompanied NES patients to the ED. Although family involvement in patient care will be more fully described in Chapter VI, and nurses infrequently used family as interpreters during the entire care encounter, its utility to nurses' attempts at obtaining accurate triage and assessment data and establishing connections warrants a brief mention. Involving English-speaking family

members is advantageous to a nurse's practice in several ways. First, it alleviates the need to wait for an interpreter. Second, nurses in this study believed it allowed them to gather more thorough information about the patient's condition than what could have been retrieved through an interpreter. As one nurse stated:

> If a Spanish-speaking patient comes in with a family member that speaks English and Spanish, I think sometimes it's good to use that interpretation of the situation because they know that person better than we do, and better than the interpreter does. So what they're telling you, I think, is gonna be closer to the real facts than what you're gonna get from the interpreter.

Nurses' narratives revealed that the use of family members as communicators during care episodes did not always prove helpful in the patient's care. In fact, when the information family members provided was inaccurate, it sometimes led to inappropriate nursing interventions. One nurse recalled an incident that involved a young man who presented to the ED when she was working in the triage area. She described how the patient's chart did not indicate the need for interpretation services. The patient's silence led the nurse to assume he spoke no English. However, rather than assess the patient's linguistic abilities or request the assistance of an interpreter to communicate directly with the patient, the nurse obtained assessment data and organized the patient's care based on information provided by the English-speaking mother. The following excerpt is from this nurse's story:

> This patient sits down, and his family member starts saying he has this and this and this wrong with him. And he had chest pain, and shortness of breath and, you know,

> all these symptoms wrong with him. And I'm looking at him going, this is a 20 - year-old guy. "How long has this been going on?" "Oh, it just started." And she [the patient's mother] starts telling me all these things. So based on what she's telling me I say, "Okay, let's go ahead and go back, so we can get him oxygen, and get him hooked up and everything." So . . . I had a nurse take him back to a room, so they could find out what was going on, with the interpreter. And they get back to the room, and she [the nurse] comes up and she says, "Why did you bring him back?" And I said, "Well, because they said that he had chest pain, shortness of breath, that he got all sweaty and nauseated." . . . They got the interpreter, and the interpreter said [in Spanish, to the patient] "What's wrong?" And the family member, she starts saying all these things [in Spanish, to the interpreter], and is very excited. And the patient goes [in Spanish, through the interpreter], "No I don't. I have a headache."

Using family members to speak on behalf of NES Latino patients requires nurses to sort through family dynamics to get a clear picture of the patient's clinical situation. Sorting through family dynamics is not unique to the care of Latino patients in the ED. However, accurately assessing patients became more challenging for the nurses in this study in the presence of a language barrier if family members emerged as spokespersons on behalf of NES patients and nurses did not assess patient's linguistic needs or communicate directly with patients.

As with non-Latino patients, involving family members in assessment and care activities in the ED can sometimes be appropriate and beneficial to patient outcomes. However, using family members to communicate on behalf of NES patients was not a strategy that nurses in this study reported using frequently when caring for Latinos.

Narratives and observed encounters revealed that, more often than not, nurses tried their best to speak directly with patients. Although nurses relayed accounts of incidents in which they or other nurses used children to obtain assessment data and communicate care requirements on behalf of their adult NES family members, the majority of nurses in this study did not condone the use of children in patient care, and generally viewed this practice as inappropriate.

Nurses' Use of Non-Verbal Gestures

Many nurses in this study described the difficulties inherent in having minimal abilities to verbally communicate with NES patients. Nurses noted the extra effort required to convey what would otherwise have been simple messages, had they and their patients spoken the same language. Nurses' and patients' efforts at communicating with each other involved the use of non-verbal gestures and the challenges inherent in accurately reading non-verbal cues.

Several nurses discussed their use of nonverbal gestures as a means of communicating with patients with whom verbal communication was minimal. Although non-verbal gestures were not a nurse's primary means of communicating with patients, that practice surfaced repeatedly in nurses' narratives and during observed care encounters. As one nurse indicated: "You point. You gesture. You touch. Feel. You demonstrate. . . . I feel silly quite frankly, because I wouldn't do it if I was asking you about your headache or your stomach pain" [referring to English-speaking nurses in group interview]. Although this nurse described her self-consciousness about performing exaggerated movements in front of patients, she indicated that those gestures did help in her efforts to relay intended messages to NES patients. She further described patients'

non-verbal responses that confirmed for her the effectiveness of her gestures:

> People watch you when you're moving, so they attend to what you're trying to communicate to them. And you get an emotional response. A smile. A nod. I mean, nods are universal. Smiles are universal. So you get some universal confirmations like that . . . . And I don't mind floundering. But sometimes there is truly a big, sudden wall of language barrier and it's not coming down. And that's where I really have to work hard.

Despite her use of gestures, however, and whether or not the evaluative criteria she described was present and accurate in patient encounters, this nurse maintained an awareness of the "wall" that stood between herself and her patients that prevented smooth, effective, and mutually understandable communication. Additionally, this nurse's concerns did not reflect a desire for mutual engagement in the conversation or her need to connect with the patient; instead, they were focused primarily on getting her message to the patient. The patient's concerns or needs and the problems associated with relaying those to the nurse were not mentioned in this nurse's comments. Her practices contrasted sharply with the compassionate care provided by the nurse in the paradigm case presented in Chapter IV, who did not communicate verbally with the patient at all through a majority of the care episode.

Nurses' Use of Interpreters

Nurses in this study coped with the language barrier primarily by using interpreters. To some nurses, communicating through an interpreter was effortful and dissatisfying. Several nurses perceived the interpreter as a "third party," an obstacle to connecting with

Latino patients and to the nurse's determination to provide care that met his/her standard for what "good" care should be—whether conducting an accurate triage assessment, maintaining a meaningful connection throughout the care encounter, or providing comprehensive and accurate discharge instructions.

Nurses in this study recognized the importance of an interpreter's assistance in retrieving pertinent information necessary for planning and providing appropriate care, and were concerned about the accuracy and comprehensiveness of information interpreters related to them about the patient's needs. As one nurse explained:

> If I were somewhere and everybody spoke Spanish, I would feel more comfortable speaking in English, because I could get little subtle things across. . . . So sometimes the nurse, with the interpreter's help, can get those little things. . . . I just think that . . . it might make her [the patient] feel more comfortable if she can communicate in her primary language knowing that she's talking to somebody that's gonna hopefully give me verbatim what she's saying. [Observation interview]

Non-Spanish-speaking nurses described their reliance upon interpreters to assist them in developing a connection and in forming an accurate clinical impression of NES Latino patients and families. These nurses were aware that when a Spanish-speaking patient presented for care, their abilities to assess the situation and immediately intervene on the patient's behalf were often compromised due to the nurse's inability to understand what the patient was saying, the lack of an available interpreter, or to the delay inherent when communicating through a third person. Although nurses often made assumptions based on their observations of the patient's or a family member's presenting behaviors,

they realized that until an interpreter was present, verification of initial impressions was not possible. One nurse captured well NSS nurses' reliance upon interpretation services in the ED when she stated:

> I think that interpreter is a hugely important role. It's the only avenue for me to get the info. from the patient. If I don't have that avenue, I have nothing other than visual assessment. But like in triage, that is the connection between me and the patient. And when that connection's not a strong one [laughs] then you're really at a loss.

A nurse's reliance on interpreters to assist him/her with obtaining ongoing assessment data when providing patient care, irregardless of whether or not the nurse spoke any Spanish, often correlated with the comprehensiveness of triage assessment data recorded on the patient's chart and the acuity of the patient's presentation. During one observed care encounter, the nurse waited for an interpreter to become available before escorting a parent and infant to an exam room. However, during the previous care episode during that same observation session, the nurse proceeded with care by using her Spanish skills rather than waiting for an interpreter. The nurse described the thought processes that informed her decision to delay care and wait for an interpreter during this particular patient care encounter:

> It also depends on the triage. This only says rash [pointing to triage note indicating patient's chief complaint]. If this has everything that I need already written down, then I'm not gonna grab an interpreter, 'cause they've already asked the questions. Where I wanted to know, could this be a viral rash? Has the baby been sick? You

know, those types of things. And so it depends on how much they did here [in triage]. [Observation interview]

Nurses in this study relayed numerous care experiences that involved their use of interpreters and described many concerns that focused their attention during these patient interactions. Their practices involving the use of interpreters revealed qualitative distinctions in their abilities with establishing and maintaining meaningful connections with Latino patients. The nurses expressed frustration and disappointment when they were unable to connect in meaningful ways and to provide particularized patient care when using interpreters. Interpreter performance and other barriers to the nurses' efforts, will be discussed later in this chapter.

One nurse's description of a care encounter that required the constant presence of an interpreter stood out from the rest in the way it captured many of the concerns noted above. Unlike the narratives of other nurses, this nurse's story reflected the tenacity and expertise that the nurse exhibited as she overcame challenge posed when all verbal communication occurred through an interpreter, established and maintained a connection, and conveyed compassion and concern to the patient and family during their care episode.

Paradigm Case: Establishing and Maintaining a Patient Connection—A Nurse's Skillful Practices in the Use of an Interpreter

This is an account from a nurse about an episode in which she cared for a two-year old child who was brought to the ED with severely burned legs.

Establishing the Connection

The nurse began her story by describing how the baby's mother, in a reflexive action

after the baby had been burned at home, had applied cold refried beans to the baby's legs in an effort to cool the burns and soothe the baby's discomfort before bringing the baby to the ED. Competing demands in the clinical situation—attending to nuances in the mother's behavior and stance while needing to immediately care for the baby who was screaming and in severe pain—solicited the nurse's immediate attention and influenced her actions at the start of the patient encounter. The nurse, who spoke no Spanish, described how she initiated the baby's care and communicated through the interpreter with the mother, who spoke no English, amidst these demands:

> And we were going to give an IM pain medication. . . . And the mother was like freaking out, because we were going to give a shot. And she just didn't understand why we were going to hurt the baby to help it feel better. So I had the interpreter in the room, and I said, "No, this will hurt because of the needle, but it will make the baby feel better with the pain medication. And then we can wash all the burned skin." And so finally she was agreeable to that. Meanwhile the baby was just hysterical, and I felt awful 'cause that baby was miserable. And so we gave the baby the shot and essentially just let her hold the baby for about 15 minutes, and then we started washing the baby.

As an additional comfort measure, the nurse recalled how she added topical lidocaine to the cleansing solution to help minimize the pain caused by thoroughly cleaning the baby's burns. The nurse detailed the challenges that surfaced as she began to clean the baby's burns, while at the same time trying to communicate the care requirements and rationale to the mother:

> And I used topical lidocaine to wash the baby's legs, and I was trying to explain to her that there was numbing medicine in this wash. And somehow the mother. . . thought I was going to paralyze the baby's legs. And I said, "Wait a minute! No! No! I'm not telling her I'm going to paralyze the baby's legs, I'm just gonna make the legs go numb, so we can wash them!" And the interpreter, I don't know if it was the dialect or what, but the numb interpretation was getting missed. And I was saying, "No, it's not a permanent thing, it's temporary." And then the temporary interpretation was getting mixed.

The nurse's narrative of this interaction reflects the engaged presence she maintained while the interpreter relayed the nurse's verbal messages to the mother at the onset of the care encounter. The nurse remained attentive to evaluating the woman's level of understanding of the information that was being relayed to her. The nurse realized that differences in the dialects of Spanish spoken by the interpreter and the baby's mother may have caused the breakdown in communication that was occurring, something she had no control over. Her involvement in and concern for the baby's care compelled her to remain attuned to the woman's needs to be informed of what the nurse was going to do with her baby. The nurse adjusted her verbal messages to help remedy the misunderstandings that prevented the mother from clearly understanding the nurse's good intentions in the care of the baby. She detailed her attempts at clarifying the concepts into simpler terms for the interpreter to convey to the mother:

> So I was trying to then break it down, "This will be like ice. Ice makes your mouth numb, but only for a little while." [laughs] I was trying to break it down into the

simplest terms. Meanwhile this baby has burns, and they needed to be washed. And so we finally got the baby washed, and the mom did stay up at the bed and was consoling the baby with a bottle. And . . . then I had to trim some debrided skin. And that brought up a whole new, "Why are you cutting my baby? Why are you cutting the skin off my baby?" And so the interpreter, I said, "This is dead skin. This is no longer living skin. We have to cut this skin off. Infection will grow in the skin." And there were some bleeding areas from the washing on the burned skin. And, "Why are you cutting him? My baby will bleed. Why?" And oh, it was just the most explanatory thing. But it was a high acuity thing, too.

Maintaining a watchful presence.

Remaining open and attentive to the mother's needs and concerns was reflected in the nurse's efforts at breaking down difficult concepts into simpler words and phrases, and communicating the rationale for nursing actions that would obviously cause the baby additional discomfort and pain. The nurse described the thoughts that guided her actions during the clinical situation as she focused on the baby's burns and the urgent yet careful interventions they required:

Well for one thing the baby, of course, was hysterical, hurting. . . . So I just felt awful. And I felt in my mind that I knew that the mom had felt some guilt involved with the incident. And I felt awful about that, 'cause I know how that would feel, having a little one. And [pause] each step, with the shot, and then with the cleansing, and then with the trimming, I felt like we were hurting her baby. Yet we were doing things to better the wounds. But I felt like she was interpreting it as, what are you doing to my baby? I felt awful about that. And I would feel awful if that was my

baby, because it does, visually, look like you're hurting the baby.

Because of the nurse's own experiences with having a young child at home, she was able to empathize with the mother's despair at seeing her injured child in extreme pain. The nurse indicated how a similar mishap could easily occur with her own child and how this understanding sensitized her to the mother's distress: "With a little one, anything can happen just like that. [snaps fingers] And if it's your little one, then you hurt too. I don't think I connected with that 'til I became a mom." Because of this commonality in their backgrounds, the nurse came to know the woman (Tanner et al., 1993). She was able to personalize her care, so that she sustained a connection with the woman to quell her anxiety about seeing her injured child and observing the painful interventions that had to be done to treat the child's burns. Maintaining a watchful presence over the child's mother enabled the nurse to identify and attend to nuances in the clinical situation as they surfaced. The nurse's own experiences with being a mother enabled her intuitive recognition of salient aspects of the clinical situation that were affecting the mother, alerting the nurse to the woman's need for comfort and reassurance. The nurse described how she adjusted her care when she sensed the mother's increasing discomfort as the situation unfolded, "I'd stop and I would make sure that the interpreter explained what, and <u>why</u> I was doing those things. 'Cause I could sense that maybe her . . . protectiveness to the baby was kind of getting <u>more</u>" [was increasing].

The nurse's concern for the baby's well-being extended to how the mother was interpreting the nurse's actions, and this attuned stance influenced the nurse's practice through ongoing efforts at keeping the mother informed of the rationale for the care interventions that at times caused the baby additional discomfort.

Maintaining the Connection

The nurse continued in her narration of the care episode and described how she and the mother had opportunities to converse with each other while the nurse attended to the child's burns, further establishing the connection that had formed between the two women:

> I try and think of things to talk about as I'm doing something like this, because I guess it helps me to talk. [laughs] But I was trying to tell her that I had a young 2-year-old, and things happen just like that. And I said that, "It's hard to prevent mishaps with little ones." And on and on. And I said, "In the future though, don't put anything on the baby if you get a burn." And I was trying to explain to her, like the beans, maybe, had trapped in some heat. And so she did understand that. She understood that part, that if ever a burn in the future, just to leave it open to air and come right in.

Having some time to converse allowed the women to forge a common bond with one another. In addition, the conversation between the nurse and mother afforded the nurse the opportunity to provide instruction to the mother about care the baby would require post-discharge from the ED. The taken-for-granted ways that the nurse practiced, were again disrupted, however, as the nurse readied supplies needed to apply bandages to the baby's legs before discharging the baby home. The nurse described how questions from the mother jolted her out of her taken-for-granted mode of providing care:

> And finally we got the baby trimmed and excised. . . . And so then I was gonna dress this baby's legs, and I go and get a jar of Silvadene. [laughs] And I'm gonna smother

> this burn with the Silvadene. And she was like, "What are you doing? What are you putting on my baby? You just told me!" And the interpreter was saying, "You already told her not to put anything on a burn, and now you're going to put the cream on the burn." And I'm like, oh no! [puts face down into hand] Yeah. Yeah, you're right. [laughs] . . . . So I had to explain that this was soothing medication, for burns specifically. You wouldn't put this on any skin other than burned skin. And oh, it was just awful. I felt totally like I'd done that mother nothing, [laughter from all] except for the part that things happen just like that. [laughs] We agreed on that part.

The nurse's concerned stance did not waver when she became aware of how her actions contradicted what she had previously taught the mother about putting topical remedies on burns. Having already established a rapport with the baby's mother through mutual communication via the interpreter, the nurse described feeling that she had betrayed the trust that had been developed between the two women when she realized her actions were not congruent with what she had previously communicated to the mother:

> And we had gotten a rapport about midway through because we were talking about little ones getting into everything; and the moment of silence, you should always worry what they're doing. And it was one of those moments of silence where this had happened. And the mother said, "All of a sudden it was quiet, and then I heard something splash," and then she heard the baby screaming. And I said, "Always those moments of silence are bad, because then you know something's going wrong." And so we'd gotten this rapport, and I just felt awful. I felt like here we were getting this ground base of our communication, and then I was back talking

> whatever I was saying with the mother. . . . It was a heart-sinking feeling. And I think the mother knew that I was frustrated too, because I was just like, "Oh, man! Uh, uh" I just was at a loss for words sometimes because I couldn't retake what I'd already said.

The rapport that the nurse had established with the mother was grounded in the nurse's genuine care and concern for the baby and the mother, and was made possible by the nurse's tenacious and committed efforts at remaining engaged and providing information and clarification to the mother through the open line of communication the nurse had secured through the interpreter. Rather than diminish the mother's concerns or provide care to the baby without attending to the mother's needs for communication or clarification, the nurse remained engaged in the clinical situation and utilized the interpreter to ensure that the mother understood the rationale for appropriate application of cream to a burn injury. The nurse's attunement to the mother's concerns and her attendance to them through the interpreter helped to ensure that their connection was not lost.

The nurse utilized the interpreter throughout the care episode and remarked about how the interpreter's style of repeating the nurses messages verbatim to the mother assisted in the nurse's effort to maintain a caring and concernful presence with the mother:

> As I was chuckling, or thinking, I said to the interpreter, "She's gonna think I'm nuts, because I told her not to do this, and here I am doing it!" And so then she [the interpreter] would say that to the mother. And so she was pretty much verbatim

saying what I was saying out loud from my head. [laughs]

The nurse's habit of thinking out loud—especially when frustrations surfaced in the nurse's awareness that her actions contradicted what she had previously taught the mother about the care of burns—and the interpreter's practice of relaying the nurse's messages verbatim further cemented and sustained the connection formed between the two women. The nurse continued in her narration of the care episode and described additional challenges to her nursing practice that surfaced when the mother verbalized concerns regarding the follow-up and home care the child would require upon being discharged from the ED:

> And we got the baby ointment and gauzed [bandaged], and the mother, I remember her saying, "How will I keep these on?" And I thought, "You know, that's a good question! [laughs] Mobile little, almost-toddler, getting-into-everything-kid, how <u>are</u> you gonna keep these things on? And I said, "Well, they're probably not gonna stay on. You're just gonna have to do the best you <u>can</u>. You'll have to re-wrap them. You'll be washing them once a day," or whatever the instructions were. And the baby was gonna come back the next day for a check, or two days later. And I really felt that I stumbled with her because she was going to have to put this ointment on again the next day, and I'd already gotten into this talk with her about not putting anything on a burned skin.

Communicating Compassion and Concern

The nurse's engaged presence and committed efforts at ensuring that clear communication was maintained between herself and the mother succeeded in conveying

compassion and concern and in making the environment welcoming for the mother. Allowing the mother to be near the baby and to provide comfort after the injection had been given sent a message to the mother that the nurse valued her presence and involvement in the child's care. The mother's verbalization of her concerns and questions about the nurse's actions and intentions further indicated her comfort in the nurse's presence throughout the care episode. Because of the relationship the nurse had developed with the mother through the lines of communication the mother felt comfortable pointing out to the nurse her confusion with the inherent contradictions in many of the nurse's actions: the infliction of pain to alleviate pain with the IM injection; the use of medicine to "numb" the baby's legs; cutting skin that was already bleeding to promote healing; applying thick cream to the baby's burned skin after being instructed not to put anything on burns; and, wrapping the toddler's legs with gauze bandages that had little or no chance of remaining intact given the mobility of such a young child.

The nurse commented on how valuable the interpreter's assistance was to the nurse's efforts at conveying her compassion and concern to the woman during the patient care episode:

> I think at one time I said, "I'm a mother, I couldn't take care of this baby at home tomorrow." I was kind of laughing as I said it, and the interpreter kind of laughed and said, "Oh mama!" And went on to say that [to the mother]. And the mother, we had a common ground, I think . . . . She knew I truly cared and was interested about the baby now, and the baby tomorrow.

The mother's verbalization of her concerns, and the nurse's unrelenting efforts at

attending to them, evidenced the connection and the mutual desire for understanding present between the two women during the care encounter, which was made possible because of the nurse's skill in working with the interpreter, and the interpreter's engagement and performance.

The nurse's account of the care episode illustrated her committed efforts at maintaining an engaged presence to the baby's mother. As evidenced by the many quotes in the nurse's narrative from the dialogue that had occurred between herself and the mother throughout the care episode, the nurse was able to maintain a connection—despite the many breakdowns that drew her attention—and to establish and sustain an open line of communication with the NES mother through skillful work with an interpreter. Establishing and maintaining an open line of communication enabled the nurse to attend to the baby's urgent needs for care while keeping the mother informed of the plan of care and what that would entail.

The nurse's narrative of this patient care episode reflected how communication between the nurse and the mother seemed to flow in a fluid motion not apparent to the nurse until misunderstandings surfaced. The nurse's narrative focused, not on the presence of the interpreter, but on the dialogue that the nurse and mother had engaged in throughout the care episode and in the nurse's commitment to maintaining accuracy in the communication that was occurring between herself and the child's mother. In reading the nurse's account, the reader easily forgets there was a third party present in the room relaying the verbal exchanges between the nurse and mother and that *all* verbal communication during the patient situation was relayed through an interpreter. The nurse's use of the interpreter was transparent, and demonstrated a level of skill and

comfort working with an interpreter that was not always apparent in the practice of other nurses in this study. The ease with which this nurse communicated through and worked with the interpreter enabled her to attend to and carry out the critically important interventions necessary in the care of the baby's burns.

The Interpreter's Performance and its Influence on the Nurse's Practices

The interpreter's actions and performance enabled the nurse to establish and maintain a connection with the mother. The nurse's narrative reflected how the interpreter displayed concern and was involved and engaged throughout the clinical situation, stepping out of the conversation to point out to the nurse how information the nurse had already provided to the mother conflicted with the nurse's actions in applying cream to the baby's burns. In this manner, the interpreter's involvement was more than a conduit through which verbal communication was relayed. The nurse described the fortuitousness of being able to maintain consistency with the same interpreter throughout the care episode, "And I did use the same interpreter through the whole thing because, as these things just kept dominoeing into each other, yeah, I was fortunate to have the same person."

The nurse's narrative also reflected the comfortable working relationship that she shared with the interpreter that influenced the ease with which she directed the interpreter to relay and repeat her verbal messages to the mother. The nurse described how, by being able to maintain an open line of mutual and reciprocal communication with the mother through the interpreter, the nurse was able to ensure the mother clearly understood the nurse's intentions and genuine concern for the well-being of her child: "This interpreter is very good about saying, "Yes, she understands" or relaying that the family or the mother

understand. . . . And I think that that communication was satisfying because she was understanding, in the end, what we were doing."

As discussed by Benner, et al. (1996), this nurse's practice exhibited expertise in the way her actions reflected "an attunement to the situation" that allowed the nurse's responses "to be shaped by a watchful reading" of the mother's reactions "without recourse to conscious deliberation" (p. 143). The nurse remained attuned to the mother's reactions to what the nurse was doing and saying, and sensed when misinterpretations had occurred in the information relayed to the mother. Although the nurse did consciously think about the need to re-word concepts she was trying to explain to the mother, her reactions and responses came easily and without much deliberation because of her desire to keep the mother involved and informed.

Cultural Congruence of Nurses' Use of Interpreters in the Care of Latino Patients

Narratives of Latino informants revealed the importance of an interpreter's presence during their care episodes in the to meet their needs for: (a) communicating their concerns to providers, and (b) receiving information about their health conditions and the care they would require. Informants also indicated concerns regarding interpreter accuracy, and its implications on the quality of care they received.

Meeting Patients' Communication and Information Needs Through an Interpreter

Interpretation and analysis of Latino informants' narratives revealed how it was critical that NES Latino patients were able to voice their concerns and questions, and to have them accurately relayed to and addressed by health care providers throughout their ED visits. However, as evidenced by narratives from group interviews and data collected during observation sessions, nurses in this study did not consistently use interpreters. The

following excerpt from a Latino patient interview illustrates the importance of the interpreter's presence during her care episode in the ED:

> I felt better, because I could communicate and explain what I felt. When you don't have an interpreter, you struggle, and they [nurses] don't understand you. . . . One feels much better, because you know what things are going to be done. Like if they tell you to take a medicine, you know how. You understand everything they are telling you. And when there isn't an interpreter, they tell you one thing, and you understand another. At times, you struggle when they put items on the table, because you don't know how to take them, and there they stay. At times they give you the prescriptions in English, and you also struggle, and you have to call again and ask how you take them and everything.

Latino informants indicated that when nurses did not include an interpreter in their care, their concerns were not always adequately understood by nurses, and therefore, not fully addressed. Such a situation occurred during one observation session in which the nurse did not use an interpreter, despite information on the patient's chart indicating the need for one. Instead, the nurse addressed in English the patient's 8 year-old son who was present and asked him to relay messages to his mother. Although the nurse observed that the child did not relay any of her messages to the patient, this did not cause the nurse to alter her practice. With the exception of speaking a few short phrases or questions, such as, "Tiene dolor?" [do you have pain?] while providing patient care, the nurse continued to communicate in English during the rest of the patient's care episode. Although in an interview following the care episode, the nurse indicated that she believed she understood

the patient's replies in Spanish, the patient's interview revealed that the care she had received did not address her needs; as a result, she left the ED without a full understanding of the health-related concerns she brought with her to the care episode. The nurse did use an interpreter during the discharge portion of the patient's care episode; however, this did little toward meeting the patient's needs and addressing her concerns. The following excerpt illustrates the patient's experience and her impression of the care she had received:

> Well, I came here because I couldn't . . . breathe in or out. . . . I don't know why I feel like I'm going to cough . . . . I wanted them to examine my throat. Something like using a medical device to see well enough . . . because I feel real big and tight here in my throat. I'm always choking. She [the nurse] said I was depressed due to a problem. Or anger. She asked me what was wrong with me, and I told her I had a problem because someone got a ticket and used my name. She said that was probably my problem, but if I still felt bad, to go back to the clinic. . . . I'm afraid because I . . have my two children. And my husband always works, and he arrives late. And I'm alone. And I feel like I'm going to choke again, and I won't be able to ask for help. And I won't be able to do anything. . . . That is why I'm scared. They say I don't have anything wrong, but I don't believe so. I told the doctor that I don't feel good, but he says everything is perfect, that the analysis came out good, that everything is fine, and that maybe I'm depressed. But I've never had depression. Like attacks that choke me, I've never had. . . . I thought they were going to give me, I don't know, like a treatment so I could feel better, or something, like a pill, to calm me down. But they gave me nothing. . . . He said that maybe I have, because the spray that I use for

> the stove suffocates me, like I'm allergic to it. But why didn't he give me an injection or medication for allergies?

The exemplar above illustrates the importance of nurses providing interpreters so that patients can freely express their concerns and questions during their visit to the ED. It was obvious from the patient's narrative that she needed to hear more about depression and its possible link to the anxiety-related symptoms she had been experiencing. The nurse, after the care episode, indicated that her evaluation of the patient's demeanor during the discharge encounter informed her that the patient was not satisfied with the diagnosis and treatment plan she had received. However, the nurse did nothing in her interactions that addressed those nuances:

> I kind of felt like she [the patient] wanted something more substantial than what we were telling her. She wanted a diagnosis put on the problem instead of just, "Maybe, it's just your nerves. Maybe it's just anxiety.". . . That's what I got from her body language. [Observation interview]

The nurse's care described above was incongruent with meeting the needs and concerns that the patient brought with her to the ED. The nurse's lack of concernful involvement and attunement to addressing the patient's needs and concerns in a comprehensive manner resulted in care that provided little to empower the patient's self-care capacities and health-promoting behaviors. The patient's care could have been vastly more effective had the nurse not assumed that the patient understood what was happening throughout the care encounter, but instead: (a) observed more closely the patient's verbal and non-verbal behaviors that indicated her lack of understanding about her illness

condition and attended to them; (b) provided an interpreter through which communication could have been established and maintained throughout the care encounter; and (c) provided care and information that specifically assessed and addressed the patient's concerns upon realizing the patient was not satisfied with the discharge instructions given.

The patient's experience narrated above illustrates how the lack of an interpreter's presence led to misinformation that inadequately met the patient's needs and to confusion regarding what the patient should do in caring for herself at home following her discharge from the ED. The following quote from a nurse in this study who was fairly fluent in Spanish illustrates his and other nurses'concerns with providing clear and comprehensive information through interpreters when doing discharge teaching.In response to being asked, during an observed care encounter, if his Spanish abilities were adequate enough for him to ever proceed without an interpreter, he replied:

> No. And technically, and legally, and morally, I shouldn't. You know? If . . . this guy with an infected leg comes back and says, "Well, they didn't use a Spanish interpretation with me. Now I've got a fever, and a red streak headed up to my heart. And I've got now a murmur." You just don't go that way. Whatsoever. [Observation interview]

Despite being fairly fluent in Spanish, the nurse quoted above demonstrated cultural congruence when he acted upon his heightened awareness of the potential for complications that could occur if comprehensive information was not given to the patient in the patient's primary language. The nurse's realization of potential mistakes in his

efforts at communicating in Spanish directed his practice of utilizing an interpreter during every discharge encounter with NES Latino patients and even with those who spoke some English.

Informants' Concerns with Interpreter Accuracy

Several Latino informants in this study emphasized the importance of having an interpreter present during care encounters in the ED. Nevertheless, several observed patient care episodes occurred in English, despite the patient's or family member's fluency in Spanish. During one patient care episode, English was spoken because of the family member's concerns with interpreter accuracy, as was revealed in the informants' narrative from the interview that followed his care experience:

> I feel more comfortable in English, instead of having another person. . . . The interpreter, at times, doesn't tell you. He doesn't tell the doctor what you are saying. This has happened to me at the other hospital with my wife. I went in, and they didn't ask me if I wanted an interpreter. They only took us in. And I didn't feel comfortable, because I was understanding what the doctor was saying. The interpreter was not saying what was happening. Well, I was understanding everything. Everything the doctor was telling the interpreter. But the interpreter was not explaining everything. That's why at times, I prefer English . . . . If the doctor doesn't know Spanish, I prefer to be the interpreter.

Accuracy in communication is imperative if patient needs are to be met during care episodes in the ED. However, the informants' experiences relayed above, as well as nurses' narratives in this study, evidenced skepticism regarding the accuracy of

interpreted accounts during patient care encounters.

Enhancers and Barriers to Connecting with Latino Patients Through Interpreters

Many nurses in this study had a mental picture of what good nursing care should be that guided their practice; and they acknowledged that this standard of practice was not always realized when having to communicate and provide care through an interpreter. Data analysis revealed several aspects of nurses' practices and their work environments that enhanced their abilities with developing and sustaining meaningful connections with Latino patients and families through the use of interpreters. First, as was illustrated in the paradigm case involving the baby who had been burned, a nurse's desire to remain engaged during patient interactions and his/her skill in working with interpreters influences the success of meaningful connections during care episodes. As described in Chapter IV, contextual concerns such as time, interpreter availability, and interpreter accuracy, stance, and engagement in the clinical situation also enhances or poses barriers to nurses' connections with NES Latino patients. Each of these facets of nurses' practices and work environments will now be discussed.

Nurses' Skill in Working with Interpreters

Data analysis revealed variation in nurses' abilities and comfort levels when working with interpreters. For some nurses, working with interpreters was a noticeably disjointed exercise as they attempted to gather information about the patient's presentation; to others, such as the nurse from the paradigm case about the baby who had been burned, the interpreter's presence was transparent to the nurse's practice. Several nurses discussed the disconnectedness that was apparent in their attempts to provide care while trying to retrieve or give information to the NES patient through an interpreter, especially

in high acuity situations where patients required immediate interventions. As one nurse described:

> My hands are working, but my tongue's tied. And I'm trying to talk fast, 'cause I'm doing things fast. And I want to move on to the next thing, and I'm waiting for the interpreter. I'm speaking, so I'm waiting for the interpreter to follow through.

As was the case in the care of the baby who had been burned, the skills that some nurses in this study had developed from working with interpreters over a long period of time allowed them to attend directly to patient needs and to remain engaged with their care and actions instead of being distracted by the interpreter's disengagement or poor performance.

As evidenced in the care of the baby who had been burned, expertise in nursing practices revealed how nurses focused their attention on the verbal and non-verbal behaviors of NES patients and family members when interpretation services were utilized to ascertain the degree to which messages were being accurately conveyed and understood. Repeating information and emphasizing key points were strategies utilized by nurses in this study to ensure patient understanding and quality of care and to maintain engagement in and control of conversations. However, all of the nurses in this study did not consistently display or report these practices.

Maintaining Engagement in and Control of Conversation

Several nurses' narratives and observed care encounters evidenced how nurses watched interactions between patients and interpreters as a means of staying engaged in conversations and assessing interpreter performance and patient understanding. Nurses

verbalized concerns about interpreters engaging in sidebar conversations with patients that did not involve the nurse, and described the practices they developed to enable them to maintain control of conversations. As one nurse indicated, "They'll be interpreting for me, then all of a sudden they have this little interchange without me involved at all. And I'm like, "Okay, wait a minute. Back up. Did I just miss an important piece of information?"

Several nurses also verbalized concerns with interpreters condensing or leaving out what might be critical information relayed by patients or family members. As one nurse stated, "And sometimes . . . you get this whole verbal string of information from the family member, and the interpreter says, "No." [laughs] Okay, what was all of that conversation there? What did they say?" While nurses less skilled with working with interpreters remained outside of these conversations, nurses who demonstrated more skill and comfort with working with interpreters described their actions at redirecting the interpreter and clarifying the communication during these patient care encounters.

An example of how nurses redirected interpreters during patient encounters was revealed in a nurse's account of his care for a patient who had come to the ED after having been assaulted. The nurse described the interpreter's stance and how it influenced the effectiveness and quality of his nursing care of the patient that night:

> Last night I had an interpreter who . . . stood away from the patient looking toward the wall at a chart, and interpreted for me. And so you've got to interrupt what you're doing, because you want her to come over. Because part of communication is looking, talking. . . . And he [the patient] got assaulted in the face a few times, and so he's holding a bag of ice to his head, and actually he's facing the opposite way than

> she [the interpreter] was. I'm talking to him, she's talking to the wall, and he's looking through an ice bag toward the wall.

The nurse's account of the patient episode illustrates how the interpreter's body language distracted him from his concernful engagement in the clinical situation and became a hindrance to the nurse's attempts at directing and assessing the patient. The nurse described how his attention was drawn to the patient's lack of responses the nurse wanted, and how, instead, the patient laid motionless on the bed:

> He wasn't following my commands always, as to whether he was to sit back, whether he was to take off his clothes. And the guy was assaulted, and we needed to see, you know, head to toe, 'cause he could have been kicked in the ribs, even though this [points to face] was the only place that he [was visibly injured].

By remaining watchful of the interpreter's distanced stance, and the patient's subsequent lack of reaction or response to the nurse's verbal commands, the nurse redirected the interpreter to stand near him and the patient. As a result, the nurse was able to more effectively continue with his nursing care. He described the difference in patient demeanor that occurred as a result of his redirecting the interpreter: "I felt more comfortable. . . . I was at ease that he was answering my questions. I could hear what his needs were."

In contrast to the skillful practices that some of the nurses in this study had developed working with interpreters, other nurses described failed attempts at establishing connections with NES patients and blamed it on the interpreter's performance rather than realizing that the nurse's abilities—or lack thereof—played a role as well. In particular,

nurses verbalized their desire for interpreters to provide the emotional tone of messages conveyed by patients that the nurses believed would help in their efforts to ascertain the urgency of the patient's presentation. Several nurses lamented that their lack of Spanish abilities prevented them from accurately assessing the meaning and urgency behind the patient's verbalized chief complaint. These nurses emphasized their reliance on interpreters to interpret and convey the inflection in the patient's voice, even when visual assessment data were providing the nurse with a formative clinical impression. As one nurse stated,

> I am relying on the body language cues from the interpreter for information on what's going on with the patient. I mean, I can look at the patient, and I can tell they're anxious. But I can't communicate directly with them. So I will use the body language and the nonverbal cues that the interpreter gives to sometimes assess how critical the situation is.

Several nurses in this study also verbalized concerns when interpreters' messages from nurse to patient did not convey the same emotional tone used by the nurse; nurses believed that tone was important to convey the level of concern and care that he/she felt in the patient situation. This was particularly problematic when interpreters performed in a perfunctory manner and the patient and family dynamics clearly indicated to nurses the need for comfort and reassurance to assuage their anxieties and fears. As one nurse stated, "And you lose so much going through an interpreter. . . . Just feeling almost helpless trying to get that across to them. . . . You can tell they're distraught, that they have questions."

Some of the nurses in this study became stifled in their ability to communicate concern for patients and families when they could not see possibilities beyond the interpreter's role in doing this. In relinquishing this control, these nurses felt at the mercy of the interpreter in relationship to how the emotional tone of their message was conveyed to the patient. As a result, these nurses believed that the foundational support for the development and maintenance of an involved connection with the patient was jeopardized. Unlike the nurses whose practices exhibited expertise in the paradigm cases presented in this chapter and in Chapter IV, these nurses were not able to see possibilities in the care environment beyond the interpreter that would have enabled them to convey their care and concern to patients and family members, in both verbal and non-verbal ways.

Time Constraints

Unfortunately, concerns with balancing competing demands amid time constraints led some nurses in this study to cut corners in their provision of care to NES Latino patients. Inattention to the quality of care provided to Latino patients amid time constraints and competing demands was revealed when nurses did not (a) utilize resources available to them to provide patients comprehensive and accurate discharge instructions; (b) verify interpreter accuracy or patient understanding; or (c) accompany interpreters into the room to provide discharge instructions to patients, but, rather, delegated altogether the patient's discharge teaching to the interpreters. Each of these areas in which nurses adjusted their practices in the face of time constraints and competing demands will now be described.

Underutilization of Resources for Accurate Discharge Information

In all of the facilities where nurses in this study were employed, nurses were able to use specialized computer software to compose individualized, comprehensive discharge instructions and print them in English or in Spanish. In one facility, however, nurses lamented the amount of time it took to access the computer program and, as a result, did not routinely use it. Instead, registration and/or interpretation personnel in this facility were routinely directed by nurses to translate into written Spanish the discharge instructions that had been written in English by nurses and physicians. The ease with which ancillary staff proceeded in translating the information into Spanish without instruction from nurses signified the comfortable routine that had been established in this setting. As one nurse indicated, "There's an understanding here between the interpreters and the nurses. They'll come find you if they have questions." [Observation interview]. Nurses in this facility agreed it was much more expeditious to have the interpreters write the instructions for them than it was to work with the cumbersome computer software. However, there was no system in place for verifying the accuracy of such hand-written information. This practice could prove problematic given the fact that ancillary staff members were also pressured with time constraints as they balanced competing demands in their own roles as interpreters and/or registration personnel, and could easily omit content or commit errors in the translation of the information.

