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The Development of Trust in the Nurse-Patient Relationship with Hospitalized Mexican American Patients

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LOYOLA UNIVERSITY CHICAGO

THE DEVELOPMENT OF TRUST

IN THE NURSE-PATIENT RELATIONSHIP WITH

HOSPITALIZED MEXICAN AMERICAN PATIENTS

A DISSERTATION SUBMITTED TO

THE FACULTY OF THE GRADUATE SCHOOL

IN CANDIDACY FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

PROGRAM IN NURSING

BY

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ACKNOWLEDGEMENTS

To my husband Joe

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

The Hispanic population in the United States is growing and this population experiences healthcare disparities compared to non-Hispanic Whites. Mexican Americans are the largest sub-group of Hispanics and providing nursing care that is patient-centered and culturally competent is important when caring for this population. Trust is an important component of patient-centered and culturally competent care as well as a major element (*confianza*) in the Hispanic culture. Although nursing researchers have identified the need for trust in culturally competent care with Mexican American patients, none have explored how trust develops between the nurse and the Mexican American patient. The classical grounded theory methodology was used to explore the process of the development of interpersonal trust between the nurse and the hospitalized Mexican American patient. Twenty-two English-speaking Mexican American patients hospitalized at least two days on an obstetric or medical-surgical unit in a hospital in the Midwestern United States were interviewed using a semi-structured interview guide. Through data analysis using constant comparison, a model emerged that explained the development of trust. The core category was Making Me Feel Comfortable and the model had eight categories. These categories reflected stages in the model. The beginning stages of the model included the categories *Having Needs* and *Relying on the Nurse*. The middle stages of the model reflecting interaction between the nurse and patient included the categories *Coming Across to Me, Taking Care of Me*, and *Connecting*. The final stages were the

category *Feeling Confianza (Trust)* with the outcome categories *Confiding in the Nurse* and *Taking Away the Negative.* Of particular importance, anytime there was a negative element while interacting with the nurse during the middle stages, this element halted any further development of trust. Establishment of trust for the hospitalized patient with the nurse was a cyclical process, beginning again with the nurse on the next shift. Hispanic cultural values of *personalismo* and *simpatia* (personal, friendly relations) and familism impacted the development of trust and contributed to the unique findings in this study. The findings of this study have implications for nursing care with Mexican American patients that may impact patient safety and quality care.

CHAPTER ONE

INTRODUCTION

Nurses have been rated as the most trusted professionals by respondents to the Gallup Poll every year since 1999 when nurses were first placed on the survey (except 2001 when firemen were rated the highest) (Gallup, 2011). This general trust in nurses by the public is beneficial for the profession, but it is trust during personal interactions with the nurse that is fundamental to a successful caring relationship (Thorne & Robinson, 1988). Trust is an important component of nursing care since it is a component of communication, patient-centered care and culturally competent care (Kim-Godwin, Alexander, Felton, Mackey, & Kasakoff, 2006; Stasiak, 2001; Warda, 2000). Trust is particularly important when caring for Hispanic patients since trust is a key cultural value (Warda, 2000) and Hispanics are less likely to trust compared to people of other racial and ethnic groups (Weaver, 2006).

Trust, known as *confianza*, is important in the Hispanic culture and research studies have demonstrated that Hispanics report a lower level of trust toward institutions and people in general compared to Whites and other racial groups (Weaver, 2006). Hispanics also report lower levels of trust toward healthcare professionals (Sohler, Fitzpatrick, Lindsay, Anastos, & Cunningham, 2007). This lack of trust of healthcare providers impacts communication and the ability to provide patient-centered care (PCC). PCC is vital in the patient-provider relationship and can lead to patient satisfaction and

adherence to the plan of care (Frampton et al., 2008). A lack of adherence to the plan of

care could lead to poor health outcomes and contribute to the health disparities

experienced by the Hispanic population (King et al., 2008).

The term *Hispanic* is used interchangeably with the term *Latino.* The U.S.

government coined the term *Hispanic* which is defined as "a person of Mexican, Puerto

Rican, Cuban, South or Central American, or other Spanish culture or origin regardless of

race" (U.S. Census Bureau, 2007, p. 1). Of note, since different authors may use different

terms (e.g. Hispanic, Latino, Mexican, Mexican American), throughout this document,

the term used in the original work cited will be used. The Hispanic population is the

fastest growing ethnic minority group in the United States. In 2010, 16% of the total U.S.

population was Hispanic (White, non-Hispanic 64%, Black 13%, Asian 5%) (U.S.

Census Bureau, 2010a) and that number is projected to grow to 24.4% of the total U.S.

population by 2050 (White, non-Hispanic 50.1%, Black 14.6%, Asian 8%) (U.S. Census

Bureau, 2004). In the 2010 Census data compared to the 2000 Census data, there was a

43% increase in the number of people reporting to being Hispanic while those reporting

being non-Hispanic increased only 4.9% (U.S. Census Bureau, 2010a). This growth is

primarily due to the young age of the current Hispanic population and the high birth rate

in this group.

The Hispanic population in the U.S. is composed of sub-groups and, when

completing research related to Hispanics, it is important to identify the Hispanic sub-

group (Smedley, Stith, & Nelson, 2003). The largest subgroup of Hispanics in the U.S. is

Mexicans (64%), with other sub-groups being Puerto Ricans (9.6%), Cubans (3.6%), Dominicans (2.6%), and Spanish-speaking Central (7.2%) and South Americans (5.5%) (U.S. Census Bureau, 2007). The language Hispanics speak in the home is a concern related to trust and communication for health professionals. Language use is often seen as a proxy measure of acculturation although not considered a valid measure in research studies (Marín, 1992). A language other than English is spoken in the homes of 19.4% of the total U.S. population; Spanish is spoken in 12% of the homes in the U.S. Finally, in 2008, 82.2% of the employed U.S. registered nurse population was non-Hispanic White while only 3.9% of nurses were Hispanic (U.S. Department of Health and Human Services, 2008). One could assume the non-Hispanic White nurses may be more likely to speak English only, while Hispanic nurses are more likely to also speak Spanish and identify culturally with Hispanic patients. The likelihood of a cross-cultural encounter grows as the Hispanic population increases and research related to trust is especially significant for this ethnic group.

The Institute of Medicine (IOM) has provided two major reports in recent years related to patient care and health disparities (Institute of Medicine, 2001; Smedley, et al., 2003). *Crossing the Quality Chasm* (Institute of Medicine, 2001) highlighted the need for improved quality in patient care through patient-centered care (PCC) and equity in care. "Patient-centered encompasses qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient" (Institute of Medicine, 2001, p. 48). The subsequent IOM report, *Unequal Treatment* (Smedley, et al.,

2003), supported the existence of healthcare disparities in racial and ethnic minority groups. The 2003 report stated that future research was needed concerning minority groups other than African Americans, such as Hispanics. The IOM had similar findings regarding research with other racial and ethnic groups in a review of the health disparities research plan of the National Institutes of Health (NIH) (Thomson, Mitchell, & Williams, 2006). In addition, the IOM identified the need for research related to other groups of healthcare providers besides physicians, such as nurses, since they provide the majority of direct patient care (Smedley, et al., 2003).

Several government entities and organizations have identified the elimination of health disparities as a major goal. The U.S. Congress called for the investigation and elimination of health disparities through the Research and Education Act of 2000 (Public Law 106-525) which established the National Center on Minority Health and Health Disparities (Thomson, et al., 2006). Likewise, in Healthy People 2020, the U.S. Department of Health and Human Services reported goals and objectives for the nation's health promotion and disease prevention to be implemented over the next decade. One of the four major goals was to "Achieve health equity, eliminate disparities, and improve the health of all groups" (U.S. Department of Health and Human Services, 2010).

Since 2003, the Agency for Healthcare Research and Quality (AHRQ) has released annual National Healthcare Quality and National Healthcare Disparities Reports (Thomson, et al., 2006). The 2009 National Healthcare Quality and Disparities Reports noted the importance of patient centeredness in quality and safe care of patients including

communication to avoid medical errors and improve adherence to the plan of care. Dimensions of quality are effectiveness, patient safety, patient-centeredness, and timeliness. The report included the findings on core quality measures for different ethnic and racial groups in comparison to the reference group, non-Hispanic Whites (Agency for Healthcare Research and Quality, 2009). Hispanics were categorized as worse (using the categories *better*, *same*, or *worse*) on 14 of the 20 core quality measures compared to non-Hispanic Whites. Although healthcare disparities have been the focus of government initiatives for over a decade, Hispanics have seen a worsening over time on six of 19 core quality measures and improvement on only five. Hispanics report fewer experiences of receiving PCC compared to non-Hispanic Whites and Blacks. This difference could be attributed to another issue, lack of culturally competent care. When providing patient-centered care to a vulnerable group, it is important to also incorporate culturally competent care (Ngo-Metzger et al., 2006). Vulnerable groups include racial and ethnic minorities including Hispanics, limited English proficiency (LEP) and lower socioeconomic (LES) people (Ngo-Metzger et al., 2006). PCC incorporates culturally competent care and trust is a key component of culturally competent care.

National nursing organizations and hospital accrediting institutions have identified the importance of culturally competent care. For example, the Joint Commission has standards for hospitals to follow that reflect culturally competent care; the standards are mandates and guidelines from the Office of Minority Health (2007) and referred to as Culturally and Linguistically Appropriate Services (CLAS). According to

the American Nurses Association's (ANA) Social Policy Statement (American Nurses

Association, 2010) the basic assumptions of nursing practice are that the patient and

nurse participate in the process of care within the context of values and beliefs of both the

nurse and patient which are culturally and contextually defined. The American Academy

of Nursing, a think tank of nursing leaders and experts established by the ANA,

appointed an expert panel on cultural competence composed of transcultural nursing

leaders (Giger et al., 2007). The panel suggested the American Academy of Nursing

should develop health policies at national and state levels and educate nursing leaders

related to the delivery of culturally competent care. The panel also noted the importance

of clarifying the concept of cultural competence and "demonstrate the usefulness of the

concept in affecting health disparities given the changing face of our nation" (Giger, et

al., 2007, p. 96). Although the experts were hopeful that eventually they would see

measureable reductions of health disparities, they acknowledged that "interventions in

health care alone, especially those focused on cultural competence, may not necessarily

reduce or eliminate health disparities" (Giger, et al., 2007, p. 96). This is in contrast to

some medical experts in health disparities who view interventions that are culturally

competent as "a key cornerstone in efforts to eliminate racial/ethnic disparities in health

and health care" (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003, p. 299).