Disregarding Verification of Interpreter Accuracy and Patient Understanding

In addition to reducing time spent with patients in reviewing discharge instructions, and in using hand-written discharge notes, some nurses reduced the attention they gave to verifying interpreter accuracy and patient understanding during the discharge encounter

because of time constraints. As one nurse indicated:

> **Nurse**: So we just do our two-minute intervention in the emergency room, and sometimes longer, if we have the time. I mean, there's a lot of restrictions in the ER around time. And . . . you're not asking the client to repeat to you, you know, all these nursing things that we're taught, "Okay, now repeat to me what you just learned from me," and asking questions. We don't take the time in the ER to do a lot of that.
>
> **Int**: What does that feel like when you can't verify what the interpreter says?
>
> **Nurse**: Well, I shouldn't use the word can't. It's more about time. I mean, I could certainly go through the questions.

Delegating Discharge Teaching to Interpreters

Another way that time constraints and the need to balance competing demands influenced nurses' practices was revealed in nurses' accounts of delegating to interpreters the patient's discharge teaching. Several nurses in this study commented that because of concerns with time and the need to attend to other patient needs, they often did not accompany interpreters when written discharge instructions were given to NES patients, especially when the patient's complaint was non-emergent and fairly innocuous, such as a runny nose or a cough. This practice was only reported by nurses in the facility where nurses routinely directed interpretation personnel to translate patient discharge information into written Spanish. And, according to these nurses' narratives, it was a fairly common occurrence in that setting. As one nurse from this facility indicated:

> Sometimes, though, when it's really very busy, I don't even get to go with the interpreter to talk to the patient, if it's something pretty clear cut. You know, "Please

> give them these instructions. If you have any questions or problems come out and find me."

At the facility where this nurse was employed, it was not uncommon for an interpreter, after translating discharge information for the nurse, to proceed into the patient's room without the nurse and deliver the discharge information verbally to the patient and family and dismiss them from the unit. The same nurse quoted above explained the thought processes that informed her decisions to delegate to the interpreter to proceed with reviewing written instructions without the nurse being present:

> I don't always go with the interpreter on discharge. I might have the interpreter in the room when the doctor is in there, and we're going over the discharge instructions verbally. And then I'll tell them [the patients] before I leave that, "I'm going to write the instructions in Spanish. If you have questions" that sort of thing. You leave, I write them, then the interpreter, they go off and do their thing and give them [instructions] to them [the patients]. So I'm not always physically in the room for discharge instructions that are given in writing.

Although this nurse, as well as others from the same facility, emphasized to interpreters to locate the nurse should the patients have any questions while the interpreter reviewed discharge instructions with them, this practice was not consistently followed nor viewed as problematic by the nurses. These nurses described their working relationships with interpreters in their facility that spanned, in some cases, over 10 years. Developing comfortable working relationships led to the nurses having confidence in the interpreter's abilities with fielding questions from patients or family members during the

discharge portion of routine, non-emergent visits. As the nurse quoted above further indicated:

> There's one I've worked with for over 15 years, and I'll say, "Here's the instructions. It's for an ear infection. If you have any questions, let me know." 'Cause we've done it so many times that I'm confident that she understands the care, understands the discharge instructions you give. [Observation interview]

An interpreter's ability to provide accurate information was not always realized in nurses' accounts of these experiences. In fact, the practice of delegating to the interpreter the patient's discharge teaching often proved ineffective at promoting quality care and ensuring optimal patient outcomes. As the nurse quoted above admitted, "There <u>still</u> <u>is</u> the potential for misinformation on those instances." Although a few of the nurses from this facility indicated that they were present in the room while physicians verbally reviewed the discharge plan with patients and, thus, were able to field any questions patients might have had at that time, several of the nurses described their observations that misunderstandings did indeed occur when interpreters provided discharge teaching without the nurse being present, and that patients often returned to the ED with the same complaints because of the inaccurate or incomplete information they had received. When asked how nurses knew that return visits were solely attributable to the interpreter's provision of misinformation, nurses from one group interview replied:

> **Nurse 1:** I think that probably the only way that I know [laughs] is that the next day, the people come back and they say, "Well, this happened. And the interpreter said that if this happened I should come back." Or, "The interpreter said if the fever

didn't come down, then I needed to return."

Nurse 2: Yeah, we get lots of that. Return visits because . . . the fever comes back, and they've only had 2 doses of antibiotics. . . . And sometimes they just don't get all that information. So they return when they really didn't need to.

Although these nurses recognized their absence during the discharge encounter influenced the quality of the care provided to NES patients, only one of them described how, through reflection on his practice, he gained insights and changed his practice based on observations made during and after he had participated in the first group interview. This nurse described, during his second group interview, how he had begun to accompany interpreters more often during discharge encounters to verify accuracy and patient understanding, despite the ever-present concerns with time and the need to balance competing demands. In addition to ensuring patient understanding, the nurse relayed an additional benefit to being present for patients' questions during encounters in which he had previously thought his presence was unnecessary:

And the other reason why I've done that is a lot of times they have questions. And if the nurse isn't there to answer them, the interpreter will do their best to answer them. But most of the interpreters that we have don't really have a medical background. . . . And typically it's good advice, but it's not from a nursing professional. And so I've tried to be there a little more often and answer those same questions. And sometimes that can be the difference between a return visit and not having the person come back.

Lack of Interpreter Availability

Knowing that interpreters were scarce at times, nurses often proceeded without them. They made use of the Spanish they knew to get the gist of the patient's presentation and pertinent history, so that they could initiate patient care while minimizing their usage of interpretation services. In the absence of an interpreter, nurses with minimal Spanish abilities recalled instances in which they found themselves in a quandary given their desire to attend to patients' needs while realizing their limited ability to verbally communicate prevented them from understanding what those needs were. As one nurse stated, "If I don't have an interpreter with me, I find myself ignoring somebody that doesn't speak English, to do something that I can be useful at. This person's gonna have to wait, because I can't communicate with them." This same nurse recalled an incident in which a woman was brought to the ED and described his actions upon realizing the patient spoke no English:

> I walked in to do a triage, and this lady is in a wheelchair. And she's all covered up. She's got two blankets around her, and a hood on her. And she's kind of slumped over. Nobody spoke English. And I wheeled her into triage and just kind of left her there, and had to go do something else until I got an interpreter. And when we walked in there and uncovered her, this lady was very sick, had a very high fever.

The nurse described his feelings about being unable to initiate care and lamented the fact that the woman's care was put on hold until an interpreter became available:

> I felt real bad that this lady had to wait an extra 10 minutes to be seen. . . . This was on a weekend, and we were really swamped. And so it's kind of bad that you neglect

somebody just because you can't communicate with them.

Although his perceptual acuity enabled this nurse to notice certain aspects of the patient's presentation, the nurse lacked the ability to identify other possibilities in the environment that would have enabled him to intervene on the patient's behalf and initiate care. His practice reflected an inability to proceed with investigating the situation until he had an interpreter present and could verbally communicate with the patient.

Ignoring NES patients was not a strategy commonly identified by nurses in this study. However, the lack of available interpreters was verbalized as a major hindrance in nurses' practices, one that prevented them from establishing and sustaining concernful involvement with patients. The hectic and oftentimes unpredictable environment in the ED lessened the availability of interpreters, which in turn left nurses unable to promptly attend to patient needs and remain present with patients during their time of need.

Lack of Interpreter Presence and Consistency

Many of the nurses' narratives and observations of care encounters in this study reflected nurses' unquestioning confidence that interpretation services effectively met the communication needs of NES Latino patients and their family members during their ED visits. However, one nurse shared insights she had gained from listening to other nurses during a group interview as they discussed their observations that, despite the presence of an interpreter, NES Latino patients asked fewer questions than their English-speaking counterparts. The nurse reflected on her experiences of care episodes that involved her use of interpreters, and described her sudden, newfound awareness of how the manner in which nurses and staff in the ED routinely utilized interpretation services prevented NES patients from freely communicating their needs and concerns throughout their time in the

ED:

> When you think about it, we have an English-speaking patient that comes into triage, and they have every opportunity [to speak] from the moment they make contact with you, as things come and go through their minds. 'Cause you know how it is. You take your car to the mechanic and, of course, as you're driving away in it, after he's told you there's nothing wrong and it starts making the noise again, you think, "Oh yeah, I forgot to tell him it only does it when I do this!" [laughs] And it's the same sort of scenario when you take yourself or you talk to the doctor. Oftentimes all of a sudden we're asking them all these questions or interviewing them, but they can at any given time during that interaction present a question if it comes to them. And they're probably more comfortable doing so as well since the communication lines are a little bit easier to come by. Whereas when we have a Spanish-speaking patient, it's common for us non Spanish-speaking nurses, you call the person back. You identify the need for an interpreter. You call your interpreter back. You ask your barrage of questions via the interpreter. The interpreter, because . . . they are pretty high in demand, then leaves the room once you say, "Okay, I'm done with the interview process.". . . So I think we've, without really meaning to, probably really limited their opportunity to just freely communicate as they <u>think</u> of things.

In an effort to counter the lack of an interpreter's constant presence during patient care episodes, many nurses described efforts to use the same interpreter throughout the care episode whenever possible. As evidenced in the care of the baby who had been

burned, nurses found that consistency with the same interpreter enhanced the connection the nurse had established. Interpreter consistency also afforded the interpreter familiarity with the patient's situation, which, in turn, enhanced interpreter engagement and performance.

Discussion

According to the 2000 census, 24% of Latinos in the U.S. live in linguistically isolated households, that is, all members 14 years-old and older have at least some difficulty with the English language (U.S. Census Bureau, 2000a). Non-English-speaking Latino immigrants are faced with many challenges as they settle into the U.S. When ill, their lack of English proficiency may present to their receiving appropriate and timely health care.

Title VI of the Civil Rights Act of 1964 (DHHS—Office of Civil Rights, 1998) protects patients with limited English proficiency (LEP) from discriminatory practices based on their national origin. This protection extends to all LEP patients seeking health care from facilities funded by the U.S. Department of Health and Human Services. Four of the 14 culturally and linguistically appropriate services (CLAS) standards (DHHS-OMH, 2000) are mandates for language services that must be offered and provided to LEP individuals. Through its mandates, DHHS requires that providers take reasonable steps to overcome language barriers so that LEP individuals can participate in and benefit from health care services (DHHS-Office of Civil Rights, 1998; DHHS-OMH, 2000).

Nurses in this study often evaluated their Latino patients' fluency in English to determine the need for interpretation services. However, these encounters did not involve a formal protocol on which nurses based their decision to use or not use an interpreter.

Although nurses often determined that an interpreter's presence was not necessary, the subjectivity with which these decisions were made is of concern, especially given the potential for misinterpretation of the patient's linguistic abilities if they say "yes" or nod to all of the nurse's queries or comments. As indicated by the comments made by the nurse who related to his own experiences with being in a place where he did not speak the language, these acquiescing behaviors may indicate a lack of understanding. Enslein, Tripp-Reimer, Kelley, and McCarty (2002) provide a guide that not only assists nurses and other providers with assessing a patient's English proficiency, but offers guidelines to facilitate their use of interpretation services. However, these authors do not cite evidence of this tool having been tested for its utility in patient care settings. Further studies using these tools in nurse—NES patient encounters are warranted.

The use of professional medical interpreters is one strategy used by health care organizations to bridge the cultural and linguistic gaps between patients and providers. The importance of using interpreters when nurses not know the Spanish language has been discussed (Baldonado et al., 1998; Zoucha, 1998). However, just as previous research has described (Baldonado et al., 1998; Bollenbacher et al., 2000), and data from this study has revealed, a consistency in nurses' use of medically trained interpreters in patient care situations is lacking.

Nurse in this study were not always able to work with a medically trained interpreter either because: (a) the facility where they were employed did not have any, or (b) they were discouraged from using them if it meant calling them in, or (c) the interpreter was busy elsewhere in the hospital. As a result, nurses in this study often used bilingual ancillary staff who had not received any formal training as medical interpreters.

According to the guidelines presented in the CLAS standards (DHHS-OMH, 2000), "It is insufficient for health care organizations to use any apparently bilingual person for delivering language services. They must assess and ensure the training and competency of individuals who deliver such services. . . . Health care organizations should verify the completion, or arrange for, formal training in the techniques, ethics, and cross-cultural issues related to medical interpreting (a minimum of 40 hours is recommended) (p. 80875-80876). In addition to using ancillary staff who had not received formal interpreter training, some nurses in this study also used children or other English-speaking family members as interpreters in the care of NES patients. The practice of using family members, especially children, is discouraged in the CLAS standards (DHHS-OMH, 2000) due to issues with ensuring completeness, accuracy, impartiality, and confidentiality.

There are no nationally recognized standards for medical interpretation services, and varying definitions of the interpreter's role and responsibilities exist (Fortier, 1999; Riddick, 2000). The Massachusetts Medical Interpreters Association (1996) provides the following definition of interpreter role and responsibility: "The interpreter is committed to accurately and completely transmitting the content and spirit of the original message into the other language, without omitting, modifying, condensing, or adding" (p. 1). Although definitions may vary from state to state, ethical guidelines have emerged in various locales across the U.S. expressing similar core values of interpreter performance that include respect, confidentiality, and accuracy (Kaufert & Putsch, 1997).

Many studies have explored cultural and linguistic barriers to effective health care, and provide evidence that miscommunication between providers and NES patients

influences the quality and effectiveness of the health care encounter (David & Rhee, 1998; Ebden, Bhatt, Carey & Harrison, 1988; Erzinger, 1991; Hu & Covell, 1986; Perez-Stable, Napoles-Springer & Miramontes, 1997; Rodriguez, Bauer, Flores-Ortiz & Szkupinski-Quiroga, 1998). Investigators have examined the effectiveness of interpreters in health care delivery to Latino patients (Baker, Hayes & Fortier, 1998; Baker, Parker, Williams, Coates & Pitkin, 1996; Hatton, 1992), and Latino patient satisfaction with interpretation services (Kuo & Fagan, 1999). As was revealed in data from this study and others (Baker et al., 1996), using interpreters during patient encounters often results in patients leaving the encounter with a poor understanding of their illness and recommended treatment. Interpreter use has also been related to decreased patient satisfaction with interpersonal aspects of the patient-provider relationships, such as perceived provider friendliness, respect, and concern (Baker et al., 1998). Latino patients and providers have identified the importance of availability, accuracy, and confidentiality in interpretation services (Kuo & Fagan, 1999). Policy implications have been proposed for interpreter services that include mandatory training about the standards of healthcare interpretation and the complexity involved in securing confidentiality, objectivity, accuracy, proficiency, and cultural sensitivity "to safeguard the quality of interpretation" services (Tang, 1999, p. 28). Although there is agreement that "verbal communication is a primary, albeit essential, component of an effective clinical encounter" (Hornberger et al., 1996, p. 846), many of the studies reviewed for this research did not consider how nursing care, in particular, was influenced by linguistic differences.

As data in this study revealed, and as other research has demonstrated, limitations and challenges emerge for nurses when working with interpreters during patient care

encounters. Nurses and other health care providers have identified several areas of concern involving the use of interpreters in the clinical setting. These include confidentiality and accuracy (Enslein et al., 2002; Laws, Heckscher, Mayo, Li & Wilson, 2004), interpreter stance regarding comfort with content being relayed (Rothenburger, 1990), and being able to maintain a caring relationship with the patient (Kirkham, 1998). Establishing rapport and building trust with patients who were from cultural backgrounds different from the provider have been viewed as challenging, yet are requisite to establishing effective provider–patient relationships (Warda, 2000). Cultural skills discussed in the literature that might serve to improve quality of care provision to Latinos include training providers in the effective use of interpreters (Kirkham, 1998; Tang, 1999).

"Language is essential for obtaining an accurate and comprehensive patient and family assessment, formulating and implementing a treatment plan, determining the efficacy and acceptability of nursing care, and evaluating associated outcomes" (Villarruel et al., 1999, p. 262). The patient encounter is dependent upon accuracy in communication, and linguistic differences challenge nurses' abilities to provide culturally congruent, effective care. Nurses and NES Latino patients must have access to accurate communication through which concerns and information can be conveyed that fully addresses needs brought to clinical encounters. As nurse and Latino informant narratives in this study revealed, nurses were able to provide for the ongoing needs of their patients and family members as the clinical situation unfolded when avenues of communication were secured.

The nurses in this study revealed many issues, challenges, and concerns related to

their use of interpretation services and the effect it had on their efforts to provide quality care and establish and maintain meaningful connections with NES Latino patients and their families. Just as nurses noticed that English-speaking Latino patients were more apt to verbalize questions and concerns than did their NES counterparts, several nurses remarked how their ability to speak Spanish enhanced and encouraged their patients to communicate during their ED stay.

The discussion will now turn to the concerns and practices that emerged in relationship to the nurse's use of Spanish when caring for Latinos. It will highlight how nurses exhibited expertise in using Spanish as a means of comforting NES patients, and as a way to become involved and maintain a meaningful connection with patients and families.

Nurses' Use of Spanish as a Means of Connecting with Latino Patients

Nurses in this study unanimously viewed the ability to speak Spanish as a strength in their practice. Not only did the ability to speak Spanish afford nurses the opportunity to proceed with care without being concerned about the availability of an interpreters, it gave NES patients the opportunity to more freely communicate with the nurses. Nurses indicated that NES patients often asked more questions or offered more information once they discovered that the nurse spoke Spanish.

By virtue of working in care environments that serve a vast number of NES patients, some nurses described learning Spanish from exposure during patient encounters and from listening to and interacting with bilingual staff members. Others knew Spanish from living in or having been raised in a bilingual household, while others described taking formal language classes outside the work environment.

Many of the nurses in this study who knew some Spanish described how they often proceeded with assessing the patient without having an interpreter present; with a few nurses this entailed only the ability to ask routine questions in the triage or exam room. Using limited Spanish did not always prove fruitful, however, for the nurse or the patient, as was the case for one nurse who shared his experiences with attempting to speak Spanish during triage encounters:

> Our sheet that we go by in our triage room, I can ask all those questions in Spanish, and then they start explaining to you why they hurt, or when it started. They're trying to give you a history, and I don't understand a word they're saying.

Several nurses described the limits of their Spanish language abilities. For many nurses, understanding patients' responses diminished in direct relation to the rapidity with which Latino patients spoke. As another nurse stated, "And if they start talking in more than one sentence at a time, then I will stop them and say, 'Wait a minute. I think I better get an interpreter because I'm not understanding all of that.'" Some nurses became disheartened when they sensed their limited Spanish abilities caused additional discomfort to patients when they realized the nurse was unable to understand their responses to the nurse's queries. This sentiment was evidenced in the following nurse's comments:

> **Nurse:** They're sick. They want somebody to understand what's going on. And when you go in and you say a few words in Spanish, they think you know what you're saying. . . . And when they realize you don't, then it's just, "Well, get somebody in here that knows what I'm talking about!"

Int: How does that make you feel?

Nurse: I should know Spanish. Being born and raised in the valley, you know, I've been around it all my life. And I've not really picked that much of it up.

Nurses in this study described how they remained attuned to patient needs as well as their own limitations when they used the Spanish that they knew while providing care. Some nurses, despite being fairly fluent in Spanish, recalled care episodes in which they sought the assistance of interpreters when they felt their Spanish was not adequate for the patient situation. As one nurse stated:

> When something strikes me as they're [the patient] not really telling me everything, or I've missed something in there, even though I speak Spanish, what I will do is finish the triage and put a star there. Then I'll go get an interpreter, and I'll talk with the interpreter [and enlist their assistance in getting the rest of the story].

Several nurses in this study worked with bilingual and bicultural Latina nurses, and described how, when patient situations exceeded the nurse's Spanish or cultural knowledge, they relinquished patient care to a nurse more knowledgeable with the language and culture. A nurse who spoke Spanish described one particular patient situation during which she realized that her limited Spanish and cultural knowledge were not sufficient to meet the needs the situation demanded. The nurse recalled how a family presented to the ED with concerns that their teenaged child was possessed by evil spirits. The nurse described how she felt uneasy with her Spanish abilities during the triage assessment when she sensed there was more to the presentation than what she was able to glean. With an interpreter's assistance, the nurse realized the complexity of the situation

was beyond her capabilities in providing the family the nursing care they needed:

> It became very complicated to find out that . . . they literally believed that she was possessed. . . . So I went to get the interpreter to get the rest of the story. And it turned into one of those patients that's there for 6 hours, because a mental health evaluation then becomes part of the process. And then the pastor of their church came in. It was way over my Spanish ability.

The nurse described the loss she experienced in her nursing practice when her Spanish abilities fell short and she was unable to fully meet the particular needs the situation demanded:

> It's kind of like having your hands tied behind your back and you know there's more driving the problem, whether it's physical or mental or emotional. And all the nursing skill that you've acquired, or schooling or whatever, is not gonna help you because you can't talk on an equal level.

Nurses lamented their limited Spanish skills and the resultant delay in patient care when having to wait for an interpreter or a bilingual peer. Some nurses who were more knowledgeable and comfortable with their Spanish language abilities displayed confidence in their ability to proceed with, not just because they were able to speak some Spanish, but because they were also comfortable with their ability to determine the urgency and acuity of the patient's presentation through visual assessment. As one nurse stated:

> I wouldn't say there's a delay in care because as nurses we can look at the patient.

> We can do our ABCs. There's certainly the question asking: "Now, what did the child take? When did you give the child Motrin? Did you give Tylenol? Did you give a Mexican med?"

Nurses in this study who knew some Spanish were more likely to proceed with patient care without an interpreter, especially if the patient presented with a fairly benign complaint, such as a runny nose or an ear infection. Even with Spanish abilities, however, nurses' decisions to involve an interpreter were heavily influenced by the availability of this resource, as evidenced by the following nurse's comments:

> If they [interpreters] are directly available, I'll take them with me. And if they're not, then the doctor's gonna get an interpreter anyway. I don't like that they would have to wait. Where, my Spanish is <u>enough</u> and the triage note was enough that I could bring them back [bring patient to an exam room and initiate care]. [Observation interview]

Although many of the nurses in this study claimed to know some Spanish, they varied in their ability and in their confidence with applying their Spanish during patient care situations. Like using non-verbal gestures and feeling silly or self-conscious, several nurses who knew very little Spanish described inadequacies with their abilities and, therefore, avoided these interactions.

Nurses in this study provided many accounts of patient encounters in which nurses used their Spanish abilities. However, only one nurse described a patient situation in which the nurse's use of Spanish enabled a deep and meaningful connection between the nurse and patient that was sustained throughout the care episode. A paradigm case

illustrating this connection will now be presented.

Paradigm Case: Establishing and Maintaining a Patient Connection—A Nurse's Skillful Practices in the Use Spanish

This is an account about a patient situation that was most memorable for a nurse in this study who had less than one year of experience in the ED. The nurse's narrative of the care encounter illustrates expertise in the nurse's use of Spanish as a means of developing and maintaining concernful involvement with a patient who was brought to the ED after sustaining a severe, traumatic back injury as a result of a car accident.

Establishing the Connection

The nurse's attunement to the patient's critical condition and subsequent needs was established immediately after family had dropped the patient off at the ED and left. The nurse's narrative of the experience illustrates how observations of the patient's verbal and non-verbal behaviors solicited the nurse's concern and influenced the nurse's actions from the moment he first encountered the patient.

> When we got him out of the car, he was really scared. And he just kept continually saying, "I can't feel my legs," and I felt like he needed some comforting. And so that was something that I was able to provide by speaking Spanish to him. 'Cause there were all these people speaking English to him, and that seemed to make him more confused and more scared.

The nurse's knowledge of Spanish, and his concernful stance and attunement to the patient's behavior after getting him out of the car enabled the nurse's immediate grasp of the gestalt of the patient's serious condition and the worsening effects that those who were speaking English had on the patient's emotional stability and well-being. By paying

attention to the patient's verbal and non-verbal behaviors as the patient was being brought into the ED, the nurse intuitively knew to communicate with the patient only in Spanish and recognized that speaking Spanish helped to calm his escalating fears and anxiety about the accident and was happening to him in the ED. The nurse recalled how, since family members did not stay and provide the patient with any support, "It was he and I basically for the first hour, and then finally his wife and his baby showed up." Knowing the patient was alone to endure the diagnostic work-up and treatment interventions, the nurse described how he maintained his presence with the patient as he was rushed to an exam room. In an effort to comfort and calm the patient, the nurse continued to speak in Spanish, and even acted as an interpreter during the physician's assessment:

> When he first came in, the interpreter was busy with something else, so I kind of did my best to interpret for the doctor as he did his assessment. And I kind of made it a point to call him by his first name, 'cause I knew that he was going to need somebody to lean on.

Maintaining a watchful presence.

The nurse described cues in the patient's nonverbal behaviors that alerted him to the patient's needs for particularized measures of support and presence: "You could just see it in his eyes. He could tell that something was not right. And he was scared. And he kept saying over and over, 'I can't feel my legs. I can't feel my legs.'" The nurse's experiences with caring for other patients with similar injuries and his knowledge about back injuries and their sequelae, including the inability to feel or move one's legs, alerted

the nurse to the need to attend to the patient's immediate fears and concerns about the symptoms he was experiencing. The nurse recalled how he explained to the patient the reasons for his symptoms in an effort to calm the patient's anxiety and despite the nurse's slight misgivings about his Spanish abilities. "Even though I don't speak fluently . . . I was able to kind of explain the basics of what had happened to him, and why he couldn't feel his legs."

The nurse further described how he maintained a constant presence at the patient's bedside once the patient was settled into an room. He strove to secure a calm atmosphere in the midst of the flurry of activity with many staff persons performing diagnostic procedures and assessments as efforts were underway to stabilize the patient before transferring him to a regional trauma center. The nurse described behaviors displayed by the patient that informed the nurse's sense of the connection that had been established between himself and the patient. Cues from the patient's demeanor that alerted the nurse to the patient's reliance upon the nurse's continued presence and support, and the trust that the patient held in the nurse's concernful care, are evidenced in the following comments made by the nurse:

> He would look around in the room for me if there were multiple people in the room, the doctor, the lab tech, or whatever. He would look around specifically to see if I was there. And when I introduced myself, I told him my name. And he actually would call me by my first name if he needed something. . . . And his facial expressions, I guess, were a cue also. And his speech seemed to slow down and became more clear as he became more comfortable. . . . But when people would come in and speak English to him, it seemed to kind of start all over again. His . . .

> not panic, but the way that he felt. I don't know how to describe it. It wasn't a panic, but he just seemed more comfortable obviously when you spoke to him in his language.

As was the case in the previously presented paradigm cases of expertise in nurses' care derived from analysis of data from this study, this nurse's careful watching and reading of nuances in patient demeanor and activities in the care environment informed his actions to remain present and to continue to offer reassurance and comfort measures.

Maintaining the Connection

The nurse's engaged presence in the patient situation and his concern in maintaining the patient's comfort level prompted him to manipulate the environment and coordinate with the charge nurse on a fairly busy night not to be assigned other patients while he was attending to this patient's needs. The nurse described how providing the one-on-one attention to the patient helped to calm the patient and further develop the relationship between them:

> And I think [pause] he seemed to calm down more as things went on. We kind of talked more about, not just his medical condition, but about general social things. Where he worked, what his family structure was. And I kind of tried to divert his attention from this horrible thing that had happened, kind of as a comfort measure to take his mind off of it. And I think he seemed to calm down more and you could tell that he felt more comfortable when I was in the room with him. So, in fact, that was the only patient that I ended up taking just because I felt like he needed somebody there pretty much the whole time until his family arrived.

The nurse's narrative revealed how he was immediately drawn into and became emotionally and physically invested in the patient situation, and his concerns focused on providing the patient comfort and compassionate care. The nurse stayed in the patient's room even after all of the diagnostic tests had been performed, and continued to converse in Spanish to provide the patient reassurance, support, and presence. By maintaining a concernful presence, the nurse and patient developed a bond that the nurse sensed was deep and meaningful to both him and the patient. The nurse described the relationship that developed as a result of the time he and the patient had spent together:

> I felt like we were just a couple of buddies, that we'd known each other for a long time. We seemed to talk freely about the issue at hand and also just kind of general life. And I think that had people seen us they probably would have thought that I knew him previously and that he just happened to come into my emergency department, and I just happened to be caring for him.

From the start of the patient's care, the nurse realized the implications of the patient's serious injuries, and his concernful involvement extended to how the injuries affected the patient's past, present and future. The nurse came to know the patient (Tanner et al., 1993) as more than someone who had incurred a serious back injury. The conversations with the patient, coupled with the nurse's background knowledge and understanding of Latino cultures and family values, enhanced his awareness of and ability to see the patient as a husband, a new father, and a hard-working man whose main concerns centered on providing for his family. Knowing the patient in this way made the clinical situation stand out for the nurse in a particular way:

> The case kind of stood out in my mind, because he was a Spanish-speaking only gentleman. And just because of the way that Latino families are set up . . . I think it touched me more than it would have had it been a Caucasian family. This dad was working very, very long hours in the fields to support [his family]. He just did have a new baby. . . . And he described his fears that he wouldn't be able to take care of his family now, because this had happened. And he was really concerned about the well-being of his family, even more so than how it was going to affect himself. And I think that's typical of Latino families. They have a very, very strong bond with one another.

The nurse's concernful stance and knowledge of Latino cultures enabled his openness to nuances in the patient's demeanor that solicited his actions in providing particularized care through remaining physically and emotionally available to the patient in his distress. The nurse described the significance that the relationship he had established with the patient had on his nursing practice, and how sustaining his involved presence served to foster the bond that he felt with the patient:

> I think that it was gratifying to me to be able to be a fairly big part of this man's life, even though it was only for a couple of hours. . . . Just to be able to provide him with some level of support in this huge crisis time for him was gratifying for me. . . . But I think that that was a case where I formed a pretty good bond with the patient. And that's not something that we're always able to do. Because of time restraints, or if the patient's too critical, then we have to focus more on life–saving measures than we need to form that bond. But I felt like he was stable enough that we could really bond

to one another, and I could give him some support.

Communicating Compassion and Concern

The nurse's account of this experience reflected his awareness of the contextual embeddedness of his ability to form a deep and meaningful connection with the patient. Rather than maintaining a distanced and clinical stance that regarded the patient as a damaged body, the nurse approached the patient and interacted with the patient as a person. The nurse's demeanor throughout the care encounter enabled him to sustain the connection that had been formed and enhanced the nurse's ability to convey compassionate care and comfort. Indeed, as has been found in previous studies of expertise in nursing practice, "Connection and the development of a relationship with another person set up the possibility of comforting. Whether in the midst of a crisis or not, meeting the patient and family as persons presents the ethical demand to respond to the other person's suffering" (Benner, et al., 1999, p. 258).

The nurse's narrative reflected how he responded to the patient's particular needs by reading the situation in a skillful manner and orienting his stance and actions according to the patient's responses. Cues from the patient influenced the nurse's decisions to continue speaking Spanish throughout the care encounter, and he recalled how remaining attuned to the patient's particularized needs and following the patient's lead in using Spanish actually enhanced the concernful involvement the nurse was able to develop and sustain in the patient's care:

> I think that case was one where I didn't attempt to even speak any English. He came out of the car speaking Spanish, and so I just immediately went into what I thought would be the best way to communicate with him. . . . And even after things had

> calmed down, and he was more relaxed, and I was more relaxed, I never really attempted to speak English to him. And I guess that's because our initial bond had been formed in Spanish.

Unlike other nurses in this study, who knew some Spanish but who often assessed patient's English language abilities first to determine if Spanish was indeed necessary, a large part of this nurse's concernful stance and ability to form the meaningful bond with the patient centered on his use of Spanish throughout the patient's stay in the ED. The nurse described the impact that using Spanish throughout the care episode had on the connection he and the patient had developed:

> I think that had I not been able to speak with him that way, not only would we have not formed a bond, but I don't know if things would have gone as well as they did, because he was definitely in a panic state when he got there. And I think that had I not been able to comfort him that way, by being able to communicate just what he was feeling and explain why he was feeling that way to him, I think things would have escalated, and it would have become more and more difficult to be able to communicate with him. Definitely. So yes, I think that that was a key in forming a bond in my relationship with him because I could speak with him.

Cultural Congruence of Nurses' Use of Spanish in the Care of Latino Patients

Nurses' efforts at speaking Spanish were noticed and appreciated by Latino patients and family members who were interviewed in this study, especially those patients who spoke no English. As one NES Latino informant indicated, "I felt comfortable, especially because she spoke my language, Spanish. Since I don't know any English, for me, that

was fine." Latino informant narratives revealed that patients also appreciated nurses' efforts with speaking Spanish, despite a lack of fluency with the language. As another Latino informant indicated:

> Well, the nurse, from the moment that she called us back, behaved very nicely with our son and with us as well. The nurse tried to talk to us in Spanish so we could understand her. And even though you could see that she did not speak Spanish, she tried to speak to us. And with the boy as well.

Nurses who knew very little Spanish made small attempts at inserting the Spanish they knew into conversations with patients and family members as friendly gestures that nurses felt helped to personalize care, decrease anxiety, and promote comfort in the unfamiliar and frightening environment. Nurses barely versed in Spanish used such words as "hola," [hello] "gracias," [thank you] and "adios" [good-bye] with ease, even in situations when the majority of the communication during the care episode was relayed through an interpreter. As evidenced by Latino informant narratives, these efforts were noticed and appreciated.

In some care encounters, bilingual nurses used both English and Spanish when the patient or family members present were bilingual. As discussed in the literature, Latino immigrants often experience transitions within the family "from Spanish to English language usage with each successive generation in the United States," and most often the children learn English sooner than their parents (Hurtado, 1995, p. 51). During care encounters where the patient and family had mixed language needs, bilingual nurses usually spoke English to children who were present—whether they were the patients or

accompanying a family member who was being seen—then addressed the adult patient or parent(s) in Spanish.

In one particular episode, the nurse was caring for a young boy who was accompanied to the ED by his NES mother. The nurse moved easily between the two languages, talking to the boy in English as he palpated and listened to his abdomen, then turning and speaking in Spanish to the mother, who sat behind the nurse, to communicate his findings and to seek additional information from her in Spanish. The nurse remained engaged with both the patient and the boy's mother during the care episode, and their replies to his questions in English and Spanish respectively indicated their involvement and understanding. When asked his rationale for using both languages, the nurse replied, "To keep the mom involved. Like when I was taking his vital signs and listening to his stomach, I spoke to her in Spanish so that she would be involved in knowing that what I was finding was normal." [Observation interview] Although in an interview following the care encounter the mother verbalized some misgivings about the nurse's comprehension of the Spanish language, her overall impression of the nurse's communication was positive, as indicated in the following comments that she made:

> I think he just talked it, but he probably doesn't understand it very well. It was okay, also with this nurse, because other nurses, in reality, don't talk any Spanish. . . . We understood each other a little bit. That is what's important.

As evidenced in the informant's comments above, despite the nurse's lack of fluency with Spanish, the woman felt that her concerns were understood by the nurse based on his Spanish skills. She appreciated the nurse's use of Spanish, considering that in her

experience not many nurses did.

Allaying Patient and Family Anxiety Through the Nurse's use of Spanish

Latino informants' narratives revealed how parents and family members were concerned and often fearful and anxious when their loved one was being cared for in the ED, especially when the patient was an infant or young child. The data from this study indicates that in such situations, a nurse's use of Spanish not only helped to allay parents' anxieties, but also helped to calm the child who was being seen. The following quote exemplifies the sentiments expressed in several interviews with NES parents about their appreciation for the nurse's ability to speak Spanish, how the nurse's use of Spanish made them feel about the nurse's care, and the overall influence that the nurse's use of Spanish had on their experiences in the ED:

> When he [the nurse] entered the room, he took his [the child's] temperature, and my son started to cry. I felt sad, as a mother, knowing that my son was crying. The nurse spoke Spanish. I felt confident talking in Spanish. Even though some words weren't spoken very well by the nurse, I could comprehend, and I felt confident. I felt confident that I could continue speaking in Spanish. They were very welcoming with my son and patient with him. I felt good.

The parent's anxiety about having a sick child and being in the ED was reduced by the nurse's ability to converse with her in her preferred language. This parent sensed the nurse's concern and care for her child, and the nurse's use of Spanish—albeit not consistently fluent—put her and the child at ease in what is often an anxiety-provoking situation.

One of the nurses in this study whose practice was observed lamented her lack of Spanish abilities and indicated that she preferred that at least one parent speak English during clinical situations in which a child is being seen in the ED. This nurse described how her lack of Spanish abilities influenced the care she was able to provide to anxious and concerned parents, specifically in relation to the comfort and reassurance she would be able to offer them if they spoke English. She stated, "Because I can offer them a lot more support. And I can hear her feelings of, 'I'm worried. I'm scared.' And be able to just say, without having to . . . run and grab an interpreter. I can talk with her. [Observation interview]

Enhancers and Barriers to Connecting with Latino Patients Through the use of Spanish

Nurses in this study described facets of the work environment that enhanced or became barriers to their abilities with connecting with patients through the nurse's use of Spanish. Encouragement received from patients and coworkers served to enhance nurses' use of Spanish in forming connections with patients during care encounters. Obstacles to a nurse's ability to connect with patients through the use of Spanish included: (a) the nurse's limited skills with the language, (b) discouragement received from co-workers, and (c) a lack of administrative resources that would have provided nurses with opportunities to learn the language.

Encouragement of Nurses' use of Spanish

A few nurses in this study who were less versed in Spanish described how valuable interpreters were as resources in the work place for nurses who wanted to learn the Spanish language. Nurses' narratives revealed how nurses often turned to interpreters to find out how to say certain words or phrases in Spanish. As one nurse indicated:

> I'm always asking them, "How do you say this? How do you say that?" And asking it multiple times. I've asked I don't know how many times until I've finally remembered how you say, 'Take off your clothes' or, "Open your mouth, lift your tongue, and close your mouth." [Observation interview]

Another nurse described how interpreters in her work environment, and other bilingual staff such as registration personnel, had nurtured her abilities as a new nurse. Not only did co-workers offer assistance with the nurse's developing linguistic skills, they also provided the nurse with valuable cultural insights to help her avoid social faux pas that could result in misunderstandings and embarrassment. The nurse described how co-workers in her work environment fostered her personal and professional growth:

> It certainly has been a healthy environment for me as a new nurse and new to a predominantly Hispanic patient base. And it's been a very nurturing environment for working with a group of people with a language barrier for me, and a lot of different cultural variances. I've had people there to explain to me, to help me to learn the Spanish. To tell me, "Oh no, don't say that! Because if you look in the dictionary, yes, it looks like that, but what you really said is this!" [laughs] And little things like that. I wasn't just hung out there to dry . . . which is good. [laughs]

This same nurse further described differences in patients' behaviors and interactions with her once patients became aware of her ability to speak some Spanish. In particular, she described how patients made more effort toward communicating with her, and would often try to teach her words in Spanish when they discovered that she was trying to learn the language. She continued:

> And some of the more easy-going patients . . . they'll have fun with that. And I notice that then they will pop their head out of the room, or they will address me, and ask me [questions]. And when I look back, they will break it down into very simple one or two words at a time, and point things out and such. They will make more of an effort then to communicate with me.

Several nurses in this study sensed the appreciation they felt from NES patients and families as a result of the nurse's use of Spanish, even when the Spanish was not eloquent or fluent. One of the nurses, in particular, indicated how responses she often received from Latino patients and families encouraged her continued attempts, despite her own awareness of her limitations with the language:

> And they appreciate it . . . and I probably do sound dumb. But I haven't had one look at me like, "You're dumb." [laughs] 'Cause I'll fumble, and I'll say, "Oh, mi Español is muy mal" [My Spanish is very bad]. And they say, "Oh no, no, no!" And they smile, and they say, "Thank you." [Observation interview]

Nurses' Lack of Spanish Skills

All of the nurses in the study recalled many care episodes in which they sought the assistance of interpreters or bilingual peers when their Spanish was not adequate for a given patient situation. One nurse's description of frustrations she experienced with her limited Spanish abilities reflected sentiments expressed by several other nurses in the study:

> Sometimes it's frustrating, especially when you have a concerned parent or patient

> . . . and I'm not getting what they're saying, but their body language indicates to me that this is not a matter where we can stand here in the room and play charades about it. Then I get frustrated with myself that, oh gosh. I wish I just knew what that was!

Several nurses in this study described how, when patient situations exceeded their Spanish language abilities, they sometimes had to relinquish patient care to a bilingual nurse because of a lack of readily available interpreters. Nurses described a sense of loss to their practice when they had to transfer a patient's care to a bilingual peer and let go of the connection they had begun to establish with the patient and family. One of the nurses with limited Spanish abilities described a particular situation in which she relinquished care to a bilingual coworker who lacked the compassion and empathy the nurse felt the situation required and that the nurse desired on behalf of the patient's rather complicated situation. The nurse recalled the sense of loss to her practice that resulted from her inability to remain involved and engaged in the patient's care because of her lack of Spanish:

> I <u>really</u> wanted to stay in and help that girl and help that family. I wanted to be their nurse. And I had to step back and say, "They <u>need</u> somebody who understands and speaks <u>better</u> Spanish than I do." Even though I know the gist of what's going on, I couldn't stay and be the interpreter and the nurse, and <u>be the RN</u> that linked them in to their health care, or their <u>spiritual</u> care. I didn't have enough Spanish, and it felt like I had my hands tied behind my back.

Relinquishing care came at a price, however. Nurses voiced concerns with the negative attitudes held by their peers about Spanish-speaking patients and families. As

the same nurse quoted above indicated:

> And sometimes the nurses who are truly bilingual, one of them in particular, [pause] doesn't go an extra mile or put in some extra caring because she is of the feeling that these people need to learn to speak English. And that's the way it is.

Negative attitudes by nurses' bilingual peers were manifested in actions that displayed a less-than-caring manner and blatantly disregarded the linguistic needs that patient situations required. The nurse involved in the situation described above recalled a particular episode in which she had provided care to a child and then asked a bilingual peer to assist her with providing discharge instructions to the child's NES mother. The nurse described the actions of her peer that first alerted her to the negative attitudes held by this bilingual nurse:

> When she came in with the medication and discharge instructions, she started speaking English to the mother. And I said, "In Español."[in Spanish]. And instead of continuing talking to the mom about the necessity for the antibiotics, she turned to the girl who had had her hand sutured up, who was 10 years old, and gave her the instructions in English. And walked out of the room. And I don't think she even knows how that comes across. . . . And, you know, I agree with [pause] the statement that it's a benefit for them to speak English. Still, when you're in the hospital, I highly believe that if you're getting health care, in order to remember it and have it be the best health care, you probably should get it in a language that you would understand and are the most comfortable with. They say that patients don't really remember everything you tell them anyway.

Nurses' narratives revealed genuine concern for meeting patients' linguistic needs; in doing so, however, nurses often learned from negative role models in their work environments. Nurses in this study verbalized outrage at these coworkers' blatant lack of empathy and sensitivity to patient diversity as well as disregard for the moral and ethical obligation to provide nursing care that maintains the dignity of NES Latino patients and families. In response to the nurse's comments presented above and his own experiences working with bilingual nurses who held such views, one nurse stated:

> I don't think the ER's a place that a nurse or anybody should be teaching anybody a lesson. You know, your job is to go there and to help the patient there. Whatever they [Latino patients] do when they walk out the door is their business. And your [nurses'] business I think, is not if they [Latino patients] learn English or not. . . . That's too bad that that nurse has that type of an attitude or has that type of an outlook on things at her workplace. Because I mean, it goes deeper than just, "You're in the United States now, and you need to speak English." It's far deeper than that.

Discouragement of Nurses' use of Spanish

Nurses in this study reported their experiences working with those who supported and encouraged their Spanish abilities as well as those who discouraged their use of Spanish during patient care situations. One nurse who was fairly fluent in Spanish shared observations from his many experiences with interpreters who looked with disdain on his use of Spanish:

> I think part of the reason with that is that they feel like that's their job. And if they're

not doing it, then they kind of feel, not that you're stepping on their toes, but they're almost kind of insulted like, "Well, why am I here if I don't need to do the interpreting?" [Observation interview]

Lack of Administrative Resources for Nurses' Use of Spanish

A few nurses in this study verbalized their desire to learn Spanish and indicated that hospital administrators could do more, such as offering classes, to support and encourage nurses in this endeavor. Nurses emphasized that educational opportunities offered in their places of employment would be valuable strategies that could to improve care provided to Latino patients in the ED. As one nurse indicated, "I wish that the organization I work for would put its money where its mouth is and do some staff development to deal with cultural issues." This nurse further described the benefit that such education would provide to her practice in the ED: "I would like to continue learning to communicate effectively in Spanish. . . . I realize there's some resistance, but for people who are interested, willing, and motivated to learn, there should be a system for the encouragement from the hospital."

Nurses readily admitted that not all nurses they worked with shared their enthusiasm for learning to speak Spanish. The nurses in this study who discussed the desire to learn the language also indicated interest in learning more about Latino cultural beliefs and behaviors, realizing the positive effects this knowledge would have on their nursing abilities in the ED. As one of these nurses indicated, "Some general language and cultural studies would go a long way in being able to help bridge that gap." This nurse further described the impact that such learning opportunities would have on broadening nurses' understanding of cultural lifeways and on their abilities to provide culturally appropriate

care:

> Well, I think just in the 3 years working in an ER that had a tremendous amount of Hispanic employees as well as patients, I've learned a lot just from the exposure, about some of the cultural differences. And that certainly has an effect on nursing. I know now to make sure that I point out fever measures, things that are going to be helpful and things that are not. What kinds of foods and things to give to the person with the stomach upset, early signs of worsening. Those kinds of things that I realize need to be driven home.

Discussion

Language differences add another dimension to a potential for lack of cultural understanding and challenges in establishing trust during nurse—patient encounters (Villarruel & Leininger, 1995). Learning the languages used by other cultural groups has been cited as an area of knowledge development that could improve the practices of nurses and other health care providers (Austin et al., 1999). Mexican-Americans' perspectives of culturally competent care reveal that bilingual abilities of health care providers significantly improve the quality of interactions as well as patient satisfaction (Warda, 2000). As data in this study revealed and other research has demonstrated, Latino patients appreciate nurses using Spanish and are satisfied with such interactions during care encounters (Warda, 2000). In this and other studies (Zoucha, 1998), even feeble attempts at speaking Spanish are perceived as caring, and nurses have described their lack of Spanish language fluency as disadvantageous to their practice (Bollenbacher et al., 2000).

Certain facets of the work environments of nurses in this study included enhancers

and barriers to their concernful involvement and connection during care encounters with NES patients. Nurses with limited Spanish abilities reported often relying on others in the care environment to assist them with conveying compassionate care. However, as evidenced in the nurses' narratives, negative attitudes and beliefs about Latinos held by peers and co-workers often prevented this from happening.

Unfortunately, stereotypes about cultural minority groups, including Latinos, are perpetuated in the U.S. and deeply influence attitudes and perceptions about ethnically diverse populations (Erkel, 1985a; Erkel, 1985b; Rodriguez et al., 1998). Negative stereotypes of Latinos have existed for many years in this country (Gutiérrez, 1996; Reisler, 1996; Toro-Morn, 1998), and are perpetuated by the media (Reisler, 1996; Rodriguez et al., 1998). Those stereotypes have resulted in discriminatory practices that, unfortunately, have extended into the health care arena (Erkel, 1985a; Erkel, 1985b; Mukamel, Murthy & Weimer, 2000). Research has demonstrated that nurses and other health care providers have made inaccurate assumptions about patients based on skin color or linguistic ability, which has influenced the quality of care they provided (Hartog & Hartog, 1983; Jarvis, 1998). As evidenced in this study, negative attitudes about Latinos held by nurses and other patient care providers in the ED greatly influenced the quality of patient interactions and outcomes.

Summary

This chapter discussed nurses' concerns and practices while caring for Latino patients in the presence of a language barrier. Selected exemplars presented in this chapter demonstrated the contextual embeddedness of nurses' concerns and caring practices as they strove to overcome the language barrier, and practices that nurses

developed to transcend the barrier and provide comfort, empathy, and compassionate care to NES Latino patients and families were illustrated. Paradigm cases provided thick descriptions of nurses' concernful engagement during care encounters using interpreters and their own Spanish-speaking skills. These cases illustrated the situated meanings ascribed to nurses' thoughts and actions and the knowledge embodied by nurses who practiced in an expert manner in the ED with this patient group. Facets of nurses' work environments were also identified as enhancers or barriers to nurses' abilities to establish and maintain meaningful connections with patients in the face of a language barrier. Analysis of nurses' narratives revealed that nurses not only connected with patients under such circumstances, but also established connections with family members present during patient care episodes. The paradigm cases presented in this chapter illustrated how nurses recognized the importance of family to the patient's well-being, and were attuned to how the illness episode affected both the patient and the family unit.

In the next chapter, nurses' concerns related to the presence of family in the ED will be described. Emphasis will be placed in particular on illustrating the ways that a nurse's background understanding about the value of family within the Latino patient's cultural context directed his/her intentional actions toward involving family in the patient's care.

CHAPTER VI

FINDINGS AND DISCUSSION: FAMILY PRESENCE AND INVOLVEMENT IN THE CARE OF LATINO PATIENTS IN THE EMERGENCY DEPARTMENT

In this chapter, nurses' concerns and practices related to family presence and involvement in the care of Latinos will be explicated and described. Concerns embedded in the care given to Latino patients by expert nurses—in particular, concerns that directed intentional actions toward advocating family presence and accommodating family involvement—will be illustrated in the following discussion through paradigm cases and exemplars. The discussion will highlight the background understanding nurses have of family in Latino cultures and how their understanding influenced the meanings they attributed to the presence and involvement of family in the care of Latino patients. Narratives from Latino informants will provide verification of the cultural congruence of family involvement in patient care. Facets of the care environment will be identified as enhancers of or barriers to providing care that is sensitive to the concerns brought to the ED by Latino patients, as well as their need for family involvement.

Nurses' Background Understandings of Latino Families

Nurses bring to their practice unique perspectives and significant background knowledge that influences the way they provide care to patients and their families. The nurses in this study described a variety of means by which they developed a knowledge base that informed their background understandings of Latino families. All of the nurses lived in ethnically diverse communities and had many experiences caring for Latino patients in the ED and interacting with their family members. Several nurses described their participation in individual classes, courses of study or cultural immersion

experiences from which they learned about the value placed on family in Latino cultures. Four of the nurses were Latina/o, and one was an Anglo nurse who had married into a Latino family. All of the nurses in this study acknowledged having at least a basic understanding of the supportive network that family provided to the majority of Latino patients.

Family as Supportive Network for Latino Patients

Support for Daily Living Needs

As was revealed by or expressed in nurses' narratives, the meanings that nurses attributed to family focused on the supportive networks they provided that enhanced the patient's well-being. Many of the nurses in this study acknowledged the reliance of Latinos on cooperative family relationships involving interhousehold and intrahousehold efforts to meet the needs of individuals and families and were sensitive to the importance that such support networks held for Latino patients. The following nurse's comments capture the essence of how several nurses in this study understood the structure and importance placed on family within Latino cultures:

> I've found that Latino families are very close knit. . . . Many, many times you have multiple families—uncles, aunts, grandparents—all living together. . . . And I've actually seen a lot of cases where the mom and dad work and the other family members—the grandfather or grandmother—will watch the children, 'cause a lot of the families have young children. But there's a really close bond between extended family, I think more so than Caucasian culture. . . . And part of that, I think, is because they have to rely on one another for things like babysitting, or even things such as housing and income. They rely on their extended family more than, I think,

we do.

As evidenced by the nurse's comments above, the value of maintaining close kinships results in an expansive network for emotional and financial support in many Latino families.

Support for Health Needs

In addition to supporting each other with daily living and sustenance needs, nurses also described how Latino patients relied on family members—especially parents—for health-related information long into adulthood. One nurse remarked how this differed from her experiences with Anglo patients:

> A Caucasian person, typically, they don't turn to their mom and say, "Mom, I have a headache, what should I do?" Or, they're not gonna say that they did that. Where, when I speak with the Latino population, they'll say, "Well, my mom told me to do this."

Nurses in this study described how it was not out of the ordinary for a Latino adult to present to the ED accompanied by a parent or a member of their extended family, as is illustrated by the following comment from the nurse previously quoted: "I hear people say, when, like a 21 year-old boy comes in, and he's got his mom, 'Oh, he's a mommy's boy.' But when a 21 year-old Hispanic man comes in with his mom, that's the norm."

Most of the nurses in this study acknowledged the concern family members held for their loved one and the family's desire to be a supportive presence for them when they were ill. As evidenced by the following dialogue from a group interview, nurses also recognize that Latino patients *want* their family members with them during their stay in

the ED:

Nurse 1: Well, within the Hispanic community it seems like, more often than with some of the Caucasian patients and families we have in this general area, there are large families with numerous people that all want to be very involved in the care.

Nurse 2: And they all want to be in the room. And the patient wants them all there!

Nurse 1: You could end up with a dozen people in this little tiny space!

Nurse 3: And more people still waiting in the waiting room to come back.

Nurse 2: And outside.

Communication networks often result in members of the patient's immediate and extended family congregating in the ED, concerned and asking about their loved one often before the patient had even arrived. One nurse shared her observations of this phenomenon, which was also discussed by several other nurses in the study:

I've had a situation where we had a large group of family gathering in a room before an ambulance even got there. . . . I haven't even heard yet that we're getting an ambulance, and somebody is suddenly in the back of the ER saying, "Where's my mom? Where's my brother? My sister? My daughter? They called me, and said the ambulance was bringing them here." And I'm like, okay, I don't know anything. But now all of a sudden there's two people asking, and then five people asking, and then six people asking.

Nurses' Concerns with Family Presence and Involvement

Nurses discussed concerns about family members' desire to be involved in the care of their loved one and to be kept informed of the patient's condition, treatment plan, and

prognosis. As revealed through analysis and interpretation of nurses' narratives and observations of care encounters, nurses' concerns regarding family presence centered around: (a) the need to maintain order in the care environment, (b) the family's emotional reactions to patient situations, and (c) the family's stance that indicated their level of comfort with their surroundings. Each of these areas of concern that focused nurses' attention and influenced their actions will be briefly discussed.

Maintaining Order in the Care Environment

Awareness of the cultural importance of family notwithstanding, nurses varied in how they perceived the importance of family members being present in the ED, especially when the ED is very busy or the patient is brought in with a critical illness or injury. In an oftentimes chaotic environment, the nurses in this study placed attending to family needs low on their priority list, since immediate concerns revolved around stabilizing their patients and orchestrating care for several patients simultaneously. Several nurses in the study described concerns with directing large numbers of family and maintaining order in the ED. Amidst an already frenzied environment in which situations change and become more hectic with little or no warning, maintaining some degree of control is necessary—not only for practical reasons, such as space limitations, but also for keeping all who are present safe in an environment fraught with unpredictability. Some nurses in the study, however, remained attuned to the need for family to be present to support the patient, despite patient acuity and other activity in the unit. Sensitivity to the presence of family often comes from feelings of deep concern that the nurse has for his or her own family. The following quote is from a nurse who advocated family presence and disagreed with practices to control it:

> I've only been an ER nurse for 2½ years, but I think the family's place is with the patients in the room. And I'm not a . . . one-family-member-per-patient person. That's not the background I came from. . . . And who am I to say mom can come back, but dad can't, dad and mom can come back, but grandma can't? I'm a grandma. I want to go back.

Family's Emotional Reactions to Patient Situations

In addition to the cultural distinctiveness of having large numbers of Latino family members accompanying patients to the ED, nurses in this study described attributes unique to Latino families in relation to how they demonstrate emotional reactions during patient care episodes. Nurses acknowledged that emotions run high among Latino patients and family members present in the ED, and that it was not unusual for family members to become emotionally overwhelmed to the point of fainting when they were unable to effectively handle all that was happening in their surroundings. Safety concerns surfaced in nurses' narratives in relation to attending to overwrought family members. The following nurse's comments illustrate concerns that influenced nurses' practices aimed at restricting family presence:

> It's very emotional. . . . They've seen them [the patient], and then they come out, and they pass out. Or they pass out there [at the patient's bedside], because the person hasn't been cleaned. The anxiety to see their loved one covered with blood, that's it. You're reviving that one.

The nature of sudden illness or injury gives patients and family little time to digest

what has happened and what is being done in the ED on their behalf. Additionally, when a patient is brought in with a traumatic injury or illness, is unconscious, or being resuscitated, nurses need critical information to piece together the patient's story and make sense of their presentation. Nurses rely on family members to handle the emotions that surface and cope effectively with their surroundings, at least to the degree that would permit this exchange of information. Nurses in this study acknowledged that when they were unable to retrieve coherent information from emotionally distraught family members, they became frustrated, feeling that this may have influenced the quality of the care the nurse was able to immediately provide.

Nurses in this study described how too much emotion and attention from family often exacerbated the patient's discomfort and caused additional distress. As one nurse indicated, "I guess the quick example that comes to mind is the 3 year-old that you're gonna put stitches in. . . . Everybody starts talking to him, telling him it's going to be okay. There's so much anxiety and noise, that it [the patient's anxiety] escalates." Displays of emotions were sometimes viewed as inappropriate by nurses who did not consider the far-reaching effects that the illness episode had on the lives of Latino patients and their families. Nurses described how outbursts of emotion were sometimes disruptive and, therefore, could not always be accommodated in the ED. Some nurses also described becoming distracted by visual displays of emotion and preferred that family members be more subdued or absent entirely.

Family Stance and Comfort with Environment

Concerns surfaced in nurses' narratives in relation to sorting through and making sense of family dynamics to determine the most appropriate ways to intervene on behalf

of the patient and family. Some nurses in the study were more attuned than others with regard to noticing nuances in family behaviors that revealed the family's understanding and comfort with what was happening during patient care. A careful reading of family stance influenced nurses' decisions to interact with and involve family members in the patient's care.

Nurses described nuances in family behaviors, both verbal and non-verbal, that informed them of how the situation was affecting the family and how comfortable the family was in the surroundings. Several nurses described instances from care encounters in which their attention was drawn to the patients' or family members' lack of understanding about terminology used or procedures being performed in the ED. One nurse recalled an incident during a patient care episode in which a NES husband and wife presented with concerns about the woman's pregnancy. The nurse described how her attention focused on the couple's non-verbal behaviors during their interactions with the nurse and doctor:

> And we were saying, 'We can do an ultrasound.' Just saying it, like everyday knowledge. They didn't know what an ultrasound was . . . and then I had to explain an ultrasound. And they were just looking at me like they had no clue.

Nurses recalled that while some family members displayed curiosity and were actively engaged and asking questions about what was happening, others maintained a more distanced and quiet posture. Several nurses noticed that language abilities attributed to some of these differences, as evidenced in the following nurse's comments:

> A lot of times it seems like if they don't speak any English, they're a lot more stand-

> offish. . . . You see some of the other cultures, or Latino patients that actually speak some English or speak English well, they're right there with their daughter or son, or mom or dad, and they're kind of more freaked out about what's going on. And they're talking and crying. Except then some of them that don't speak any English at all, it seems like they're just kind of in the background waiting for somebody to come talk to them. Or kind of trusting you to just take care of things, I guess, 'cause they don't know any different.

Several nurses in this study described how they paid careful attention to the demeanor of family members to gauge how the ED surroundings were affecting them. Carefully observing a family's stance enabled nurses to recognize when family members might not be understanding what was happening, thus revealing the need for nurses to provide detailed information about tests and procedures as the care episode unfolds. Although many nurses in the study realized that family presence helped to alleviate anxiety about procedures being performed, nurses also realized that viewing invasive procedures often caused additional anxiety for family members present. As another nurse noted:

> Working in the emergency room you know that the things you do . . . appear harmful, or that you're [the patient is] going to incur pain by putting in an IV. You're [the nurse is] stabbing somebody with a needle, you've got four people holding them down, your [the parent's] child's screaming. And the perception of pain is more powerful than the actual pain itself. And so you're trying to do a lot in the emergency room dealing with people's perceptions of what you're doing. You're trying to help

control that by saying, "Okay, this is going to hurt." And so we usually do a lot of teaching, whether in Spanish or in English that, "Your child is just going to be afraid. . . . This is very awkward." You're explaining the procedure.

Nurses' Practices in Involving Family in Patient Care

Data analysis revealed qualitative differences between nurses' narratives and observed practices in relation to the extent to which nurses in this study attended to and involved family members during Latino patient care episodes. Whereas some nurses' practices reflected advocacy for family presence and involvement during patient care, other nurses' practices revealed a general lack of concern for attending to family needs and a disregard for family members' and patients' desires for family presence. The nurses who viewed family as a source of strength and support that enhanced the patient's well-being put more effort into ensuring that the family was included in the patient's care. Conversely, nurses who lacked this view used their own or another's authority to exert control to restrict family presence, despite the nurses' knowledge of the importance of family in Latino cultures and the family's desire to be involved in the care of their loved ones. These nurses viewed the presence of family as a hindrance to providing care to their loved one, a problem they dealt with amidst an already chaotic environment.

Sensitivity to the strength and well-being that Latino patients derived from close and supportive family relationships resulted in nurses' practices that promoted and maintained family involvement during the patient's illness episode in the ED. The following paradigm case illustrates how one nurse advocated for family presence by accommodating the environment to allow a large number of family members to gather around the patient and be fully involved in the patient's care.

Paradigm Case: Expertise in Nurses' Practices—Involving Four Generations of Family in Patient Care

The following narrative is from one of the nurses whose practice exhibited expertise. The nurse's story reflects how his concerns were immediately drawn to the family's presence as he cared for a woman brought in from a nursing home after suffering a hemorrhagic stroke. The nurse described how he remained attuned to the family's needs for information about the status and prognosis of the family's matriarch from the moment the patient was admitted to the ED:

> She came in, basically, unconscious. We worked her up for a stroke, and she had her CAT scan and everything. . . . We had to intubate her, and she wasn't in very good shape. She was going to pass away, and we tried to explain that to the family. And they decided that they wanted everything done to keep her alive as long as it took, until the rest of the family could get there and see her. And so we did that.

The majority of this nurse's narrative focused on family members who were present in the patient's room, and who solicited his concern and attention. The nurse commented on how the family dynamics in the patient's room differed considerably from what would have been the norm in the nurse's family. He continued,

> And when she came in, there was about 25 people that came with her, and they were all family. And I think if my grandmother had a stroke, first of all, she lives so far away that I would do my best to get there. But, I think that that's something that's typical of their culture, is that they're typically geographically close to one another and if something happens, they're gonna be there no matter what obstacles they have

to get through to be there.

The nurse's background understanding of Latino cultures and the value placed on family enabled him to immediately grasp the significance of their presence, and informed his actions toward accommodating their continued presence and involvement in the patient's care. The nurse described how he involved family members in care decisions and chose not to utilize an interpreter due to a family member's fluency in English. By involving the English-speaking son as a spokesperson, the nurse was able to maintain the family's intimate involvement with each other during this emotional and life-changing time. The nurse shared his observations of and interactions with the family as the situation unfolded:

> There were three sons there and then <u>their</u> immediate families also. And I think it was actually the middle son who kind of seemed he'd be the spokesperson for the family. And I think the reason for that was because he spoke the most English. I don't even know that we utilized an interpreter in that situation because he was fairly fluent in English. And we kind of mostly used him as an interpreter to the rest of the family. And so we would explain things to this son, he would then explain that to the rest of the family and they would kind of have a little meeting there about what they thought needed to happen. But it was interesting because we saw so many generations. Here was this older woman, I think she was in her 80s, and her three sons. <u>Their</u> children, who were [in their] 20s, and then their babies. I think the youngest was 12 months, and then ranging up to about 6 years old. So you got to see all these different generations come together to see grandma, or great-grandma. And

> it seemed like they involved nearly all generations except for the small children in the decision making process. They asked the kids that were even in their 20s what they thought should be done and whether they needed to keep her alive in order for the rest of the family to be able to come on their own.

This nurse's practices exhibited expertise in the personalized care and concern he held for this woman, whom he never referred to as "patient," and her family. Rather than maintaining a distanced and more clinical-oriented stance, the nurse was immediately drawn into the family's concern and the emotional depth the situation held for them. The nurse's grasp of the significance of the patient's grave condition and prognosis, and his understanding of the closeness and supportiveness of Latino families informed his actions of maintaining an engaged connection with the family and enabling their continued presence and involvement in decisions regarding the patient's impending death. His attention was drawn to the love and concern the family members had for the patient and how this extended through the several generations who had gathered. The nurse described the cultural uniqueness of the family dynamics and noticed how the young children were encouraged to demonstrate loving gestures toward their grandmother:

> And I think that a lot of times, if it was myself and I had my son, I don't know that I would have taken my son in to see his great-grandma right there. But they involved the children. . . . And the family invited the children to come up and speak with grandma, even though they explained that grandma couldn't speak back, and touch her and give her love and kisses and everything. . . . And I think that's a cultural issue.

Despite the nurse's awareness of how different this practice would have been in his own family, he did nothing to restrict family members from being physically close and involved in this Latina woman's care. Although he mentioned the large number of family members who had congregated in the patient's room, he did not mention any difficulties it may have posed to his providing care to the patient. This is in stark contrast to other nurses in this study who clearly regarded family as an obstacle to their providing care in the ED.

Accommodating Family Presence

Through extensive experiences with caring for Latino patients, nurses in the study recognized the concern for the patient manifested by family members, and the family's need to provide emotional support for and be physically present with the patient. Decisions to allow family presence and involvement were contextually based and dependent upon the nurse's grasp of the clinical situation and the nurse's attunement to the cultural importance of family. Some nurses in this study were more culturally attuned to the importance of family presence and involvement than others, and as a result, modified the environment to accommodate them. Other nurses were culturally comatose with regard to the importance of family and demonstrated a blatant unwillingness to accommodate family presence. One nurse's comments exemplified a lack of cultural attunement to family presence as she described difficulties she encountered in her usual practice of restricting Latino family presence in the ED:

> Everybody has to come visit. . . . But if you try and keep them out of the room, you have a lot of problems. . . . And it's hard to explain to them that we <u>can</u> do this, one or two at a time. And not 20. And they don't accept that . . . they make a big scene.

> "No, I gotta be there." . . . We let immediate family in, but a lot of uncles, aunts, we keep out. And they don't accept that.

The number of family members allowed into patient rooms varied from nurse to nurse. Some nurses reported following the rules set by the hospital in limiting or restricting family presence, while others—as illustrated in the paradigm case presented above—openly disregarded such rules when they felt the situation required the family's presence. Although nurses routinely allowed parents into the room when the patient was a baby or a young child, nurses varied in the extent to which they offered encouragement to other family members who wished to remain in close proximity and offer support, comfort and reassurance to the patient.

Nuances in the environment informed nurses of patient needs for family presence, and the level of involvement that a family desired and could tolerate in a particular patient situation. Realizing family members were often uncomfortable with their surroundings, some nurses allowed family members to determine the level of involvement they desired. As one nurse noted, "I think it's really important that you let them choose to be in or out" [Observation interview]. In the paradigm case presented earlier, the nurse remained attuned to the stance taken by family members and their obvious desire to be actively engaged in care decisions. Acknowledging their deep love and concern for the patient, the nurse involved the family throughout the patient's time in the ED. In an effort to maintain family involvement in the patient's care, the nurse provided the family with information about the patient's status and treatment as care unfolded, sought guidance from them as to how they desired the patient's care to proceed, and allowed family members to remain physically close to the patient as care was being

provided. Realizing the importance of family in Latino cultures, the nurse accommodated the large family's presence throughout the care episode.

Noticing an Unusual Lack of Family Presence

In a few experiences reported by nurses in this study, their attention was drawn to the lack of family accompanying Latino patients to the ED. The unusual absence of family caught the attention of one nurse, in particular, who recalled a situation in which a baby was found unresponsive at home by his mother. The nurse described how a neighbor noticed the woman's screams and notified emergency personnel, who brought the baby to the ED. The nurse recalled how the Spanish-speaking woman was left behind by the ambulance crew and then brought to the ED by the neighbor:

> And the neighbor was left there with this mom on the front lawn. And the mom was still trying to comprehend, trying to wrap her brain around everything that's going on. So the neighbor brings the mom to the hospital. That was one case where we were like looking around going, "Well, you know, what happened with this baby? Do we have a story? Where is the huge family that all tell us at once what happened?" There was nobody there.

The nurse noticed the unusual lack of family presence when the baby had arrived to the ED. Her initial motivation in looking for family was to get pertinent information and history about the baby's condition. However, as the situation unfolded, she focused her attention on the lack of emotional support for the mother:

> We finally heard, okay, there's a mom here. And we put her in a room with the neighbor, who didn't really know her that well. And I don't know what happened in

> that situation, but it was the longest time before any family showed up. And that poor mom. You're so used to . . . I mean, I'm like, frantic, where is all the family this time, to be with this mom? The mom was obviously going through a terrible time . . . . I can't imagine that woman's pain. Talk about any person's worst nightmare.

This nurse was immediately drawn into the woman's situation and she remained emotionally attuned to the woman's need for support through this tragic circumstance. The nurse's reflection on previous experiences involving family as a means of providing necessary support informed and maintained her concernful engagement. The nurse was relieved to discover the pediatrician who responded to the ED was someone who the mother knew, realizing how, in the absence of family members and the nurse's need to provide resuscitative efforts, the woman was left to experience this traumatic event alone. The nurse described how the pediatrician was able to speak with the mother in Spanish and inform her of the baby's grave prognosis, and eventual death:

> And she was actually the one to explain to the mom what had happened to her baby. Which was good because they at least knew each other. We all wanted to say something. To feel like you've passed something on to that mom in that situation. And when you can't, it's horrible.

The nurse described her actions and interactions with the mother in the patient's room after efforts to revive the baby had proven ineffective, and the nurse was preparing the baby's body in anticipation of the coroner's arrival. The following excerpt illustrates how the nurse maintained concernful involvement during her interactions with the mother, despite the nurse's limited Spanish abilities, and how this proved critical in

ensuring that appropriate care was provided in a particularized manner:

> And so when the coroner came, I had been in the room pulling lines and such when he was going to take the baby, and cleaning the baby up and all that. And the mom was yelling and screaming at the coroner. And I didn't . . . you know, I'm thinking, "Oh, she doesn't want to let the baby go." At that point I was the only other person in the room.

The nurse recalled how she had attempted to comfort the mother, "I was trying to kind of put my arm around and tell her it's gonna be okay. I mean, what else could you say?" However, nuances in the woman's behaviors and obvious rejection of the nurse's attempts informed the nurse that there was something more to the woman's screaming than sheer grief at the loss of her baby. Awareness of her limited Spanish abilities did not dissuade the nurse's concernful engagement. Rather, her inability to recognize the words spoken by the woman prompted the nurse to seek the assistance of a bilingual nurse who was working that day. The nurse described the compassionate care provided by her colleague and the critical difference it made having the assistance of a bilingual peer who could understand and attend to what the woman was trying to communicate:

> And I went and got another nurse who spoke Spanish. And what she was saying was not that he couldn't take the baby or anything. She knew he was there to take the baby. But she was saying, "Don't treat my baby like trash. Don't put my baby in a bag like trash." . . . The nurse, knowing what she was saying, picked the baby up. She gave the mom a big hug. Said a bunch of things to her, I have no clue what. Basically reassured her that she would never let him do that to her baby. And then

she carried the baby out to the coroner's car and seat-belted the baby in on the seat, wrapped in blankets, so that the mom didn't have to. And that's what she got to see. And I had no clue. I mean, I could have and certainly would have done the same thing, if I'd just understood. And she was repeating a statement over and over but none of the words were even . . . usually I can often pick out a subject . . . one subject word [laughs] and then run with it. And I had no clue what she was saying. I didn't know about the bag and trash. And I just was getting "no" and "my baby." . . . When really she was trying to say, quickly, before this man did this, she was trying to catch his attention. She did not want me to even touch her, comfort her, or hug her while she said goodbye to her baby. She wanted to make sure she knew how it was gonna go.

Narratives revealed how nurses remained attentive to nuances in patient and family behaviors that alerted nurses to salient aspects of situations that demanded particularized attention. Extensive experiences with caring for Spanish-speaking Latino patients and families led some nurses to intuitively grasp the significance of verbal and non-verbal behaviors, and identify possibilities that existed in the clinical situations that facilitated culturally appropriate and compassionate care. Attunement to the woman's lack of family support and compassionate presence prompted the nurse's continued emotional involvement in the tragic event described above. The nurse realized how, in the absence of her concerned and involved stance originating from her sensitivity to the unusual lack of family presence, the situation could have had significantly detrimental consequences.

Accommodating Family Emotion

Nurses varied in their comfort with and reaction to emotions exhibited by Latino

families during patient care episodes. Nurses who were more understanding of emotional displays accommodated family presence, while others restricted family presence. As one nurse stated, "Sometimes if the emotions in the room are getting too high, then we try and lessen that by removing family from the room." Some nurses felt torn with having to proceed with patient care while realizing they could not always attend to family members' emotional displays with patience and compassion, especially when numerous members of the patient's immediate and extended family had gathered. As one nurse stated, "You're torn sometimes. Like, okay, there's this mass hysteria and now there's 50 people here. But, if that was me, I'd be mass hysteria, with 50 people." Nurses who practiced in an expert manner recognized the contextual appropriateness of displays of deep emotion; rather than viewing them as detrimental to the family's well-being or as something needing to be controlled or curtailed, such emotions were anticipated and nursing care that met the family's particularized emotional needs was provided.

One nurse whose practices exhibited expertise recalled an experience in which she maintained concernful engagement in the midst of a life-changing and very emotional event for a woman whose husband had died in the ED. During a group interview, the nurse described how she extended her compassionate care to the patient's wife and family by assisting them with coming to terms with this sudden and unexpected loss. The nurse's narrative revealed the strong emotions exhibited by the woman upon seeing her deceased husband. The nurse described her interactions with the wife once they entered the patient room:

> She walked in the room and threw herself across her husband on the bed and started talking to him. She'd look up and talk to me, and she'd talk to him, and she'd turn to

> me. And she kept saying, "My Jimmy. Almost 60 years, the king of my castle." And now by this point, I'm bawling. And we're offering each other Kleenex! And so we sat in there and cried and cried and cried. And she told me these stories and she plucked him and fixed him up, and did all this stuff for her kids' sake. And then her kids arrived she introduced me to all of them. And she kept giving me hugs and saying all these nice things about me! And they were all hugging me, and I'm thinking to myself, "Well, we didn't save your husband. What are you thanking me for?"

Knowing the deep and mutual bonds present in many Latino families, and seeing the patient as a member of such a loving family enhanced the nurse's ability to personalize the care she provided. The nurse's attention was drawn to the woman's strength throughout the care encounter, and the ways in which the nurse, herself, drew strength from the woman:

> I looked at that woman, and I thought to myself, "Boy, if I could pick who I was gonna be in moments of duress, that's what I would want to be." And she was emotional. She was not stoic and cold. . . . She wasn't one of those people you worry about who's gonna go on for months before she has this traumatic meltdown. She was obviously trying in bits and pieces, as you can in a moment like that, to comprehend what had truly happened. She knew she was going home without him. But at the same time . . . she was processing her emotions. She was leaning on the people there making themselves available. She was just waltzing through all of them with open, open raw emotions and grace all at the same time.

What was not expressed in this narrative was the nurse's judgment about the woman's display of open, raw emotions. Instead, they were conceptualized as a dance, a fluid movement exhibited by the woman amongst family members gathered at the deceased patient's bedside. The nurse's actions created a safe and nurturing space in which the family felt her compassionate nursing care. Being sensitive and responsive to the emotions displayed in the care encounter was requisite to the concernful, attentive, and particularized care the nurse provided.

Cultural Congruence of Involving Family in the Care of Latino Patients

Analysis and interpretation of Latino informants' narratives revealed several themes regarding family presence and involvement in patient care. These themes centered around informants' desires for nursing care that: (a) involved family by encouraging their presence and informing them of the patient's status and prognosis throughout the care episode, (b) conveyed respect for and genuine interest in the patient and family and their concerns, and (c) demonstrated kindness and compassion. These themes often overlapped during patient care episodes. Exemplars from Latino informants illustrate the cultural congruence, or incongruence, of nurses' practices in relationship to these themes in the following discussion.

Involving Family in Patient Care

Data analysis revealed the satisfaction of Latino informants being able to remain present with patients throughout the care episode. Narratives and observations of care encounters revealed how concerned patients and family members carefully watched nurses' actions while they performed procedures such as urinary catherizations, IV starts, dressing changes, or blood draws. Informants appreciated efforts by the nurse to address

them and to offer information and verbal reassurances during the procedures. Culturally congruent nursing care was also manifested when family members were allowed to hold and comfort the patient once procedures were completed. One informant expressed her appreciation for being able to console her daughter during their stay in the ED: "I liked it when . . . they told me to pick her up and give her some affection, because she was crying."

Observed encounters and the narratives from Latino informants revealed the family members' and patients' curiosity and interest in the nurse's actions while he or she performed procedures and provided care. Some patients and family members were more assertive and comfortable than others with asking questions during care encounters. As one informant noted: "I always ask because I want to know. I need to know because it concerns me a lot. . . . It lets me know what is really going on with the person that's being seen." Although patients and family members felt they had the right to be kept informed of what was happening in the ED, some verbalized reluctance to voice questions or concerns during care episodes. As one informant, the family member of a patient, stated:

> I feel kind of like it's their responsibility to let us know why they're doing what they're doing, because sometimes we can't ask, "Well, can you guys do this? Can you guys do that?". . . And then sometimes they don't let us know.

Meeting the Information Needs of Family

Informants indicated the importance of being appraised of patient status and prognosis, including the outcomes of laboratory and diagnostic procedures and assessments that were conducted, as well as care requirements through post-discharge

from the ED. Many Latino informants described the fears and concerns they had about their own or their loved one's illness that they brought with them to the ED. For instance, parents verbalized fears about the severity of their child's illness. One parent stated, "I was worried about my daughter, that she had an infection or something. One thinks the worst." And another indicated, "I was scared because I was thinking they were gonna tell me that something was seriously wrong with him." Narratives revealed that informants often feared that patients' illnesses would be serious in nature. As another informant indicated: "I thought botulism or something like that. I got scared. But he [the nurse] told me no, that it was like a virus." Being informed of the patient's status and the outcomes of procedures allayed the anxiety of patients and family members, which in turn increased their comfort with their surroundings and the care they were receiving.