Culturally competent care may have a role in the patient's clinical outcomes which could

impact health disparities (Betancourt, et al., 2003).

A component of culturally competent care is trust. Trust (*confianza*) is also a major factor in the Hispanic culture. Several research studies related to culturally competent care and the Hispanic population noted the importance of developing trust in the nurse-patient relationship (Belknap & Sayeed, 2003; Stasiak, 2001; Warda, 2000; Zoucha, 1998). However, none of these studies explored the process of developing trust in the nurse-patient relationship.

Since trust is important in the Hispanic culture and a major component of culturally competent care, it is important to conceptualize the process of developing trust in the nurse-patient relationship with Hispanics. This leads to the following research question, How does trust develop in hospitalized adult, Mexican American patients?

Conclusion

Cultural competence is significant to nursing as part of patient-centered care for the increasing Hispanic population that already experiences healthcare disparities in the U.S. The Joint Commission and nursing organizations support culturally competent nursing care in the alleviation of health disparities. Trust is an important component of culturally competent care as well as a significant cultural value in the Hispanic culture. Yet, no nursing research studies have explored the development of trust in this fast-growing, vulnerable population. It is imperative that the process of developing trust be examined as a foundation to nursing research related to culturally competent care of the Hispanic patient. In the next chapter, a review of the literature related to trust; patient-centered care and cultural competence; and Hispanic culture will be presented.

CHAPTER TWO

REVIEW OF THE LITERATURE

This chapter discusses key literature related to trust in general and in the nurse patient-relationship, patient-centered care and cultural competence, and the Hispanic culture. Terms referring to racial and ethnic groups have changed over time. The term used in the original work is presented to preserve the author's original work. Key research studies presented in this chapter are summarized in table format (see Appendix E Tables of Research Studies). Theoretical and conceptual papers are not included in the tables in Appendix E.

Trust

Trust is important in the nurse-patient relationship, culturally competent care, and as the following section notes, patient-centered care. Trust has been described in the research literature as institutional trust or interpersonal trust (Weaver, 2006). Institutional trust is trust in institutions such as a hospital or trust in a group such as nurses or physicians. Interpersonal trust is trust between people at an individual level and is the focus of this dissertation study. A patient initially places trust in the institution (hospital, profession of nursing) but the nurse needs to earn the interpersonal level of trust in the nurse-patient relationship (Carter, 2009). Previous research studies have found Hispanic Americans have less trust in people in general as compared to White non-Hispanics (Weaver, 2006); have less trust in healthcare providers even when they are the same

ethnicity or race (Sohler, et al., 2007); and migrant Hispanic farm workers have less trust in Whites and other Mexican Americans than more acculturated Hispanics in the general U.S. population (Chavez, Wampler, & Burkhart, 2006). Discussion in the following sections will address the definition and characteristics of trust and research studies related to interpersonal trust and Hispanics, trust and the patient-provider relationship, and trust and nurse-patient relationships.

Concept of Trust

Baier (1986) presented a philosophical discussion of forms of interpersonal trust and moral features of trust in an often cited publication. The primary focus of the discussion was the importance of good will along with vulnerability, risk, power imbalance and previous experience. Good will is the difference between reliance and trust (Baier, 1986) and Sellman (2007) later discussed the difference in greater detail. People are vulnerable to another's ill will which would result in risk. Baier defined trust as "reliance on others' competence and willingness to look after, rather than harm, things one cares about which are entrusted to their care" (1986, p. 259). We trust others to care for things we value (health, people, objects) and to use discretion (judgment) in their care. Trust development is usually a gradual process but could also develop suddenly. Forms of trust are based on vulnerability and context. The context and ability to trust is affected by a person's past experience and customs. Baier noted trust is not obvious until it is lost, writing: "We inhabit a climate of trust as we inhabit an atmosphere and notice it as we notice air, only when it becomes scarce or polluted" (1986, p. 234). Baier explored

trust in a power imbalance such as parents and young children or the ill. This situation

was referred to as "one-sided dependence" (Baier, 1986, p.248) and the power balance is

not equal. In discussing the moral basis for trust, when it is morally right and wrong,

Baier noted that "watchful distrust" would not be morally wrong when vulnerable in a

relationship with a power imbalance such as women or ex-slaves (Baier, 1986, p. 253).

Likewise, Baier presented a hypothetical situation of a husband and wife who had

conflicting beliefs related to childrearing, with the wife's beliefs being hurtful to the

family. In this hypothetical situation, the husband was hopeful the wife would conform

since she needed him financially. The husband (Truster) would trust with vigilance when

the wife (Trusted), home caring for the children, may not be trustworthy. This is similar

to Thorne and Robinson's (1988) grounded theory study that noted distrust of providers

by patients and the subsequent guarded alliance in which the patient resolved to trust with

conditions. Likewise, Hupcey, Penrod and Morse (2000) noted testing of the provider's

intentions and distrust in their grounded theory study of trust in hospitalized patients.

Baier noted trust cannot be demanded from others and wrote: "Trust is much easier to

maintain than it is to get started and is never hard to destroy" (Baier, 1986, p. 242).

In a philosophical discussion of the concept of trust, Sellman (2007) supported

Baier's (1986) stance that good will is an important distinguishing characteristic of trust.

Good will is the difference between trust and a similar concept, *reliance* (Sellman, 2007).

In trust, the person being trusted exhibits good will when completing a task or action for

the person requiring trust. In reliance, a person performs a task or action but is indifferent

toward the person requiring the action. Another clarification is the continuum between faith, trust and confidence with evidence being the factor that differs along the continuum. No evidence leads to faith, similar to blind trust, and more evidence leads to confidence, with trust in between these two anchors. Perhaps this evidence builds over time along with familiarity and is a reason for the development of trust over time. Sellman (2007) noted the vulnerability and power imbalance that is present in the nurse-patient relationship is different than the equally competent adult relationship that others view as required for trust. Therefore, trust in the nurse-patient relationship is more complex. The patient considers previous experiences and personal expectations in deciding to trust the nurse. For example, Sellman noted the patient expects the nurse "to look after goods" (2007, p. 32) and if the nurse does not see the value in the goods, for example healing crystals, or the nurse does not see this falling under nursing practice, it can lead to a breakdown of trust. Likewise, trust is contextual with certain situations requiring more trust and others less trust. Sellman noted in the literature of psychology, trust is an attitude but in the literature of sociology, trust is a social contract. Sellman referred to trust as a social contract that may be unarticulated. Thus, according to Sellman, trust is a social contract that incorporates good will, vulnerability, familiarity and expectations for future behavior. Likewise, nurses have a social contract with society to provide care that encompasses patient values and beliefs (American Nurses Association, 2010).

De Raeve (2002) explored the philosophical basis of trust in the nurse-patient

relationship and cited Baier (1986) in identifying two forms of trust, trust as confidence

and trust as reliance, and a third form of trust attributed to Hertzberg (1988), primary

trust. Trust as confidence reflected trust in a situation due to laws such as not being hit by

a car due to people following traffic laws. Trust as reliance referred to people completing

tasks as expected and used the example of a plumber. Both of these would indicate

institutional trust and a higher level of evidence to trust as discussed by Sellman (2007).

De Raeve noted the difference between the nurse-patient relationship and that of a

plumber and customer; the nurse-patient relationship is not contractual, is flexible and

unique to each situation and more like a "'covenant'" (de Raeve, 2002, p. 156). De Raeve

did not provide a definition of the term *covenant*, but Webster's dictionary defines

covenant as a formal, solemn binding agreement (*Webster's Ninth New Collegiate*

Dictionary, 1986). One distinction between the relationship doctors have and the one that

nurses have with patients is that although doctors and nurses both have physical contact

with patients during their care, nurses have the patient's permission for more extended

bodily contact with patients (bathing and dressing patients). A third form of trust de

Raeve attributed to Hertzberg (1988) was primary trust in a person which is an attitude of

trust with a lack of mistrust; primary trust cannot exist if one distrusts something about

the other person. De Raeve noted that in the beginning patients trust nurses at an

institutional level of trust and expect nurses to act based on considering the patient's best

interests. Some patients trust blindly and others may have limited trust. De Raeve stated

that in order for a patient to trust a nurse, the nurse must not only care *for* the patient but also care *about* the patient. De Raeve (2002) wrote:

> Caring about, whilst not to be confused with liking, seems to require some reflective scrutiny of motives and reactions on the part of the nurse and some active moral commitment to try to see patients with attitudes of generosity, charity and compassion (p.161).

This caring about goes beyond reliance of performing tasks (de Raeve, 2002) but also would incorporate good will, a requirement noted by Baier (1986) but not specifically identified by de Raeve (2002). Caring about the patient requires the nurse to have "an attitude of concern and commitment" (de Raeve, 2002, p. 159). The presence of this nurse attitude is important for a patient to develop trust beyond simply reliance in institutions and occasionally reaches the interpersonal level of trust with the individual nurse (de Raeve, 2002).

Carter (2009) reviewed several sources from philosophy, medicine, nursing, and psychology in exploring the philosophical basis of trust. Carter (2009) noted trust is a future oriented activity and familiarity is a precondition of trust. Trust grows in a climate of familiarity (Carter, 2009) which could partially explain why speaking Spanish to Hispanic patients may earn trust (Stasiak, 2001) or the duration of a relationship leads to trust. Trust is based on life experiences (Carter, 2009) which might explain differences in level of trust among different ethnic or racial groups in previous research studies (Sohler, et al., 2007; Weaver, 2006). Carter (2009) noted a German sociologist, Luhmann (1979), identified trust can be offered, earned and sustained, but it cannot be demanded of another person. Likewise, Baier (1986) made the same observations of Luhmann and

expanded on these. Carter noted Luhmann identified three stages in initiation of trust

between persons. The first stage is the circumstances whereby the truster is taking a risk

and being vulnerable, and the truster learns to trust and notes the chance of abuse of trust.

This vulnerable position of the truster would indicate a power imbalance. The second

stage is cognitive appraisal with both (truster and trustee) assessing the situation, and

factors of familiarity and communication between the truster and trustee (Carter, 2009).

The second stage includes assessment of personality and usual role expectations. The

third stage is reflecting back on expectations and social norms and mutual trustworthiness

being established if the power imbalance is stabilized. Luhmann noted persons in the

trusting relationship should not engage in an exchange of favors but should trust without

obligation to respond by "discharging obligations in advance" (Luhmann, 1979, p. 43).