Communicating Information During Patient Care Episodes

Nurses in this study who practiced in a culturally congruent manner maintained concernful involvement from the moment they brought the patients back and initiated the plan of care, to the moment the patients were discharged from the unit. These nurses formed connections with patients and families through ongoing attention and communication, and took the time to fully explain the clinical situation and plan of care throughout the patient's visit. Latino patients and family members in this study voiced appreciation for nurses who involved them and kept them informed throughout the patient's stay in the ED. Not only did the information serve to enforce what they might already have known or suspected—and thus, decrease any anxieties they may have had—it also enabled them to better understand their own or their family member's condition, affecting how they would be able to manage it once they left the ED. One parent shared

her appreciation for the nurse's care and the information he provided that enabled her to better understand her son's symptoms:

> I felt very confident with my consultation and the nurse today, because he spoke to me very confident. At first I was a bit fearful with my son, because it's been months since he's ate good. I usually take him to the clinic, and they say that his symptoms are normal. I told the nurse that today, and I was afraid they were going to tell me that he had something more serious, such as anemia. But he told me my son was fine. . . . I felt good, because he also told me that when children are growing their eating habits and appetites change. At times, they don't want to eat nothing, and other times they do, and other times they don't, etc.

As evidenced in the parent's comments above, the information and assurances provided by the nurse enabled this parent to better understand the reasons for her child's lack of appetite. Additionally, her fear that something more serious was wrong with her child was quelled by the nurse's concernful and responsive stance.

Unfortunately, several informants' indicated that their need for information was not met during the care episodes recorded in this study. During one observed care episode, a young child was being seen for a complaint of nausea and headache. During the encounter, the nurse explained to the 11-year old patient that she was going to be doing "orthostatic blood pressures" and told the child that she would need to change position several times. Although the nurse proceeded with gathering further assessment data and involved the patient and her parent by asking them questions—both English-speaking—they were not informed of any of the nurse's assessment findings. Although the parent

watched the nurse's actions carefully throughout the encounter, the nurse did not respond to the parent's inquisitive gaze. The parent shared her concerns about the nurse's actions in an interview following the care episode:

> Well, she did the blood pressure, you know, like laying down, sitting down, standing up. It was way different 'cause they never do that. It got me scared, 'cause I thought it was because something else was going on. And she never told me why she was checking her blood pressure. And I didn't even ask, 'cause sometimes I feel scared to ask because I think it makes them feel uncomfortable. Like, "Why do you ask? We know what we're doing."

Several observations of nurses' practices revealed nurses' casual use of medical terminology and performance of technical procedures during patient care episodes. In the episode described above, the nurse offered no explanation for what she meant by "orthostatic" blood pressure. Because she failed to provide an environment conducive to the parent verbalizing questions and concerns, the parent remained silent and alone with her fears. Her perception that her questions might be viewed as challenging the nurse's knowledge or authority left her reluctant to verbalize her concerns. The nurse's lack of communication served to worsen the parent's concerns rather than to alleviate them. As the parent stated: "It doesn't make me feel good because we have to ask in order to find out if she's got a temperature or not. What if I wouldn't have brought her on time? Something would have happened." Noticing the nurse's failure to share information, the parent further indicated, "I think that communication should be a little bit more open between a patient and a…nurse."

Nurses who practiced in a culturally congruent manner maintained an open dialogue that invited questions or concerns and provided ongoing information to patients and families about what was happening during the care episode. Informed of their conditions, patients and families felt knowledgeable and comfortable with their prognosis and treatment plans, especially when offered opportunities to verbalize questions or concerns.

Communicating Post-Discharge Care Requirements

Informants' narratives revealed the importance of nurses not only providing information during the patient care episode, but providing comprehensive discharge instructions and the rationale for the patient's follow-up care requirements. Patients and families wanted to know about and understand their diagnoses, and why they were going to take certain medications or follow prescribed activity limitations.

Latino informants in this study who were most satisfied with their nursing care and who felt good about their ability to follow their plan of care were those who received detailed discharge instructions and follow-up information from their nurse whether or not a language barrier existed between them. Nurses in this study who practiced in a culturally congruent manner attended to potential gaps in understanding by offering explanations and detailed information about care requirements. During one patient care episode, a nurse taught the mother of an infant seen in the ED how to check her baby's temperature rectally. He not only demonstrated the procedure, but also provided her with written instructions that he carefully reviewed with the mother. The following comments from the mother indicate the comprehensiveness of the discharge instructions provided by the nurse and how, as a result of the nurse's careful instructions, she understood the importance of following the discharge plan:

> He said to be cautious with her temperature and to take a rectal temperature instead of doing it under the arm, because he said that the rectal temperature was more accurate than underneath the arm. . . . He said . . . that if I didn't understand any of the information on the form that they had given me, to ask him any question, and he would answer me. . . . And the instructions that they put down on the paper, I understood. . . . But I feel a little bit uncomfortable doing a rectal temperature. I have [not] done it to my daughter. . . . That made me feel uncomfortable, and I didn't like it. But in the case of my daughter being ill, well, I needed to do it.

Despite the woman's misgivings about performing a somewhat unfamiliar procedure on her baby, the information she was given helped her to understand the importance of taking the temperature in this manner. The nurse provided care that addressed the parent's concerns by reviewing the discharge teaching and answering the parent's questions in an unhurried fashion. The mother left the visit feeling prepared and capable of caring for her baby in the manner prescribed by the plan of care.

Providing discharge paperwork that outlines follow-up treatment and home care is standard nursing practice in the ED. The amount of time nurses in this study spent reviewing discharge information with patients varied from nurse to nurse, and was, to a great extent, influenced by how busy the ED was at that time and how urgent or complex the patient's needs were. Interpretation of nurses' narratives revealed that the busier the unit, and the more routine—or less urgent—the patient's health concerns were, the less time nurses spent on the discharge portion of the patient's visit. As was discussed in Chapter IV, some nurses in this study, due to time constraints, shortened the time spent with NES patients during discharge encounters, or delegated to interpreters the review of

discharge information. These practices did not go unnoticed by Latino patients or family members. In fact, several informants commented on the difference in the depth and breadth of information provided to them by nurses when the ED was busy at the time they presented for care. As one informant stated: "They do explain to us, but it seems like they're kind of in a hurry, you know. [laughs] And I understand because there's some patients that need more care than others. But it's like they want to get us out of the room."

As evidenced by the informant's comments above, Latino informants noticed when nursing care was hurried. Although several alluded to and understood that the nature of the ED required that patients with more urgent needs be attended to by nurses in a priority fashion, they emphasized how important it was that nurses allow time for verbalizing questions and concerns. Taking time for patients and their family members was especially critical when nurses had to relay complex, or otherwise detailed, discharge instructions and directions for follow-up treatment. One informant, the parent of a child who was seen in the ED, shared her observations of the lack of discharge information that she usually received in the ED:

> Sometimes they don't tell us. Only what they tell us is, "Oh, she's got this. She's got that." But that's about it. They give us a paper, and then they tell us, "Here's all the instructions." They go over the paper, and they don't really explain to you, "Well, if this and this happens." Only, "If she gets worse, bring her in. Or take her to the clinic."

As evidenced by narratives from informants and nurses in this study, discharge

information provided by nurses in a hurried fashion often proved ineffective and resulted in inadequate care that did not meet the needs and concerns of patients and their families. Several Latino informants voiced dissatisfaction with the amount of information given to them upon discharge from the ED; one offered a suggestion as to how nursing care could be improved in this area:

> Maybe they could in the future, explain more to people when they come, like Hispanic people. . . . Because . . . a lot of people, well, they don't know how to read. So I think they should always ask, "Do you know how to read?" I know it's probably gonna make them [nurses] feel like it's kind of rude, but in a way it's better, because there's a lot of people that just go by whatever they [the nurses] tell them. And sometimes things don't work out the way they could.

Conveying Respect and Genuine Interest

Several Latino informants described nuances in nurses' behaviors that alerted them to the level of concern and involvement the nurse was investing in their care, and the extent to which the nurse respected them and viewed their health needs as important. Informants could sense when nursing actions were respectful, heartfelt and genuine. As one Latino informant indicated:

> If you're a person that treats people well when you come in, and show interest in the child that's here or with the parent, then it makes you feel good. If you come and you feel that you're not receiving attention, then you feel their only interest is in the money.

Informants indicated the importance of nursing care that reflected the nurse's respect

and genuine interest in their well-being. Patients and family members felt valued and were put at ease when nurses conveyed interest in them and remained actively engaged during the care episode. One Latino informant described how the nurse's demeanor conveyed his genuine interest in the patient's well-being:

> Satisfied is like being grateful with him, because he is there to listen to what you are telling him. It's to say that he's not just doing it because. You can be explaining things to him, and he could be doing other things. He is paying attention to what you are telling him, or what you have wrong with you, or what is happening, instead of him just being there, turning the other way and talking. It is like saying, "I'm alone."

Several patients and family members who were interviewed in this study verbalized uncertainty and fear about their own or their loved one's illness that exposed their vulnerability with bringing health concerns to the ED. Latino informants were most satisfied with nursing care that was conveyed in a respectful manner because their vulnerability was protected when their needs were addressed in a caring and concernful manner. Another informant described how the nurse's attentive stance and concernful engagement validated his health-related concerns rather than minimized them, and thus, made him feel respected and valued as a patient:

> The way he talked to me. He explained everything. What was happening. They don't blame or treat you bad. . . . It's like they're bothered by something or they are bothered because we arrived. It's like saying "Why do you come if there's nothing wrong with you?" You come because you are concerned. . . . At times, there are nurses . . . it's like they are saying, "If you don't have anything [wrong

with you], why did you come?"

Nurses in this study varied in their perceptions of the acuity and urgency of Latino patient presentations. Many nurses described experiences with Latino patients and families who accessed care for non-emergent needs, especially for conditions that nurses viewed as benign, such as a fever or an upper respiratory infection. While many nurses in this study discussed concerns regarding the high cost of services provided in the ED, their opinions varied as to the causes that lead Latinos and others to access the ED for their primary care needs. While some nurses recognized the sociocultural and political influences within society and the health care system that limited treatment options available to under- and uninsured persons, others did not. Rather, those nurses blamed patients and families for "abusing" the health care system, and attributed non-emergent ED access to a general lack of knowledge and education on the part of patients and families.

The parent of a young child seen with complaints of coughing and nasal congestion described his feelings about accessing care in the ED and the negative attitudes he felt from the providers in the ED during the episode in which his child received care. The following quote from this informant illustrates the predicament that many patients and families are caught in when needing to have their health concerns addressed, while at the same time realizing the limitations inherent in accessing the health care system:

> Well, when the doctor entered . . . I wasn't comfortable in the manner that he told me that I could take my daughter to her doctor so he could take an x-ray. . . . They have the equipment here [in the ED]. One comes here to be examined. And the

> doctor doesn't attempt [to do a thorough examination, including x-rays] because he told me, "Okay, I'll order an x-ray on your request.". . . That is where one can feel a bit bad that they tell you to go to your doctor in order to do those analyses. . . . Because at times we can't talk to the doctors. You can't go in when you want, not until they give you an appointment. . . . You have your doctor, you call and say, " My child is sick," and they give you an appointment to go in to be seen. That is why, at times, we use the emergency [room]. And that is only at times. It's like the doctors question you for your visit to the hospital. . . . Like I said, if I leave and then tomorrow I call my doctor at the clinic, and I tell him that I went to the hospital last night and they require that I have an x-ray taken, next, they'll tell me, "Come back next week, and we'll do it next week." But, what if I feel like I have something wrong? [a more urgent health problem]They should take it [the x-ray] right away.

Demonstrating Kindness and Compassion

Latino informants expressed satisfaction when nurses provided care in a kind and compassionate manner. A nurse's friendly and compassionate demeanor brought comfort to patients and their families and alleviated their fears and anxieties about being in the unfamiliar and often frightening environment of the ED.

Narratives revealed how nurses demonstrated compassion and kindness in several ways, including small gestures of friendliness offered to patients and family members. For instance, it was not uncommon to observe nurses making small talk with patients and family members, and offering children popsicles or stickers at the end of their ED stay, regardless of whether or not the child was the patient. Latino informants appreciated

these efforts by nurses, and saw them as attempts to allay the children's uneasiness with all that was happening around them. As one parent stated:

> She treated him very well. Very nicely. Including trying to make him laugh. . . . In another instant, when we were ready to leave, and they came to give us the results, she began to play with the boy. Meaning, she began to make him laugh. And later, she asked him if he wanted stickers, and if he liked them.

In one observed patient care episode, the nurse brought a small stuffed animal to the parents of an infant who had endured several painful and invasive procedures during the course of her ED stay. The nurse gave the stuffed animal to the parents and said: "Everything I've done has been mean. She needs something nice to remember me by. She can take this home." Later, as the infant was being admitted to the pediatric unit, the nurse reassured the parents that they did the right thing by bringing the baby to the ED for what initially appeared to be a benign condition, and praised them for their ability to deal with the emotional difficulty of having a sick child and with seeing their child endure painful procedures. She told them, "You have done a good job with letting us do what we have to do, 'cause you're scared and you're sad, and you gave her love after we did the bad stuff we had to."

Informants described how the nurse's compassion and friendliness helped to alleviate their fears about their own, or the patient's, condition and the care that was required. Nursing care provided in this manner calmed the patients and put family members at ease as well. The following comments made by another parent illustrate the sentiments expressed by several informants about the compassionate, caring behaviors

exhibited by nurses, which conveyed the nurse's concern for them while receiving care in the ED:

> Well, once my son sees a doctor or a nurse, he always fears them. He cries and starts yelling, but this time . . . the nurse began to talk to him, and he actually let the nurse weigh him. But when he was giving him the medicine and my son was crying, it clinched me as his mother. It's an awful feeling to see your child cry. He weighed him, and next he was playing with my son so he wouldn't cry. And the nurse began telling the baby what pretty shoes he had. He complimented his sweater, and his hair. He was trying to make him smile so he wouldn't cry. Also, when he tried to give him the medicine, my son wanted to cry, and he was very patient with him.

The parent quoted above, aware that her child usually feared health care providers and reacted to them emotionally, appreciated the extra time and effort extended by the nurse to help soothe the child. The nurse's friendly and compassionate demeanor helped calm the child, which, in turn, enabled the nurse to gather pertinent assessment data and administer medication required for the child's illness. The nurse's demeanor comforted this parent. Observing her son comply with the nurse's actions gave the mother confidence in the nurse's practice. In describing her feelings about the care episode, the mother indicated that she was, "Very confident with the nurse," and further stated, "The nurse was very welcoming and talkative with me and my son."

Latino informants described their satisfaction with nursing care that conveyed kindness and provided comfort and reassurance to them as they received care in the ED. These behaviors set a tone of warmth that helped to make the environment more

welcoming and less frightening to patients and their families. Such nursing practices helped to create an atmosphere in which patients and family members felt at ease.

Enhancers and Barriers to Nurses' Involvement of Family in Latino Patient Care

Facets of the nurses' practices and work environments enhanced and/or became obstacles to their abilities to accommodate family presence and involvement in the care of Latino patients. Data analysis revealed that efforts by their administrators as well as the nurses' personal orientation toward family presence in the ED facilitated family involvement. Ironically, these same facets also served as barriers to family involvement. Additionally, structural limitations, such as small exam rooms, impaired nurses' efforts toward accommodating family presence.

Administrative Support for Family Involvement

During one group interview, a nurse recalled a care episode in which the nursing supervisor facilitated the concernful involvement the nurse extended to a patient and family that sustained the family's deep concern and love for one another. The nurse described caring for a woman who, accompanied by her 11 year-old son, came to the ED experiencing a possible myocardial infarction [heart attack]. The nurse recalled how her attention was immediately drawn to the complexity of the situation and the fact that the family was newly immigrated and had no support nearby that could look after the boy while his mother was hospitalized:

> And he was basically her only support system. She was very sick, and she didn't want to stay in the hospital because who was going to take care of her son? He didn't want her to go home, because he was so afraid that she was <u>so sick</u>. But there was

nobody to take care of them. There was no family up here. They were just up from Mexico.

The nurse's attunement to the clinical situation informed her understanding of the hardships faced by the patient and her son, not only heading a single parent household, but also being newly immigrated, and geographically distanced from supportive family networks. The nurse, realizing the stability of the family unit was in jeopardy due to the patient's serious condition and hospitalization, asked the nursing supervisor to make an exception to a hospital rule, which did not allow children to stay overnight with a hospitalized parent. Because the exception was granted, the boy was allowed to stay with his mother until the following morning when more permanent arrangements could be made for him. The nurse discussed the uniqueness of the environment in which she worked that facilitated her ability to keep the family together: "With our hospital, it is so small that, you know . . . we just kind of break the rules if we need to, and accommodate the patients if we need to. . . . It's just a little different, I think, than a bigger hospital." The nurse's efforts to sustain the family's presence were successful, because of the support of the nursing supervisor, who allowed the nurse to "break the rules" and let the boy stay with his mother in the intensive care unit.

Administrative Barriers to Family Involvement

Nurses' narratives also revealed negative attitudes of supervisors in nurses' work settings that influenced the degree to which nurses were able to accommodate family needs during patient care episodes. Another nurse in this study relayed an experience in which the nursing supervisor's actions were aimed at impeding family presence. The following excerpts from this nurse's story illustrate the nurse's outrage regarding his

supervisor's reaction to the large number of family members who had gathered following the death of a baby. The nurse's narrative highlights how the supervisor's stance conflicted with the nurse's philosophy of supporting and providing concernful care and involvement to family members during critical and emotional life events. The nurse talked about the family dynamics that caught his attention during this patient care situation:

> There was quite a bit of family there that arrived in the emergency room, and the police were there, because it was a death. And the family, they were very, very loud. They were yelling and screaming, and moaning and crying; just a lot of family dynamics going on outside the room. And what stands out in my head was the nursing supervisor. We're . . . cleaning the baby and . . . getting the baby ready . . . so that the family could come hold the baby. The thing I remember the most is that the nursing supervisor really fruitcaked when the family started getting carried away. They all wanted to come back at once and be with the baby, and she had asked the police officer to make the family leave.

The nurse's sense of this situation—his intuitive grasp of the appropriate ways to accommodate family needs when a death occurred—informed his actions toward advocating family presence and involvement, and fueled his anger and frustration toward the supervisor's insensitive reaction.

> I think if I would have been able to have a little bit of control over that situation … I would have made sure that the family had every opportunity to be with the baby whenever they wanted, even while we were coding the baby. If they wanted in there

> that's fine. And directly after. As soon as we jerked all the stuff out of there, we wrapped this little one in a warm blanket, and we got the family back there.

The nurse's empathy and concern for the family members was manifested through his caring actions toward domesticating the environment (Benner, et al., 1996), making it as welcoming and non-technical as possible as a comfort measure for the family. His story indicated how he readied the room by removing invasive lines from the baby's body, clearing away equipment and supplies, and wrapping the baby in a warm blanket. By placing chairs in the room he created an area where family members could sit with one another. The nurse's sense of purpose in these practices was in providing comfort to the grieving family members, not in restricting or limiting their presence, or trying to control their emotions. Previous experiences with caring for family members after a death influenced the nurse's feelings and actions during this particular patient situation. The nurse further described a heightened awareness of the need for family-focused comfort measures when an untimely death occurred, such as when a baby died. This awareness served to further exacerbate his reaction to the supervisor's actions:

> I was just stunned that she did that. The first thing after somebody dies, you get that family in there, if they want to be there. . . as long as they want. You make it accommodating for them. . . . For goodness sake, their family member just died. And she was going in the opposite direction with this family.

The nurse was "stunned" by the supervisor's actions, because they contrasted so sharply with his practice of making every accommodation possible for grieving family members. He recalled how a co-worker intervened on behalf of the family and advocated

for the family's presence by interacting with the nursing supervisor and calming her down: "And, luckily, one of my co-workers . . . got the nursing supervisor squared away and just basically told her, 'Absolutely not. This whole family's gonna stay with this baby until tomorrow if they need to.'" The nurse's expectations that all in the care environment would respond in the same sensitive manner were not met. Rather than viewing the family dynamics as unnatural or problematic and as something to be controlled by security personnel, this nurse and his co-worker understood and expected the emotions; their concern was that the family felt cared for during their tragic loss.

Structural Barriers to Family Involvement

Most nurses in the study acknowledged that limited space in the ED prevented them from accommodating large numbers of family members wanting to be with the patient. Nurses lamented that the nature of the ED, specifically, its unpredictability in knowing from one moment to the next how many patients may present and how critical their condition may be, made it impossible to guarantee that extra rooms would be available for concerned family members. While some nurses described how they were able to adjust the care environment to make it more conducive to family members dealing with tragic and emotional events by channeling family members into an unused exam room, rearranging the patient's assigned room to allow a larger room to be used by the patient and family, or relocating the patient and family to another area of the ED that had access to several rooms the family could utilize simultaneously, most nurses described the inadequacy of the ED for providing family with private space in which to gather. The following quote exemplifies feelings voiced by many nurses in the study in relation to the lack of adequate space for accommodating family needs in the ED:

Even having an adjacent area where family can meet. We've often had to use an adjacent exam room for the family. Okay, you guys all cluster in here for a minute. Because we'll be so busy and the waiting room's full. And if they can't even go out there and sit amongst themselves and discuss what's going on, and hug and cry and whatever, then the agitation is just gonna grow and grow and grow.

Discussion

There are certain cultural values described in the literature that were evident in narratives from Latino informants and nurses in this study that are important for nurses to consider when providing culturally congruent care to Latino patients and families. These were the concepts of *respeto*, *personalismo* and *familism*. Each of these will now be briefly discussed.

Respeto (respect) is a cultural value that is important to consider when caring for Latino patients. *Respeto* "dictates the appropriate deferential behavior toward others, according to factors such as age, gender, social position, and is an element of positive interpersonal and reciprocal relationships" (Villarruel & Leininger, 1995, p. 371). In Latino cultures, minimizing an individual's concerns is viewed as a sign of disrespect (Villarruel & Leininger, 1995). As evidenced by the exemplars in this chapter, Latino informants in this study described experiences in which the nursing care they had received made them feel that their ED visits were non-important and unnecessary. Such disrespectful nursing care discounted the relevance the patient had placed on his/her symptoms and health-related concerns, and caused patients to feel that their needs and concerns were not valued or viewed as important by the nurse.

It is important for nurses and other health care providers to understand that an

individual's cultural background greatly influences their subjective assessment of their illness state—as well as health—and their subsequent decision to seek treatment (Blumhagen, 1982; Good & Good, 1981; Kleinman, 1988; Kleinman et al., 1978). As discussed by Loustaunau and Sobo (1997), "the sufferer's judgment rather than that of biomedicine defines the underlying problem," and symptoms or health conditions that are considered problematic vary from person to person and across cultures (p. 87). As evidenced by the Latino informant narratives in this study and corroborated by other research, discounting or failing to acknowledge the patient's perception of the health care situation or blaming the patient for his/her or a family member's health status were viewed as culturally incongruent practices (Warda, 2000).

Personalismo (personhood) refers to the preferences of personal contacts over more distanced, or institutional contacts (Villarruel & Leininger, 1995). Findings from this research and from previous research has demonstrated that Latino patients are more satisfied with care that is delivered in a personal manner rather than with a distanced approach; this is especially true for Latinos who espouse more traditional cultural lifeways (Torres, 1996). The concept of personalismo "is demonstrated in provider-client relationships when providers: (a) appear to be unhurried; (b) take the time to ask about some aspect of the personal life of the client, such as the health of a family member; (c) share small aspects of their personal life with the client; or (d) acknowledge the skill or some strength of the client" (Villarruel & Leininger, 1995, p. 371).

Several studies addressed the importance of interpersonal aspects to nursing care of Latinos such as nurses demonstrating sensitivity and kindness during patient interactions (Warda, 2000; Zoucha, 1998), displaying empathy (Warda, 2000), and concern and

personal attention toward the patient (Berry, 1999; Lipton et al., 1998; Warda, 2000; Zoucha, 1998). Personable nursing actions such as these have been shown to enhance treatment adherence (Lipton et al., 1998) and increase the patient's confidence in the nurse's abilities (Stasiak, 1991; Warda, 2000; Zoucha, 1998).

"Familism is a cultural value that involves individuals' strong identification with and attachment to their nuclear and extended families, and strong feelings of loyalty, reciprocity, and solidarity among members of the same family" (Marín & Marín, 1991, p. 13). The commitment to family in Latino cultures (Chavez, 1998; Marín & Marín, 1991; Siems, 1992; Villarruel & Leininger, 1995; Young, 1999; Zambrana, 1995) as well as patterns of social support and interaction among Mexican American families (Zambrana, 1995) have been extensively described in the literature and were evidenced in the narratives of the nurses and Latino informants in this study. Large kin networks of families living geographically close to one another contrasts with non-Latino whites, who generally maintain close family relationships but not in geographic proximity to each other (Vega, 1995). Anglo nurses in this study acknowledged cultural differences between their own family and that of their Latino patients. Their sensitivity to those differences often directed their efforts toward accommodating family presence and involvement during care episodes.

Nurses in this study who did not practice in a culturally congruent manner minimized or disregarded the importance of advocating for and accommodating family presence. Although some nurses recognized cultural attributes of interdependence in Latino families in relation to the patient's health-seeking behaviors, the views they held regarding treating the individual, as opposed to involving family in the care, were in

conflict with basic principles of Latino cultural groups in which interdependence is highly valued (Clark, 1970; Loustaunau & Sobo, 1997; Villarruel & Leininger, 1995; Zambrana, 1995).

Although previous research has described family involvement as an essential component of providing culturally appropriate nursing care of Latinos (Baldonado et al., 1998; Berry, 1999; Bollenbacher et al., 2000; Lipton et al., 1998; Stasiak, 1991; Warda, 2000), none of these studies specifically mentioned the unique challenges that come with trying to accommodate the large numbers of family members who, as evidenced by this study, routinely accompany Latino patients to care encounters in the ED. The narratives from nurses in this study showed efforts to advocate for family presence when large numbers of family members had gathered were inconsistent. Policies that prohibit or advocate for family presence influence nurses' practices in the ED (MacLean et al., 2003). Although nurses in this study did not overtly indicate that written policies such as these (prohibiting or advocating family presence) exist in their work settings, narratives revealed how their orientation toward family presence and sensitivity to the value of family in Latino cultures influenced the degree to which they adapted their practices to accommodate large numbers of family.

The Emergency Nurses Association (ENA) has long regarded the importance and value of including family in the care of patients in the ED (ENA, 2001b; ENA, 2003) and recognizes the critical role that family plays in the health and well-being of patients. Nurses in this study recognized patterns in family dynamics that identified certain family members as more involved than others in advocating for the patient's health needs. English-speaking family members usually surfaced as spokespersons on behalf of NES

patients. Differences among the English-speaking abilities of family members could be attributed to the length of time the family has lived in the United States, or to changing roles within families when family members who work outside the home become more versed in the English language and more assimilated into the culture (Hurtado, 1995).

Despite ENA position statements advocating family presence in the ED, inconsistencies prevail in nurses' practices, and the topic of family involvement remains controversial. Nurses in this study whose practices manifested expertise realized that family presence during patient care reduced patient stress—especially in the presence of linguistic differences—provided comfort for both the patient and their family in somewhat unfamiliar surroundings, and maintained the strong familial bonds present in many Latino cultures. Nurses, including those in this study, benefit from family presence by seeing the patient as a member of a concerned and loving family (MacLean et al., 2003; Zoucha, 1998). Family presence has been shown to enable a more holistic approach to the patient's care (MacLean et al., 2003). It also allows nurses to build a rapport that enhances communication with family during and after the care episode (Robinson, Mackenzie-Ross, Campbell Hewson, Egleston & Prevost, 1998). Nurses in this study who were attuned to family needs during patient care and who created an environment conducive to family members asking questions or making comments, reported increased verbalization from family members. Latino informants also indicated increased verbalization when nurses provided concernful care that solicited their concerns.

In the case regarding the nursing supervisor who was adamant about controlling family presence following the death of a baby, the nurse advocated for family presence

during resuscitative efforts and immediately following them. The ENA supports family presence during invasive procedures and cardiopulmonary resuscitation (CPR) (ENA, 2001b). Research has demonstrated the benefits of allowing relatives to be present during invasive procedures and CPR, and has found little support for their exclusion (Boie, Moore, Brummett & Nelson, 1999; Eichhorn et al., 2001; Meyers et al., 2000; Robinson et al., 1998). Family presence during invasive procedures and CPR has been shown to reduce anxiety and doubts about what was done to help the patient (Robinson et al., 1998), and facilitates the family's grieving process (Meyers et al., 2000). Nurses and Latino informants in this study commented upon how family presence during invasive procedures helped to allay family anxiety about care being provided.

Nurses in this study also knew family wanted to be involved, and that patients wanted family to be there to provide support during the ED visit. Data in this study and others demonstrate that family presence during care encounters brings comfort to patients and helps to maintain patient-family bonds in the ED (Eichhorn et al., 2001; MacLean et al., 2003) as well as in other health care settings (Baldonado et al., 1998; Berry, 1999; Bollenbacher et al., 2000; Lipton et al., 1998; Niska, 1999; Stasiak, 1991; Warda, 2000). Although the ENA has long advocated that family be included in the care of patients in the ED (ENA, 2001b; ENA 2003), the nurses' narratives and observations of patient care encounters in this study provide evidence that the practice remains inconsistent.

Summary

The degree to which nurses in this study involved family in the care of Latino patients was dependent upon the nurse's background understanding of and orientation to the importance of family within the patient's cultural context, as well as the nurse's

attunement to the stance taken by family members during care episodes evidencing the degree to which they wanted to be involved. Nursing care was culturally congruent when nurses met Latino patient and family concerns related to information needs and family involvement in the patient's care. Cultural congruence was also manifested in nursing care provided in a manner that conveyed the nurse's respect, and genuine interest in and compassion for patients and their families. Providing care beyond technical-oriented tasks enabled nurses in this study to connect with patients and families in meaningful ways on a more personal level that was noticed and appreciated by Latino informants. Rather than disabling the capacity of Latino patients and family members to care for themselves and to learn ways to maintain and improve their health status, nurses who provided care in a culturally congruent manner addressed concerns that Latino patients and family members brought to the ED, and empowered them as individuals and families knowledgeable about their health.

The American Nurses Association (ANA) (1991) and the ENA (2001a) have emphasized the need for nurses to be cognizant of and respond to the cultural beliefs, values and practices of the patients they care for. According to the ENA's position statement on diversity in emergency care, "The competent nurse views patients…as unique individuals, each with their own influences and attitudes, and incorporates these unique characteristics into the development of a plan of care" (ENA, 2001a, p. 2). Cultural nuances beyond language and family in this study surfaced in nurses' narratives as concerns that solicited their attention when caring for Latino patients. Nurses described episodes of care in which other culture-based undertones to Latino patient presentations became evident as clinical situations unfolded. The next chapter will fully

explicate and describe nurses' concerns related to providing culturally sensitive and appropriate care as well as the ways that nurses attempted to do so when cultural nuances beyond language and family surfaced during patient care encounters.

CHAPTER VII

FINDINGS AND DISCUSSION: NURSES' CONCERNS AND PRACTICES WITH ATTENDING TO CULTURAL NUANCES IN THE CARE OF LATINO PATIENTS IN THE EMERGENCY DEPARTMENT

In addition to concerns related to language and family needs, nurses in this study described a variety of cultural nuances such as health- and illness-related beliefs and behaviors unique to Latino patients and families that focused their attention and influenced their nursing practices. Unlike nurses' abilities with meeting patients' linguistic needs and accommodating family involvement in an expert and culturally congruent manner, however, data analysis revealed conflicts nurses had with providing particularized care in a culturally sensitive manner when other cultural nuances surfaced. The following discussion will address the concerns that focused nurses' efforts to recognize and attend to cultural nuances. Particular emphasis will be placed on describing the lack of culturally sensitive care provided by the nurses in this study, and the lack of resources to provide such care in the institutions where they were employed. Since none of the observed care encounters or Latino narratives in this study involved cultural nuances beyond family and language, literature regarding culturally competent nursing care will augment the following discussion and verify the cultural appropriateness or inappropriateness of nurses' efforts toward accommodating the needs of Latino patients regarding unique, culture-based, health- and illness-related beliefs and behaviors.

Nurses' Concerns with Attending to Cultural Nuances

Data analysis revealed three themes that captured the concerns and practices that surfaced in nurses' everyday clinical experiences involving cultural nuances during patient care encounters. These included concerns and practices related to nurses' abilities

to: (a) assess the cultural beliefs and behaviors and their relevance to the clinical situation, (b) understand the meaning of cultural beliefs and behaviors, and (c) incorporate the beliefs and behaviors into the patient's care. Each of these areas of concern will be illustrated in the following paradigm case. A discussion of the practices that nurses in this study developed in response to these concerns will follow the paradigm case.

Paradigm Case: Attending to Family Concerns Regarding Susto

A care experience relayed by one nurse during a group interview stood out from the other nurses' narratives in how it captured the concerns that focused nurses' attention and directed their efforts toward providing care in response to cultural nuances that surfaced during patient encounters. The case exemplifies how nurses in this study struggled to assess, understand, and incorporate into care, culture-based, health-related beliefs espoused by Latino patients and their families. In this case, the nurse was unaware of the Latino concept of *susto*, or fright, which many Latinos believe causes illness. The nurse began her story in her first group interview by describing how she discovered culture-based concerns brought to the clinical encounter by the parents of a small child seen in the ED for an ear infection:

> The interpreter was helping me discharge a patient and was giving instructions in Spanish to the parents of a child with an ear infection. And the parents asked through the interpreter if living next to the fire department had caused the ear infection. And I remember thinking that was pretty funny, and showed their ignorance of how medicine worked because they thought that the noise would cause a bacterial ear infection. And so I'm trying to explain to the interpreter the bacterial infection, and

the interpreter turns to me and says, "No, he's worried about a susto." At the time I didn't know what susto was.

Concerns with Assessing Relevance of Patients' Cultural Beliefs

The nurse's lack of cultural knowledge and understanding prevented her from grasping the significance of the parents' concerns and addressing them in a culturally appropriate manner. Her initial impression of susto conflicted with her own belief system, which was influenced by the biomedical paradigm, or how "medicine" works. As a result, the nurse immediately dismissed the cultural belief as insignificant, a result of the parents' lack of education. As the nurse stated, "And you never know, if you don't speak the language well, the educational level of who you're talking to. And so I thought maybe they were fairly ignorant." The nurse's lack of cultural knowledge left her unable to recognize the legitimacy of the parents' beliefs. She described how her beliefs about illness directed her interventions, which were aimed at correcting the parents' thinking rather than further assessing their beliefs and incorporating them into the plan of care:

> So we had to address the susto as far as this patient's care, culture wise. . . . And so I had to go with my beliefs about a bacterial infection through the interpreter and explain that we didn't think that the noise had caused the ear infection. And I don't know that the family still believed that or not, but we did the best we could by trying to explain that the antibiotic would fix the infection, and that the noise probably did not cause the infection.

The nurse described her thoughts during the care encounter and her realization that her care was insufficient in fully meeting the parents' needs:

> I still was a little baffled. I was still trying to incorporate what the interpreter had told me. . . . And it was something that I couldn't incorporate into my belief system immediately. It took me some time to process that information. So I just did the best I could then. But then later on I had to go back to understand what susto is, and how people believe that, and how you talk about that with their care.

Concerns with Understanding Meanings of Cultural Beliefs

The nurse's concernful involvement in the patient's care did not end when the family was discharged from the ED. Rather, she remained attuned to her inability to address the cultural belief in a way that met the parents' needs and the cultural sensitivity that she desired in her own practice. The nurse's openness to the unfamiliar concept of susto motivated her efforts toward gaining a better understanding of it. She described how she sought additional information to further her understanding of this new concept after the care episode had ended:

> And so then I had to go ask the other interpreters when I had a chance about what susto is and what they think of it. And they do believe it. And I find particularly if they're from Mexico, that's more incorporated into their belief system than say if they were raised here from a Mexican background, or raised in the United States.

The nurse further described her newfound understanding of susto after she sought information from interpreters in her work setting. She described how learning more about the concept helped her to make sense of it from her own worldview:

> And susto . . . is a fright, and a fright causes an illness. And in my work, I couldn't really relate to that. But the way I can incorporate their belief system into mine is

> that I believe that too many stressors in life cause illness, like lack of sleep and not eating right. So, therefore, if you relate a susto to a stress reaction, and you believe that would cause illness, then that's their belief.

The nurse was challenged in her ability to reconcile differences she and the parents had regarding their respective beliefs about what caused the child's illness. After learning more about susto, the nurse realized the inaccuracy of her initial impression that the parents' thinking was faulty, and acknowledged that she was the one who lacked cultural knowledge and abilities with which to appropriately and comprehensively address the parents' concerns. She admitted, "And when we were done, I was the one who felt ignorant, because I was very ignorant of their culture." The nurse realized that to make sense of the parents' beliefs in a way that would have meaning for her nursing practice and enable her to provide culturally appropriate care in future encounters with Latino patients and families, she needed to incorporate their beliefs into her own. Indeed, the nurse's initial impression could have become a barrier to this end had it not been for her concernful stance and desire to learn more about the cultural belief. The nurse further demonstrated her ongoing commitment to the provision of culturally sensitive and appropriate care of Latinos by indicating how she often shared the susto experience with others in her work environment:

> I guess it's satisfying now to know that you understand another culture's belief. . . . I like to tell that story to other nurses, and I like to tell it to the interpreters, because then they also know. It reminds them of our ignorance of certain things about the Hispanic culture.

During the second group interview, the nurse recalled how reflecting on the experience regarding susto made her realize how much she still did not understand with regard to how to incorporate it into her nursing practice in the ED. As a result, she again took her knowledge deficit to others in her work environment and sought additional information to help her develop a clearer understanding of that cultural belief to broaden the knowledge base from which her nursing practice emerged:

> Well, I started talking to the interpreters about susto. And I was trying to get a better handle on that. After talking here, I realized that there was still a lot I didn't know and . . . I still don't know. Because I think of a fright as a short term, but they feel it can affect you for years.

As will be further described in a later section of this chapter, several nurses in this study described seeking additional information from a variety of sources to further their understanding and knowledge of patients' culture-related beliefs and behaviors. However, the concepts, at times, remained foreign to the nurses.

Concerns with Incorporating Cultural Beliefs into the Plan of Care

The nurse involved in the care episode regarding susto indicated how, despite seeking additional knowledge about the cultural concept, her basal understanding remained incomplete with regard to its application to her nursing practice:

> The one thing that I'm still not clear on is I think that they believe it <u>continues</u> to cause the illness until you <u>deal</u> with that susto. And so I'm still <u>learning</u> about it. But I used to think, oh, well the susto was kind of something that happened at one point in time. But that's something I need to pursue now that we're talking about this. I

> think now that they believe this is on a time continuum, that it's not a one-shot deal like I thought originally after talking with the interpreter. I'm not sure I know how to tap into the fact that they feel this could have happened 5 years ago and still be bothering them, 'cause that's not the way we think in medicine.

Many nurses in the study verbalized how their frames of reference and skills were inadequate for putting together the gestalt of clinical situations when culture-based symptom expressions or concerns surfaced and focused their attention during Latino patient encounters. Nurses verbalized their struggles with making sense of the beliefs, usually as a result of the biomedical influence from which their nursing practice derived. The nurse in the case regarding susto further described her confusion with how to incorporate the concept into her nursing practice:

> They may have a headache or maybe almost more like a psychosomatic illness in a way, in that it can affect you for years. . . . I don't understand susto being a long-term problem. Because oftentimes when the interpreter talks to you, and you ask about what happened, they [patients] will say, "Well, 5 years ago . . . ." And. . . as a white health care worker, I dismiss the 5 years and I say, "Well, let's go up to now, and what's happened." But they feel that's relevant information. So I'm not sure that I've figured out exactly how to tap into their version of health care or how they view illness.