Luhmann noted trust occurs in a framework of personality and the social system and

these cannot be separated. Based on the literature review of philosophical writings, Carter

(2009) stated:

> Trust is an attitude held toward those who are expected to be trustworthy. Trust is
> a complex process of internal mediation, which incorporates risk and vulnerability
> whenever a future action or decisions that one cares about is encountered. This
> mediation might well result in decisions to withhold one's trust or even to
> mistrust another for prudent reasons (p. 403).

This description of trust is appropriate for the nurse-patient relationship and notes the

dynamic, contextual basis of trust. Carter found the nurse-patient relationship has an

unbalanced power dynamic with the nurse in the power position and the patient as

vulnerable. Patients feel dependent, need comfort, control, protection and help and want

needs met in a "culturally respectful manner" (Carter, 2009, p. 403). The nurse needs to be aware of this unequal power relationship and try to develop a shared power which allows for mutual growth and development (Carter, 2009). This shared power is similar to collaboration in PCC. Carter (2009) noted the need for more research on the development of trust.

Hupcey, Penrod, Morse, and Mitcham (2001) completed a concept analysis of trust and developed an interdisciplinary definition of trust. The researchers reviewed literature in nursing, medicine, psychology and sociology and found the concept of trust was not well developed. They noted in the nursing literature the concept of trust was not well-defined, was based on the nurse-patient relationship, and had limited measures of trust. Further exploration using the literature from the four disciplines identified the following antecedents of trust: need, prior experience or knowledge, and risk. The attributes of trust were dependency on another, expectation of behavior, focus on behavior, and testing of the other. Related concepts were faith (but doesn't require prior knowledge or testing), confidence (but doesn't require testing or position of dependence) and risk-taking (but in risk-taking "benefits do not always outweigh the risk") (Hupcey, et al., 2001, p. 290). Boundaries of trust identified were (a) one must be in a position of risk, (b) one must have a choice, and (c) the benefits from trust must outweigh the risks. The outcome of trust identified was "an evaluation of the congruence between expectations of the trusted person and actual behaviours" (Hupcey, et al., 2001, p. 290). This outcome was supported by the psychology and sociology literature primarily and the grounded

theory nursing study by Hupcey and colleagues (Hupcey, et al., 2000) that was cited

throughout the paper. Expectation of behavior is not unique to the trust concept and is

evident in the concept of patient satisfaction as well; this similarity will be addressed later

in the discussion of the grounded theory study (Hupcey, et al., 2000). Based on the

concept analysis, Hupcey et al. (2001) provided the following interdisciplinary theoretical

definition of trust:

> Trust emerges from the identification of a need that cannot be met without the assistance of another and some assessment of the risk involved in relying on the other to meet this need. Trust is a willing dependency on another's actions, but it is limited to the area of need and is subject to overt and covert testing. The outcome of trust is an evaluation of the congruence between expectations of the trusted person and actions (2001, p. 290).

This definition is adequate, however, it seems the outcome of trust (evaluation) is not

specific and leads to the question, what is the outcome after the evaluation is completed?

Bell and Duffy (2009) published an evolutionary concept analysis of nurse-patient

trust with similar findings to Hupcey et al. (2001) using many of the same sources.

However, the consequences (outcomes) of trust for nursing practice were (a) trust leads to

patient self-fulfillment, (b) lack of trust leads to increasing vigilance, and (c) healthcare

provider's trust of patients leads to positive relationships. Bell and Duffy noted trust is

essential to nursing practice. Based on the concept analysis, the authors' definition of trust

was "'the optimistic acceptance of a vulnerable situation, following careful assessment,

in which the truster believes that the trustee has his best interests as paramount' " (Bell &

Duffy, 2009, p. 50). Although *best interests* was not part of the attributes or antecedents

identified by Bell and Duffy (2009), others have noted the importance of good will in

developing trust (Baier, 1986; Sellman, 2007) which would suggest having the patient's best interests in mind. The concept analysis had a major flaw; the model case provided in the published article (Bell & Duffy, 2009) was an example of a patient's trust in the institution and not an appropriate example of nurse-patient trust.

Finally, in commenting on Hupcey's definition of trust, Robinson (2000) provided a more succinct definition based on clinical experience and previous research. According to Robinson, trust is "the belief that the other will act in one's best interest" (2000, p. 247). Although this definition is brief, it encompasses need and good will. And, depending on the context of the situation, if one must rely on another, it also implies vulnerability and with vulnerability comes risk. However, the definition lacks a reference to familiarity.

Interpersonal Trust and Hispanics

Hispanic Americans have rated trust in people in general lower than non-Hispanic Whites (Weaver, 2006). Weaver (2006) used secondary data analysis of the General Social Survey to explore trust in people (interpersonal trust) comparing Hispanic Americans to non-Hispanic Whites. The General Social Survey was administered in face to face interviews from years 1972 to 2000 with 1,500 or 3,000 English-speaking participants each year (4 years missing). The survey included items related to trust in people measured as three separate single items: people can be trusted, people try to be fair, and people try to be helpful. These items were adapted from a study of trust in people and political ideology by Rosenberg (1956). The sample from the General Social

Survey compiled over the years was Hispanic Americans (n=979, 57% female, 60%

Mexican origin, mean age female 36.3 (SD 12.1) years, mean age male 37.2 (SD 13.6)

years) and non-Hispanic Whites (n=16,202, 55% female, mean age female 47.0 (SD

17.2) years, mean age male 46.2 (SD 17.3) years). Findings indicated Hispanic

Americans reported lower levels of trust compared to non-Hispanic Whites on all three

items (people can be trusted 24.8% vs. 46.7%, p<.001; try to be fair 43.3% vs. 64.5%,

p<.001; try to be helpful 37.4% vs. 55.2%, p< .001). Even when controlled for age,

education, occupation (blue collar vs. white collar), marital status, employment status,

and economic status, Hispanic Americans reported less trust than non-Hispanic Whites

on all three items. In discussion, Weaver suggested the difference in trust between non-

Hispanic Whites and Hispanic Americans could be due to low socioeconomic status

(SES), discrimination or acculturation. However, Weaver controlled for SES and

Hispanic Americans still had a lower trust level and discrimination was not a statistically

significant effect on trust in Hispanic Americans when comparing responses on two

discrimination items of the survey (Weaver, 2006). Weaver used generational status as a

measure of acculturation. However, since the survey was given to English-speaking

participants only and language use is a proxy measure of acculturation, the range of

acculturation was very limited to the more acculturated. The only statistically significant

finding was first generation Hispanic American males (parents and grandparents born

outside U.S.) were less likely to respond that people can be trusted. Using a single item to

measure a construct is a limitation of the study; however, Weaver did address the

limitation and presented an argument from other research studies that it was acceptable (Weaver, 2006). Weaver stated the need for further research to determine the reasons for differences in levels of trust between Hispanic Americans and non-Hispanic Whites.

Chavez and colleagues (2006) completed research with migrant seasonal farm workers related to the influence of acculturation and migration on their trust of non-Hispanic Whites and Mexican Americans. Of note, only 2.7 % of Hispanic adults are migrant farm workers (U.S. Census Bureau, 2003). Migrant seasonal farm workers in Idaho (n=555, 99.9% Mexican American, 65% male, 89.6% less than ninth grade education; 53.4% annual income less than $15,000) completed surveys in a face to face format in Spanish with Mexican and Mexican American college students. The surveys had 30 items including three trust items, (a) people can be trusted, (b) trust of Mexican Americans in the community, and (c) trust of non-Hispanic Whites in the community. Findings indicated that migrant farm workers had low levels of trust for Whites and Mexican Americans. Interestingly, there was no statistically significant difference in the level of trust for Mexican Americans (27% of migrant workers trusted a lot or some) and Whites (26% of migrant workers trusted a lot or some). In multivariate analysis, those that were more educated (B = 0.58, p<.05), those that used the English language more (B = - 0.68, p<.05), and those that were older (B = 0.05, p<.05) displayed more general trust, although the age variable was a weak contributor. The negative Beta value for language use was due to the coding used for language, 0 (excellent English-speaking skill) to 3 (no English-speaking skill). Considering that more education and use of English language are

associated with a higher level of acculturation, this might indicate that the less

acculturated have a lower level of trust. In further multivariate analysis of trust toward

Mexican Americans and trust toward Whites, those with a higher English fluency rated a

higher level of trust towards Mexican Americans (B= - 0.33, p< .10) and, even more so,

trust in Whites (B= -1.21, p<.05). However, education level had an inverse relationship

and was not statistically significant when evaluating trust towards Whites (B= - 0.06, p

>.10) yet was associated with trust towards Mexican Americans (B= 0.29, p<.05) and

education had a stronger contribution in this group. In addition, younger age was

associated with more trust towards Mexican Americans (B= - 0.03, p<.05) and negligible

but not statistically significant for trust towards Whites (B= - 0.004, p>.10). However,

older age on first arrival in the U.S. was associated with trust toward Mexican Americans

(B= 0.04, p<.05) and Whites (B= 0.05, p<.05), but again, the age variable was a weak

contributor. The proxy measures for acculturation (language use, education level, and age

upon migration) have conflicting results. However, it should be noted that 89.6% of the

sample had less than a 9th grade education so the range of education level is limited and

the age factors have very low weights and, therefore, influence. It seems English

language use had significant findings and higher weights and influence; the researchers

suggested offering English classes to migrant farm workers. This may seem like a good

idea, however, the basic finding still remains, migrant farmworkers have lower levels of

trust. These studies explored the Hispanic population's interpersonal trust with people in

general. In the following sections, the patient's trust in healthcare providers and nurses

will be discussed.

Trust and Patient-Provider Relationship

Thorne and Robinson (1988) published an influential work related to trust

between patient and physician in the patient-provider relationship. Previous theory held

that in the patient-provider relationship the patient takes on the sick role and cooperates

fully with the provider (Thorne & Robinson, 1988). In their grounded theory study from

the patient's perspective, Thorne and Robinson found that ultimately trust developed

through a process of mutual respect and decision sharing and was "fundamental to

successful, effective health care relationships" (Thorne & Robinson, 1988, p. 788). The

authors noted that previous research was done from the provider's perspective and with

single encounters. Thorne and Robinson completed interviews with patients with chronic

illness and their family members (n=77 participants) and asked about their encounters

with physicians. Using a grounded theory (classical) approach for analysis, an important

finding was the role of trust in the patient's perception of quality health care and patient

satisfaction. The authors found a three stage process in the development of the

relationship and trust was prominent in each stage as the relationship evolved over time.