Like several other nurses in this study, this nurse acknowledged that Latino patients commonly referred to events in the recent or distant past as significant to their present illness condition. But unlike other nurses in this study, this nurse recognized this

phenomenon as potentially having meaning within the patient's cultural context and worldview. The nurse's comments revealed her on-going concern and desire to provide culturally appropriate care. Her engagement with learning about cultural nuances and how to assess and incorporate them into patient care manifested an openness to possibilities for how her practice could become more culturally sensitive. Her attunement to the cultural belief of susto as well as her acknowledgment that she lacked a full understanding of it alerted her to the limitations that knowledge deficit posed in her ability to further tap into the patient's views of illness and incorporate it into patient care in a culturally appropriate manner.

Nurses' Practices in Attending to Cultural Nuances

Narratives revealed a multitude of experiences in which nurses in this study recognized culture-based nuances in Latino patient presentations. For example, many nurses in the study described incidents in which patients presented with injuries on which topical home remedies had been applied before coming to the ED. These remedies included salves and poultices made from a variety of foods or over-the-counter products, such as toothpaste or Maalox. In addition, nurses also described common experiences in which patients had used body rubs for various illnesses or conditions. Research has shown that a variety of foods and other treatment modalities are utilized across cultures in traditional, or folk, medicine as forms of healing. Practices believed to draw illness out through the skin, such as the application of poultices, are practiced in cultures throughout the world, in both traditional and modern societies (Clark, 1970; Fadiman, 1998; Heinrich, 1997; Helman, 1994; Loustaunau & Sobo, 1997; Villarruel & Leininger, 1995). Nurses in this study reported that many of their Latino patients used folk remedies.

Nurses who practiced in a more culturally attuned manner framed these practices in a positive light, and recognized their significance and importance to patients and families who believed these practices would have medicinal value and would bring comfort.

When faced with cultural nuances, however, nurses were at a loss for how to address them in a culturally sensitive manner. Indeed, only a few nurses in the study even talked about "culturally sensitive" nursing practice and what it would look like. As revealed through analysis of nurses' narratives, nurses developed practices in their attempts to address cultural nuances during patient presentations; albeit they were not always culturally sensitive or appropriate. These practices, which were similar to the areas of concern described earlier in this chapter, included: (a) tapping into cultural nuances and assessing the related patient concerns, (b) acquiring cultural knowledge to gain a better understanding of the cultural nuance, (c) acquiring cultural awareness, and (d) incorporating the patients' beliefs and practices into the plan of care.

Tapping into Patients' Culture-based Beliefs

Whereas some nurses negated, minimized, or otherwise ignored patients' culture-based beliefs and concerns about illness, other nurses displayed an interest in them, but were unsure of how to ask the patient about them and their significance to the patient's illness condition. Nurses in the study indicated that it was important to provide care that met Latino patients' particularized needs and concerns, and they expressed a desire to do so, but narratives revealed that the specific tools or skills necessary to do so were generally unavailable. For instance, several nurses voiced discomfort with the notion of asking patients and families pointed questions about cultural beliefs or practices and how they influenced the patient's ED presentation for fear of offending or otherwise coming

across as judgmental to the patient. In relation to particular practices that nurses encountered, such as patients using foods as topical remedies, one nurse indicated that she did not ask directly about patients' beliefs or their rationale behind these actions, "because I think I would be offending their culture and upbringing and traditions. . . . I would hate to belittle them if they've done it for six generations. That's all they know, and that's what they think is right."

Rather than ask patients directly about their beliefs or practices, several nurses in the study described their reliance upon interpreters to point out cultural nuances and to assist them in the nurse's efforts to tap into patient beliefs and concerns. As one nurse indicated: "The interpreter has to identify what the patient's belief is for you. And then you have to address that—whether you believe it to be true or don't believe it to be true—and why, and try to convey that." One nurse recalled how an interpreter's input caused a paradigmatic shift in her practice during an episode in which the nurse, due to her lack of cultural knowledge, had grossly overlooked the cultural significance of nuances in a particular patient encounter:

> I always thought I was confident to take care of Mexican American patients, and the interpreters have bailed me out a couple of times. I have had two major faux pas. [One] was expounding on the fact that a child of one year of age didn't really need to be eating tortillas when they were sick. [laughs] The mother's prime focus was her child was not eating his tortillas! And the interpreter took me aside and said, "You know, this is important. This is a cultural thing. Be quiet!" And I said, "Okay, I got it. Thank you."

Several nurses in this study described learning cultural meanings behind patient behaviors because of the interpreter's cultural insights and attunement. The nurse quoted above acknowledged her oversight and inability to see beyond her own experiences with and expectations about sick children and their lack of appetite. Acknowledging her ethnocentric stance, unlike other nurses in the study, this nurse concluded that her ethnocentrism blinded her during the clinical situation and was a barrier to her ability to further assess the significance the child's behavior held for the mother. When asked what value she placed on the interpreter's input, and what she learned as a result, she noted:

> I think accepting other people's values, first of all. And I'll hold myself up as the pariah here. I mean, in the first month I was in the emergency room, I screwed up with the tortilla factor . . . because it wasn't important to me. It wasn't part of my upbringing. . . . I would never worry that they couldn't eat. Kids didn't eat toast in the morning. They're sick; they're not gonna eat. I mean that was my value that I was attributing to somebody else, and that was the wrong thing to do.

Several investigators have emphasized the importance of eliciting the meaning of the illness episode from the patient; without this understanding, providers risk imposing narrow biomedical models of care that have little relevance to the patient's culturally constructed reality (Good & Good, 1981; Kleinman, 1988; Kleinman et al., 1978). When the patient is not involved as a therapeutic ally in the provision of care (Kleinman et al., 1978), issues and concerns brought to the clinical encounter by the patient are not attended to, and care that is provided is not culturally competent. Cultural assessment tools can be used in the clinical setting as a strategy to assist nurses in collecting

appropriate information from culturally and ethnically diverse patients (Gonzalez-Calvo et al., 1997; Kleinman et al., 1978; Thompson, 1997; Tripp-Reimer, Brink, & Saunders, 1984) Cultural skills discussed in the literature that could enhance culturally appropriate care also included health care providers modifying their approach to acknowledge the clients' perception of the health care situation (Warda, 2000). Only one nurse in this study described how she modified her approach to Latino patients in an attempt to uncover culture-based nuances and the patient's expectations for the care they sought in the ED. The nurse involved in the episode with the sick child who did not eat his tortillas recalled a significant learning experience from a book she had read about culturally sensitive nursing practice. She stated:

> There is a wonderful book that's called *The Spirit Catches You and Then You Fall Down* [actual title is *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*]. And that was truly an illuminating book for me. And off the bat, what I try to do is ask the patient, "How may I help you right now?" And it kind of cuts through cultural issues that don't always hit me here [points to forehead] but go over my head. And that's been a helpful tool for me.

Another nurse in the same group interview noted: "That is important, to know what their expectations [are], so they feel like you've met them." However, the nurse verbalized her frustration that, despite a desire to assess patients' culture-based concerns, getting this information was not always possible. She lamented:

> And sometimes it is more difficult to find out with the patients, because you'll ask the

interpreter that [What can I do for you right now?]. And they'll ask [the patient], and then they [the interpreter] will say, "Well, I told you, these symptoms!" [laughs] And I'm saying, "No! What do they need from me tonight? What is their need?"

As evidenced by this nurse's comments, nurses' efforts toward tapping into patients' culture-based concerns were not always successful when interpreters did not realize the intent of the nurse's inquiries. Nurses in this study did not have a cultural assessment tool to assist them in asking patients about their beliefs related to illness and health and, as a result, were at a loss for how to gather this information and incorporate it into the patient's care.

Acquiring Cultural Knowledge

Learning about health-related beliefs and practices of various cultural groups has long been relevant to nursing practice (Chrisman, 1982; Leininger, 1970) and critical to understanding how best to meet the needs of ethnically diverse patient populations. Nurses in this study described a variety of means by which they developed a knowledge base that informed their understanding of the cultural beliefs and behaviors of Latino patients, which, in turn, heightened their awareness of and attunement to cultural nuances. First, through reflection on numerous care experiences, nurses discussed how they were able to recognize patterns of similar culture-based beliefs and/or behaviors present in Latino patient encounters. With increased exposure and reflection, nurses became more familiar with nuances that surfaced.

Second, as described in Chapter VI in relation to nurses' knowledge development and the importance placed on family within Latino cultures, several nurses described participating in individual classes, courses of study or cultural immersion experiences

that enhanced their understanding of culture-based beliefs and behaviors and the importance of addressing them in patient care. Cultural immersion programs have been shown to be powerful experiences in which nurses can learn the lifestyles and ways of culturally and ethnically diverse populations (Austin et al., 1999; Kavanagh, Absalom, Beil, & Schliessmann, 1999). Two of the nurses in this study had experienced immersion programs in Latin American countries. These nurses demonstrated a more open and less ethnocentric stance than did nurses who had not had that experience.

Third, coworkers—such as interpreters, registration personnel, and other nurses—often served as cultural consultants, or informants, as did members of the nurse's family and the Latino patients themselves. Many nurses in this study described the role that these individuals played in bringing cultural nuances present in patient care encounters to their attention as well as the cultural meaning behind the behaviors or concerns of patients or their family members. The nurse involved in the care episode involving susto emphasized how important interpreters were in augmenting her knowledge about cultural beliefs and behaviors. She verbalized sentiments expressed by several nurses in this study with regard to how interpreters bridged cultural differences between nurses and Latino patients:

> They're the bridge, because they understand I don't know about susto, and they understand that it's a real thing for the patient's family. So they're the ones . . . getting the patient's family and me on the same page. So that's where I rely on them.

As evidenced in the nurses' accounts, coworkers became cultural informants in the nurses' quests for knowledge that they hoped would enhance their abilities to provide

culturally sensitive nursing care to Latino patients and families. Cultural consultants (members of a specified cultural group) have been shown to provide valid and meaningful information to nurses seeking to learn about cultural differences that influence health-related beliefs and behaviors. Kirkham (1998) discussed how working with a culturally diverse staff provided nurses with additional resources for cultural information. This was found to be true in this study as well, as many nurses reported how the exposure to a diverse staff enriched their nursing practice in the ED.

Acquiring Cultural Awareness

The ANA (1991) and ENA (2001a) have emphasized the importance of nurses recognizing and embracing diversity in cultural practices and beliefs. Although all of the nurses in this study recognized cultural diversity in their practice, variations surfaced in their levels of cultural awareness, that is, their awareness of their own cultural identity and how their own worldview shaped their perceptions of Latino patients' beliefs and behaviors. Salient features of cultural awareness include an awareness of self, including one's own culture and the attitudes it may hold about ethnically diverse groups, as well as an awareness of cultural differences between and within groups (Campinha-Bacote, 1995).

Awareness of Own Culture

Only a handful of nurses in this study spoke about their own cultural beliefs and practices, including attitudes and biases learned from family, friends, and/or from the dominant culture, and described how these influenced their interactions with Latino patients. As one nurse indicated: "You first have to know your own culture to understand that there's a difference between you and even East Coast American. That the West Coast

has a culture of its own." Another nurse stated: "I don't think you can realistically escape from your own cultural biases. I think what you can do is work to recognize your own frame of reference . . . and try to maintain perspective when you're dealing with people from another culture."

Awareness of Diversity Within and Among Cultural Groups

In addition to an awareness of variations within Anglo cultures, a few of the nurses in this study who were quite knowledgeable about Latino cultures mentioned intragroup variations found within them, not only in relation to ethnicity, as was indicated by one nurse—"Latino brings up a huge definition with all the way from Cuba, to South America with the Indians, versus Hispanic American,"—but also in relation to language, as was indicated by another: "Talking about Latino people, I immediately go to the people that just speak Spanish. And I think that my comments have reflected that. But Latino has a very wide definition. We have people that speak Portuguese that are Latino."

Homogeneity is often incorrectly assumed within cultural groups, and attention is not always given to intragroup variation (Marín & Marín, 1991). As one nurse in this study stated:

> I try not to let the fact that they're Latino change . . . I'm not saying make it worse or make it better, but change the standard of care that I give them. There's a standard of care for every set illness, and you want to live up to your standard of care.

Universally applying care interventions to all patients disregards cultural attributes that may be important to patients and increases the likelihood of poor outcomes due to cultural irrelevance. Austin et al. (1999) found that nurses do not always acknowledge the

implications that arise out of cultural differences (between patient and nurse). Surprisingly, these investigators found that nurses who viewed themselves as "very competent" denied the influence of culture, and saw culture as a "non-issue" in their care of ethnically diverse clients (p.15). Recognizing diversity within a group is critical to preventing stereotypical beliefs from influencing interventions (Kirkham, 1998). Caution must be applied when incorporating cultural knowledge to the clinical encounter so as to avoid generalizations and stereotypes about cultural groups (Austin et al., 1999).

In this study, cultural awareness was manifested by the nurses recognizing the unique attributes of Latino patients' beliefs and behaviors and in the nurses' efforts to overcome their own biases and ethnocentric attitudes to find shared cultural meanings that would enhance their nursing practice and provision of care to Latino patients. The following quote was taken from a group interview in which nurses were discussing the concepts of cultural awareness and sensitivity. The nurse's comment illustrates how his practice reflected both his awareness of how illnesses were viewed differently across cultures, and how nursing care should be provided in a nonjudgmental manner:

> I think immediately when people say things, you go back to your own cultural context and say, "Well, that's silly. That's not the way I do it." Or "why would you do it that way? That doesn't make any sense." But just keeping an open mind . . . ask those questions. "Why do you do it that way? I'd like to know why you do things this way or why did you come in this time?" And not implementing your own cultural concepts on the reasons why they came in. The viral URI [upper respiratory infection] is a good example. Saying, "Well, your kid has a fever." That doesn't necessarily mean that they're sick. In our culture, we understand that. But I think that

> fever in the Hispanic culture is that it means illness, and that's how they've interpreted it for a long time. . . . And I think that they have some very old beliefs that are still continued on today.

Nurses who recognize diversity of belief systems found within the pluralistic communities in which they live and practice realize limitations imposed upon their nursing care abilities when their cultural views remain myopic. One nurse admitted how her frame of reference limited her ability to see others' perspectives: "That just centers me to know that this is the way that I grew up. . . . I was educated in this framework, this box over here. But there's a lot of other boxes that I'd like to crawl into." Nurses' narratives revealed their concerns with accepting patients' worldviews and remaining open to learning more about them. As one nurse indicated: "The bottom line of nursing is being nonjudgmental, and that's not always an easy one [small laugh] with our personal biases, and our boxes, and not knowing what's in someone else's box."

Education, life experiences, and family are all influential in the development of an individual's worldview. Being a member of a health care profession that has its own language, values and behaviors and that, to a great extent, is influenced by the biomedical paradigm, also affected the abilities of nurses in this study to make sense of patients' culture-based presentations. Biomedicine, which provides only a small portion of health care throughout the world, is the core health care system in the U.S., and "is based upon a biomedical model that generally has not supported cultural awareness and sensitivity in health care delivery, recovery, or rehabilitation" (Loustaunau & Sobo, 1997, p. 5). Rather, it views the body mechanistically, reduces problems to the organic level, suggests health and wellness are physiological issues, and emphasizes pathology and cure (Good

& Good, 1981; Helman, 1994; Loustaunau & Sobo, 1997).

Awareness of cultural practices or illness beliefs different from a nurse's may prove problematic in the coordination of care. Data from this study and others have shown that nurses may pathologize ethnically diverse individuals without considering the context from which they come that influences their health behaviors (Gonzalez-Calvo, Jackson, Hansford, Woodman, & Remington, 1997; Kavanagh et al., 1999). Research has also demonstrated that being nonjudgmental (Gonzalez-Calvo et al., 1997; Kavanagh et al., 1999) as well as flexible with incorporating patients' cultural beliefs and behaviors into the plan of care (Austin et al., 1999; Warda, 2000) are strategies that nurses can use to create environments sensitive to the unique cultural needs of patients.

Developing an awareness of one's own cultural beliefs, attitudes, and behaviors is critical to recognizing not only cultural differences in others, but similarities as well (Austin et al., 1999; Kavanagh et al., 1999; Kirkham, 1998; Napholz, 1999; Thompson, 1997). Awareness of the effects of one's own cultural values, beliefs, and attitudes has been shown to enable nurses to be "more empathic and culturally relevant" in their care planning (Napholz, 1999, p. 83). In this study, culturally attuned nursing practice revealed that self-awareness came with an awareness of similarities across cultures, which, in turn, led to nurses being able to empathize with the human condition and being willing to see from the other's perspective the meanings found in cultural beliefs and practices.

Incorporating Patients' Cultural Beliefs into the Plan of Care

Several nurses described the uniqueness of culture-based concerns brought to clinical encounters by Latino patients and families and the importance of attending to those needs

in a compassionate and comprehensive manner. As one nurse indicated, "If I believe driving a yellow car gave me bronchitis, then that's my belief. And so, as a nurse, you deal with that belief no matter how crazy it sounds to you." However, data analysis did not reveal any example of culturally competent care by nurses in this study with regard to incorporating cultural nuances into patient care. The nurses' narratives did reveal two care episodes in which nurses attempted to address cultural nuances in a culturally sensitive manner, but both examples had more to do with the nurses trying to change the cultural practice, than they did with understanding the nuances and incorporating them into patient care.

Nurses described a variety of experiences in which they noticed patterns in health-related beliefs and behaviors relative to the patient's or family member's generational status. One nurse described conflicts in his own family experiences with regard to changing the views of his mother, who espoused more traditional beliefs than he did, about causes of illness:

> I used to have to educate my own mother saying that you gotta put a coat on or you're gonna get pneumonia. And it would upset my mother to explain to her, that's not what causes pneumonia . . . because that's the way she was taught. And for me to correct her, saying that's not what causes pneumonia would just . . . you know, it's hard to break the chain, if you want to call it that. . . . And in the Hispanic population, it's probably even harder, because the mother is always right. Always.

This nurse's experience with the way culture-based beliefs are changed from one generation to the next in his own family informed his practice of a similar dynamic in the

families of Latino patients he cared for. Nurses in this study unanimously attributed traditional beliefs and behaviors encountered during patient care situations to less acculturated family members' teachings, or, as was illustrated by the nurses' remarks about Latinos raised in Mexico verses those raised in the U.S., to how recently the patient or the patient's family had immigrated to the U.S.

Acculturation refers to the process of modifying cultural behaviors when culturally distinct groups come in contact with a culture different from their own (Samaniego & Gonzales, 1999). It is a multidimensional process of adaptation to differences in values, beliefs, language, and ways of life experienced by those who have immigrated to a culture different from their own (Rueschenberg & Buriel, 1989). Several dimensions are used to gauge one's level of acculturation, including language preference, generational status, and recency of migration (Marín & Marín, 1991; Rueschenberg & Buriel, 1989). However, the most widely used measure of acculturation is an individual's command of the English language (Marín, Sabogal, Marín, Otero-Sabogal, & Perez-Stable, 1987). The measure that caught the most attention of nurses in this study and was used to form the basis for determining generational status among their patients and families in the ED was command of the English language. Many nurses noticed differences in the health- and illness-related practices of Latinos who spoke English, and those who spoke only Spanish. As revealed in nurses' narratives, English-speaking patients and family members exhibited less traditional, or more contemporary, health-related practices, whereas those who only spoke Spanish espoused more traditional practices and beliefs.

As was the case with the nurse who felt the need to change the way his mother viewed the causes of pneumonia, several other nurses in this study discussed the need to

"break the chain." They described their attempts at undoing the cultural practices and beliefs of Latino patients and families, including several motivators for undoing particular cultural beliefs or behaviors. For instance, narratives and observed care encounters revealed nurses' concerns about cultural practices that could prove harmful to the patient's well-being if continued in the same manner culturally ingrained. Less concernful motivators that led nurses to take actions to undo a particular belief or practice included a nurse's lack of attunement to, or a disregard for, the relevance of a cultural practice that was innocuous to their patient's immediate safety or well-being. Additionally, a nurse's desire to change the belief or behavior originates from the nurse's disagreement with it, an opinion that his or her beliefs are more appropriate for the given situation. Cultural imposition, or imposing one's cultural beliefs onto another (Leininger, 1991), stems from an ethnocentric stance in which one believes his or her own cultural ways to be superior to that of others, and uses his or her own culture as the standard whereby other cultures are judged (Tripp-Reimer, 1999).

Most nurses in this study had experienced Latino families presenting to the ED with feverish infants or young children covered with multiple layers of clothing and blankets. Nurses struggled to make sense of this cultural practice and held differing perspectives as to its cultural relevance. During one observed care encounter, a nurse shared his observations about this phenomenon after he had discharged a family from the ED:

> With Hispanics more than other people, they'll bundle their kids up if they have a fever . . . and make them even warmer. And they'll feed them hot foods and hot liquids. But if they're cold, then they'll continue to give them cool foods and cold liquids. I don't really know much about that, but it is interesting. I'd like to learn

more about it someday. [Observation interview]

Despite acknowledging that the practice of bundling feverish babies held some cultural meaning, most nurses in the study agreed that it was a practice that could prove harmful to the child's well-being, and viewed it as a practice that needed to be changed because of the worsening effects they believed it could have on the child's fever. Two examples of how nurses attended to this phenomenon emerged from nurses' narratives and illustrate the varying degrees of cultural sensitivity espoused by nurses in this study. The following comments illustrate one nurse's actions toward intervening on behalf of the patient's well-being:

> I've explained to many young moms, "Baby has a fever. While it's good to keep baby warm under normal circumstances, today baby has a fever, and it's really important that you not put all these blankets on.". . . And if you take the time to do that teaching piece, then in my experience, it's always been really well received. . . . I've always gotten very good reception, in general. . . . They're very receptive to teaching. Tylenol. Motrin. Blankets. Rubbing alcohol doesn't make the fever go away on its own . . . you know, those kinds of things. They're interested. They're grateful. They'll thank you for the time. They'll stop putting the blankets back on the baby.

The exemplar above illustrates how the nurse reflected on her many experiences with caring for similar patients and families, and, as a result, gained insights into appropriate and inappropriate ways of intervening to undo a cultural practice that the nurse believed was ineffective in fever reduction. Reflecting on previous encounters helped the nurse to

become aware of which actions were ineffective at meeting her goals of educating the family and maintaining the well-being of the patient. Her efforts to undo the cultural practice were tempered with qualifying statements that demonstrated basic, good nursing care. The nurse reinforced the family's behaviors of keeping the baby warm, but added the caveat about certain conditions when the practice would be unwarranted. Although the nurse provided teaching to undo the cultural practice and imposed her views onto the family, her teaching included other culture-based means of fever reduction used by Latino families that the nurse had learned from similar experiences. This nurse's teaching efforts were built upon her recognition of the family members' interest and concern for the child's well-being and health, and the connection and involved engagement that the nurse was able to develop and maintain was apparent in how her teaching efforts were received.

In contrast to the exemplar presented above, another nurse described his interactions with Latino families as he intervened to undo the same cultural practice:

> When you get them unwrapped, and tell them, "No, they don't need all these blankets. They have a fever," they don't understand. . . . And I tell them, "No, that's wrong. That's dangerous, because it makes their fever get higher." They don't understand that. "This is what my mother [grandmother of the infant patient] has taught me. It has to be right."

Although this nurse approached the situation with the view that the culture-based practice was dangerous to the patient's well-being, his approach toward the family was almost forceful and lacked an engaged involvement that would have relayed to the family

his intentional concern and care for the well-being of the child. The nurse imposed judgment upon the cultural practice and provided no explanation beyond the practice being "wrong" and "dangerous." Rather than trying to understand the significance of the actions from the family's cultural perspective—that the practice had been handed down through generations and reflected the strong familial concern found in many Latino families—this nurse attributed the culture-based actions to the family's knowledge deficit.

Barriers to Culturally Sensitive Nursing Practice

Narratives revealed several aspects of nurses' work environments that influenced their abilities to provide care in a culturally sensitive manner. These included: (a) a lack of administrative support that would enhance nurses' practices, (b) a nurse's ethnocentrism, and (c) a lack of time to fully assess a patient's concerns.

Lack of Administrative Support for Culturally Sensitive Practice

Acquiring information about cultural beliefs and behaviors is requisite to nurses' abilities to develop awareness of and sensitivity to worldviews different from their own (Campinha-Bacote, 1995). Several nurses in this study viewed the hospital where they were employed as having a responsibility to provide ongoing staff development opportunities to improve nurses' abilities to provide care to Latino patients. Surprisingly, only one nurse in this study indicated that she had participated in workplace training aimed specifically at developing cultural competence. Nevertheless, several nurses identified this as a strategy that could improve care provided to Latino patients in the ED. As one nurse indicated, "I wish that the organization I work for would put its money where its mouth is and do some staff development to deal with cultural issues." In

addition to administrative support such as educational offerings, this nurse also indicated that she wished the facility where she worked would routinely seek feedback from Latino patients as a means of ensuring that Latino patient needs were being met:

> I know that they do patient satisfaction surveys, but I'm thinking maybe it would be nice to get some feedback from patients served in the emergency room of Mexican American or Latino origin of <u>their</u> perception of care received. 'Cause I don't think those are separated out. I think that they just go out to every 13th patient or something like that, and we get x number back. But I'm wondering if it wouldn't <u>hurt</u>, in the spirit of the mission, to do something a little more focused with such a big population. Send it out in Spanish.

Receiving cultural education, and gathering input from Latino patients and families about their nursing care would assist nurses in their efforts toward developing culturally congruent practices.

Ethnocentrism as Barrier to Culturally Sensitive Practice

Barriers to nurses' abilities to attend to cultural nuances in a culturally sensitive manner included the nurse's blindness to the significance of the belief or practice stemming from the nurse's ethnocentric views about health and illness. As was briefly mentioned by the nurse in the case regarding susto, nurses in this study recalled many experiences in which Latino patients presented to the ED and relayed lengthy histories that related their present illness to an event that had occurred in the past. One nurse's comments exemplify the sentiments expressed by many in regard to the lack of relevance nurses assigned to these verbal accounts of patients' present illness episodes, because of

the nurse's ethnocentric views:

> A perfect example is, you say, "When did this start?" And they say, "Well, six months ago this happened and this happened, and I did this and did that." And it's been going on for six months. . . . I mean, you have to just really sit them down and say, "Why did you come to the hospital today?" "Well, I threw up and I had a fever." Ah, now we're getting somewhere. Forget the six months. I just toss it out in my head because that's not really the issue. It is to them, but I'm not going to change that. . . . And I don't know whether these are less educated people, 'cause we don't know that.

As evidenced in the nurse's comments above, nurses who lacked cultural sensitivity immediately attributed behaviors to a patient's lack of education. Rather than maintaining a concernful stance that sought to meet the patient's particularized needs, the nurse's ethnocentric views regarded them as irrelevant and directed the nurse to ignore them altogether.

Time as Barrier to Culturally Sensitive Practice

As evidenced in the nurse's comments above, nurses who practiced from an ethnocentric stance immediately attributed beliefs and practices to a Latino patient's lack of education. Some nurses, however, had some sense that these beliefs and practices were culturally relevant, as evidenced in comments made by the nurse in the case regarding susto after she had sought additional cultural information. Despite having some idea how the patients' oral disclosures of past events were relevant to the current visit, time constraints in the ED limited the amount of attention nurses could give to patient

encounters involving this phenomenon. As one nurse stated:

> A lot of times, a lot of that stuff never gets addressed. It just goes by the wayside, and you deal with the problem that they're coming in with. If we stopped and solved every problem that came through the ER, we'd still be back in the ER somewhere in the past [laughs].

Nurses' narratives revealed that the nature of the ED did not always afford nurses time to tap into patients' worldviews and related information by dialoguing with patients about cultural beliefs that may tie into the patient's present illness condition, or how these beliefs might impact the outcome of the care received. Several nurses described the push to provide care in a timely fashion in the ED, especially when the unit was extremely busy with many patients waiting to be seen, and how this cultural nuance was often left unattended. And, as another nurse lamented:

> Even though I said that I've kind of been paying a lot more attention and kind of slowing my communication down with Spanish-speaking patients . . . I had a guy that came in. [I said] "Well, what's going on today?" "Well, two months ago at my sister's house, I hit my elbow." And you can see on the thing [chart] it says "Chest pain." And then it's like, "Okay, what's going on tonight?" . . . I was trying to slow down and do a better job at it. . . . I was just getting the ramble on, and it was just too much. We were too busy, and I had too many things that I needed to be doing.

Summary

There was variation among nurses in this study in relation to how well they grasped the implications of cultural nuances in patient care episodes involving Latinos. Nurses in

this study were not always cognizant of cultural influences on Latino patients' health-related beliefs and behaviors. Described elsewhere as "cultural blindness" (Cross et al., 1989, p. 15), some nurses believed that their care interventions could be universally applied to all patient populations. With regard to their abilities to recognize and attend to patients' culture-based needs and concerns, data analysis revealed that nurses in this study were at varying points along the continuum of becoming culturally competent (Campinha-Bacote, 1998; Cross et al., 1989; Giger & Davidhizar, 1999; Spector, 2000) Although their practices demonstrated varying degrees of awareness of cultural influences present in care encounters with Latino patients and families, recognition of the need to attend to those cultural influences in a particularized manner to meet patients' needs in culturally appropriate ways was not always realized. Nurses who attempted to practice in a culturally sensitive manner: (a) recognized the relevancy of Latino patients' unique, culture-based beliefs and behaviors, (b) acquired additional knowledge to further their understanding and enhance their practice, and (c) strove to address the needs and concerns in a particularized manner that promoted the integrity of the Latino patient and family and empowered them as advocates for their own well-being. In contrast, nurses who lacked cultural sensitivity did not attempt to uncover the significance of the beliefs or practices from within the patient's cultural context, instead viewing patients' cultural lifeways as the result of a knowledge deficit, a need for education, or as something to be changed.

CHAPTER VIII

SUMMARY, IMPLICATIONS, AND CONCLUSIONS

Summary of the Study

Purpose of the Study

This study had two purposes: (a) to describe concerns embedded in the care given to Latinos by nurses identified by their peers as expert in the care of Latinos in the ED so that the knowledge guiding their practices could be explicated; and (b) to determine if expert nursing practices were congruent with concerns brought to clinical encounters by Latino patients and could, therefore, be considered culturally competent. An interpretive, phenomenological design was used to elicit narrative accounts of the meanings and concerns directing the everyday experiences of nurses providing care for Latino patients in the ED and of the Latino patients who received that care.

Methods

Fifteen registered nurses from four hospitals located in urban or rural settings in a northwestern state participated in this study. Four of the nurses were identified as expert in the care of Latinos by their peers and 11 were not. Group and individual interviews were conducted during which nurse participants were asked to describe significant experiences they had in caring for Latino patients. Observations of selected nurses' practices enabled descriptions of the everyday, often-taken-for-granted context within which care occurred, including the environment, resources used by nurses, and events of clinical situations as they unfolded. Twenty-two Latino patients participated in this study by allowing the investigator to observe the nursing care they received from nurses whose practice was observed. Ten Latino participants were interviewed following their care to

uncover the concerns and issues they brought to the care encounter and to elicit their perceptions of the nursing care they received. All interviews were audio-recorded and transcribed verbatim in the language in which they were conducted. Nine of the 10 Latino participant interviews were conducted in Spanish. Verification of transcribed accounts, as well as English-language translations of Spanish transcriptions were done to ensure accuracy as well as to ensure that interpretation of these accounts was done within the linguistic and cultural context from which they emerged.

Data in this study consisted of interview transcripts and field notes from interview participant observation sessions. Data were analyzed through an iterative process of thematic analysis. A rereading of the narrative accounts led to the emergence of themes left unseen or unnoticed on previous readings. Emerging themes were used as a generative guide for writing the results. Exemplars and paradigm cases that captured concerns embedded in nurses' and Latino informants' experiences were selected. Trustworthiness of data and analysis was established through prolonged engagement; persistent observation; triangulation; peer debriefing; rich, thick descriptions; and reflective journaling.

Findings

Nurses' Concerns in Caring for Latinos in the Emergency Department

Nurses' concerns in the care of Latino patients centered around three over-arching categories: (a) coping with the language barrier, (b) involving family in patient care, and, (c) recognizing and attending to cultural nuances beyond language and family. These concerns are often interrelated and overlap as they focus nurses' attention and direct their actions during the triage, care, and discharge portions of a patient's care episode in the

ED. The context of the clinical situation determines the appropriateness of certain actions over others. A multitude of contextual concerns direct nurses' attention and guide their actions when patients present for care in the ED, not the least of which is concern with meeting the needs of patients and families amidst constant pressures to use time and other resources efficiently in an ever-changing and often hectic environment.

Expertise and Cultural Competence in Nursing Care of Latino Patients

Expertise is manifested in a nurse's involvement and concernful engagement in the patient situation (Benner et al., 1996). A caring and concernful stance impels the nurse to maintain an awareness of nuances in the environment that solicit his or her attention. Concernful attunement exposes possibilities that exist in the care encounter (Benner & Wrubel, 1989) upon which nurses act to provide care that is contextually based. Connecting with patients in a concernful and engaged manner allows nurses to know the patient (Tanner et al., 1993) and to provide care that meets the particularized needs that solicit the nurse's attention during the care episode.

Expertise and cultural competence in nurses' practices are also found when nurses establish meaningful connections with patients despite the presence of a language barrier. Care is culturally competent when the nurse's actions convey compassion, respect, and concernful engagement and genuine interest in the patient's well-being. Care that offers validation, comfort, and reassurance sets a tone of friendliness and warmth, which puts Latino patients and family members at ease and encourages verbalization of their concerns and needs. Nurses provide expert and culturally congruent care through charades and other non-verbal gestures that convey compassionate concern and respect, motivated by a desire to connect with the patient despite the inability to verbally

communicate. Using an interpreter in a skilled manner enables maintenance of concerned involvement and mutually satisfying relationships between nurses and NES patients through which a nurse's compassion and interest is conveyed. Finally, connecting with patients using a nurse's own Spanish-speaking abilities enables the formation of meaningful and personalized care that validates the patient's cultural uniqueness. Through Spanish, nurses recognize the immediacy of meeting patient needs in a concernful manner that promotes the person's cultural integrity.

Expertise and cultural competence in nurses' practices are found when nurses advocate for family presence during patient care episodes, involve family in care, and provide comfort, reassurance, and validation to family members present. Attunement to culturally distinct family networks solicits nurses' concerns and informs actions toward adapting the care environment to facilitate family presence and involvement. Providing information about diagnoses and treatment plans, and offering reassurances and comfort measures not only alleviate anxiety associated with being in an unfamiliar and often-frightening environment, it also validates concerns brought by patients and families to care encounters and enhances their abilities to remain active agents in their health promotion and maintenance.

Enhancers and Barriers to Expert and Culturally Competent Nursing Care of Latinos

Facets of nurses' practice and work environments that enhance or pose obstacles to expertise and cultural competence in the nursing care of Latino patients and families in the ED include: (a) a nurse's ability to speak Spanish; (b) interpreter availability, accuracy and stance, and nurses' abilities with working with them; (c) language-appropriate materials; (d) time; (e) cultural knowledge; and (f) bilingual and/or bicultural

peers, coworkers, and nursing supervisors. A nurse's reflection on knowledge and experiences and a desire to connect in meaningful ways enables provision of expert and culturally competent care. Additional facets that could pose as barriers to expert and culturally competent care in nurses' work environments include: (a) structural limitations posed by small examination rooms that impair nurses' abilities to accommodate family presence and involvement; (b) the culture of the ED, which inherently prioritizes care needs from emergent and life-saving to less urgent concerns from which nursing practices emerge; and (c) a deficit of cultural skills among nurses.

A nurse's ability to speak Spanish enhances connections formed with Latino patients and families and enables nurses to immediately intervene on behalf of NES patients, especially when interpreters are not readily available. A nurse's use of Spanish during care encounters puts patients and families at ease in an unfamiliar and frightening environment; in turn, it increases their verbalization of concerns and questions.

Interpreter availability, consistency, accuracy, and engagement enhance culturally competent and expert care. Conversely, unavailability of interpreters and an interpreter's disengagement impede culturally competent and expert nursing care. Having interpreter assistance readily available enables nurses to remain present with patients' concerns and to establish and maintain open lines of communication throughout care episodes. When interpreters are not readily accessible, or are called away to other duties during the patient's ED visit, nurses are often left feeling as if their care falls short, not only of what patients desire, but what nurses desire as the standard of quality for their practice.

An interpreter's accuracy is dependent upon the comprehensiveness and adequacy of training received, as well as the level of involvement the interpreter invests during care

episodes. An interpreter's accuracy, and engaged and interested stance enhances the likelihood that messages between nurses and patients are relayed completely and in the spirit in which they are intended. An interpreter's attunement also adds to nurses' understandings of cultural nuances and the contextually embedded meanings they hold for patients and families. For instance, nurses' concernful involvement is augmented when interpreters direct nurses' attention to cultural phenomena and provide nurses with additional cultural information to assist in planning and providing appropriate care. Interpreters displaying discomfort with what is happening in the care environment, or disinterest or displeasure during the patient encounter focus nurses' concerns on the extent to which patients feel cared about and valued. Non-verbal cues displayed by interpreters that convey disrespect toward Latino patients and families interrupt nurses' involvement in the clinical situation and pose challenges to nurses' efforts toward conveying concern, respect, and compassionate care.

The concernful involvement nurses are able to sustain with their patients is enhanced when nurses are skilled at working with interpreters. Nurses who are less skilled in this area lack the confidence and/or ability to redirect the interpreter, so that an engaged, concernful involvement with patients and families is maintained. As a result, the interpreter's involvement becomes an interference, a disruption to their nursing practice; their natural way of communicating with patients is made more visible and effortful, and their ability to intervene to ensure the patient and family feel valued is impaired.

The ability to quickly retrieve pre-printed, linguistically appropriate information and discharge instructions enhances nurses' abilities to provide culturally competent care by enabling the delivery of comprehensive and individualized patient information. Directing

bilingual coworkers to transcribe English language information by hand exposes the potential for misinformation to be relayed to patients, especially when the ED is busy and bilingual ancillary staff are in high demand.

Concerns regarding the importance of expediting the flow of patients through the ED, especially when the unit is extremely busy, inhibit nurses' concernful involvement and causes them to shorten the time they spend with NES patients. For instance, time constraints prevent nurses from listening intently and remaining engaged to patients' elongated histories of presenting health concerns. This practice disregards any cultural relevance the information may have to the patient's presenting illness and the impact it may have on the patient's care needs and outcomes. Concerns about using time efficiently also influence how much attention nurses can give to reviewing discharge instructions and to allowing patients time to ask questions.

Although nurses are concerned with time constraints, which necessarily challenge their practice, they are able to remain engaged in patient situations when they are attuned to their patients' needs for their presence. Nurses report manipulating the care environment to allow one-on-one time and care for patients, as occurred in the nurse's care of the NES patient who presented with a severe back injury.

Informants, such as nurses' family members, coworkers, peers, and Latino patients and their families are sources of information that assist nurses with learning about beliefs and practices unique to Latino cultures. Developing a cultural knowledge base helps avoid oversimplification of salient features of cultural groups and assists nurses in identifying ways to assess variation within these groups. Cultural knowledge is requisite to a nurse's ability to develop cultural attunement and skills to incorporate cultural

nuances into the provision of care. Knowledge of Latino patients' cultural beliefs and practices enables nurses to plan and provide care that meets particularized needs that maintain the cultural integrity of their patients. With cultural knowledge, nurses gain an awareness of differences that exist between the belief systems, or worldviews, of patients and nurses.

A lack of cultural knowledge leads nurses to impose their ethnocentric views onto patients in an effort to undo the cultural practice in a culturally insensitive and inappropriate manner. As in the case regarding susto presented in Chapter VII, some nurses are quick to intervene and to work to undo a cultural belief without first considering its significance from the cultural perspective of the patient or family. Some nurses who lack cultural knowledge struggle with knowing whether to intervene on behalf of a patient's culture-based beliefs and behaviors, without knowing if those beliefs or behaviors are attributable to a lack of knowledge or to the patient's worldview.

Bilingual peers and coworkers enhance culturally competent and expert care by: (a) adding to the knowledge base that informs nurses' understanding of cultural nuances by teaching nurses about cultural practices and beliefs, and appropriate and inappropriate interventions in the care of Latinos; (b) providing an environment in which nurses are encouraged to learn about cultural nuances and to learn and use Spanish; and (c) providing compassionate care to Spanish-speaking patients when a nurse's Spanish abilities falter. Nursing supervisors can support nurses' expertise and cultural competency by being flexible with policies and allowing family presence and involvement. All of these features of nurses' work environments become barriers to their efforts when coworkers, peers, and supervisors hold negative views about Latino patients

and families and remain inflexible and ethnocentric in their beliefs and actions. Discouragement from coworkers and supervisors, and the inflexible and distasteful attitudes they may embrace, serve as negative role models for nurses who realize the far-reaching implications of such culturally insensitive behaviors.

Clinical situations present nurses with indeterminate and sometimes ambiguous elements that demand their attention (Benner, 1984; Benner et al., 1996; Benner et al., 1999; Schon, 1983), such as in patient encounters that involve cultural nuances unfamiliar to nurses. Nurses look for the familiar in the unfamiliar to see how it links with what knowledge they might already have (Polanyi, 1962). To reflect means to ponder, to think carefully (Landau, 2002). Nurses' personal appraisals, and reflection on experiences and knowledge influence their interpretation of the clinical situation (Schon, 1983), and guide them in their actions to effect positive patient outcomes. With reflection upon one's knowledge and practice experiences comes insights into how one understands nuances in clinical situations and approaches patient care.

Stories told by nurses in this study revealed how some nurses focused on patients' strengths, and how nurses embraced the importance of values found within Latino cultures during patient care encounters. A few nurses also offered insights into limitations within their nursing practice that impaired their abilities to provide culturally sensitive care. Such insights only come to nurses from time spent carefully pondering care experiences and reflecting upon the ways their actions resulted in care that went well, or those that did not go as well. Some of the nurses in this study reported insights gained in their own practice—both good and bad—as a result of being in this study, and made changes in the ways they approached, spoke with, treated, and spent time with Latino

patients and families.

In addition to reflecting on their practice, nurses in this study whose care exhibited expertise, cultural competence, and/or cultural attunement demonstrated a desire to develop concernful involvement with patients and their families through which their compassion and concern could be conveyed. Described elsewhere as *cultural desire* (Campinha-Bacote, 1999), this attribute impels nurses to provide care in a genuine and concernful manner that aspires to meet patients' needs in a culturally sensitive and appropriate manner. Patients and families sense when nurses are genuinely interested in and invested in their well-being. "Cultural desire includes a genuine passion to be open and flexible with others, to accept differences and build on similarities, and to be willing to learn from others as cultural informants" (Campinha-Bacote, 2002, p. 183). Nurses with such a desire admit when their own knowledge and understanding fall short, and they seek additional resources that will enhance their abilities to provide care in a manner that respects the dignity and cultural integrity of Latino patients and families.

Nurses without this desire remain myopic in their views about the cultural practices of Latino patients. A lack of desire leads to little, if any, effort toward acquiring cultural knowledge to improve one's understanding and cultural awareness. Nurses who lack cultural awareness and desire remain culturally blind (Cross et al., 1989) to the need to incorporate patients' beliefs and behaviors into the plan of care. Instead of recognizing heterogeneity in patient populations, these nurses espouse a belief that a one-size-fits-all approach to nursing interventions is sufficient in meeting patient needs. Despite having some awareness of cultural beliefs, and despite continued exposure to culturally and ethnically diverse patients, nurses who lack this desire continue to embrace ethnocentrism

and view biomedicine as the gold standard by which other cultural beliefs and practices are judged. As a result, these nurses' practices remain inviolate, and their concerns continue to focus upon imposing their beliefs onto patients and families in an effort to change their culturally prescribed practices.

The culture of the ED manifests itself in unspoken values, beliefs and behavioral norms that serve as a transparent set of assumptions within the nurses' workplace. The influence that the culture of the ED has on nurses' lack of involvement and concernful attendance during patient situations is evident when nurses talk about inappropriate access of the ED, by Latinos and non-Latinos alike. Several nurses in this study voiced concerns regarding return visits to the ED made by Latino patients and family members for the same health-related concerns they were seen for previously in a clinic or in the ED. Nurses had differing views as to what they attributed this phenomenon to. While some understood that repeat visits were directly attributable to a patient's receipt of insufficient discharge instructions or information during their previous ED visit, others attributed the visits to a lack of knowledge on the part of the Latino patient or family.

While nurses' concerns with patients' inadequate understanding of diagnoses and treatment and inappropriate use of the ED are not unique to Latino populations and are not entirely unfounded, the culture of the ED can blind nurses to their own inadequacies with accurately assessing patient needs and expectations in the first place. Challenges surface when providing care to culturally and ethnically diverse patients who lack an understanding of biomedical beliefs and practices. Incorporating patient concerns, needs and expectations into care provision is imperative if desired outcomes, including culturally congruent care, are to be realized.

As illustrated in the discussion presented in Chapter VII, nurses' lack of skills, such as cultural assessment tools that could assist in appraising patients' concerns and culture-based needs for their ED visit, prevent nurses from providing appropriate interventions. Unlike the language barrier and family presence, other cultural nuances are less tangible and less readily accessible to nurses; these nuances present a unique challenge in the care of Latino patients and families. Without sufficient knowledge and skills, nurses remain reluctant to ask patients directly about their culturally unique practices for fear of offending them or of embarrassing themselves or the patients. Meeting patients' particular expectations for care would impact the clinical episode and the outcome of the care.

Limitations of the Study

Although the methodology for this study was appropriately applied for its aims, there were several limitations. First, the sampling method for identification of expert nurses posed several limitations. Nurses who were informed about the study at staff meetings were asked to identify nurses in their workplace "to whom other nurses turn for guidance and assistance in providing care to Latino patients in the emergency care setting" (see Appendix N). These criteria for the nomination of experts were vague and ambiguous given that the underlying assumption was that these nurses' practices would be culturally competent. Close examination of the practices of nurses who were identified as experts by their peers revealed that the only commonality they shared was their ability to speak Spanish. Three of the 4 nurses identified as experts by their peers did not exhibit expertise or cultural competence in their care of Latinos. Additionally, the narratives from these 3 nurses revealed a lack of cultural attunement and sensitivity, in total contrast

to the cultural competence one would expect to find in their practices. A distinctive characteristic of the one nurse who was nominated as expert and whose practices exhibited both expertise and cultural competence was that he had had extensive immersion experiences in Latin American countries that enriched his cultural knowledge and skills, whereas the other three nurses had not. In this study care was found to be culturally competent when nurses attended to patients' concerns related to communication and information needs, family involvement, and the need to feel cared about and valued; this included being provided respectful care that offered validation, comfort, and reassurance. Therefore, simply asking nurses to identify those nurses to whom they turned for guidance and assistance in the care of Latinos did not provide nurses with clear direction in differentiating the quality of nursing practices relative to a peer's cultural knowledge and skills, and ability to provide compassionate and respectful care.

A second limitation with the sampling method was in the self-selected nature of the nurses who volunteered to participate in the study. The nurses who participated in the study may have had more interest in the care of Latino patients than nurses who did not return contact information to the investigator. Although no claims for generalizations are made in qualitative research, a sample that is representative of ED nurses' experiences is desired. Nevertheless, the findings from this study can enhance other nurses' understanding and offer insight into the care of Latino patients in the ED, and the practical concerns that direct the provision of culturally competent nursing care.

A third limitation of the study was the geographical clustering of participating hospitals. The four hospitals in which ED nurses' and patients' experiences were

examined are located within a 20-mile radius. Additionally, 9 of the 10 Latino informants immigrated from areas that are in geographic proximity to one another in central Mexico. Due to immigration patterns and migratory practices that suggest clustering of family and wider social networks (Gutiérrez, 1996; Vega, 1995) having a broader geographical sampling of nurses' practices and Latino patients' experiences may have revealed differences in concerns and patterns embedded in nurses' practices relative to specific ethnic or cultural groups not found in the present findings.

Several limitations of the study are related to the credibility of findings. One strategy that was used to enhance the credibility of findings was prolonged engagement. However, several Latino informants indicated that the nursing care they received was better during observed encounters than what they had previously received from the same nurse; they alluded to the possible effect the investigator's presence had on the nurse's performance. The following quote from one informant reflects how the care her family received was different from treatment they had received from the same nurse on previous occasions, and exemplifies the sentiments expressed by other informants in this study:

> She explained more the procedures, what they were gonna do. What they needed. Like the urine sample, or the x-rays. . . . But like this time it was way different than the last time. Maybe it was because somebody was there watching them and they felt kind of like, you know, they gotta do things.

As evidenced by the descriptions of several nurses who had reflected on and subsequently changed their practices, an increasing awareness of one's practice was a by-product of being a participant in this study. Although the study becoming an intervention,

of sorts, could be viewed as a strength, and although efforts were made to minimize the potential "halo effect" on nurses' performance by scheduling observation sessions in close proximity to each other, the possibility that being observed heightened nurses' awareness and influenced their actions and provision of care cannot be discounted. Additionally, and somewhat connected is the concern that an Anglo nurse conducted the study in a predominantly Anglo community. Efforts were made to establish safe environments in which nurse participants could freely and openly describe their nursing care experiences with peers during group and individual interviews. However, the potential exists that participants may have held back honest accounts of experiences, actions or thoughts for fear of being ostracized by other nurses in the group and/or by the investigator if nurses admitted to having negative biases or providing culturally insensitive care.

An additional limitation of this study was that participant observation sessions were not conducted with any of the bicultural, bilingual nurses who participated in this study. None of these nurses met the inclusion criteria for selection to participate in this additional data collection activity. However, the examination of any differences that the nurses' language and culture may have made in the contextually embedded concerns that directed their practical knowledge and actions in relation to non-Spanish-speaking Latino/Latina nurses in the study was not done.

Another limitation of the study is related to the data analytic process. All of the data collection took place within a 5-month period. Although earlier interviews were transcribed and reviewed via a global reading of nurses' narratives, and emergent themes were brought to subsequent interview sessions for further exploration, the majority of the

data were not analyzed until after all data collection had occurred. Thus, themes that emerged through analysis of interviews conducted later were not further explored or clarified by participants. Additionally, due to an oversight in the investigator's construction of the informed consent forms, member checks were not built into the design of the study. This further precluded review of analysis by study participants.

The last limitations of the study relate to the inexperience of the investigator and the research assistant. Although the investigator has had some experience in conducting research, it has generally been quantitative. The research assistant also had had some experience with research, mainly in conducting interviews following a closed-ended question format. This inexperience with the interview process and with probing participants to fill in details of their experiences proved challenging and limited the fullness of narratives obtained. A broader background in qualitative inquiry may have resulted in eliciting thicker descriptions of participants' experiences. Instead, Latino informant interviews were generally sparse, and nurse interviews were oftentimes directed more at gathering nurses' conceptualizations of their experiences than their recalling stories as if they were still involved in them. Additionally, although the investigator has had experience with providing nursing care to Latino individuals and families, familiarity with concerns and challenges that surfaced in those experiences may have biased the interpretation of the data. To enhance trustworthiness of the findings, the dissertation committee members provided varying viewpoints and objective review of the analyses, which challenged the investigator's interpretations and minimized personal biases that were brought to these processes.

Implications of the Study

The findings from this study have several potential implications for nursing, particularly in the areas of education, administration and practice, research, and health policy. First, it is hoped that this study will contribute to the body of knowledge informing culturally competent nursing care of Latino individuals and families. However, cultural competence cannot be assumed unless a patient's perceptions of that care are elicited, as was the case in this study in the form of Latino informant narratives, and the care is found to be congruent with the patient's particular needs. Therefore, throughout the following discussion, the term "cultural competence" implies that a patient's voice provided such verification. Explicating the concerns embedded in nurses' practices reveals knowledge and skills that can inform nurses' practice and stimulate nurses' reflection and examination of their own practices in the context of caring for Latinos. In addition, the study can sensitize nurses and policy makers to the far-reaching effects of the insidiousness of ethnocentric and biomedical influences that impede provision of effective care to Latino populations. The various ways this study has the potential to inform nursing will now be discussed.

Implications for Nursing Education

Nursing literature reveals substantial interest in the concept of cultural competence as it relates to nursing education (ANA, 1986; Andrews & Boyle, 1997; Davis et al., 1992; Fletcher, 1997; Gonzalez, Gooden, & Porter, 2000). Emphasis is placed on nurses' adequate preparation for delivering appropriate and effective care to culturally and ethnically diverse patient populations in this increasingly pluralistic society. Cultural competence is developed from a basis of extensive experience and (a) reflecting upon

caring for individuals from culturally diverse backgrounds, (b) acquiring cultural knowledge about one's own culture as well as the cultures of others, and (c) incorporating the patient's belief system and value orientation into a plan of care that addresses the patient's needs and concerns in a particularized manner (Andrews & Boyle, 2003; Campinha-Bacote, 2002; Giger & Davidhizar, 1999; Spector, 2000). Findings from this study that reveal successes and struggles in these areas of a nurse's development of cultural competence can be extended into nursing education.

The findings from this study reveal a great need to demystify cultural beliefs that differ from biomedical beliefs and acquaint nurses with understanding and talking about broader belief systems encountered in their everyday practice. Students and practicing nurses need to realize that biomedicine may be considered alternative to practices and beliefs espoused by Latino patients and families. Nursing curricula need to include content that orients students to commonly prescribed beliefs and practices found within Latino cultures. Educational programs must prepare students to adequately conduct cultural assessments to identify patients' worldviews and to incorporate these into the provision of care. Students need to participate in cross-cultural care encounters so that they can recognize variation among and within cultural groups. Learning opportunities such as these assist students with understanding that universally applying some cultural knowledge to all Latinos is insufficient in meeting patients' particularized needs. Additionally, educational offerings must sensitize students to how their own perspectives of patients' practices and beliefs will influence their nursing actions. For instance, simply framing language barriers as the fault of nurses' inabilities with speaking Spanish is a first step toward cultivating students' cultural sensitivity.

Nursing students must have proficiency in the Spanish language if their nursing practice is to occur primarily with Latino individuals and families. Data in this study reveal the advantages brought to nurses' practices when they are able to speak with NES patients directly. Speaking Spanish enables nurses to remain present with patients, and to convey respect for the patient's cultural identity.

Finally, as evidenced by nurses' accounts in this study, a lack of ability to work effectively with interpreters impairs the gathering of valuable and applicable cultural information. Therefore, it is suggested that students be given opportunities to engage in situations requiring the use of interpreters to familiarize themselves with nuances that must be attended to in maintaining an engaged stance and orchestrating care in a manner that encourages verbalization from NES patients and family members. Practice encounters such as these will also support students' skills in developing collegial relationships in health care settings.

Applying the abovementioned areas of content to classroom and clinical situations in which nursing students can practice cultural assessment skills will assist students in identifying and working through areas of discomfort related to working with interpreters, discussing patients' cultural lifeways that differ from their own, and in discovering the ways in which their ethnocentric views may act as barriers to incorporating patients' cultural beliefs into the plan of care. Ensuring that nursing students understand diversity among belief systems, including their own, and that they risk operating from an ethnocentric stance until challenged by their own or another's cultural attunement, will further efforts toward developing students' cultural attunement and ability to provide culturally competent care. Awareness of one's own culture is the first step toward

acceptance of the views of others; this, in turn, is a necessary component as one moves toward developing cultural competence (Campinha-Bacote, 2002). Cultural relativism does not mean that anything goes and that nurses should condone unsafe behaviors. Findings from this study regarding nurses' efforts to undo cultural practices they viewed as potentially harmful can fuel discourse in educational institutions preparing students for the nursing profession by encouraging students to examine such practices and challenge assumptions they may hold about culturally prescribed practices.

Implications for Nursing Administration and Practice

Health care systems must foster environments that promote culturally competent nursing care. Nurse administrators can play a key role in ensuring that systems in place have the necessary resources for nurses to achieve this goal. Likewise, nurses bear a responsibility in the quality of patient care and must use resources effectively to enhance their abilities in care provision. Findings from this study reveal obstacles in nurses' work environments that impede their efforts at providing culturally competent care. Findings also reveal the value of insights gained and changes made to nurses' practices as a result of reflecting on one's own nursing practice, and hearing and learning from the experiences of others. Findings can inform nursing administration in the following ways: (a) ensure that care environments foster acceptance of cultural diversity and reject notions of racism, (b) ensure that staff development opportunities that adequately promote cultural knowledge and skills are made available to nurses, (c) provide nurses with opportunities to dialogue with other nurses, sharing stories of challenging, puzzling, rewarding, or discouraging care encounters, and (d) allow nurses extra time when caring for NES patients to ensure appropriate and comprehensive care. The ways these

implications for nursing administration can inform nursing practice will now be discussed.

The concept of race has more to do with socially embedded meanings of classification between socioeconomic and cultural groups than it has to do with genetic variance (Jones, 2000). Racism exists on several levels, including institutional and personally mediated (Jones, 2000). "Institutional racism is often evident as inaction in the face of need" and "manifests itself...in material conditions" that lead to differential access to resources and services (Jones, 2000, p. 1212). Personally mediated racism, or, prejudice and discrimination, can be intentional or unintentional, "includes acts of commission as well as acts of omission" and "manifests as a lack of respect" displayed by providing "poor or no service" (p. 1213). Findings from this study reveal institutional racism in facilities that do not have, or discourage nurses from accessing medically qualified and trained interpreters who would ensure that patients' linguistic needs are met accurately and efficiently. Findings from this study reveal that personally mediated racism exists when nurses' peers, coworkers, and supervisors blatantly ignore the needs of Latino patients, purposefully provide less attention to the quality of care because of negative attitudes held about Latinos, and provide differential care that is intolerant of divergent, culturally distinctive characteristics. It is hoped that negative attitudes and behaviors exhibited by nurses' coworkers, peers and supervisors that, as findings from this study reveal, become barriers to nurses' abilities with maintaining concernful involvement with patients and families, can be remediated by nursing administrators enforcing policies against discrimination and racism in nurses' work environments. Promoting an environment in which nurses, other providers, and staff are comfortable

with challenging the prejudiced statements and actions of others fosters awareness and acceptance and, in turn, aids in eliminating racism.

Institutions play a large role in the ongoing professional and cultural development of nurses. All are stakeholders in the provision of culturally competent care in the ED – administrators, nurses, patients, and families. Nurses need to learn about cultural beliefs and practices of the patient populations for whom they routinely provide care, and administrators hold much responsibility for contributing to a nurse's knowledge base by providing ongoing staff development opportunities. A major, and surprising finding in this study was nurses' lack of familiarity with cultural nuances present in many care encounters, given the long-standing pluralism of their communities. This study finding begs the question as to why nurses lack the ability to readily identify and incorporate the patient's belief system into the plan of care. Staff development in the following four areas can foster nurses' professional growth and enhance culturally competent care of Latino patients and families: (a) cultural awareness activities, (b) cultural information and assessment activities, (c) classes aimed at improving nurses' Spanish abilities and skills with working with interpreters, and (d) peer debriefing and information exchange sessions.

Cultural awareness activities in which nurses identify their own cultural upbringing, including illness- and health-related beliefs and behaviors espoused by their families of origin, would encourage nurses' development of acceptance and understanding of culturally prescribed practices different from their own. Providing nurses with sufficient opportunities to interact with culturally and ethnically diverse individuals and families outside of the ED setting to inquire about beliefs and behaviors different from their own

and helping them to appropriately incorporate these into patient care could contribute significantly to nursing practice. Findings from this study reveal a need for care environments that are open to a mutual exchange and reciprocity of information sharing between nurses and patients so that both parties can begin to understand the other. To do this, nurses need to develop ease with conducting cultural assessments. As evidenced in nurses' narratives in this study, attempts at uncovering cultural nuances related to patients' ED presentations were not always successful. Various factors impeded nurses' successful cultural assessments, such as interpreters who misunderstood the intent of questions such as, *"What do you need from me right now?"*, or because of the nurse's reluctance to directly ask patients about their health and illness beliefs and practices. As discussed in Chapter VI, there are guidelines available to assist nurses in this capacity (Gonzalez-Calvo et al., 1997; Kleinman et al., 1978; Thompson, 1997; Tripp-Reimer et al., 1984). The model provided by Kleinman et al. (1978) provides questions that can be easily applied by nurses during patient care situations. For example, simply asking patients, *"What do you think has caused your problem?"* might help in uncovering patients' culturally embedded beliefs about illness (Kleinman et al., 1978, p. 256). Additionally, nurses may find it easy to ask a fairly innocuous question such as this, whether working with or without interpreters.

Transferring knowledge and abilities with assessing cultural information gained from activities such as those described above to the nurse's practice setting may result in nurses becoming more attuned, more understanding and accommodating, and less ethnocentric in their efforts toward meeting the needs and concerns of Latino patients. Although it is important for nurses to recognize and appreciate diversity in belief systems

found in the care of Latinos, nurses must be careful not to approach Latino patients as *Latinos*, but rather to approach *all* patients by first acknowledging that as people, we all face the same human dilemmas. An approach such as this, as discussed by Tripp-Reimer and Fox (1990), serves to eradicate the "paradigm of distance" that exists in many health care encounters and that "fails to take into account the separating and alienating effects of the method" of categorizing differences (Tripp-Reimer & Fox, 1990, p. 544).

Being open to the patient's perspective and communicating openly about cultural practices would assist nurses with understanding the patient's cultural lifeways. Likewise, nurses must share with patients the rationale for biomedical beliefs and treatment modalities to enhance their patients' understandings of practices different from their own. Open discourse such as this may not lead nurses to abandon all negative judgments about cultural practices that are different from their own, nor will the care necessarily support the original cultural belief of the patient or family. However, maintaining an open approach does involve making sense of others' actions and beliefs by trying to understand them in the cultural context from which they emerge and demonstrating a willingness to critically examine one's own pre-understandings. Ethnocentrism and cultural blindness have no place in culturally competent care. The findings from this study reveal the need for the focus in nursing practice to shift from a dichotomous choice between tolerance or intolerance to one of dialogue and mutual understanding.

Findings from this study reveal that nurses lack access to tools that could assist them with assessing a patient's English language proficiency. To accurately and comprehensively meet patients' linguistic needs and to determine the need for interpretation services, this is an area in nurses' practices that requires attention. As was

mentioned in Chapter IV, tools are available to nurses for this activity (Enslein et al., 2002). Additionally, in relation to patients' linguistic needs, findings reveal nurses are inadequately prepared for working effectively with interpreters to ensure that communication needs are met during care encounters. Nurses should participate in training sessions to observe cues in the environment that may indicate a lack of patient understanding or miscommunication. Additionally, nurses need to know how to redirect interpreters as needed to maintain concernful involvement with patients and families. Arranging for nurses and interpreters to participate in joint sessions would allow both to practice their skills and to understand what is expected of each one in the health care arena as well as the intentions behind the actions and messages relayed by both during care episodes. Finally, nurses must routinely invite interpreters to direct nurses' attention to cultural nuances that nurses may not notice or may not fully understand.

Nurses could benefit from staff development aimed at helping them to improve their Spanish skills. Although several nurses in the study claimed some ability with the Spanish language, it was evident that without the desire to learn, which was often fostered through positive feedback and a nurturing environment that supported nurses' continued efforts, relying upon an interpreter became an easier and more effective way of attending to patient needs than having to deal with difficulties encountered when nurses attempted to use their own Spanish. To convey care and concern to NES patients and families, nurses working in settings that provide care to Spanish-speaking populations should, at the very least, learn how to communicate to patients, when interpreters are not available, that they matter and are important. Findings from this study revealed how patients noticed when nurses were concernfully involved in their care. Nurses, too, felt

torn at leaving a patient's presence to locate an interpreter and not being able to assure the patient of their return. Nurses must be able to communicate important phrases so that NES patients and families know that they are cared about. At the minimum, nurses should be able to say, *"I am sorry, I do not speak much Spanish. You are important to me. We are waiting for an interpreter."*

It is believed that without reflection, nurses cannot develop expertise in practice (Benner et al., 1996). Certainly, as evidenced by findings from this study, reflection on one's practice adds to a nurse's development of expertise. An additional caveat that emerged from this study is that reflection without cultural awareness impedes a nurse's development of cultural competence. To foster their own and the professional and personal growth of others, practice settings must encourage nurses to share stories of critical incidents with each other (Benner et al., 1996; Benner et al., 1999). Nurses should be encouraged to hold forums or debriefing sessions about their experiences with culturally diverse patients. Hearing the experiences of others would benefit seasoned as well as inexperienced nurses. Nurse administrators must encourage nurses to talk openly with other nurses about their experiences caring for culturally and ethnically diverse patients, to give nurses the opportunity to ask about actions and thought processes, and to "confess" mistakes made in an environment that is supportive and nurturing to the nurse's growth (Benner et al., 1999). Findings from this study revealed that in addition to enhancing a nurse's awareness of his or her own practice, hearing others' stories added to nurses' cultural knowledge base when other nurses acted as cultural informants during group interviews.

An additional implication of this study to nursing practice that does not directly

involve staff development but that can inform practice, relates to findings that highlight time constraints that undercut nurses' efforts toward providing culturally congruent care in the ED. Findings from this study reveal that although nurses may well be aware of the need to attend to cultural nuances in patient encounters and have the skills to do so, the extent to which they could do so is often mediated by expectations to move patients through the ED in an expeditious manner.

Concerns regarding time appreciably shortened or obliterated nurses' presence with Latino patients. Nurses were aware that their actions often resulted in patients leaving the ED not fully understanding their diagnosis or treatment plan, and, at times, returning to the ED for the same complaint. However, the norms of the ED environment led nurses, more often than not, to negatively judge patients for doing so rather than adapting the care environment in a patient-focused manner. Nurses' minimizations of patients' concerns, especially when patients presented with what nurses viewed as benign conditions such as ear infections, led to views of Latinos as uneducated abusers of the system for accessing non-emergent care in the ED. These sentiments were exacerbated during extremely busy moments in the ED due to nurses' concerns with time allocation. What these findings reveal is that nurses need to develop attunement to patients' particularized concerns, and make every effort to identify their own roles in patients' unnecessary use of the ED. A related finding was that nurses readily admitted that Spanish-speaking Latino patients had to wait for longer periods to receive care, due to the unavailability of interpreters. If taking more time to provide care to NES patients because of interpreter unavailability has become an expectation, then nurses and administrators could also view the need to routinely provide nurses with more time in which to

comprehensively address patients' concerns. Nurse administrators must support nurses' efforts toward adjusting patient assignments in order for nurses to satisfactorily and comprehensively meet patients' needs and concerns in a non-hurried fashion.

No one can deny the need for Latino patients and families, as well as non-Latino patients and families to learn appropriate usage of the ED. A more critically important facet of this phenomenon is the lack of access to healthcare elsewhere. Latino informants in this study readily admitted difficulties they encountered when trying to access health care at clinics or other ambulatory health care settings. These difficulties, such as delays in getting appointments for current health concerns, led them to utilize the ED instead. Until solutions to such health care system issues can be found, however, nursing care will continue to need to be provided in a culturally sensitive manner that strives to promote the patient's cultural integrity rather than views patients as uneducated and burdensome.

Implications for Nursing Research

This interpretive study uncovered practical concerns embedded in nurses' and Latinos' care experiences that, in turn, exposed several concerns regarding nurse–patient encounters and the broader environment in which care is provided that compel further study. First, nurses' assessments of patients' English-speaking abilities warrants further study, given the subjective nature of the resultant determination, at times, to not use interpreters. Application of tools such as the one presented by Enslein et al. (2002), and the resultant influence they may have on nurses' actions as well as on quality of care from patients' perspectives, bear further examination. It is suggested that similar screening tools be developed to assist nurses with recognizing other measures of a patient's acculturation that could illuminate the potential to be more closely attuned to

cultural nuances underlying patient presentations and influencing patient outcomes.

Second, this study uncovered the contextual embeddedness of nurses' practices that proved to be culturally competent in the ED. Extending this research to other areas within nursing practice would contribute further to the knowledge base informing cultural competence in nursing care. Somewhat related is the need to determine the extent to which culturally competent nursing practices influence patient outcomes. According to Anderson, Toledo, and Hazam (1982), "We need outcome studies to demonstrate what impact, if any, is realized by making clinical care more culturally appropriate" (p. 326). Satisfaction surveys that solicit qualitative as well as quantitative data, and tools to measure physiological outcomes could provide evidence for efficacy or inefficacy of nurses' actions.

Uncovering non-Latino/a nurses' understandings of Latino cultures and how their nursing practices are influenced by these understandings was a strength of this study, especially in light of the fact that the four paradigm cases presented in Chapters IV-VII illustrating expertise in nurses' practices through using charades, using an interpreter, using Spanish, and involving family, were care episodes in which the nurses were non-Latino/a. The findings from this study have valuable implications for extending this research to other areas of nursing practice, for determining whether or not differences exist between Latino and non-Latino nurses' desire to connect in meaningful ways with Latino patients and for identifying to what these differences might be attributed. Future research could also explore more deeply the differences found in nurses' abilities to provide culturally competent care to Latino patients, and the way nurses develop expertise with particular cultural groups.

Future research must also examine more closely nurses' work settings to further explore facets that serve as enhancers and barriers to the provision of culturally competent care. For instance, *does a qualitative difference exist between the accuracy and completeness of discharge information transcribed by bilingual ancillary staff and that which nurses could retrieve from computer software*? If so, *does this difference have any correlation to inadequate information being relayed to patients and to repeat ED visits*? Research focusing on ways that barriers to nurses' efforts can affect Latino patients and the outcome of care is also suggested. Several questions need to be asked. For example, *to what extent do patient presentations that involve lengthy historical accounts relate to susto, or other culture-based beliefs about illness?* And, upon discovering that the information does relate to a cultural belief, *to what extent are repeat ED visits a result of not having that culture-based belief addressed?* There exists a need to study whether or not culture influences behaviors related to patients' presentations when accessing care in the ED and other ambulatory care settings. *Should nurses cue into culture when the Latino patient starts to provide lengthy verbal accounts of their present illness? Do non-Latino patients routinely present in the same manner?*

Another strength of this study was the inclusion of Spanish-speaking and non-Spanish-speaking Latinos. Explication of patients' concerns and perceptions of care to verify the congruence of expertise in nurses' practices has been absent from previous research. There is a paucity of research involving NES Hispanic individuals. Frayne et al. (1996) reported that only 22% of studies they reviewed involved NES participants. The reasons NES participants were excluded from the studies ranged from investigators simply not thinking about this population, to concerns about the feasibility of adapting

methods and related budgetary constraints. The principle of justice discussed in the Belmont Report mandates that there be fairness in the distribution of benefits and burdens associated with research participations (Department of Health, Education, and Welfare, 1979). Involving NES persons in research may have associated risks and costs, but the benefits derived can enhance the well-being of this population and nursing practice through the development of knowledge that can inform health care interventions. Diversity must be embraced using the unique cultural attributes of individuals as a basis for developing culturally appropriate research methods.

A few Latino informants in this study expressed appreciation for the ability to voice their perceptions of and concerns regarding the nursing care they had received in the ED. Further research exploring nursing care of Latinos must include Latino participants to validate efficacy and cultural competence of nursing interventions. It is imperative that research continue to focus on ways to effectively intervene on behalf of Latino populations to effect desired changes in disparate outcomes. Latinos must be involved as active participants in this research agenda (Torres, 1996).

Implications for Health Policy

This study can inform health policy in several areas of nursing, first, by using the findings to help shape nurses' work environments to become better equipped at providing nurses with resources necessary to provide culturally competent care. As Warda (2000) indicates, "hospital bureaucratic requirements tend to standardize practice so that representational cultural tendencies are obscured" (p.220). Kirkham (1998) also described institutional constraints that inhibit the effectiveness of nursing care. Acknowledging that "the unavailability of a translator [sic] results in a reduced standard

of care " (p. 135), nurses felt strongly that institutions "should be visible and deliberate in establishing policies and providing resources that promoted culturally sensitive care" (p. 138). Nurses and their administrators must continue to advocate for improving the health care of Latino populations by demanding policies that mandate the allocation of resources to assist them in furthering their knowledge and skills in caring for Latino patients.

The second manner in which this study can inform health policy addresses the role nurses can take in their work environments to promote quality of care by informing policies aimed at measuring Latino patient satisfaction with care provided in the ED. Findings from this study reveal the importance of soliciting feedback from Latino patients and families in relation to quality of care, satisfaction with care, and suggestions for how care could be improved. Without the voice of Latino patients, it is not possible to determine the cultural congruence, and, therefore, the cultural competence of the care provided. Additionally, as found in this study, there is a need to elicit feedback from Spanish-speaking patients and families, not just from those who speak English. Given the multitude of challenges that surfaced in nurses' abilities with providing linguistically appropriate care and the inherent potential for miscommunication even when resources are utilized appropriately, it is imperative that policies in place mandate the collection of evaluative data from patients whose care is so uniquely planned and provided. As suggested in the findings from this study regarding Latino informants' perceptions of *improved* care from nurses being observed, if nurses know that feedback about their care is being sought from Latino patients, might nurses challenge themselves to increase their efforts to satisfy patients' needs and provide care in a more culturally sensitive and attentive manner?

The ENA (2003) promotes measuring customer service, quality of care and patient satisfaction as an on-going commitment of health care delivery systems to not only solicit customer feedback through instruments measuring these outcomes, but to provide staff members with continuing education related to improving customer service. According to the ENA (2003), "The primary customers of the emergency department are patients, families, and significant others," and "respect for the diversity of [customers] is inherent in emergency nursing practice" (p. 2). Gathering input regarding quality of care from Latino patients and families could prove invaluable considering the far-reaching implications that poor quality of care has on patients' repeated, unnecessary, and costly ED use for the same health concerns.

Nurses and Latino informants in this study readily acknowledged flaws in the current health care system that lead many to inappropriately use the ED for their primary care needs. The costs of unnecessary ED use are manifested in several ways: money, time, and other valuable resources such as health care personnel, equipment and medications. Findings from this study highlight the necessity for creating broader social and health policies that address issues related to accessibility and availability of health care services. It is suggested that community clinics extend their hours of operation, or have a provider available who would only see patients on an "urgent need" basis, those who would not otherwise have scheduled patient appointments. Policies are needed that direct efforts toward empowering Latino individuals and families to maintain healthy lifestyles. Clinics and/or hospitals could provide bilingual, bicultural health education specialists to provide instruction to Latinos about adequate care of illness, and appropriate use of the health care system in their community. Additionally, community resources such as parish nurses

or other knowledgeable community members, and/or language-appropriate, printed health care pamphlets from which information could be easily retrieved are ways that unnecessary or inappropriate ED use can be prevented or minimized.

Finally, findings from this study can influence broader health policy affecting the provision of culturally competent care provided to Latinos. As discussed by DiFranza (1996), the attention that important topics are given in the national media is likely to attract consideration by policy makers. Articles and news briefs focusing on underserved and vulnerable populations evoke emotional responses and are controversial in subject matter. Conclusions presented by Feetham, Hinshaw and Shaver (1999) emphasize the need for nurse scientists to inform health policy through their research findings, and to make considerable contributions to how nursing practice understands and intervenes on behalf of Latino patients. It is apparent from the development and implementation of the CLAS standards (DHHS-OMH, 2000) that major attention has been given to improving the health status of this nation's minority and underserved populations. The basic tenets of liberalism speak to human rights and equality for all individuals despite the wide variety of differences found among them, including race, religion, gender, culture, or nationality (Ball & Dagger, 1995). The role of government is to facilitate the improvement of the health of culturally diverse and underserved individuals through policy development and allocation of resources to those ends (Baradat, 1984). Publication of these findings in scholarly journals, newspapers, and through continued research has the potential to make valuable contributions toward changing public perceptions about the multifarious influences affecting the health status of Latinos, and to shape public policy toward efforts to achieve cultural competence in health care provided to Latino

populations.

Conclusion

This phenomenological study is a first step in a program of research that will explore the concept of cultural competence in nursing practice and generate and test culturally relevant nursing assessment, intervention, and evaluation strategies to improve the health of culturally and ethnically diverse patients. According to Fjelland and Gjengedal (1994), the aim of the science of nursing should include "exploring what good nursing is" (p. 5). This interpretive account of expertise and cultural congruence of nurses' practices in the care of Latinos in the ED uncovered contextually embedded concerns that focus nurses' efforts toward providing concernful and compassionate care that is uniquely planned relative to the Latino patient's ethnicity. Wanting to connect with patients and provide particularized care was requisite to providing expert and culturally competent care. Expertise in nurses' practices emerged from extensive experiences and reflection upon caring for Latino patients and families. In addition, nurses who practiced in an expert manner: (a) acquired additional cultural knowledge that enhanced their understanding of cultural nuances, (b) applied their cultural knowledge to patient care encounters and, (c) demonstrated an on-going commitment to learning how to incorporate patients' belief systems into a plan of care that addressed needs and concerns in ways that promoted the cultural integrity of Latino patients. Nursing care provided in an expert manner was found to be culturally competent when nurses' actions were congruent with the concerns brought to clinical encounters by Latino patients and family members, particularly in relation to communication and information needs, and the need to feel respected, cared about, and valued as human beings. Nursing care provided in a personable manner that

offered validation, comfort, and reassurance was also found to be culturally competent.

Uncovering expert clinical knowledge discloses patterns of meaning and behavior in nurses' practices that hitherto were practiced tacitly (Polanyi, 1962; Schon, 1983). This study revealed the extent to which nurses' practices are directed by internalized meanings of Latino patients' culture and culture-based needs, and how these internalized meanings develop and are tested over time. The results of the study contribute to a deeper understanding of the complexity of the ED setting and the challenges inherent in that practice setting that nurses must overcome in their provision of care to Latino patients.

Although an interpretive account involves unique attention to establishing its credibility amidst a scientific world laden with rational-empirical concerns: "There is the possibility of an account that is coherent, well interpreted, and systematically and rigorously worked out via the available points of access to nursing practice and that derives from a careful orientation of the researcher to the lived experience of the nurse-in-context" (Benner et al., 1996, p. 369). It is the hope of the investigator for this study that this interpretive account has accurately captured and illustrated the lived experiences of nurses and Latino patients and their family members. It is also hoped that this study will broaden nursing's knowledge base and enhance nurses' abilities with providing culturally competent care by revealing the contextually embedded concerns and practices, and the meanings ascribed by nurses in their experiences of providing care to Latino patients in the ED.

References

Allen, D.G., Benner, P., & Diekelmann, N.L. (1986). Three paradigms for nursing research: Methodological implications. In P.L. Chinn (Ed.), *Nursing research methodology: Issues and implementation* (pp. 23-38). Maryland: Aspen Publishers

American Nurses' Association (1991). *Position statement: Cultural Diversity in Nursing Practice*. Retrieved December 1, 2003, from http://nursingworld.org/readroom/position/ethics/etcldv.htm

American Nurses' Association, Council of Cultural Diversity in Nursing Practice (1986). *Cultural diversity in the nursing curriculum: A guide for implementation*. Kansas City, MO: American Nurses Association.

Anderson, B.G., Toledo, J.R., & Hazam, N. (1982). An approach to the resolution of Mexican-American resistance to diagnostic and remedial pediatric heart care. In, Chrisman, N.J.& Maretzki, T.W. (Eds.), *Clinically applied anthropology: Anthropologists in health science settings* (pp. 325-351). Boston: D. Reidel.