In the first stage, the patient started with a blind trust of the healthcare provider and

expected the provider would be dedicated to and share the patient's best interests in

resolving the healthcare problem. In the second stage, the patient realized that the

healthcare provider's decisions about treatment were not based on the patient's values and

beliefs and the patient had a loss of trust in the provider. Of note, the lack of

consideration for the patient's values may seem unusual; however, when viewed in the

historical context, the study was completed before publications related to patient-centered

care and standards for culturally appropriate care. This loss of trust was quickly followed

by resolution since the patient needed to resume their health care. In the third stage,

resolution, the patient held a reconstructed trust which was termed *guarded alliance*.

There are four possible types of guarded alliance based on the perception of the provider's

trust in the level of competence of the patient. The patient's competence was the patient's

knowledge and skill in managing the patient's chronic illness. The four types of guarded

alliance were (a) absolute trust of an individual healthcare provider with general distrust

of providers, (b) trust in predictable healthcare provider behavior and the patient

manipulates services, (c) general distrust of providers, and (d) interpersonal relationship

and trust with selected healthcare providers including patient collaboration in care

decisions (Thorne & Robinson, 1988). This last form of guarded alliance reflects current

factors in PCC- communication, information sharing, and shared decision-making

(Frampton, et al., 2008). PCC will be discussed in more detail in a later section.

All the participants reported shattered trust after the initial encounter with

healthcare providers and subsequently holding realistic expectations with guarded

alliance rather than the blind faith they originally held (Thorne & Robinson, 1988). The

authors noted that once naïve (blind) trust is lost, it cannot be regained and the provider

needs to understand the social context in which they function with their patients (Thorne

& Robinson, 1988). Although not explored in detail by Thorne and Robinson (1988), the authors noted expectations of care in the discussion of trust which is similar to a subsequent grounded theory study of trust by Hupcey and colleagues (2000). In the third stage, resolution, the patients would "doctor shop" to find a healthcare provider that appreciated and acknowledged the patient's competence, and this led to the partnership and the provider's trust in the patient to arrive at decisions together for managing the chronic illness (Thorne & Robinson, 1988). The patients noted that decisions were made primarily by the healthcare provider during instances of acute illness and hospitalization, but in managing the chronic illness in general, the patient and provider shared in decision-making. Trust in the patient from the healthcare provider led to increased patient self-esteem, and improved the patient-healthcare provider relationship. Trust was reciprocal between patient and provider rather than the unilateral trust solely in the provider. If the patient perceived not being trusted or seen as an individual, then this led to dissatisfaction in the relationship. To demonstrate competence and develop trust with the new healthcare provider, the patient would (a) share their illness story, (b) demonstrate appropriate use of services, (c) make explicit requests for help, (d) share information selectively (i.e. not mention non-compliance episodes or use of alternative therapies), and (e) humanize the encounter. Selective sharing of information was done to maintain continued approval and trust from the provider. Humanizing the encounter was the patient's attempt to reduce the power imbalance and develop an interpersonal

relationship through joke telling, asking about the provider's family, and gaining medical knowledge to communicate more fluently with the provider.

Interestingly, although the term *patient-centered care* (PCC) was not in use at the time, early ideas consistent with the PCC movement were identified in this article. The authors addressed the anticipated shift in healthcare relationships and "participative decision-making" (Thorne & Robinson, 1988, p. 787). And although trust is not explicitly stated as a characteristic in PCC, the findings of this grounded theory study (Thorne & Robinson, 1988) support the role of trust in PCC. The authors noted:

> Clearly, from the perspective of the chronically ill person, trust is one of the most significant elements in health care relationships. It serves as a foundation for the kind of relationship that permits collaboration and cooperation with regard to illness management (Thorne & Robinson, 1988, p. 786).

This collaboration is the foundation of PCC (Gerteis, Edgman-Levitan, Daley, & Delbanco, 1993) which will be discussed in further sections.

Hupcey, Penrod and Morse (2000) completed a grounded theory study (classical method) related to the establishment of trust in hospitalized patients. The research question was focused on development and maintenance of trust in healthcare providers and was focused on hospitalization and not specifically the nurse-patient relationship. The authors noted that trust was not defined in previous research articles but that *need* is an antecedent for trust. The researchers interviewed English-speaking patients (n=50, 5 minority participants) with chronic conditions that had been hospitalized one week to several weeks. The interviews lasted 20 minutes to an hour. Interviews took place in the patient's hospital room at a teaching hospital in the U.S. The general opening interview

question was "Tell me about your experiences while hospitalized" (Hupcey, et al., 2000, p. 230). Participants reflected on the current hospitalization and past hospitalizations including other facilities. The authors noted it was difficult for participants to describe trust and a follow-up question was "What is it about nurses that makes you trust them?" (Hupcey, et al., 2000, p. 231). This question lends itself to an explanation related to institutional trust in nurses in general rather than interpersonal trust. The authors noted in the discussion that patients focused on global trust rather than specific interpersonal relationships with care providers and that nurses were seen as a group representing the hospital and not as individuals.

Through data analysis, the researchers developed a model with three stages to establishing and maintaining trust and a fourth category, the *Changing Nature of Trust* which referred to the "looping back" in the process (Hupcey, et al., 2000). Meeting Expectations (Hupcey, et al., 2000) was the core variable. Patients have expectations and evaluate care received based on these expectations. In the *Changing Nature of Trust* category the authors noted trust was a dynamic process and the patient could begin to distrust due to a negative experience but would change course after a positive interaction regardless of unmet expectations at times (Hupcey, et al., 2000). The three stages to establish and maintain trust were: (a) *Entering the System*; (b) *Interacting with Providers* which included the subcategories *facilitating behaviors* and *inhibiting behaviors*; and (c) *Evaluating* which included the subcategories *expectations met, expectations exceeded,* and *expectations unmet.*

For the *Entering the System* stage, familiarity with the institution was a basis for expectations at baseline and therefore trust or mistrust at baseline (Hupcey, et al., 2000). The authors provided the example of one participant from out of the area that was not familiar with the institution and had no trust at baseline (Hupcey, et al., 2000). Similarly, familiarity was noted as an antecedent for trust by Carter (2009). In the *Interacting with Providers* stage, patients used testing behaviors to assess if the provider was acting in the patient's best interests (Hupcey, et al., 2000). Thorne and Robinson noted in guarded alliance while doctor shopping the patient evaluated whether the provider trusts the patient, which would be similar to testing. Likewise, in philosophical discussions, Baier (1986) and Sellman (2007) noted the importance of good will intentions which is similar to acting with the patient's best interest. In the *facilitating behavior* sub-category, treating the patient as an individual was an important factor in developing trust (Hupcey, et al., 2000). Likewise, Thorne and Robinson (1988) noted the development of interpersonal trust through humanizing the encounter. In the *inhibiting behaviors* sub-category, waiting, having different caregivers, and not knowing the patient's history all inhibited trust formation (Hupcey, et al., 2000). In this study, caregivers referred to a variety of hospital personnel (nurses, physicians including residents, technicians, transport staff, admitting staff). The standard and unavoidable practice of different nurses caring for a patient over time could, therefore, contribute to inhibiting behavior.

In the *Evaluating* stage, patients compared expectations to actual care received which led to general trust if expectations were met, global trust (of institution) if

expectations were exceeded, and, if expectations were not met it led to one of three subcategories (Hupcey, et al., 2000). The subcategories were (a) *rebuilding trust* (change expectations), (b) *distrust with no way out* (vigilance, anger), or (c) *distrust with a way out* (change providers, institutions) (Hupcey, et al., 2000). According to the authors, the provider's competence was not a stated factor for either trust or distrust, but was implied.

The comparison between expectations and actual care received is also present in expectancy theory (Linder-Pelz, 1982) with met or exceeded expectations resulting in patient satisfaction and unmet expectations resulting in the patient not being satisfied. Many components of the development of trust (Hupcey, et al., 2000) reflected dimensions and influences of patient satisfaction including patient expectations, interpersonal relations, communication, and continuity along with technical competence (Johansson, Oleni, & Fridlund, 2002; Turner & Krizek, 2006; Ware, Davies-Avery, & Stewart, 1978). For example, in the *expectations met* sub-category the authors provided a participant statement, "I didn't see nothing that I could say was bad... If I wanted something...I used to get it right away. So, I had no complaints about the hospital" (Hupcey, et al., 2000, p. 236). This appears to be general satisfaction rather than trust. In a grounded theory study of trust, Trojan and Yonge (1993) noted patient satisfaction with the nurse affected trust. The question arises: Does the model really demonstrate development of trust? The researchers did not distinguish trust from patient satisfaction (Hupcey, et al., 2000) and the model provided does not seem to be unique to trust development. In a later qualitative descriptive study of community member's perceptions

of trust in healthcare providers and interpersonal trust in individuals, Hupcey and Miller

(2006) noted the possibility that "earlier studies were confusing meeting expectations as

trust vs. meeting expectations as satisfaction" (p.1138).

In the discussion section of the grounded theory study, the authors noted updating

the patient related to their prognosis and treatment was important in altering expectations

and rebuilding trust in their model (Hupcey, et al., 2000). This information sharing and

communication is also important in PCC (Gerteis, et al., 1993). The authors (Hupcey, et

al., 2000) noted that the interpersonal relationship could cause a shift of trust or distrust

to a generalization of global trust to the institution. This is the only point in the article

(Hupcey, et al., 2000) in which the authors identified the nurse-patient relationship. The

authors noted the need for more research related to trust on discrete relationships instead

of simply interactions and the development of trust in non-Western cultures although they

did not expect a difference based on culture, race or ethnicity (Hupcey, et al., 2000). At

the end of the article (Hupcey, et al., 2000), a definition of trust was attributed to the

grounded theory study and the concept analysis which was published the following year

(Hupcey, et al., 2001).