Andrews, M.M., & Boyle, J.S. (2003). *Transcultural concepts in nursing care* (4th ed.). Philadelphia, PA: Lippincott.

Austin, W., Gallop, R., McCay, E., Peternelj-Taylor, C., & Bayer, M. (1999). Culturally competent care for psychiatric clients who have a history of sexual abuse. *Clinical Nursing Research, 8*(1), 5-25.

Baker, D.W., Hayes, R., & Fortier, J.P. (1998). Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. *Medical Care, 36,* 1461-1470.

Baker, D.W., Parker, R.M., Williams, M.V., Coates, W.C., & Pitkin, D. (1996). Use and

effectiveness of interpreters in an emergency department. *Journal of the American Medical Association, 275*, 783-88.

Baldonado, A., Beymer, P.L., Barnes, K., Starsiak, D., Nemivant, E.B., & Anonas-Ternate, A. (1998). Transcultural nursing practice described by registered nurses and baccalaureate nursing students. *Journal of Transcultural Nursing, 9*(2), 15-25.

Ball, T., & Dagger, R. (1995). *Political ideologies and the democratic ideal* (2nd ed.). New York: Harper Collins.

Baradat, L.P. (1984). *Political ideologies* (2nd ed.). Englewood Cliffs, NJ: Prentice-Hall.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley.

Benner, P. (1994). The tradition and skill of interpretive phenomenology in studying health, illness, and caring practices. In, Benner, P. (Ed.), *Interpretive phenomenology: Embodiment, caring, and ethics in health and illness* (pp. 99-127). Thousand Oaks, CA: Sage.

Benner, P., Hooper-Kyriakidis, P., & Stannard, D. (1999). *Clinical wisdom and interventions in critical care: A thinking-in-action approach*. Philadelphia, PA: W.B. Saunders.

Benner, P., Tanner, C., & Chesla, C. (1996). *Expertise in nursing practice: Caring, clinical judgment, and ethics*. New York: Springer.

Benner, P., & Wrubel, J. (1989). *The primacy of caring: Stress and coping in health and illness*. Menlo Park, CA: Addison-Wesley.

Bent, K. (1999). Seeking the both/and of a nursing research proposal. *Advances in Nursing Science, 21*(3), 76-89.

Bernstein, R.J. (1983). *Beyond objectivism and relativism: Science, hermeneutics and praxis.* Philadelphia: University of Pennsylvania Press

Berry, A.B. (1999). Mexican American women's expressions of the meaning of culturally congruent prenatal care. *Journal of Transcultural Nursing, 10*, 203-212.

Blumhagen, D. (1982). The meaning of hyper-tension. In, Chrisman, N., & Maretzki, T. (Eds.). *Clinically applied anthropology*, (pp. 297-323). Boston: D. Reidel.

Boie, E., Moore, G., Brummett, C., & Nelson, D. (1999). Do parents want to be present during invasive procedures performed on their children in the emergency department? A survey of 400 parents. *Annals of Emergency Medicine, 34*(1), 70-74.

Bollenbacher, L.M., Heck, J.L., & Davidhizar, R. (2000). Maternity nurse's attitudes towards Mexican-American clients. *The Journal of Practical Nursing, 50*(3), 14-16.

Brach, C., Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review, 57*, 181-217.

Brooks, T. (1992). Pitfalls in communication with Hispanic and African-American patients: Do translators help or harm? *Journal of the National Medical Association, 84*(11), 941-947.

Brown, S.A., & Hanis, C.L. (1999). Culturally competent diabetes education for Mexican Americans: The Starr county study. *The Diabetes Educator, 25*(2), 226-236.

Bureau of Health Professions (2001). *Preliminary findings from the national sample survey of registered nurses: Distribution of registered nurses by racial/ethnic background.* Retrieved February 26, 2002, from http://bhpr.hrsa.gov/healthworkforce/reports/rnsurvey/default.htm

Campinha-Bacote, J. (1995). The quest for cultural competence in nursing care. *Nursing Forum, 30*(4), 19-25.

Campinha-Bacote, J. (1998). *The process of cultural competence in the delivery of healthcare services: A culturally competent model of care* (3rd ed.). Cincinnati, OH: Transcultural C.A.R.E. Associates.

Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education, 38*(5), 203-207.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing, 13*(3), 181-184.

Chavez, L. (1998). *Shadowed lives: Undocumented immigrants in American society* (2nd ed.). Orlando, FL: Harcourt Brace College Publishers.

Chesla, C. (1995). Hermeneutic phenomenology: An approach to understanding families. *Journal of Family Nursing*, 1, 68-78.

Chrisman, N. (1982). Anthropology in nursing: An exploration of adaptation. In, Chrisman, N.J.& Maretzki, T.W. (Eds.), *Clinically applied anthropology: Anthropologists in health science settings* (pp. 117-140). Boston: D. Reidel.

Clark, M. (1970). *Health in the Mexican-American culture.* Berkeley: University of California Press.

Council of Economic Advisors (1998). *Changing America: Indicators of social and economic well-being by race and Hispanic origin.* Washington, D.C.

Council on Scientific Affairs (1991). Hispanic health in the United States. *Journal of the American Medical Association, 265*, 248-252.

Creswell, J. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.

Cross, T.L., Bazron, B.J., Dennis, K.W., & Isaacs, M.R. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed, (Vol 1),* Washington, DC: Georgetown University Child Development Center.

Darbyshire, P. (2004). Rage against the machine? Nurses' and midwives' experiences of using computerized patient Information systems for clinical information. *Journal of Clinical Nursing 13*(1) 17-25.

David, R.A., & Rhee, M. (1998). The impact of language as a barrier to effective health care in an underserved urban Hispanic community. *The Mount Sinai Journal of Medicine, 65*(5 & 6), 393-397.

Davis, L.H., Dumas, R., Ferketich, S., Flaherty, M.J., Isenberg, M., Koerner, J.E., Lacey, B., Stern, P.N., Valente, S., & Meleis, A.I. (1992). Culturally competent health care. *Nursing Outlook, 40*(6), 277-283.

Department of Health, Education, and Welfare (1979). *The Belmont Report.* Bethesda, MD: National Institutes of Health.

Department of Health and Human Services (2000). *Healthy people 2010.* Retrieved March 1, 2001, from http://www.health.gov/healthypeople/

Department of Health and Human Services, Office of Civil Rights (1998). *Guidance memorandum: Title VI prohibition against national origin discrimination—Persons with limited-English proficiency*. Washington, DC.

Department of Health and Human Services, Office of Minority Health, (2000).

National standards on culturally and linguistically appropriate services (CLAS) in health care. *Federal Register, 65*(247), 80865-80879.

DiFranza, J.R., & Staff of the Advocacy Institute. (1996). *A researcher's guide to effective dissemination of policy-related research*. Princeton, NJ: Robert Wood Johnson Foundation.

Dreyfus, H. (1997). *Being-in-the-world: A commentary on Heidegger's being and time, division I.* Cambridge: Massachusetts: The MIT Press

Dzurec, L.C. & Abraham, I.L. (1986). Analogy between phenomenology and multivariate statistical analysis. In P.L. Chinn (Ed.), *Nursing research methodology: Issues and implementation* (pp. 55-66). Maryland: Aspen Publishers

Ebden, P., Bhatt, A., Carey, O.J., & Harrison, B. (1988). The bilingual consultation. *The Lancet, 1*(8581), 347.

Eichhorn, D., Meyers, T., Guzzetta, C., Clark, A., Klein, J., Taliaferro, E., & Calvin, A., (2001). Family presence during invasive procedures and resuscitation: Hearing the voice of the patient. *American Journal of Nursing, 101*(5), 48-55.

Emergency Nurses Association (2001a). *Position Statement: Diversity in emergency care*. Des Plaines, IL: Emergency Nurses Association.

Emergency Nurses Association (2001b). *Position Statement: Family presence at the bedside during invasive procedures and resuscitation.* Des Plaines, IL: Emergency Nurses Association.

Emergency Nurses Association (2003). *Position Statement: Customer service and satisfaction in the emergency department.* Des Plaines, IL: Emergency Nurses Association.

Enslein, J., Tripp-Reimer, T., Kelley, L., & McCarty, L. (2002). Evidenced-based Protocol: Interpreter facilitation for individuals with limited English proficiency. *Journal of Gerontological Nursing*, 5-13.

Erkel, E.A. (1985a). Conceptions of community health nurses regarding low-income Black, Mexican American, and White families: Part 1. *Journal of Community Health Nursing, 2*(2), 99-107.

Erkel, E.A. (1985b). Conceptions of community health nurses regarding low-income Black, Mexican American, and White families: Part 2. *Journal of Community Health Nursing, 2*(2), 109-118.

Erzinger, S. (1991). Communication between Spanish-speaking patients and their doctors in medical encounters. *Culture, Medicine & Psychiatry, 15*(1), 91-110.

Fadiman, A. (1998). *The spirit catches you and you fall down: A Hmong child, her American doctors, and the collision of two cultures*. New York: Farrar, Straus and Giroux.

Feetham, S., Hinshaw, A.S., & Shaver, J. (1999). *Informing health policy through the synthesis of clinical nursing research* (Abstract), 47.

Fjelland, R., & Gjengedal, E. (1994). A theoretical foundation for nursing as a science. In, Benner, P. (Ed.). Interpretive phenomenology: Embodiment, caring, and ethics in health and illness (pp.3-26). Thousand Oaks, CA: Sage.

Fletcher, V.C. (1997). Where is nursing's role in promoting culturally competent care? *Association of Women's Health, Obstetric and Neonatal Nurses Lifelines, 1*(3), 13.

Fortier, J.P. (1999). *Multicultural health best practices overview*. Retrieved February 17 2004, from http://www.diversityrx.org/BEST/index.html

Fortier, J., Convissor, R., & Pacheco, G. (1999). *Cultural and linguistic competence standards and research agenda project: Part two: proposal for a research agenda.* Silver Spring, MD: Resources for Cross Cultural Health Care.

Frayne, S.M., Burns, R.B., Hardt, E.J., Rosen, A.K., & Moskowitz, M.A., (1996). The exclusion of non-English-speaking persons from research. *Journal of General Internal Medicine, 11,* 39-43.

Freda, M., Devine, K. & Semelsberger, C. (2003). The lived experience of marriage after infertility. *American Journal of Maternal Child Nursing. 28*(1),16-23.

Frey, J., & Fontana, A. (1993). The group interview in social research. In, Morgan, D.L. (Ed.), *Successful focus groups: Advancing the state of the art*, (pp. 20-34). Newbury Park, CA: Sage.

Giger, J.N., & Davidhizar, R.E. (1999). *Transcultural nursing: Assessment & intervention* (3rd ed.). St. Louis, MO: Mosby.

Gonzalez, R.I., Gooden, M.B., & Porter, C.P. (2000). Eliminating racial and ethnic disparities in health care. *American Journal of Nursing, 100*(3), 56-58.

Gonzalez-Calvo, J., Jackson, J., Hansford, C., Woodman, C., & Remington, N.S. (1997). Nursing case management and its role in perinatal risk reduction: Development, implementation, and evaluation of a culturally competent model for African American women. *Public Health Nursing, 14*(4), 190-206.

Good, B.J., & Good, M.D. (1981). The meaning of symptoms: A cultural hermeneutic model for clinical practice. In, Eisenberg, L., & Kleinman, A. (Eds.), *The relevance of social science for medicine* (pp. 165-196). Boston: D. Reidel.

Gordon, S.M. (1994). Latino cultural health beliefs and folk remedies. *Journal of Holistic*

Nursing, 12(3), 307-322.

Gullickson, C. (1993). My death nearing its future: A Heideggerian hermeneutical analysis of the lived experience of persons with chronic illness. *Journal of Advanced Nursing, 18*, 1386-1392.

Gutiérrez, D.G. (Ed.). (1996). *Between two worlds*. Wilmington, DE: Scholarly Resources.

Hartog, J., & Hartog, E.A. (1983). Cultural aspects of health and illness behavior in hospitals. *Western Journal of Medicine, 139*, 910-916.

Hatton, D.C. (1992). Information transmission in bilingual, bicultural contexts. *Journal of Community Health Nursing, 9*(1), 53-59.

Heidegger, M. (1962). *Being and time.* (J. Macquarrie & E. Robinson, Trans.). San Francisco, CA: Harper Collins. (Original work published 1927).

Heinrich, M. (1997). Herbal and symbolic forms of treatment in the medicine of the lowland Mixe (Oaxaca, Mexico). In, Romanucci-Ross, L., Moerman, D.E., & Tancredi, L.R. (Eds.), *The anthropology of medicine: From culture to medicine* (3rd ed., pp. 71-95). Westport, CT: Bergin & Garvey.

Helman, C.G. (1994). *Culture, health and illness: An introduction for health professionals* (3rd ed.). Oxford: Butterworth-Heinemann Ltd.

Hornberger, J.C., Gibson, C.D., Wood, W., Dequeldre, C., Corso, I., Palla, B., & Bloch, D.A. (1996). Eliminating language barriers for non-English-speaking patients. *Medical Care, 34,* 845-856.

Hu, D.J., & Covell, R.M. (1986). Health care usage by Hispanic outpatients as a function of primary language. *Western Journal of Medicine, 144*, 490-3.

Hu, D.J., Keller, R., & Fleming, D. (1989). Communicating AIDS information to Hispanics: The importance of language and media preference. *American Journal of Preventive Medicine, 5,* 196-200.

Hurtado, A. (1995). Variations, combinations, and evolutions: Latino families in the United States. In, Zambrana, R.E. (Ed.), *Understanding Latino families: Scholarship, policy, and practice*, (pp. 40-61). Thousand Oaks, CA: Sage.

Immigration and Naturalization Services (October 1997). *Immigration fact sheet 1996.* Retrieved December 12, 2001, from http://www.ins.gov/graphics/aboutins/statistics/299.htm

Johnson, M., Noble, C., Matthews, C., & Aguilar, N. (1998). Towards culturally competent health care: Language use of bilingual staff. *Australian Health Review, 21*(3), 49-66.

Jones, C. (2000). Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health, 90*(3), 1212-1214.

Kaufert, J.M., & Putsch, R.W. (1997). Communication through interpreters in healthcare: Ethical dilemmas arising from differences in class, culture, language, and power. *The Journal of Clinical Ethics, 8* (1), 71-87.

Kavanagh, K., Absalom, K., Beil, W., & Schliessmann, L. (1999). Connecting and becoming culturally competent: A Lakota example. *Advances in Nursing Science, 21*(3), 9-31.

Kirkham, S.R. (1998). Nurses' descriptions of caring for culturally diverse clients. *Clinical Nursing Research, 7*(2), 125-147.

Kirkman-Liff, B., & Mondragon, D. (1991). Language of interview: Relevance for

research of Southwest Hispanics. *American Journal of Public Health, 81*, 1399-1404.

Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition.* New York: Basic Books.

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine, 88,* 251-258.

Koch, T. (1994). Establishing rigour in qualitative research: The decision trail. *Journal of Advanced Nursing, 19*, 976-986.

Kuo, D., & Fagan, M.J. (1999). Satisfaction with methods of Spanish interpretation in an ambulatory care clinic. *Journal of General Internal Medicine, 14*, 547-50.

Landau, S. (Ed.). (2002). *The new international Webster's collegiate dictionary of the English language*. Trident Press International.

Laws, M., Heckscher, R., Mayo, S., Li, W., & Wilson, I. (2004). A new method for evaluating the quality of medical interpretation. *Medical Care, 42*(1) 71-80.

Leininger, M. (1970). *Nursing and anthropology: Two worlds to blend.* New York: John Wiley & Sons, Inc.

Leininger, M. (Ed.). (1991). *Culture care diversity & universality: A theory of nursing.* New York: National League for Nursing.

Leonard, V. (1994). A Heideggerian phenomenological perspective on the concept of person. In, Benner, P. (Ed.), *Interpretive phenomenology: Embodiment, caring, and ethics in health and illness* (pp. 43-64). Thousand Oaks, CA: Sage.

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Lipson, J.G., & Meleis, A.I. (1999). Research with immigrants and refugees. In A.S. Hinshaw, S.L. Feetham, & J.L. Shaver (Eds.), *Handbook of clinical nursing research* (pp. 87-105). Thousand Oaks, CA: Sage.

Lipton, R.B., Losey, L.M., Giachello, A., Mendez, J., & Girotti, M.H. (1998). Attitudes and issues in treating Latino patients with type 2 diabetes: Views of healthcare providers. *The Diabetes Educator, 24*(1), 67-71.

Loustaunau, M.O., & Sobo, E.J. (1997). *The cultural context of health, illness, and medicine*. Westport, CT: Bergin & Garvey.

MacLean, S., Guzzetta, C., White, C., Fontaine, D., Eichhorn, D., Meyers, T., & Desy, P. (2003). Family presence during cardiopulmonary resuscitation and invasive procedures: Practices of critical care and emergency nurses. *Journal of Emergency Nursing, 29*(3), 208-221.

Mallin, S.B. (1979). *Merleau-Ponty's philosophy*. New Haven, CT: Yale University Press.

Marín, G., & Marín, B. (1991). *Research with Hispanic populations.* Newbury Park, CA: Sage.

Marín, G., Sabogal, F., Marín, B., Otero-Sabogal, R., & Perez-Stable, E.J. (1987). Development of a short acculturation scale for Hispanics. *Hispanic Journal of Behavioral Sciences, 9*, 183-205.

Massachusetts Medical Interpreters Association and Education Development Center. (1996). *Medical interpreting standards of practice*. Boston, MA: MMIA & EDC.

Meleis, A.I. (Ed.). (1995). *Diversity, marginalization, and culturally competent health care: Issues in knowledge development*. Washington, DC: American Academy of

Nursing.

Meyers, T., Eichhorn, D., Guzzetta, C., Clark, A., Klein, J., Taliaferro, E., & Calvin, A. (2000). Family presence during invasive procedures and resuscitation: The experience of family members, nurses, and physicians. *American Journal of Nursing, 100*(2), 32-43.

Moran, D. (2000). Maurice Merleau-Ponty: The phenomenology of perception. In, *Introduction to phenomenology*, (pp. 391-434). New York: Routledge.

Mukamel, D., Murthy, A., & Weimer, D. (2000). Racial differences in access to high-quality cardiac surgeons. *American Journal of Public Health, 90*, 1774-1777.

Napholz, L. (1999). A comparison of self-reported cultural competency skills among two groups of nursing students: Implications for nursing education. *Journal of Nursing Education, 38*(2), 81-3.

Niska, K.J. (1999). Family nursing interventions: Mexican American early family formation. *Nursing Science Quarterly, 12*(4), 335-340.

Patton, M. (2002). *Qualitative evaluation and research methods* (3rd ed.).Thousand Oaks, CA: Sage.

Perez-Stable, E.J., Napoles-Springer, A., & Miramontes, J.M. (1997). The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes. *Medical Care, 35*, 1212-19.

Polanyi, M. (1962). *Personal knowledge: Towards a post-critical philosophy.* Chicago: The University of Chicago Press.

Qualitative Solutions & Research Pty Ltd (2000). *QSR N5*. Melbourne: Australia.

Racher, R. (2003). Using conjoint interviews to research the lived experience of elderly

rural couples. *Nurse Researcher, 10*(3), 60-72.

Rankin, S., Monahan, P. (1991). Great expectations: Perceived social support in couples experiencing cardiac surgery. *Family Relations, 40*, 297-302.

Reisler, M. (1996). Always the laborer, never the citizen: Anglo perceptions of the Mexican immigrant during the 1920s. In, Gutiérrez, D.G. (Ed.). *Between two worlds* (pp. 23-44). Wilmington, DE: Scholarly Resources.

Riddick, S. (2000). *Overview of models and strategies for overcoming linguistic and cultural barriers to health care*. Retrieved March 30, 2003, from: http://www.diversityrx.org/ html/movera.htm

Robinson, S., Mackenzie-Ross, S., Campbell Hewson, G., Egleston, C., & Prevost, A. (1998). Psychological effect of witnessed resuscitation on bereaved relatives. *The Lancet, 352*, 614-617.

Rodriguez, M.A., Bauer, H.M., Flores-Ortiz, Y., & Szkupinski-Quiroga, S. (1998). Factors affecting patient-physician communication for abused Latina and Asian immigrant women. *The Journal of Family Practice, 47*, 309-11.

Rothenburger, R.L. (1990). Transcultural nursing: Overcoming obstacles to effective communication. *Journal of the Association of Operating Room Nurses. 51,* 1349-1363.

Rueschenberg, E., & Buriel, R. (1989). Mexican American family functioning and acculturation: A family systems perspective. *Hispanic Journal of Behavioral Sciences, 11*, 232-244.

Samaniego, R.Y., & Gonzales, N.A. (1999). Multiple mediators of the effects of acculturation status on delinquency for Mexican-American adolescents. *American*

Journal of Community Psychology, 27, 189-210.

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science, 16*(2), 1-8.

Sandstrom, A.R. (1991). *Corn is our blood: Culture and ethnic identity in a Contemporary Aztec Indian village*. Norman: University of Oklahoma Press.

Schon, D. (1983). *The reflective practitioner: How professionals think in action*. New York: Basic Books.

Siems, L. (1992). *Between the lines: Letters between undocumented Mexican and Central American immigrants and their families and friends*. Hopewell, NJ: The Ecco Press.

Singer, M., & Baer, H. (1995). *Critical medical anthropology*. New York: Baywood.

Smith, B. (1999). Ethical and methodologic benefits of using a reflexive journal in hermeneutic-phenomenologic research. *Image: Journal of Nursing Scholarship, 31*, 359-363.

SmithBattle, L. (1995). Teenage mothers' narratives of self: An examination of risking the future. *Advances in Nursing Science, 17*(4), 22–36.

Spector, R.E. (2000). *Cultural diversity in health & illness* (5th ed.). Upper Saddle River, NJ: Prentice-Hall.

Stasiak, D.B. (1991). Culture care theory with Mexican-Americans in an urban context. In, Leininger, M. (Ed.), *Culture care diversity & universality: A theory of nursing* (pp. 179-201). New York: National League for Nursing.

Taira, D.A. (1999). Improving the health and health care of non-English-speaking patients. *Journal of General Internal Medicine, 14*, 322-23.

Tang, S.Y. (1999). Interpreter services in healthcare: Policy recommendations for healthcare agencies. *Journal of Nursing Administration, 26*(6), 23-29.

Tanner, C.A., Benner, P., Chesla, C., & Gordon, D.R. (1993). The phenomenology of knowing the patient. *Image: Journal of Nursing Scholarship, 25*, 273-280.

Therrien, M., & Ramirez, R.R. (2000). *The Hispanic population in the United States: March 2000, current population reports* (P20-535). Washington, D.C.: U.S. Census Bureau.

Torres, S. (Ed.). (1996). *Latino voices: Latino health educators speak out.* New York: National League for Nursing.

Toro-Morn, M.I. (1998). The family and work experiences of Puerto Rican women migrants in Chicago. In, McCubbin, H., Thompson, E., Thompson, A., & Fromer, J. (Eds.), *Resiliency in Native American and immigrant families* (pp.277-294). Thousand Oaks, CA: Sage.

Tripp-Reimer, T. (1999).Critical health needs of communities and vulnerable populations: Clinical nursing research for vulnerable populations. In A.S. Hinshaw, S.L. Feetham, & J.L. Shaver (Eds.), *Handbook of clinical nursing research* (pp. 71-73). Thousand Oaks: Sage Publications.

Tripp-Reimer, T., & Fox, S.S. (1990). Beyond the concept of culture: Or, how knowing the cultural formula does not predict clinical success. In, McCloskey, J.C., & Grace, H.K. (Eds.) *Current issues in nursing* (3rd ed.), (pp. 542-546). St. Louis: Mosby.

Tripp-Reimer, T., Brink, P.J., & Saunders, J.M. (1984). Cultural assessment: Content and process. *Nursing Outlook, 32*(2), 78-82.

U.S. Census Bureau (2000a). *Data Table QT-P17. Ability to speak English:2000.* Retrieved February 8, 2004 from http://www.census.gov

U.S. Census Bureau (2000b). *State and County QuickFacts*. Retrieved August 18, 2001, from http://factfinder.census.gov/home

U.S. Department of Commerce (2002). *Coming to America: A profile of the nation's foreign born (2000 Update)*. U.S. Census Bureau: Economics and Statistics Administration.

Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Ontario, Canada: The University of Western Ontario.

Vega, W.A. (1995). The study of Latino families: A point of departure. In, Zambrana, R.E. (Ed.), *Understanding Latino families: Scholarship, policy, and practice* (pp. 3-17). Thousand Oaks, CA: Sage.

Vega, W., Warheit, G., Buhl-Auth, J., & Meinhardt, K. (1984). The prevalence of depressive symptoms among Mexican Americans and Anglos. *American Journal of Epidemiology, 120,* 592-607.

Villarruel, A.M., & Leininger, M. (1995). Culture care of Mexican Americans. In *Transcultural nursing: Concepts, theories, research & practices* (2nd ed., pp. 365-382). New York: McGraw-Hill.

Villarruel, A.M., Porter, C.J., & Kane, P. (1999). Communicating with limited English proficiency persons: Implications for nursing practice. *Nursing Outlook, 47,* 262-70.

Warda, M.R. (2000). Mexican Americans' perceptions of culturally competent care. *Western Journal of Nursing Research, 22*(2), 203-224.

Young, B. (1999). *A dream for Gilberto: An immigrant family's struggle to become*

American. White Bear Lake, MN: J-Press.

Zambrana, R.E. (Ed.). (1995). *Understanding Latino families: Scholarship, policy and practice.* Thousand Oaks: Sage.

Zoucha, R.D. (1998). The experiences of Mexican Americans receiving professional nursing care: An ethnonursing study. *Journal of Transcultural Nursing, 9*(2), 34-41.

Appendix A

Spanish Language

Script for Permission to Approach Latino Patient

Permission Form for Research Assistant to Approach Latino Patient

Triage personnel will read the following script to every Latino patient with a non life-threatening condition who presents for care in the Emergency Department while the investigator is present to observe a nurse's practice. The script will be read after triage personnel have assessed the patient and before the patient proceeds to the designated area to wait to be seen by a provider.

Hoy se encuentran algunas personas aqui que estan investigando como son atendidos por las enfermeras, los latinos que vienen a este cuarto de emrgencias. Una de esas personas quiere platicar con usted acerca de este proyecto mientras usted espera ser atendido. Podría tener su permiso para decirles que usted esta aqui para que vengan a hablar con usted?

Yes _____ No _____ ***If NO, thank the patient for their time and end conversation.***

*If **YES**, continue:*

Muchas Gracias. Por favor firme abajo para que yo pueda decirles que esta aqui y que pueden venir a hablar con usted.

_____

Firma del paciente

Appendix B

English Language

Script for Permission to Approach Latino Patient

Permission Form for Research Assistant to Approach Latino Patient

Triage personnel will read the following script to every Latino patient with a non life-threatening condition who presents for care in the Emergency Department while the investigator is present to observe a nurse's practice. The script will be read after triage personnel have assessed the patient and before the patient proceeds to the designated area to wait to be seen by a provider.

There are some people here today who are looking at how well Latinos are cared for by nurses when they come into this emergency room. One of them wants to talk to you about this project while you wait. Can I have your permission to tell them that you are here so that they can talk to you?

Yes _____ No _____ ***If NO, thank the patient for their time and end conversation.***

*If **YES**, continue:*

Thank you. Please sign your name below so that I can tell them that you are here and it is okay to talk to you.

_____

Signature of patient

Appendix C

Spanish Language

Script to Approach Latino Patient

Hola. My nombre es _____. Cómo está usted hoy? *If family present*: Es ésta su familia? Hola *addressed to family members*. Me permite sentarme y platicar con usted unos minutos? *addressed to patient or parent of child-patient.*

Yes _____ No _____ ***If NO, thank the patient and end conversation.***

If **YES**, continue:
Es usted Hispano/Latino? Yes _____ No _____ ***If NO, thank the patient and end conversation.***

If **YES**, continue:
Estoy trabajando como asistente en un proyecto de investigación. Como parte de mi trabajo, les platico a los pacientes Latinos acerca de este proyecto, y les estoy preguntando si les gustaría participar en él. El propósito de este proyecto es describir el cuidado y la atención que las enfermeras dan a los pacientes Latinos en el departamento de emergencia de los hospitales. Esto es lo que va a pasar si usted esta de acuerdo en participar en este proyecto:

- La persona encargada de este proyecto estará en el cuarto cuando usted reciba la atención hoy. Esta persona estará ahi para observar a la enfermera que lo esta atendiendo, y no hablará con usted ni le preguntará nada.

Esta usted interesado en participar en este proyecto permitiendo a esta persona observar a la enfermera que lo atiende?
Yes _____ No _____ ***If NO, thank the patient for their time and end conversation.***

If **YES,** depending on data collection needs, continue with '**A**' **OR** '**B**' below.

A. If SAMPLING FOR PATIENT OBSERVATION DATA ONLY, continue:

Gracias. Ahora voy a leer un formulario que le pediré que firme y que explica su participación en este estudio. Al firmar este formulario le da a la persona encargada de este proyecto su permiso para observar a la enfermera que se hara cargo de usted. ***Read informed consent form for observing care only and obtain patient signature.*** Continue:

Muchas gracias. Su asistencia es muy valiosa para este proyecto. Después de que reciba la atención de la enfermera, su participación en este proyecto se habra terminado y usted se podrá retirar. ***Give a copy of signed consent form to patient.***
Continue: Que tenga un buen dia/buena tarde o noche. **END OF CONTACT.**

B. If SAMPLING FOR PATIENT OBSERVATION AND INTERVIEW DATA, continue:
Gracias. Además de tener a alguien que lo observe mientras lo atiende la enfermera, hay otra parte del proyecto que requiere que le pregunte sobre la atención y el cuidado por parte de la enfermera que usted recibió hoy. Esto es lo que pasará si usted accede a participar en este proyecto:

- Despues de que sea atendido por la enfermera, le haré algunas preguntas sobre el cuidado de la enfermera que usted recibió hoy. El hablar conmigo no le llevará mas de una hora y se le pagarán $20.00 por su tiempo.

Esta usted interesado en responder algunas preguntas sobre el cuidado y la atención que recibió hoy?
Yes _____ No _____ ***If NO, continue as in 'A' and proceed with consent to observe care.***

If **YES**, continue:
Muchas gracias. Le leeré un formulario que le pediré que firme y que explica su participación en este estudio. Al firmar el formulario usted le da permiso a la persona encargada de este proyecto de observar a la enfermera mientras lo (la) atiende, y me da permiso de hacerle algunas preguntas acerca del cuidado que acaba de recibir.
Read informed consent form for observing care and interviewing patient and obtain patient signature.

Continue:
Muchas gracias. Su asistencia es muy valiosa para este proyecto. Yo esperaré aquí. Cuando usted salga del cuarto donde ha sido atendido, iremos a un cuarto de descanso cercano y yo le haré algunas preguntas. Al final de la entrevista, Le pagaré $20.00 en efectivo por su tiempo. ***Give a copy of signed consent form to patient.*** **END OF CONTACT UNTIL AFTER PATIENT RETURNS TO WAITING AREA.** ***Continue with directing patient to interview room.***

Appendix D

English Language

Script to Approach Latino Patient

Hello. My name is _____. How are you today? *If family present*: Is this your family? Hello *addressed to family members*. May I sit down and talk with you for a few minutes? *addressed to patient or parent of child-patient.*
Yes _____ No _____ ***If NO, thank the patient and end conversation.***

If **YES**, continue:
Are you Hispanic/Latino? Yes _____ No _____ ***If NO, thank the patient and end conversation.***

If **YES**, continue:
I am working as an assistant on a research project. As part of my job, I am telling Latino patients about this project, and am asking them if they would like to participate. The purpose of the project is to describe the care that nurses give to Latino patients in the emergency department of hospitals. This is what will happen if you agree to participate in this project:

- The person in charge of this project will be in the room when you receive care from the nurse today. This person will be there to watch the nurse take care of you, and will not talk to you or ask you to do anything.

Are you interested in participating in this project by allowing this person to watch the nurse take care of you?
Yes _____ No _____ ***If NO, thank the patient for their time and end conversation.***

If **YES,** depending on data collection needs, continue with 'A' OR 'B' below.

A. If SAMPLING FOR PATIENT OBSERVATION DATA ONLY, continue:

Thank you. I am now going to read a form that I will ask you to sign that explains your involvement in the study. Signing this form gives the person in charge of this project your permission to watch the nurse take care of you today. ***Read informed consent form for observing care only and obtain patient signature.*** Continue:

Thank you very much. Your assistance is very valuable to this project. After you receive care today, your participation in this project is over and you may leave. ***Give a copy of signed consent form to patient.***
Continue: Have a good day/evening/night. **END OF CONTACT.**

B. If SAMPLING FOR PATIENT OBSERVATION AND INTERVIEW DATA, continue:
Thank you. In addition to having someone watch the nurse take care of you, there is another part to this project that involves my asking you some questions about the nursing care that you receive today. This is what will happen if you agree to participate in this project:

- After you have been taken care of today, I will ask you some questions about the nursing care that you received. Talking with me will not take longer than 1 hour and you will be paid $20 for your time.

Are you interested in answering some questions about the nursing care you receive today?
Yes _____ No _____ ***If NO, continue as in 'A' and proceed with consent to observe care.***

If **YES**, continue:
Thank you. I am now going to read a form that I will ask you to sign that explains your involvement in the study. Signing this form gives the person in charge of this project your permission to watch the nurse take care of you, and it gives your permission for me to ask you some questions about the nursing care that you receive today. ***Read informed consent form for observing care and interviewing patient and obtain patient signature.***

Continue:
Thank you very much. Your assistance is very valuable to this project. I will wait here. When you come out after you have been taken care of, we will go to a quiet room nearby and I will ask you some questions. At the end of the interview, I will pay you $20 in cash for your time. ***Give a copy of signed consent form to patient.***
END OF CONTACT UNTIL AFTER PATIENT RETURNS TO WAITING AREA.
Continue with directing patient to interview room.

Appendix E

Spanish Language

Consent Form to Observe Latino Patient Care

IRB # 7053
Approved: May 16, 2002

UNIVERSIDAD DE CIENCIAS Y SALUD DE OREGON
Formulario de Información y Consentimiento

TITULO: Cuidado y Atención de Pacientes Latinos: Estudio Cualitativo.

INVESTIGADORA PRINCIPAL: Regina E. Nailon RN, Candidata a Doctorado. Escuela de Enfermería.509-249-5834.

CO-INVESTIGADORA: Chistine A. Tanner PhD, RN. 503-494-3742; Mireya Esqueda 509-469-3708.

PATROCINADOR: Fundación de Salud del Noroeste; Fundación de Enfermeras del Edo. de Washington.

PROPOSITO: Usted esta siendo invitado a participar en este estudio de investigación porque es un paciente latino que hoy sera atendido por una enfermera en el Departamento de Emergencias. El Propósito de este estudio es describir el conocimiento que las enfermeras utilizan cuando dan atención a pacientes latinos en el Departamento de Emergencias, y encontrar si el cuidado que usted recibe es el adecuado a sus necesidades como paciente. Alrededor de 108 a 192 pacientes latinos participarán en este studio. Su participación en este estudio no durará mas tiempo que el que usted tarde hoy en recibir atención en el Departamento de Emergencias.

PROCEDIMIENTOS:

La persona encargada de este estudio estará en el cuarto cuando usted sea atendido por la enfermera hoy. Ella es la Investigadora Principal. Ella no va a hablar con usted ni le pedirá que haga nada. Ella solo estará presente para observar a las enfermeras que lo estan atendiendo.

RIESGOS Y MOLESTIAS:

Usted se puede sentir avergonzado y molesto de tener a alguien en el cuarto mientras la enfermera lo esta atendiendo. Usted le puede pedir a la enfermera que haga que esa persona salga de la habitacion en cualquier momento, si su presencia lo hace sentir a disgusto.

BENEFICIOS:

Usted puede o no beneficiarse personálmente de participar en este studio. Sin embargo, por servir como participante, usted puede contribuir con nueva información, la cual puede beneficiar a los pacientes latinos en el futuro.

BN

ALTERNATIVAS:

Usted puede negarse a participar en este estudio.

CONFIDENCIALIDAD:

Su nombre no sera utilizado en la publicación.

La investigadora tomará notas mientras la enfermera lo esta atendiendo acerca de lo que ella esta haciendo. Estas notas tendrán información que lo identifica a usted y seran destruidas una vez que el estudio haya sido terminado.

Cualquier abuso al paciente que la investigadora observe sera reportado a las autoridades correspondientes.

Usted será identificado por el código que le fue asignado anteriormente por la investigadora principal en los resultados del estudio.

Las notas que ligan su nombre con el código seran guardadas en un archivo cerrado en la casa de la investigadora principal y estarán separadas de cualquier información que usted haya proporcionado acerca de la atención que recibió. Estas notas seran destruidas cuando se termine el estudio.

COSTOS:

Su participación en este estudio no tendrá ningún costo. A usted no le sera ofrecido ningún dinero por permitir ser observado por la investigadora mientras la enfermera lo atiende.

RESPONSABILIDAD LEGAL:

La fundación de salud del noroeste y la fundación de enfermeras del edo. de Washington no ofrecen pagar los gastos médicos por daños que no esten relacionados con este estudio o que sean causados por su condición médica o enfermedad. Ninguna otra compensación es ofrecida por la fundación de salud del noroeste o por la fundación de enfermeras del edo. de Washington.

En caso de que ocurra algún daño como resultado de este estudio, habra tratamiento disponible. Usted, su seguro médico o una tercera persona pagarán o recibirán una factura. Ninguna compensación es ofrecida por el Centro medico , el hospital o el hospital Memorial del valle del . Esto no es una renuncia a sus derechos legales.

La Universidad de Salud y Ciencias de Oregon (OHSU) esta sujeta a la Ley de Demandas Judiciales del Estado de Oregon (ORS 30.260 a 30.300). Si usted sufre cualquier lesión o daño por participar en este proyecto de investigación por culpa de la Universidad, sus oficiales o empleados, usted tendrá derecho a una acción legal en contra de la Universidad para recuperar el daño hecho a usted y esta sujeto a las limitaciones y condiciones de la Ley de Demandas Judiciales del Edo. de Oregon. Usted no ha renunciado a sus derechos legales por firmar este documento. Para cualquier aclaración en esta materia, o si usted tiene otras preguntas, por favor llame a la oficina de apoyo a la investigación de la Universidad de Salud y Ciencias de Oregon (OHSU) al teléfono (503) 494-7887.

PARTICIPACION:

Regina Nailon (509) 249-5834 se ha ofrecido a contestar cualquier pregunta que usted pueda tener acerca de este estudio. Si usted tiene alguna pregunta acerca de sus derechos como sujeto de la investigación, usted puede llamar a la oficina de apoyo a la investigación de la Universidad (OHSU). Usted no tiene que participar en este estudio o ningun otro. Si usted decide participar y luego cambia de parecer, puede dejar el estudio en qual quier momento. Si se niega a participar o quiere dejar el estuido antes de tiempo, no habra ningun castigo o perdida de beneficios a los que usted tiene derecho.

Si usted elige retirarse de este estudio, cualquier información recabada acerca de la atención recibida por la enfermera no sera incluida en los resultados del estudio.

A usted le será entregada una copia de este documento una vez que lo haya firmado.

OREGON HEALTH & SCIENCE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
PHONE NUMBER (503) 494-7887.
CONSENT FORM APPROVAL DATE
JAN 2 1 2003
APPROVED BY:
Do Not Sign This Form After The
Expiration Date Of: 5/15/03

FIRMAS:

Su firma abajo indica que usted ha leído todo lo anterior y que está de acuerdo en permitir a la investigadora principal observar a la enfermera que lo atiende hoy.