Hupcey and colleagues (2000) noted their findings were sometimes in contrast to

previous research published by Thorne and Robinson (1988) who found naïve trust at

baseline and disenchantment and reconstructed trust whereas this study found

expectations at baseline and outcomes of expectations met and trust and global trust

established. However, Hupcey and colleagues interviewed chronically ill patients in the

hospital who also recounted previous hospitalizations and thus would not be reputed to display naïve trust. As Thorne and Robinson (1988) clearly stated, once naïve trust is lost, it never returns and guarded alliance prevails. Furthermore, a review of the outcomes of trust in the Hupcey et al model includes *distrust with a way out* (changing systems) which is very similar to doctor shopping in reconstructed trust noted by Thorne and Robinson (1988). Also, *distrust with no way out* (vigilance) is similar to the disenchantment noted by Thorne and Robinson (1988). In a commentary accompanying the article (Hupcey, et al., 2000), Robinson (2000) raised several fundamental concerns with the study and resulting theory including the lack of definition of trust at the start of the study, the subsequent definition developed at the end that seemed to be ill-fitted to the model developed, and the context of interviewing patients in a hospital setting where they may not feel free to make negative comments.

In another study, Hupcey and Miller (2006) completed a qualitative descriptive study to broaden understanding of the concept of trust in healthcare providers. One of the purposes of the study was "to investigate community dwelling adults' definition of trust in health care providers vs. interpersonal trust" (Hupcey & Miller, 2006, p. 1134). This purpose is confusing but, based on the introduction, the trust in healthcare provider the authors refer to is institutional trust, although the term is not used, rather than the trust between provider and patient which would be interpersonal trust. Adult community members (n=32, mean age 54 years old (SD 18)) in Pennsylvania who had recent contact with a healthcare provider were interviewed. Participants were recruited from a senior

health center, churches, and community centers. Participants were asked (a) to think

about a person they trusted and explain trust, (b) to think about being a patient and trust

in that situation, (c) to discuss loss of trust with a provider, and (d) discuss rebuilding

trust. Most of the participants did not experience loss of trust with a healthcare provider,

so they were then asked about loss of trust in an interpersonal relationship and discussed

an experience with a friend or coworker. Researchers used thematic analysis and

categories to guide analysis; the categories were trust definitions, trust attributes, factors

influencing development and loss of trust, and rebuilding trust.

Findings indicated it was difficult for participants to define trust and trust was

"entangled" with satisfaction and reliance (Hupcey & Miller, 2006, p. 1135). The

researchers identified a difference between interpersonal trust and trust in provider,

stating:

> One of the main differences between the discussion of an interpersonal trusting
> situation, i.e. trust in a non-professional (such as a close friend or a plumber) and
> trust in health care providers, was the attributes of that person in relation to their
> role. For example, a close friend would be someone you could confide in and who
> would keep a secret, the plumber is someone who would provide an agreed upon
> service, while the health care provider would be a caring and concerned
> individual (p.1135).

This finding seems to weave interpersonal trust and institutional trust together with the

plumber reference reminiscent of trust as reliance, a form of institutional trust (de Raeve,

2002). Findings indicated the definition of interpersonal trust included being honest,

feeling relaxed and having no concerns. Trust in healthcare providers required the

provider to provide competent care, to have communication skills, and to have the

patient's best interest. Participants had varying views on interpersonal trust vs. trust in provider. Some participants thought interpersonal trust and trust in provider were the same while others thought trust in healthcare provider were not the same as trust in family. Some participants established interpersonal and provider trust immediately based on a gut feeling with the person while other participants noted trust built over time for both interpersonal and provider trust. Trustworthy healthcare providers displayed "caring interpersonal attributes" (Hupcey & Miller, 2006, p.1137) which included compassion, being truthful, being personable, and being a good listener. Trustworthy nurses were seen as caring. The participant quotes provided by the authors related to nurses and trust in healthcare providers reflected institutional trust although the authors did not make this distinction. Loss of trust with an individual occurred if the person lied or did not do what was promised and rebuilding trust with an individual was a slow process. Loss of trust with the healthcare provider was the result of competence issues or lying and usually trust could not be rebuilt or, if trust was rebuilt, the patient was vigilant.

The authors alluded to institutional trust in the published report but never used the term or made the distinction of institutional trust (Hupcey & Miller, 2006). It seems the interview questions asking participants to distinguish between trust in individuals and then trust in the healthcare provider lend themselves to findings that make a distinction between interpersonal trust and institutional trust in provider rather than considering a person could have interpersonal trust with the provider as an individual. However, in the discussion section, the authors wrote:

Most participants, however, went into a health care interaction with a degree of pre-existing trust, based on the provider's role, as a physician or a nurse. But even with this pre-existing trust, or maybe more accurately reliance based on presumed knowledge, actual trust was not built unless the provider showed some of the 'caring' interpersonal attributes (p.1137).

This author statement reflects the difference between institutional trust in a provider (*pre-existing trust*) and interpersonal trust between the patient and the provider (*actual trust*) although this distinction is not made by the authors.

Finally, the authors noted expectations related to trust were not a factor in this study, simply expectations of the healthcare encounter (Hupcey & Miller, 2006) which was in contrast to the Hupcey et al. study (2000) which identified expectations in the core category. In this study of community members (Hupcey & Miller, 2006), if expectations of the encounter were not met, the participant changed providers or became vigilant rather than changing expectations as occurred in the previous study (Hupcey, et al., 2000). The authors (Hupcey & Miller, 2006) further stated:

It is unclear if this is a result of the ability of these participants to fairly easily change providers until they found someone who met their expectations or if the *earlier studies* (emphasis added) were confusing meeting expectations as trust vs. meeting expectations as satisfaction. (p.1138).

Earlier studies is a reference to the Hupcey et al. (2000) study that noted expectations in the final stage and incorporated evaluation of expectations and actual experience as an outcome of trust. These expectations in the Hupcey et al. (2000) study seemed to reflect satisfaction rather than trust. This study (Hupcey & Miller, 2006) provided community members' perceptions of factors that contribute to trust development with a healthcare

provider, but, while trying to broaden understanding of trust, the authors seemed to have confused the two types of trust, institutional and interpersonal.

In an exploratory, qualitative descriptive study of trust in the physician-patient relationship, patients who were chronically ill were interviewed (Mechanic & Meyer, 2000). The sample consisted 30 patients with breast cancer, 30 patients with Lyme disease, and 30 patients with mental illness (n=90, predominantly female and non-Hispanic White). The interview questions were based on the five dimensions of trust the authors identified in a previous literature review: (a) competence (technical and interpersonal), (b) fiduciary responsibility and agency (serve patients interests only), (c) control (physician able to control plan of care in managed care environment), (d) disclosure (of physician incentives), and (e) confidentiality (protect patient information). In coding the transcripts, the three coders used codes based on these five dimensions. Unfortunately, using pre-established codes would limit discovery of emerging themes in a qualitative study, however, the authors noted ample latitude in discovering new themes. The authors noted the responses incorporated only three of the five dimensions: competence (interpersonal and technical), agency, and confidentiality. The key findings reviewed here are related to interpersonal competence. Technical competence was mentioned in a limited manner which the authors attributed to the limited ability of patients to evaluate technical competence. The authors noted the most prominent concept under interpersonal competence was listening and others were concern, compassion, and caring. The authors noted that caring could be a separate category. Other concepts that

were common and labeled as skills for interpersonal competence included truthful, non-judgmental, attentive, reassuring, respectful, friendly, sensitive, responsive, sincere, warm and understanding. The authors also included concepts with negative connotations, for example, arrogant, rigid, condescending, and distracted. To determine if a doctor can be trusted, the participants revealed they tested the doctor's response against the patient's expectations but they noted it was difficult to articulate how to decide to trust. This testing and expectations is similar to findings by Hupcey, Penrod and Morse (2000). In reviewing the actual quotes provided in the article, additional key phrases represented seeing the patient as an individual which was not identified by the authors. This study added to the research related to interpersonal trust in the physician-patient relationship in the clinic setting, from the patient perspective, and incorporating a variety of illness types.

In a qualitative descriptive research study in Norway (Skirbekk, Middelthon, Hjortdahl, & Finset, 2011), researchers explored interpersonal trust between the physician and older adult patients in the clinic setting. The authors interpreted trust in medical consultation as "the patient's implicit willingness to accept the physician's judgment in matters of concern to the patient" (Skirbekk, et al., 2011, p. 1183). This seems to be an empirical definition that can be observed as an outcome rather than an actual definition of the concept of trust. Researchers videotaped a consultation between ethnic Norwegian physician (n=8) and patients (n=16, 2 from each physician); patient inclusion criterion was the patient had to be between the ages of 50 to 75 years old so

they would likely experience either simple or complex illnesses. The researchers then

viewed the videotape with both patient and physician together immediately after the

consultation and asked for their comments. A few days later, the researchers interviewed

the physician and patient separately. The authors found trust was conditional and not

explicitly stated. This conditional trust seems similar to Thorne and Robinson's (1988)

guarded alliance, however, this was not cited by the authors. Findings indicated two

types of interpersonal trust, *Limited Mandates of Trust* and *Open Mandates of Trust*. In

the *Limited Mandates of Trust*, patients were limited in their openness with the physician

and the patients had general role expectations for the physicians. The patient expected the

physician would listen to their problems, help them find a solution, and display medical

competence. In the *Limited Mandates of Trust*, the patient and physician stuck to the

simple specific illness concern. In the *Open Mandates of Trust*, patients who were

chronically ill noted having more than general role expectations for the physician and the

patient expected the physician to know the patient as a person, the patient was at ease in

speaking to the physician, and the patient felt he/she could tell the physician more and

speak openly. The participants who were chronically ill were the only ones to discuss

Open Mandates of Trust. The descriptions from the patient interviews led to five

elements associated with establishing *Open Mandates of Trust*: (a) showing early interest

in patient, (b) sensitivity to patient emotions, (c) giving time/continuity (time for

consultation and long term relationship with physician), (d) forming alliance against

adversary (illness, bureaucracy), and (e) bracketing normal role behavior. Bracketing

normal behavior referred to stepping outside the expected physician role and then the patient was able to interact on a personal level which had the effect of laying aside the power imbalance in the situation. In conclusion, the authors noted "more open trust relationships depend on more personal involvement with the patient" (Skirbekk, et al., 2011, p. 1189). Interestingly, the authors noted testing to see if the physician may be more open and lead to *Open Mandates of Trust* which is similar to the testing noted by Hupcey, Penrod, and Morse (Hupcey, et al., 2000). Surprisingly, the authors did not cite the work of Thorne and Robinson (1988) in the article. This more recent study was conducted in Norway which has a different health system than the U.S., yet it provides both the physician and patient perspectives related to trust in the physician-patient relationship.

In a cross-sectional, non-experimental study researchers examined the impact of healthcare relationship factors, including trust in physician, on mammography adherence of Latinas (Sheppard et al., 2008). The study was conducted by the Latin American Cancer Research Coalition (LACRC) in Washington, DC and researchers used the Adherence Model as the theoretical framework. The researchers adapted the Adherence Model by adding interpersonal trust as a construct. According to the Sheppard et al., (2008), the Adherence Model was developed for use in research for cancer control adherence issues and is a synthesis of (a) the Health Belief Model which encompasses the person taking action to avoid illness given personal susceptibility to the illness; (b) the Theory of Reasoned Action/Planned Behavior which encompasses motivational factors

and behavioral intentions; and (c) the Transtheoretical Model of Change which encompasses stages of behavior change (Glanz, Rimer, & Lewis, 2002). Existing measures were used to measure the variables and were available in both Spanish and English. The outcome variable, adherence to mammography, was measured as self-report and subjects were considered adherent if they had undergone a mammography in the last two years. The independent variables were "art of care" factors, perceived risk, subjective norms and attitudes (discrimination, racism), and demographic factors (Sheppard, et al., 2008, p. 2025). Art of care included four factors: satisfaction with healthcare relationship (1 item, 0 to 10 scale, dichotomized high or low satisfaction); communication with healthcare provider (2 items, one item was clarity of provider's explanation on a 4 point scale ranging from poor to excellent, and the other item was patient leaves with unanswered questions measured on 5 point scale ranging from always to never); patient trust in provider (1 item, 0 to 10 scale; dichotomized high or low trust); and length of relationship with provider (2 years or more, less than 2 years). The trust in provider item was, "All things considered, how much do you trust your doctor?"(p.2025), with a response on a scale of 0 (not at all) to 10 (completely). The trust response was then dichotomized to low trust (very low and low trust) and high trust (medium, high and very high trust). Satisfaction in the healthcare relationship was measured using a summary item which ranked overall satisfaction with provider, ranging from 0 (low) to 10 (high). Perceived risk was measured as 1 item, perceived likelihood of getting cancer. Subjective norms and attitudes were measured in two areas: experiences of discrimination in health

care (6 items, yes/no responses, dichotomized any experience vs. no experience) and

perceptions of racism in health care (4 items, rating race and US healthcare system).

The sample inclusion criteria were Latina women at least 40 years old with no

prior history of breast cancer (Sheppard, et al., 2008). The sample was recruited from

three LACRC clinics (consecutive sampling protocol) (n=99) and listeners to a Latino

radio program related to health issues (n=69). The sample (n=166; 58% South American,

31% Central American, 11% Mexican; median age 51.6 (SD 8.9); monolingual Spanish

75%) had a higher than average rate of mammography adherence (73% vs. 59% national

average for Latinas) which was attributed to access to low cost screenings in the area.

Findings indicated the best predictor of mammography adherence, based on

model testing, was patient satisfaction with the physician (Sheppard, et al., 2008). Trust

in the physician was a predictor for high patient satisfaction in the provider according to

model testing (OR 2.95, 95% CI 1.45-5.89, p<.01) but trust was not a statistically

significant predictor of mammography adherence (p =.40). Communication with the

provider was also associated with high satisfaction with the provider (p<.001) and the

authors attributed this to the bilingual staff, both medical and administrative, at the area

clinics (Sheppard, et al., 2008). Communication was not included in the intermediate

model testing of satisfaction and the reason for the exclusion was not clear from the

published report. Main model testing for mammography adherence found Latinas rating a

high satisfaction in healthcare relationships had an adjusted OR of 3.34 (95%CI 1.47-

7.58) of undergoing a recent mammography. Other statistically significant factors

contributing to adherence with mammography were an age over 50 years old (OR 2.37, 95% CI 1.03-5.47) and having more than a high school education (OR 3.45, 95% CI 1.45-8.23). One limitation of the study not considered by the authors was the recruitment of the sample from clinics and those who listened to a program focused on health. One could assume those recruited were already interested in their health. This might explain the relatively high rate of mammography adherence as well. Perhaps recruiting from local shopping areas, churches, and social events would have provided a more diverse sample. Regardless, based on the purpose of the study, the subjects needed to have a regular healthcare provider. This study of Latinas does provide evidence of the association between trust and patient satisfaction with provider.

Using a quantitative design, Sohler and colleagues (2007) completed a cross-sectional, correlational study of racial concordance and trust in healthcare providers and mistrust of the healthcare system. The researchers hypothesized that patients with racially concordant providers would have greater trust in the provider and less mistrust of the healthcare system. The racially and ethnically diverse sample was English or Spanish speaking patients diagnosed with HIV living in low income, single room occupancy hotels in New York City (n=380; 71.8% male, 59.5% Black, 32.6% Hispanic, 7.9% non-Hispanic White; mean age 44.5 (SD 7.7) years; 60.3% completed high school; 85.5% Medicaid; 11.3% Spanish-speaking). Only 25.3% of the sample was the same race as their provider (provider characteristics 57.9% male; 47.1% White, 22.1% Black, 12.9% Hispanic, 17.9% other) and 13.2% of the sample had providers that were not physicians.

Trust in provider was measured with eight items from the Primary Care Assessment

Survey (Safran et al., 1998), with seven items scored with a 5-point Likert-type scale,

ranging from 1 (strongly disagree) to 5 (strongly agree) with some items being reverse

scored (Cronbach alpha 0.78). One item was "My provider cares as much as I do about

my health" (Sohler, et al., 2007, p. 886). The eighth item was a 0 to 10 rating of overall

trust in provider which was recoded to a 5 point scale. The eight trust item scores were

converted to 1 to 100 score with higher scores indicating higher trust in provider.

Mistrust in the institution was measured using seven items from a scale developed by

Altice, Mostashari, and Friedland (2001) through qualitative analysis of focus group data

and interviews of prison inmates. The mistrust in institution scale was scored with the

same Likert-type scoring but with no reverse scoring and converted to a 1 to 100 score

with higher scores indicating more mistrust (Cronbach alpha 0.93). One item was "I think

there is a cure for AIDS, but the government is keeping it from me" (Sohler, et al., 2007,

p. 887). An instrument measuring mistrust developed from the perspective of prisoners

may not be valid to measure the concept for the general population. Participants

completed the computer based survey and only data from those with a regular provider

were analyzed (Sohler, et al., 2007).

Findings indicated the first hypothesis, racial concordance and higher trust in

provider, was not supported but the second hypothesis, racial concordance and less

mistrust of institution, was supported (Sohler, et al., 2007). Racial concordance was not

statistically significantly associated with increased trust in provider and actually

participants in racially discordant relationships rated trust in provider higher (concordant mean 68.7 (SD 21.1) vs. discordant trust mean 72.0 (SD 20.9), t-test -1.3, df 377, p<.20). Researchers attributed the lack of higher trust in providers to the higher level of trust overall (total sample, trust mean 71.2 (SD 21.0) however, 71.2 is still low in a 1 to 100 range. Reported mistrust in institution was significantly lower for patients with a racially concordant provider (concordant mistrust mean 49.5 (SD 28.0) vs. discordant mistrust mean 58.6 (SD 25.5), p< .01). For the total sample, mistrust in institution was 56.3 (SD 26.4). Participant education, age and gender as well as provider being a physician were not statistically significantly related to trust or mistrust. In analysis based on race and ethnicity, Hispanics had the least trust in provider (Hispanics n=124, mean 66.6 (SD 21.1), Whites n=30, mean 67.1 (SD 22.1), Blacks n=226, mean 74.2 (SD 20.2)) and Hispanics had the most mistrust of institutions (Hispanics mean 59.2 (SD 24.9), Blacks mean 56.4 (SD 26.2), Whites mean 43.8 (SD 31.4)), and Spanish speaking patients (n=43) had even less trust in provider than English speaking patients (n=337) (Spanish mean 62.8 vs. English mean 72.2,). Of note, Hispanics in the sample were mostly of Puerto Rican origin.

An interesting finding was that male providers (n=220) were rated with lower levels of trust than female providers (n=160) (male provider mean 69.3 (SD 21.8) vs. female provider mean 73.8 (SD 19.5)) but gender of provider was not statistically significant in mistrust of the healthcare system (Sohler, et al., 2007). The only statistically significant covariates in a multiple regression model of trust in provider

(dependent variable) and racial concordance and other characteristics were health status (fair/poor) (Beta = -7.4, p<.01) and female gender of provider (Beta = 5.5, p<.05). Interestingly, Hispanic patients had the least trust of Hispanic providers and Black patients had the least trust of Hispanic providers. In discussion, the authors (Sohler, et al., 2007) noted a limitation of the study was the small amount of racially concordant pairs. This research study supports the findings of Weaver (2006) related to the Hispanic population reporting lower levels of interpersonal trust.

Given that the majority of nurses are female, perhaps this difference in the level of trust in female providers may contribute to an increased level of trust in nurses. In the following section research studies related to trust and the nurse-patient relationship will be discussed.

Trust and Nurse-Patient Relationship

Trojan and Yonge (1993) completed a grounded theory study (Strauss and Corbin method) related to the development of trusting relationships in the nurse-patient relationship. The research question was "What is the process of developing a trusting relationship between home care nurses and elderly clients" (Trojan & Yonge, 1993, p. 1904). Seven home care nurses and 6 elderly clients were interviewed. The authors did not mention how the participants were recruited, only that they volunteered, had to be English speaking and clients had a minimum of 1 year of home care services except one participant only had services for a few months. Data collection ended when all volunteers

had been interviewed and data were being duplicated; financial and time constraints were also reported as a factor in the small sample size.

In the results, the core category was Trusting, Caring Relationships (Trojan & Yonge, 1993). This core category is nearly identical to the research question of trusting relationships and seems to be a superficial finding for a core category. The stages identified were *Initial Trusting, Connecting, Negotiating,* and *Helping* (Trojan & Yonge, 1993). The stages were non-linear and could occur simultaneously. Trust could spiral upwards or downwards based on patient satisfaction with the nurse.