Su firma: _____ Fecha:_____

_____ Fecha:_____

Firma de la persona que obtuvo el consentimiento

DECLARACIÓN DE DERECHOS DE PERSONAS SUJETAS A UNA INVESTIGACIÓN MEDICA

Los derechos abajo descritos son los derechos de toda persona a la que se le pida participar en una investigación médica.

Como sujeto de investigación, usted tiene los siguientes derechos:

1. Ser informado de la naturaleza y propósito de la investigación.
2. Ser informado de lo que pasará y si alguno de los procedimientos, medicamentos o aparatos son diferentes de los que se usan en la práctica normal.
3. Ser informado acerca de cualquier riesgo insignificante, efecto secundario o malestar que razonablemente se pueda esperar de esta investigación.
4. Ser informado de cualquier beneficio esperado por participar en esta investigación.
5. Ser informado de cualquier otro tratamiento disponible que pueda ser elegido en lugar del usado en este momento, y como puede ser mejor o peor.
6. Permitírsele hacer cualquier pregunta concerniente a esta investigación antes de aceptar participar en esta investigación y durante el curso del estudio.
7. Ser informado de que clase de tratamiento médico esta disponible si surge cualquier complicación.
8. Negarse a participar del todo o retirar su permiso a participar a cualquier hora, sin poner en riesgo sus derechos de recibir tratamiento médico en el presente o en el futuro.
9. Recibir una copia de la forma de consentimiento firmada y fechada.
10. Estar libre de presiones cuando decida participar en la investigación.

Appendix F

English Language

Consent Form to Observe Latino Patient Care

IRB# 7053
Approved: 5/16/02

OREGON HEALTH & SCIENCE UNIVERSITY
Informed Consent Form

TITLE: Nursing Care of Latino Patients: A Qualitative Study.

PRINCIPAL INVESTIGATOR: Regina E. Nailon RN, Doctoral Candidate, School of Nursing. 360-636-5453.

CO-INVESTIGATOR(S): Christine A. Tanner PhD, RN. 503-494-3742.

SPONSOR: Northwest Health Foundation; Washington State Nurses Foundation.

PURPOSE: You have been invited to participate in this research study because you are a Latino patient who will receive care from a nurse in the emergency department today. The purpose of this study is to describe the knowledge that nurses use when they provide care to Latino patients in the emergency department. Approximately 108 – 192 Latino patients will participate in this study. Your participation in this study will last no longer than the time you spend receiving care in the emergency department today.

PROCEDURES:

The person in charge of the study is going to be in the room when you receive nursing care today. She is the principal investigator. She is not going to talk to you or ask you to do anything. She is only going to be there to watch the nurse take care of you.

RISKS AND DISCOMFORTS:

You may feel embarrassed and become uncomfortable having someone in the room while the nurse is taking care of you. You may ask your nurse to make this person leave the room at any time that her presence makes you too uncomfortable.

BENEFITS:

You may or may not personally benefit from participating in this study. However, by serving as a participant, you may contribute new information which may benefit Latino patients in the future.

ALTERNATIVES:

You may choose not to participate in this study.

CONFIDENTIALITY:

Neither your name nor your identity will be used for publication or publicity purposes.

While watching the nurse take care of you, the investigator may take notes about what the nurse is doing. These notes will contain information that identifies you and will be destroyed upon completion of the study.

Any patient abuse that the principal investigator observes will be reported to appropriate authorities.

You will be identified by a code name assigned to you by the principal investigator in the study findings.

Notes linking your name with your code name will be stored in a locked file cabinet in the principal investigator's home separate from any information that is collected about your nursing care. These notes will be destroyed upon completion of the study.

COSTS:

There is no cost for you to participate in this study. You will not be offered any money for allowing the investigator to observe the nurse take care of you.

LIABILITY:

The Northwest Health Foundation and the Washington State Nurses Foundation do not offer to pay for medical expenses for injuries unrelated to the study protocol or that are caused by your disease or condition. No other compensation is offered by the Northwest Health Foundation or the Washington State Nurses Foundation.

In the event that injury occurs as a result of this research, treatment will be available. You or your insurance carrier or another third party payor will be billed. No compensation is offered by [redacted] Medical Center, [redacted] Hospital, or [redacted] Hospital. This is not a waiver of your legal rights.

The Oregon Health & Science University is subject to the Oregon Tort Claims Act (ORS 30.260 through 30.300). If you suffer any injury and damage from this research project through the fault of the University, its officers or employees, you have the right to bring legal action against the University to recover the damage done to you subject to the limitations and conditions of the Oregon Tort Claims Act. You have not waived your legal rights by signing this

[redacted]H
Institutional Review Board
SEP 25 2002

APPROVED

form. For clarification on this subject, or if you have further questions, please call the OHSU Research Support Office at (503) 494-7887.

PARTICIPATION:

Regina Nailon (360) 636-5453 has offered to answer any other questions you may have about this study. If you have any questions regarding your rights as a research participant, you may contact the OHSU Research Support Office at (503) 494-7887. You may refuse to participate, or you may withdraw from this study at any time without affecting your relationship with or treatment at the Oregon Health & Science University.

If you choose to withdraw from the study, any information that was collected about the nursing care that you received will not be included in the study findings.

You will be given a copy of this consent form after you have signed it.

SIGNATURES:

Your signature below indicates that you have been read the foregoing and agree to let the principal investigator observe the nursing care that you receive.

Subject's signature: _____ Date: _____

_____ Date: _____

Signature of person obtaining consent

MEDICAL RESEARCH SUBJECT'S BILL OF RIGHTS

The rights below are the rights of every person who is asked to participate in medical research.

As a research subject, you have the following rights:

1. To be told the nature and purpose of the research.
2. To be told what will happen and whether any of the procedures, drugs or devices are different from what would be used in standard practice.
3. To be told about any significant risks, side effects or discomforts that can be reasonably expected from the research.
4. To be told of any expected benefits from participating in the research.
5. To be told the other available treatments that could be chosen instead, and how they may be better or worse than participating in the research.
6. To be allowed to ask any questions concerning the research both before agreeing to be involved and during the course of the study.
7. To be told what sort of medical treatment is available if any complications arise.
8. To refuse to participate at all or to withdraw consent to participate at any time, without jeopardizing the right to receive present or future care.
9. To receive a copy of the signed and dated consent form.
10. To be free of pressure when considering whether to agree to participate in the research.

Appendix G

Spanish Language

Consent Form to Observe and Interview Latino Patient Care

IRB #_7053_
Approved: May 16, 2002

UNIVERSIDAD DE CIENCIAS Y SALUD DE OREGON
Formulario de Información y Consentimiento

TITULO: Cuidado y Atención de Pacientes Latinos: Estudio Cualitativo.

INVESTIGADORA PRINCIPAL: Regina E. Nailon RN, Candidata a Doctorado. Escuela de Enfermería.509-249-5834.

CO-INVESTIGADORA: Chistine A. Tanner PhD, RN. 503-494-3742; Mireya Esqueda 509-469-3708.

PATROCINADOR: Fundación de Salud del Noroeste; Fundación de Enfermeras del Edo. de Washington.

PROPOSITO: Usted esta siendo invitado a participar en este estudio de investigación porque es un paciente latino que hoy sera atendido por una enfermera en el Departamento de Emergencias. El Propósito de este estudio es describir el conocimiento que las enfermeras utilizan cuando dan atención a pacientes latinos en el Departamento de Emergencias, y encontrar si el cuidado que usted recibe es el adecuado a sus necesidades como paciente. Alrededor de 108 a 192 pacientes latinos participarán en este studio. Su participación en este estudio durará aproximadamente una hora más de lo que usualmente tarda una consulta en el Departamento de Emergencias.

PROCEDIMIENTOS:

La persona encargada de este estudio estará en el cuarto cuando usted sea atendido por la enfermera hoy. Ella es la Investigadora Principal. Ella no va a hablar con usted ni le pedirá que haga nada. Ella solo estará presente para observar a las enfermeras que lo estan atendiendo.

Despues de que haya sido atendido, le haran algunas preguntas acerca del cuidado que usted acaba de recibir de la enfermera.

RIESGOS Y MOLESTIAS:

Usted se puede sentir avergonzado y molesto de tener a alguien en el cuarto mientras la enfermera lo esta atendiendo. Usted le puede pedir a la enfermera que haga que esa persona salga de la habitacion en cualquier momento, si su presencia lo hace sentir a disgusto.

Durante la entrevista le pedirán que hable del cuidado que usted recibió por parte de la enfermera en el Departamento de Emergencias. Algunas de las preguntas de la entrevista le pueden parecer muy personales y lo pueden hacer sentirse mal. Usted se puede negar a responder cualquier pregunta que usted quiera.

BW

BENEFICIOS:

Usted puede o no beneficiarse personálmente de participar en este studio. Sin embargo, por servir como participante, usted puede contribuir con nueva información, la cual puede \ beneficiar a los pacientes latinos en el futuro.

ALTERNATIVAS:

Usted puede negarse a participar en este estudio.

CONFIDENCIALIDAD:

Su nombre no sera utilizado en la publicación.

La investigadora tomará notas mientras la enfermera lo esta atendiendo acerca de lo que ella esta haciendo. Estas notas tendrán información que lo identifica a usted y seran destruidas una vez que el estudio haya sido terminado.

Cualquier abuso al paciente que la investigadora observe sera reportado a las autoridades correspondientes.

La entrevista con el asistente de investigación sera grabada en una cinta. Usted no será identificado por su nombre durante la entrevista. Todas las cintas serán destruidas cuando el estudio se termine.

La copias de las entrevistas seran guardadas durante el estudio en un archivo cerrado en la casa de la investigadora principal. Despues de terminado el estudio las copias de la entrevista seran almacenadas en un archivo cerrado durante dos años en casa de la investigadora principal, durante ese tiempo estas copias pueden ser usadas para un análisis secundario. Después de dos años las copias seran destruidas.

El asistente de investigación puede tomar notas durante la entrevista con usted. Usted sera identificado con un número o código que le sera asignado.

Una vez terminada la entrevista, el asistente de investigación tomará notas que lo identifican a usted por el número que le fue asignado. Estas notas seran destruidas cuando se termine el estudio.

Si usted reporta al asistente de investigación algún abuso ocurrido mientras recibía atención, esta información sera reportada a las autoridades correspondientes.

Usted será identificado por el código que le fue asignado anteriormente por la investigadora principal en los resultados del estudio.

Las notas que ligan su nombre con el código seran guardadas en un archivo cerrado en la casa de la investigadora principal y estarán separadas de cualquier información que usted haya proporcionado acerca de la atención que recibió. Estas notas seran destruidas cuando se termine el estudio.

COSTOS:

Su participación en este estudio no tendrá ningún costo. A usted no le sera ofrecido ningún dinero por permitir ser observado por la investigadora mientras la enfermera lo atiende.

A usted le serán ofrecidos $20.00 en efectivo si participa en la entrevista.

RESPONSABILIDAD LEGAL:

La fundación de salud del noroeste y la fundación de enfermeras del edo. de Washington no ofrecen pagar los gastos médicos por daños que no esten relacionados con este estudio o que sean causados por su condición médica o enfermedad. Ninguna otra compensación es ofrecida por la fundación de salud del noroeste o por la fundación de enfermeras del edo. de Washington.

En caso de que ocurra algún daño como resultado de este estudio, habra tratamiento disponible. Usted, su seguro médico o una tercera persona pagarán o recibirán una factura. Ninguna compensación es ofrecida por el Centro medico [illegible], el hospital [illegible] o el hospital [illegible] del valle [illegible]. Esto no es una renuncia a sus derechos legales.

La Universidad de Salud y Ciencias de Oregon (OHSU) esta sujeta a la Ley de Demandas Judiciales del Estado de Oregon (ORS 30.260 a 30.300). Si usted sufre cualquier lesión o daño por participar en este proyecto de investigación por culpa de la Universidad, sus oficiales o empleados, usted tendrá derecho a una acción legal en contra de la Universidad para recuperar el daño hecho a usted y esta sujeto a las limitaciones y condiciones de la Ley de Demandas Judiciales del Edo. de Oregon. Usted no ha renunciado a sus derechos legales por firmar este documento. Para cualquier aclaración en esta materia, o si usted tiene otras preguntas, por favor llame a la oficina de apoyo a la investigación de la Universidad de Salud y Ciencias de Oregon (OHSU) al teléfono (503) 494-7887.

PARTICIPACION:

Regina Nailon (360) 636-5453 se ha ofrecido a contestar cualquier pregunta que usted pueda tener acerca de este estudio. Si usted tiene alguna pregunta acerca de sus derechos como sujeto de la investigación, usted puede llamar a la oficina de apoyo a la investigación de la Universidad (OHSU). Usted no tiene que participar en este estudio o ningun otro. Si usted decide participar y luego cambia de parecer, puede dejar el estudio en qual quier momento. Si se niega a participar o quiere dejar el estuido antes de tiempo, no habra ningun castigo o perdida de beneficios a los que usted tiene derecho.

Si usted elige retirarse de este estudio, cualquier información recabada acerca de la atención recibida por la enfermera no sera incluida en los resultados del estudio.

A usted le será entregada una copia de este documento una vez que lo haya firmado.

FIRMAS:

Su firma abajo indica que usted ha leído todo lo anterior y que está de acuerdo en permitir a la investigadora principal observar a la enfermera que lo atiende y que está de acuerdo en ser entrevistado acerca del cuidado y la atención que recibío hoy.

Su firma: _____ Fecha:_____

_____ Fecha: _____
Firma de la persona que obtuvo el consentimiento

OREGON HEALTH & SCIENCE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
PHONE NUMBER (503) 494-7887.
CONSENT FORM APPROVAL DATE

JAN 2 1 2003

APPROVED BY: [redacted]
Do Not Sign This Form After The
Expiration Date Of: 5/15/03

DECLARACIÓN DE DERECHOS DE PERSONAS SUJETAS A UNA INVESTIGACIÓN MEDICA

Los derechos abajo descritos son los derechos de toda persona a la que se le pida participar en una investigación médica.

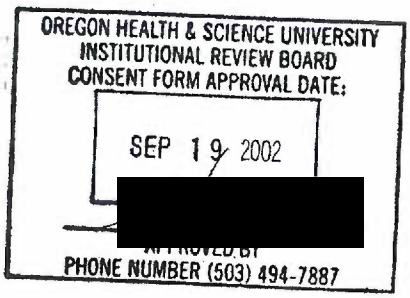
Como sujeto de investigación, usted tiene los siguientes derechos:

1. Ser informado de la naturaleza y propósito de la investigación.
2. Ser informado de lo que pasará y si alguno de los procedimientos, medicamentos o aparatos son diferentes de los que se usan en la práctica normal.
3. Ser informado acerca de cualquier riesgo insignificante, efecto secundario o malestar que razonablemente se pueda esperar de esta investigación.
4. Ser informado de cualquier beneficio esperado por participar en esta investigación.
5. Ser informado de cualquier otro tratamiento disponible que pueda ser elegido en lugar del usado en este momento, y como puede ser mejor o peor.
6. Permitírsele hacer cualquier pregunta concerniente a esta investigación antes de aceptar participar en esta investigación y durante el curso del estudio.
7. Ser informado de que clase de tratamiento médico esta disponible si surge cualquier complicación.
8. Negarse a participar del todo o retirar su permiso a participar a cualquier hora, sin poner en riesgo sus derechos de recibir tratamiento médico en el presente o en el futuro.
9. Recibir una copia de la forma de consentimiento firmada y fechada.
10. Estar libre de presiones cuando decida participar en la investigación.

Appendix H

English Language

Consent Form to Observe and Interview Latino Patient Care



IRB# 7053
Approved: 5/16/02

OREGON HEALTH & SCIENCE UNIVERSITY
Informed Consent Form

TITLE: Nursing Care of Latino Patients: A Qualitative Study.

PRINCIPAL INVESTIGATOR: Regina E. Nailon RN, Doctoral Candidate, School of Nursing. 360-636-5453.

CO-INVESTIGATOR(S): Christine A. Tanner PhD, RN. 503-494-3742.

SPONSOR: Northwest Health Foundation; Washington State Nurses Foundation.

PURPOSE: You have been invited to participate in this research study because you are a Latino patient who will receive care from a nurse in the emergency department today. The purpose of this study is to describe the knowledge that nurses use when they provide care to Latino patients in the emergency department, and to find out if the nursing care you receive matches your needs and concerns as a patient. Approximately 108 – 192 Latino patients will participate in this study. Your participation in this study will last approximately one hour longer than the time you spend receiving care in the emergency department today.

PROCEDURES:

The person in charge of the study is going to be in the room when you receive nursing care today. She is the principal investigator. She is not going to talk to you or ask you to do anything. She is only going to be there to watch the nurse take care of you.

After you have been taken care of, you will be asked some questions about the nursing care that you received today.

BN

RISKS AND DISCOMFORTS:

You may feel embarrassed and become uncomfortable having someone in the room while the nurse is taking care of you. You may ask your nurse to make this person leave the room at any time that her presence makes you too uncomfortable.

During the interview you will be asked to talk about the nursing care you received in the emergency department today. Some of the interview questions may seem personal and may cause you to feel uncomfortable. You may refuse to answer any of the questions that you do not want to answer.

BENEFITS:

You may or may not personally benefit from participating in this study. However, by serving as a participant, you may contribute new information which may benefit Latino patients in the future.

ALTERNATIVES:

You may choose not to participate in this study.

CONFIDENTIALITY:

Neither your name nor your identity will be used for publication or publicity purposes.

While watching the nurse take care of you, the investigator may take notes about what the nurse is doing. These notes will contain information that identifies you and will be destroyed upon completion of the study.

Any patient abuse that the principal investigator observes will be reported to appropriate authorities.

The interview with the research assistant will be tape-recorded. You will not be identified by name during the interview. All audiotapes will be destroyed upon completion of the study. Transcriptions from interviews will be stored in a locked file cabinet in the principal investigator's home during the study. Upon completion of the study, transcriptions will be stored in a locked file cabinet in the principal investigator's home for a period of two years, during which time they may be used for secondary analysis. After two years the transcriptions will be destroyed.

The research assistant may take notes during the interview with you. You be identified by a code number assigned to you in any notes taken by the research assistant during the interview.

After the interview is finished, the research assistant will take notes that identify you and the code number assigned to you. These notes will be destroyed upon completion of the study.

If you report to the research assistant that you were abused while receiving care, this information will be reported to appropriate authorities.

You will be identified by a code name assigned to you by the principal investigator in the study findings.

Notes linking your name with your code identifier number and code name will be stored in a

locked file cabinet in the principal investigator's home separate from any information that you give about your nursing care. These notes will be destroyed upon completion of the study.

COSTS:

There is no cost for you to participate in this study. You will not be offered any money for allowing the investigator to observe the nurse take care of you. You will be offered $20 in cash if you participate in an interview.

LIABILITY:

The Northwest Health Foundation and the Washington State Nurses Foundation do not offer to pay for medical expenses for injuries unrelated to the study protocol or that are caused by your disease or condition. No other compensation is offered by the Northwest Health Foundation or the Washington State Nurses Foundation.

In the event that injury occurs as a result of this research, treatment will be available. You or your insurance carrier or another third party payor will be billed. No compensation is offered by [redacted] Medical Center, [redacted] Hospital, or [redacted] Hospital. This is not a waiver of your legal rights.

The Oregon Health & Science University is subject to the Oregon Tort Claims Act (ORS 30.260 through 30.300). If you suffer any injury and damage from this research project through the fault of the University, its officers or employees, you have the right to bring legal action against the University to recover the damage done to you subject to the limitations and conditions of the Oregon Tort Claims Act. You have not waived your legal rights by signing this form. For clarification on this subject, or if you have further questions, please call the OHSU Research Support Office at (503) 494-7887.

PARTICIPATION:

Regina Nailon (360) 636-5453 has offered to answer any other questions you may have about this study. If you have any questions regarding your rights as a research subject, you may contact the OHSU Research Support Office at (503) 494-7887. You may refuse to participate, or you may withdraw from this study at any time without affecting your relationship with or treatment at the Oregon Health & Science University.

If you choose to withdraw from the study, any information that was collected about the nursing care that you received will not be included in the study findings.

You will be given a copy of this consent form after you have signed it.

SIGNATURES:

Your signature below indicates that you have been read the foregoing and agree to let the principal investigator observe the nursing care that you receive and you agree to be interviewed about the nursing care that you receive today.

Subject's signature: _____ Date: _____

_____ Date: _____
Signature of person obtaining consent

MEDICAL RESEARCH SUBJECT'S BILL OF RIGHTS

The rights below are the rights of every person who is asked to participate in medical research.

As a research subject, you have the following rights:

1. To be told the nature and purpose of the research.
2. To be told what will happen and whether any of the procedures, drugs or devices are different from what would be used in standard practice.
3. To be told about any significant risks, side effects or discomforts that can be reasonably expected from the research.
4. To be told of any expected benefits from participating in the research.
5. To be told the other available treatments that could be chosen instead, and how they may be better or worse than participating in the research.
6. To be allowed to ask any questions concerning the research both before agreeing to be involved and during the course of the study.
7. To be told what sort of medical treatment is available if any complications arise.
8. To refuse to participate at all or to withdraw consent to participate at any time, without jeopardizing the right to receive present or future care.
9. To receive a copy of the signed and dated consent form.
10. To be free of pressure when considering whether to agree to participate in the research.

Appendix I

Consent Form for Nurse Participants

IRB# 7053
Protocol Approved 5/16/02

OREGON HEALTH & SCIENCE UNIVERSITY
Informed Consent Form

TITLE: Nursing Care of Latino Patients: A Qualitative Study.

PRINCIPAL INVESTIGATOR: Regina E. Nailon RN, Doctoral Candidate, School of Nursing. 360-636-5453.

CO-INVESTIGATOR(S): Christine A. Tanner PhD, RN. 503-494-3742.

SPONSOR: Northwest Health Foundation; Washington State Nurses Foundation.

PURPOSE: You have been invited to participate in this research study because you are a nurse with experience in caring for Latino patients in the emergency department of a hospital. The purpose of this study is to describe the everyday concerns, habits and practices that direct the nursing care given to Latino patients in the emergency care setting, and to determine if nurses' concerns match the needs and concerns brought to clinical encounters by Latino patients. Twenty to twenty-six nurses will be involved in the study. Your participation in this study will last no longer than six (6) months.

PROCEDURES:

You will be asked to participate in two group interviews with other nurses who work in emergency departments of hospitals. Group interviews will last approximately 2 hours each.

You may be asked to participate in not more than two individual interviews with the principal investigator, if the information you provide during group interviews requires further exploration or clarification. Individual interviews will last approximately 1 hour each.

Before coming to your first group interview you will be asked to read pre-interview instructions that will direct you to reflect on your experiences of caring for Latino patients, and will ask you to recall at least one particular patient situation that stands out as memorable for you. You will be encouraged to write notes about patient experiences that will assist you with telling your stories of the experiences. Reading the pre-interview instructions and reflecting upon practice experiences may take up to two hours of your time.

Eight to twelve nurses who are identified by the principal investigator as demonstrating a wide variety of experiences with caring for Latino patients during group and individual interviews with the principal investigator will be asked to allow the investigator to observe their nursing practice as they care for Latino patients in the emergency department in the hospital in which they are employed. The principal investigator will observe each nurse who agrees to participate in this additional data collection on two separate occasions; each session will be concluded when the investigator has observed the nurse provide care to 6 to 8 Latino patients.

Nurses whose practice is observed by the principal investigator may be asked to participate in one individual follow-up interview after each observation session, in order for the principal

BV

investigator to further explore or clarify incidents that occurred during the observation session. Each individual follow-up interview will last approximately 1 hour.

RISKS AND DISCOMFORTS:

For nurses who live in , : Participation in group interviews may require you to travel up to 31 miles each way if it is not possible to arrange for the interview to be held at a location that is more convenient for you.

During group and individual interviews you will be asked to tell stories from your experiences with caring for Latino patients in the emergency department. Some of the interview questions may seem personal and may cause you to feel uncomfortable, embarrassed or defensive about your nursing abilities. You may refuse to answer any of the questions that you do not wish to answer. If you become so upset by the questions that you appear to need counseling, you will be referred to an appropriate counselor.

During observations of your nursing practice you may feel embarrassed to have someone watching you. You may be asked to explain your rationale for actions you take during patient care. Some of the questions may seem as though they are challenging your knowledge and may cause you to feel uncomfortable, embarrassed or defensive about your nursing abilities. You may refuse to answer any of the questions that you do not wish to answer. You may end the observation session before the investigator has observed you provide care to 6 to 8 Latino patients if you do not wish to continue to have the investigator observe your practice.

BENEFITS:

You may or may not personally benefit from participating in this study. However, by serving as a participant, you may contribute new information which may benefit nurses and the Latino patients that they care for in the future.

ALTERNATIVES:

You may choose not to participate in this study.

CONFIDENTIALITY:

Neither your name nor your identity will be used for publication or publicity purposes.

All incidents of patient abuse that you may report during an interview, or that may be observed during your care will be reported to appropriate authorities.

All interviews with the principal investigator and all conversations with the principal investigator during observation sessions will be audio-recorded. You will be identified on all audiotapes by a code name that will be assigned to you by the principal investigator. All audiotapes will be destroyed upon completion of the study. Transcriptions from interviews and observation sessions will be stored in a locked file cabinet in the principal investigator's home during the study. Upon completion of the study, transcriptions will be stored in a locked file cabinet in the principal investigator's home for a period of two years, during which time they may be used for secondary analysis. After two years the transcriptions will be destroyed.

You will be identified by a code name assigned to you by the principal investigator in any notes taken by the investigator during interviews and observation sessions. These notes will be destroyed upon completion of the study.

Notes linking your name and code identifier name will be stored in a locked file cabinet in the principal investigator's home. These notes will be destroyed upon completion of the study.

You will be identified by a code name assigned to you by the principal investigator in the study findings.

You are asked to keep confidential the information that is shared, and the identities of nurses who may be known to you in group interviews.

COSTS:

If you participate in interviews only, the anticipated costs for your participation in this study include the cost of travel to and from individual and group interviews, and the time involved in each interview.

If you participate in interviews and your practice is observed, the anticipated costs for your participation in this study include the cost of travel to and from individual and group interviews, the time involved in each interview, the cost of travel to and from individual interviews following observation sessions, and the time involved in each of these follow-up individual interviews.

You will be paid $25 per hour in cash for the time you spend participating in group and individual interviews during this study.

LIABILITY:

The Northwest Health Foundation and the Washington State Nurses Foundation do not offer to pay for medical expenses for injuries unrelated to the study protocol or that are caused by your disease or condition. No other compensation is offered by the Northwest Health Foundation or the Washington State Nurses Foundation.

In the event that injury occurs as a result of this research, treatment will be available. You or your insurance carrier or other third party payor will be billed. No other compensation is offered by [redacted] Medical Center, [redacted] Hospital, [redacted] Hospital, or [redacted] Hospital. This is not a waiver of your legal rights.

The Oregon Health & Science University is subject to the Oregon Tort Claims Act (ORS 30.260 through 30.300). If you suffer any injury and damage from this research project through the fault of the University, its officers or employees, you have the right to bring legal action against the University to recover the damage done to you subject to the limitations and conditions of the Oregon Tort Claims Act. You have not waived your legal rights by signing this form. For clarification on this subject, or if you have further questions, please call the OHSU Research Integrity Office at (503) 494-7887.

PARTICIPATION:

Regina Nailon (360) 636-5453 has offered to answer any other questions you may have about this study. If you have any questions regarding your rights as a research participant, you may contact the OHSU Research Integrity Office at (503) 494-7887. You do not have to join this or any research study. If you do join, and later change your mind, you may quit at any time. If you refuse to join or withdraw early from the study, there will be no penalty or loss of any benefits to which you are otherwise entitled.

If you choose to withdraw from the study, any information that was collected from you about your experiences with caring for Latino patients in the emergency department will not be included in the study findings.

You may be removed from the study prior to the study conclusion if you fail to comply with instructions provided to you by the principal investigator, or if the principal investigator determines that your experiences would not be beneficial to the study purpose.

You will be given a copy of this consent form after you have signed it.

SIGNATURES:

Your signature below indicates that you have read the foregoing and agree to participate in this study. Please indicate the extent to which you would like to participate in this study by signing on the appropriate line.

Interview only:

I agree to be interviewed about my experiences with caring for Latino patients in the emergency department.

Subject's signature: _____ Date: _____

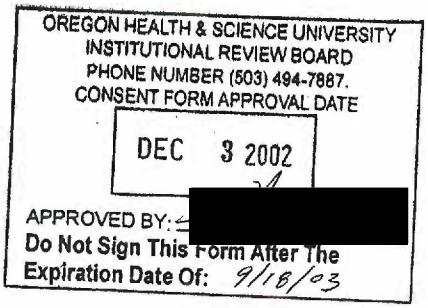
_____ Date: _____
Investigator's signature

Interview and observe practice:

I agree to be interviewed about my experiences with caring for Latino patients in the emergency department. If the principal investigator determines that my experiences with caring for Latino patients meet the criteria for this additional data collection, I agree to allow the investigator to observe me as I provide care to Latino patients in the emergency department.

Subject's signature: _____ Date: _____

_____ Date: _____
Investigator's signature



MEDICAL RESEARCH SUBJECT'S BILL OF RIGHTS

The rights below are the rights of every person who is asked to participate in medical research.

As a research subject, you have the following rights:

1. To be told the nature and purpose of the research.
2. To be told what will happen and whether any of the procedures, drugs or devices are different from what would be used in standard practice.
3. To be told about any significant risks, side effects or discomforts that can be reasonably expected from the research.
4. To be told of any expected benefits from participating in the research.
5. To be told the other available treatments that could be chosen instead, and how they may be better or worse than participating in the research.
6. To be allowed to ask any questions concerning the research both before agreeing to be involved and during the course of the study.
7. To be told what sort of medical treatment is available if any complications arise.
8. To refuse to participate at all or to withdraw consent to participate at any time, without jeopardizing the right to receive present or future care.
9. To receive a copy of the signed and dated consent form.
10. To be free of pressure when considering whether to agree to participate in the research.

Appendix J

Nurse Participant Demographic Data Questionnaire

Demographic Questionnaire for Nurse Participants

Personal data

Name _____

Institution in which you are employed _____

Date of birth _____
month / date / year

Basic nursing education _____
Degree Date

Highest degree earned _____
Degree Date

Years in emergency department nursing _____

Ethnicity (please check all that apply)

White (non-Hispanic) _____

Black or African American _____

American Indian _____

Alaskan Native _____

Asian _____

Native Hawaiian and Other Pacific Islander _____

Hispanic or Latino _____

Other (please explain) _____

Have you had any training in cultural competence specific to nursing care of Latino patients?

_____ Yes _____ No _____ Don't know

Optional. Please add any comments you may have about the information you have provided.

Appendix K

Nurse Participant Pre-Interview Instructions

Pre-Interview Instructions for Nurse Participants.

As a nurse, you have had experience with providing care to Latino patients in the emergency care setting. Before coming to the first interview, the investigator would like you to think about your nursing practice and the care that you provide to Latino patients, and reflect upon particular Latino patient experiences. These experiences may have occurred a long time ago, or may be from the recent past. Make notes to yourself if it would help you in recalling specific aspects of the patient experiences that come to mind. The patient experiences you reflect upon will serve as baseline material for the patient stories you will tell when you are interviewed with other nurses participating in this study. The following instructions will help you to better understand what is important for you to include in the stories that you will tell in the group interviews.

1. Think about a particular situation with a Latino patient that stands out for you as significant. The particular patient situation may be significant because:
    a. you felt that you made a difference in the Latino patient's life
    b. you learned something new from the care situation
    c. things went unusually well
    d. things did not go as planned
    e. the situation was particularly demanding

2. Give a brief history of why the particular patient presented to the emergency department.
3. Describe details about that particular day (the shift you were working, the time of day when the patient came in, the resources that were available).
4. Describe why this patient incident is significant to you.
5. Describe what happened in detail:
    a. How did the situation unfold?
    b. Did you and the patient speak the same language? If not, how did you communicate with each other?
    c. What were your priorities during the situation?
    d. What were you thinking about as the situation unfolded?
    e. Did your priorities change as the situation unfolded? If so, how?

6. What, if anything, did you find most demanding about the situation?
7. How would your priorities or concerns during this clinical situation have been different if the patient was not Latino?
8. What guidelines would you give another nurse for handling this patient situation?
9. What do you think the Latino patient would say about your care?

(Adapted from Benner, 1984; Benner, Kyriakidis & Stannard, 1999; Benner, Tanner & Chesla, 1996)

Appendix L

Nurse Participant Interview Guide

Interview Guideline for Nurse Participants.

1. Tell me a story about a recent care experience in the emergency department with a Latino patient where things went really well.

PROBES:

Briefly describe the history of the patient to familiarize me (us) with the patient.
Describe the context of the situation (shift, time of day, resources available).
What happens when things are going really well?
Describe what happened in detail, including as much dialogue as possible.
What were your concerns during this patient situation? What were the conflicts?
Why was the situation significant to you?
What were you thinking about as the situation unfolded?
What were you watching out for with this particular patient?
What were you feeling during and after the situation?
What were your priorities at the time of this patient situation?
Did your priorities change during the situation? How?
Have you worked with similar patients before?
Did any particular case come to mind while you were working with this patient/family?
What was the primary source of your learning about managing this particular situation?
What guidelines would you give other nurses for managing this situation?
How would these guidelines change if you were talking to an inexperienced nurse?
What did you find most satisfying about the situation?
Can you describe a patient situation that changed the way you deal with Latino patients and/or their families?
What kinds of things make caring for English-speaking/non-English-speaking Latinos easier?

2. Tell me a story about a recent care experience with a Latino patient where there was a breakdown, or when things did not go very well.

(Adapted from Benner, Kyriakidis & Stannard, 1999; Benner, Tanner, Chesla, 1996)

PROBES--Use same probes as above, in addition:

What happens when things are not going very well?
What kinds of things make it difficult to care for English-speaking/non-English-speaking Latino patients?

Work Environment

1. What resources are available in your facility that make it easy to care for Latino patients?
2. What barriers exist within the institution that prevent you from providing nursing care to Latino patients in the emergency department?

PROBES:

1. What resources could be added within your facility that would make caring for Latino patients easier?
2. How does your facility support nursing care of Latino patients?
3. Could more be done? If so, describe how nursing care of Latino patients could be better supported. What resources are available in your facility that make it easy to care for Latino patients?
3. What barriers exist within the institution that prevent you from providing nursing care to Latino patients in the emergency department?

Closure

1. What sort of things do you think would help you to provide better care to Latino patients? --English/Non-English-speaking?
2. Is there anything we haven't talked about that you think is important for me to know about the care of Latino patients in the emergency department?

Appendix M

Latino Patient Interview Guide/Demographic Data Questionnaire

Interview Guideline for Latino Patient Participants

Thank you for agreeing to participate in this study. The information you provide is very important and may be helpful to Latino patients in the future.

Is it alright with you if I turn this tape recorder on now? Yes _____ No _____

1. Tell me about the nursing care you received in the emergency department today.

PROBES

a. Describe in detail what happened: who you were with, the reason for your visit.
b. Describe in detail what happened when you received care, including as much dialogue as possible that occurred between you and the nurse that took care of you.
c. What did you think was wrong with you?
d. What did you expect to happen when the nurse took care of you?
e. Describe the nursing care you received. Include as much dialogue as possible.
f. What things did the nurse do that made you happy with your care?
g. What things did the nurse do that made you unhappy with your care?
h. What things did the nurse **not** do that you think should have been done in your care?

Personal data: (collected with tape recorder turned OFF)

Code identifier # each form will be pre-coded with number here to identify patient in data analysis

Age _____

Occupation _____

Place of birth _____

Length of time living in ____location of interview_____

After debriefing with patient about interview experience, the Research Assistant will say the following:

Thank you for your time today. Your information is very helpful. Here is $20 for your time. Have a good day/evening/night.

Appendix N

Expert Nurse Nomination Form

Nomination Form to Identify Expert Nurses

Dear Nurse or Nurse Manager:

You are being asked to complete this nomination form because you are a nurse who works in the emergency department, or are a nurse manager who supervises nurses that work in the emergency department within the hospital in which you are employed. The purpose of this nomination form is to identify nurses who are recognized for their expertise in providing care to Latino patients in the emergency department of the hospital in which you are employed.

Think about the nurses that you work with. Below please identify the names of nurses that you feel provide expert care to Latino patients. For example, those nurses to whom other nurses turn for guidance and assistance in providing care to Latino patients in the emergency care setting.

Your completion of this nomination form implies consent for the investigator to contact you for further information. Your identity will remain anonymous and information you provide will be kept confidential.

Name(s) of nurses that I consider to give expert care to Latino patients, and/or who are a resource person for other nurses caring for Latino patients in the emergency care setting:

_____

_____

_____

_____

_____

Your regular work shift: _____

Thank you for providing this valuable information.

Appendix O

Study Information Sheet

ATTENTION EMERGENCY DEPARTMENT NURSES: AN OPPORTUNITY EXISTS TO SHARE YOUR EXPERIENCES!

Nursing Care of Latino Patients: A Qualitative Study

A nursing student in the doctoral program at Oregon Health & Science University is conducting a research study about nursing care of Latino patients in the emergency care setting. ***Would YOU like to participate?*** *Here is some additional information about the study:*

What is this study about?

- The focus of the study is to describe—***not to compare or judge***—the knowledge and skills that nurses use when caring for Latino patients in the ED.

Why is this study being done?

- Because many Latino patients access health care from emergency departments in hospital settings, ED nurses have gained a lot of experience in working with these patients and, as a result, have developed a knowledge base that guides the care they give to Latino patients. It is critical to describe ED nurses' experiences in order to understand in what ways their nursing care is uniquely planned and provided relative to the patient's Latino ethnicity.
- Many nurses lack experience in caring for Latino patients and do not know how to, or where to begin when caring for Latino patients.
- There have been no studies that have described nurses' experiences with caring for Latino patients in the emergency care setting. ***Yet there is so much that other nurses can learn from ED nurses' experiences!***

What will I have to do if I agree to participate in this study?

- Nurses who participate in this study will be asked to participate in two group interviews with other nurses who work in emergency departments of hospitals and to share stories of Latino patient situations. Nurses may also be asked to participate in up to two individual interviews with the nurse researcher, if the information the nurse provides during group interviews requires further exploration or clarification.
- ***Nurses will be paid $25 per hour in cash following each interview in which they participate.***
- Nurses with a wide variety of experiences in caring for Latino patients will be asked to allow the nurse researcher to observe their nursing practice on two occasions as they provide care to Latino patients in the ED to gain a deeper understanding of the challenges and rewards inherent in caring for Latino patients. These nurses may be asked to participate in one individual interview after each observation session.

Will my name be used in this study?

- No. The identity of nurses who participate in this study will be kept anonymous and code names will be used in the study findings.

How can I sign up to participate in this study?

- If you would like to be contacted about participating in this study, please complete the information below and return it to Regina Nailon in the attached self-addressed, stamped envelope. **ALL INFORMATION WILL BE KEPT CONFIDENTIAL**

Thank you very much for giving serious consideration to participation in this study. There is much to learn about nursing care of Latino patients in the emergency care setting. I hope that you realize how important your experiences are to this study, and that you will want to be a part of it!

If you would like additional information about this study please contact Regina Nailon, RN, Principal Investigator @ 509-249-5834 or email @ nailonr@ohsu.edu OHSU IRB#7053

Name _____

Mailing Address: _____
City State Zip

Email address (work)_____ (home) _____

Phone Number (work)_____ **(home)** _____