The stage *Initial Trusting* had sub-categories of *generalized trust, accepting, respecting,* and *trust of one's skills* (Trojan & Yonge, 1993). *Generalized trust* was trust of nurses at the initial visit but changes in trust could occur with subsequent visits. The authors noted that this generalized trust was similar to the naïve trust noted in the Thorne and Robinson study (1988) of trust between physicians and patients. The *accepting* sub-category reflected the nurse perspective that the nurse should accept the patient's environment, culture, and choices; the client did not discuss acceptance but the authors assumed the client accepted the nurse since the client was hesitant to change nurses. In the *respecting* sub-category, the nurse noted the need to respect the patient and being genuine; the client noted they wanted respect and basic characteristics of the nurse being nice. In the sub-category *trust of one's skills*, the nurses noted having confidence in their own skills and clients noted confidence in the client's skills. Unlike Thorne and Robinson's study (1988), the authors did not mention reciprocal competence although

they noted in the discussion section one client noting a strong relationship that was similar to reciprocal trust.

The stage of *Connecting* had sub-categories *getting to know each other, communications,* and *assessing* (Trojan & Yonge, 1993). In the *getting to know each other* sub-category, trust occurred over time and included knowing the nurse as a person and showing interest and physical touch. This is similar to the Thorne and Robinson (1988) interpersonal trust although the authors did not mention this similarity. In the *communications* sub-category, the nurse perceived that the first impression and being open, friendly, listening and unhurried earned the client's confidence. The client noted the nurse's humor, being positive and easy to talk to as making the clients feel comfortable. In the *assessing* sub-category, the nurse perceived assessing as the client telling the illness story. The client noted improved skills due to the nurse's visits. These findings are similar to the Thorne and Robinson (1988) finding of patient competence in guarded alliance although the authors did not note the similarity.

In the *Negotiation* stage, subcategories were *control* and *setting goals*. The nurse perceived negotiation as "contracting" while the client perceived it as "working together" (Trojan & Yonge, 1993, p. 1907). In the *control* sub-category, the client noted the client was in control of care decisions unless in a family crisis and then the nurse would be in control. Although not mentioned, this finding is similar to Thorne and Robinson (1988) as well, noting the physician in control of decisions during acute illness, but otherwise shared decision making with the patient and family. The nurse perceived the need to be

flexible, "planting seeds" (Trojan & Yonge, 1993, p. 1907), and allow time for the client

to make decisions and if they did not respect the client's choice the nurse risked losing the

client's trust. In the *setting goals* sub-category the nurses and clients set goals together,

however, nurses noted clients were in control. The authors wrote, "Nurses realized that

they could only do what elderly clients allowed them [nurses] to do" (Trojan & Yonge,

1993, p. 1908). Although not discussed by the authors, this is an interesting view of the

power imbalance usually noted in the nurse-patient relationship with the nurse considered

the one in power. This shift could be attributed to the home care setting not being one of

an acute illness situation, and further evidence that the environment (context) affects the

relationship and trust.

In the *Helping* stage the authors identified growth of the trusting relationship and

termination (Trojan & Yonge, 1993). The nursing role was to support, help, educate, and

get equipment. The authors noted the client allowing the nurse to help and in this last

stage the client could develop a deeper trust in the nurse and the relationship could end as

the goals were met. In discussion, the authors noted the findings of this study were

similar to Thorne and Robinson's (1988) findings of naïve trust but did not see a

similarity with the disenchantment and guarded alliance. It seems that guarded alliance is

evident in the interpersonal relationship building and reciprocal trust. Trojan and Yonge

(1993) noted further research was needed in different nursing environments and with

different communities and cultural groups. This study was completed in Canada.

Trust in the nurse was a key finding in a qualitative field study completed in Belgium to explore the process of adherence to leg ulcer treatment with patients who received a nursing intervention (Van Hecke, Verhaeghe, Grypdonck, Beele, & Defloor, 2011). The nursing intervention, entitled adherence to leg ulcer lifestyle advice, was delivered over 12 weeks by a tissue viability nurse, a community health nurse with specialized wound care training. The intervention included the patient telling the tissue viability nurse about the leg ulcer and the tissue viability nurse making weekly visits which included instructions to wear compression hose, undertake daily physical activity, leg exercises and leg elevation. In addition, as part of the standard care, the tissue viability nurse did weekly wound dressing changes and the community nurse completed wound care daily. The sample was 26 patients with leg ulcers who were non-adherent to treatments by a community nurse. The data collection included both field observations during the intervention, by the researcher who was an expert tissue viability nurse, and semi-structured interviews with patients one week following the completion of the 12 week intervention. Data analysis was thematic analysis to develop a theoretical framework. Researchers used data and previous models of behavior change to develop the theory.

An unexpected finding was interpersonal trust in the tissue viability nurse being the central factor in the patient adherence to the nursing intervention (compression hose, daily exercise, leg elevation) (Van Hecke, et al., 2011). When the patients developed trust with the tissue viability nurse, the patients followed the advice even if they did not know

the rationale for the interventions or were unsure of the benefits. After completion of the

12 week program, several patients stated their intention to continue with the interventions

since they realized the benefits. The published report included findings of other

determinants of adherence related to behavioral change theory models such as outcome

expectations, fear avoidance, self-efficacy, and patient related factors (age).

The researchers developed a model based on the data and previous behavioral

change theories (Van Hecke, et al., 2011). The authors noted the previous theories did not

include the nurse-patient relationship in the models. A key component of the model was

trust in the nurse labeled *Trust/feeling safe*. The model included the factors that facilitated

trust development and the outcome behavior change. The factors that facilitated trust

development were the nurse (a) developing rapport with the patient and being friendly,

(b) spending meaningful time with the patient including time for the patient's story, (c)

technical competence, (d) doing more than expected, (e) self-disclosing, and (f)

exchanging information with other healthcare providers. When the patient was faced with

conflicting information, the patient followed the advice of the healthcare provider who

the patient trusted the most. In the discussion section, the authors noted the patient telling

the leg ulcer story was similar to Thorne and Robinson (1988) and the development of

reciprocal trust.

A concern noted by the authors was that the patients may have been adhering to

the nursing intervention because of being in a study, perceiving they were receiving a

different type of treatment and wanting to please the researcher who was present during

at least one consultation with each patient (Van Hecke, et al., 2011). This would be an example of the Hawthorne Effect or social desirability. For this reason, the authors acknowledged they were unable to determine the effect of the actual intervention on patient adherence. Also, the authors could not say definitively that data saturation was achieved. A concern in the conclusion section of the published article was the authors noting the tissue viability nurse being "inherently trusted" due to her expertise and then noted interpersonal attributes impacting trust (Van Hecke, et al., 2011, p. 154). It appears the authors were not familiar with the difference between institutional and interpersonal trust. Regardless, although institutional trust may be a factor in the competence expected of the tissue viability nurse, the published findings of the study reflected interpersonal trust with the nurse was a key factor in patient adherence. Using a grounded theory methodology would have been a better approach for the study given the purpose was to explore the process of adherence and to develop a theory. Interestingly, the researchers were still able to identify the key role of trust using the data, even when using previous behavioral change theory as a guide. This speaks to the power of qualitative research methodologies. This study provides evidence in support of the impact of interpersonal trust in the nurse on patient adherence to the treatment plan in the home care setting.

Authors of a basic study completed as an undergraduate nursing honors thesis in Australia explored the development of trust in the nurse-patient relationship in the hospital setting (Belcher & Jones, 2009). In the qualitative descriptive study, seven newly graduated Bachelor of Science in nursing (BSN) nurses (female, ages 22-41) were

interviewed after the first year in an internship-type program in a hospital setting. The findings indicated building rapport was important in trust development with the patient. Key factors in building rapport were (a) communication, (b) personality of nurse and patient, (c) nurse previous experience (life and nursing), (d) bedside manner, and (e) taking the time. The nurse needed to take the time to develop a relationship through communication (listening and social conversation). The authors noted the sequence of developing trust was the nurse and patient feeling comfortable with each other, building rapport, and then trusting. The key factor the authors noted was that the nurse was instrumental in the development of trust and building rapport. Findings indicated hinderances to trust development could be language and cultural barriers, including medical terminology as a language barrier. The authors noted the nurse needs to be able to invest emotionally and noted negative home issues brought to work could impact the nurse's ability to communicate with the patient. Outcomes of trust development from the nurse's perspective were (a) increased self-esteem as a new nurse, (b) increased job satisfaction, and (c) the patient being more accepting of care. Not developing a rapport with the patient due to the new nurse not being able to answer questions led to the new nurse having a lack of confidence and distancing themselves from the patient, leading to less than adequate care as perceived by the new nurse. The findings related to factors to build rapport in this study were similar to findings in other studies of the nurse-patient relationship (Morse, 1991; Van Hecke, et al., 2011). There were several issues with trustworthiness of the study including no mention of credibility, data saturation or an

audit trail as well as some citations in the text missing from the reference list. However, given this was an undergraduate thesis, the findings reflect previous research and also include unique findings in the outcomes noted for the new nurse. This study provides the nurse's perspective of trust development in the hospital setting.

Based on a grounded theory study of high quality nursing care from the perspective of patients with cancer (n=22), Radwin, Washko, Suchy, and Tyman (2005) developed scales to measure health outcomes of cancer patients. One of the outcomes of high quality oncology nursing care was trust; other outcomes were fortitude, sense of well-being, optimism, and authentic self-representation. Trust was defined as "the patient's confidence that care was appropriate and reliable and would be as successful as possible" (Radwin, et al., 2005, p. 93). This definition encompasses the term *confidence* which, in Sellman's (2007) discussion of the definition of trust in a later publication, reflects a higher level of evidence, or familiarity, than trust does. In reviewing the literature, Radwin et al. (2005) did not find an appropriate measure of trust in the nurse-patient relationship, only measures for trust in the patient-physician relationship. Therefore, the authors developed the Trust in Nurses Scale as part of an instrument of four scales to measure oncology nursing care (Radwin, et al., 2005). The other scales were Fortitude, Optimism, and Authentic Self-Representation. The Trust in Nurses Scale is 5 items rated on a Likert-type scale reflecting frequency of activity from 1 (never) to 6 (always) plus a general question rating trust on a 1 to 10 scale. For example, one item is "How often did you believe that your nurses were acting in your best interest?" (Radwin,

et al., 2005, p. 95). The score is a sum of the items on the Likert scale adjusted to a 100-point scale with the higher score indicating a higher level of trust. The Trust in Nurses Scale was pilot tested with oncology patients (n=66; White 97%, Asian 3%, Hispanic or Latino1.5%) and demonstrated high item-scale correlations (.57-.73), suggesting items within the scale measured a similar concept, and intrascale internal consistency (Cronbach alpha reliability .81). The other three scales had lower correlations (Pearson r = 0.20 to 0.45) to the Trust in Nurses scale as would be expected for distinct scales. The mean score on the Trust in Nurses scale was 87.75 (SD 12.36) which demonstrated a high level of trust in nurses. In a subsequent study of patient centered nursing interventions and desired outcomes, including trust, Radwin, Cabral, and Wilkes (2008) eliminated one item related to providing information and the revised Trust in Nurses Scale had a Cronbach alpha of .82. Likewise, in further validity and reliability testing of the Trust in Nurses Scale, the four item scale with the providing information item eliminated, had higher fit statistics and reliability than the five item scale (Radwin & Cabral, 2010). Findings of the study (Radwin, et al., 2008) indicated that responsiveness and proficiency of the nurse led to the outcome of trust in nurses.

Keller (2008) completed a qualitative descriptive study to explore culturally competent care and the nurse-patient relationship between the clinic nurse and Mexican American parents, with trust as an important component of this study. Keller (2008) interviewed Mexican American mothers attending a southern New Mexico health clinic for their child's immunizations (n=12 mothers; 6 immigrants from Mexico, 5 first

generation Mexican Americans, 1 fourth generation Mexican American). Using semi-structured interviews in English or Spanish with a Spanish interpreter, the researcher asked participants to describe the encounter, helpful behaviors and unhelpful behaviors in the immunization encounter with the nurse.

A grounded theory approach was used for data analysis according to the author and three themes emerged: *Trust in the Nurse, Building Confidence in the Mother and Child,* and *Language Concordance* (Keller, 2008). In the *Trust in the Nurse* theme, the nurse needed to be trustworthy and the mother and child must both trust the nurse. Nurses gained trust by behaviors that put the mother and child at ease such as being social and friendly and engaging the child, as well as an unhurried approach with a social intent first, rather than a task-oriented intent. This social intent as the initial action was also noted by Trojan and Yonge (1993) in their study of home care nurses and clients. Other actions to gain trust included gentle handling of the child, not having the parent assume the role of child restrainer, and providing a reward after the injection. If parents felt hurried then they were reluctant to ask questions. The second theme, *Building Confidence*, was associated with trust. The author wrote, "Trust is the foundation for building the client's confidence in the care provided by the nurse" (Keller, 2008, p. 36). Two dimensions of confidence were identified: professional confidence and mother's confidence. Professional confidence included technical competence (preparation and skill of performing immunization) and communication competence (unhurried, friendly, explain/informative, Spanish language use, available to answer questions). Participants

expressed a lack of professional confidence if the nurse discussed the patient's health in a public setting or the parents heard nurses discussing others' health which they viewed as a breach of confidentiality. This breach was interpreted as a lack of respect and led to the parent's loss of confidence in the nurse. The mother's confidence was the nurse ensuring the mother had the knowledge and skills to care for the child at home through unhurried verbal or written explanations. The theme *Language Concordance* referred to written and verbal communication in the preferred language of the mother. The race and ethnicity of the nurse was not important with regard to language concordance.

Keller (2008) noted a limitation of the study was only interviewing parents that were regular clients of the clinic and satisfied with the care, and suggested future research with parents without a regular source of care. Keller (2008) noted that these findings were similar to Stasiak (2001), Zoucha (1998), and Warda (2000). A methodological concern with this study was, although the author stated the use of a grounded theory approach for analysis (Keller, 2008, p. 36), the findings in the published report were presented as themes, did not include a core category or mention an emerging theory and the reference list did not include a citation for the grounded theory method used. Since the aim of the study was description rather than explanation, it appears the author employed content analysis rather than true grounded theory.

Summary of Trust

Trust is fundamental in the nurse-patient relationship (Keller, 2008; Thorne & Robinson, 1988). Antecedents of trust are risk, need, and familiarity. Outcomes of trust

are increased patient competence and self-esteem, and improved patient-provider relationships. The Hispanic population has demonstrated less development of interpersonal (Sohler, et al., 2007; Weaver, 2006) and institutional trust (Sohler, et al., 2007) compared to non-Hispanic Whites and Blacks. In addition, there is limited research on the physician-patient relationship (Mechanic & Meyer, 2000; Sheppard, et al., 2008; Skirbekk, et al., 2011; Sohler, et al., 2007; Thorne & Robinson, 1988) and all were based in the clinic rather than hospital setting and only one focused on trust in the physician relationship with Hispanic patients (Sheppard, et al., 2008). There was only one qualitative study of trust in the provider relationship in the hospital setting which did not focus on the nurse-patient relationship exclusively, but rather included physicians, nurses, admitting staff, transport staff, and technicians as care providers (Hupcey, et al., 2000). Six studies were related to trust in the nurse-patient relationship (Belcher & Jones, 2009; Keller, 2008; Radwin, et al., 2008; Radwin, et al., 2005; Trojan & Yonge, 1993; Van Hecke, et al., 2011), however, only one study explored the nurse-patient relationship from the perspective of Hispanic patients and it was based in a clinic setting and focused on the immunization encounter with children so the patient perspective was actually the parent's perspective (Keller, 2008). Of the studies incorporating the grounded theory methodology, not all met the critical test of grounded theory. There has not yet been a study related to trust from the perspective of the hospitalized adult Hispanic patient.

The following section discusses PCC and cultural competence and acknowledges the role of trust in these important domains of care.

Patient–Centered Care and Cultural Competence

Patient-centered care (PCC) and cultural competence are important to ensure quality in health care and reduce health disparities (Institute of Medicine, 2001; Smedley, et al., 2003). PCC is defined as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (Institute of Medicine, 2001, p. 6). The Institute of Healthcare Improvement includes a focus on family, defining patient-centered care as care that:

> Considers patients' cultural traditions, their personal preferences and values, their family situations, and their lifestyles. It makes the patient and their loved ones an integral part of the care team who collaborate with health care professionals in making clinical decisions (Institute for Healthcare Improvement, 2009, Patient Centered Care General Section).

Taking a patient's values and culture into consideration when delivering care is the foundation of culturally competent care as well. An important dimension of PCC is cultural competence (Institute of Medicine, 2001). The Office of Minority Health (2009) defines cultural competence as "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" (Office of Minority Health, 2009, "What Is Cultural Competency?," para. 1). Cross-cultural refers to any encounter involving two people that have different ethnic, racial or even socioeconomic backgrounds. Those that demonstrate cultural competence incorporate this into PCC and apply it to vulnerable groups such as racial and ethnic minorities, limited English proficiency (LEP) and lower socioeconomic (LES) people. The following sections review literature related to PCC and cultural

competence in general, and later sections address these concepts in studies related to the Hispanic population.

Patient-Centered Care

In the medical model, the physician is more important than the patient or family while in PCC, the patient and family are the focus and develop partnerships with the healthcare provider (Zimmerman & Dabelko, 2007). Involving patients in decisions about health care can improve compliance with treatment regimens and improve outcomes (Zimmerman & Dabelko, 2007). Several major healthcare organizations support the implementation of PCC. For example, in a public policy white paper, the Joint Commission (Joint Commission, 2009) identified PCC as one of five core areas for action in hospitals in the future; the others were economic viability, technology adoption, staffing, and hospital design. A joint policy statement of the American Academy of Pediatrics and the American College of Emergency Physicians noted that patient-centered and family-centered care is a standard of practice (O'Malley, Brown, & Mace, 2006).

PCC, known as being "low-tech and high touch" (Frampton, et al., 2008, p. 8), has been the focus of two major non-profit organizations in the U.S., the Picker Institute and the Planetree organization (Frampton, et al., 2008). The Picker Institute and Planetree have both used focus groups of patients and family to develop their respective programs of PCC. Planetree team members and Picker/Planetree fellows (Frampton, et al., 2008) authored a guide related to the implementation of PCC in institutions such as hospitals. The authors stated PCC is "a collective commitment to a set of beliefs about the way

patients will be cared for, how family will be treated, how leadership will support staff, and how staff will nurture each other and themselves" (Frampton, et al., 2008, p. 20). Core concepts of PCC are dignity and respect, information sharing, participation, and collaboration (Frampton, et al., 2008). Although trust is not listed as a core concept of PCC, Thorne and Robinson noted (1988) trust is the foundation of collaboration in the provider-patient relationship. PCC should be deep rooted in the core values of an institution and is more than patient focused; it is also focused on staff (Frampton, et al., 2008).

Researchers at the Picker Institute developed a patient satisfaction survey from extensive interviews with patients about their care experiences. This survey is now a standard measure of patient perception of care (Frampton, et al., 2008) and portions have been incorporated into the Consumer Assessment of Health Plan Survey (CAHPS) group of surveys including the hospital version (HCAHPS) (Silow-Carroll, Alteras, & Stepnick, 2006). Researchers at the Planetree organization developed a model of PCC that has been adopted by over 150 hospitals, nursing homes and clinics and a pilot study demonstrated an association between some of the top Planetree hospitals and improved core measures of quality care for clinical conditions such as heart failure and patient satisfaction scores (Frampton, 2009). In one case study, outcomes of PCC were decreased length of stay, decreased costs, and increased patient satisfaction (Frampton, et al., 2008). In addition, PCC led to reduced staff and physician burnout (Gerteis, et al., 1993).

Dimensions of PCC. In the landmark book *Through the Patient's Eyes*, Gerteis, Edgman-Levitan, Daley, and Delbanco (1993) reported preliminary research findings from the Picker/Commonwealth Program of Patient-Centered Care which was started in 1987 and later became the Picker Institute. Through focus group interviews with patients and their family members, the staff and consultants of the Picker/Commonwealth program identified seven dimensions of PCC and developed a survey instrument. The dimensions of PCC were (a) respect for patients' values, preferences, and expressed needs; (b) coordination and integration of care; (c) information, communication, and education; (d) physical comfort; (e) emotional support and alleviation of fear and anxiety; (f) involvement of family and friends; and (g) transition and continuity. Respect for patients' values included respect for the uniqueness of each individual acknowledging that all patients had culturally defined beliefs that affect their perception and response to care. Coordination of care included identifying which doctor was in charge of care. Information and communication included providing information related to diagnostic testing, in-depth discharge instructions, and highlighted the nurse's role in bridging the communication gap between physicians and patients. Physical comfort incorporated presence which included listening to patients, anticipating their needs, and being aware of their environment. Emotional (and social) support included a positive attitude of caring and respect. Involving family and friends encompassed anyone the patient recognized as significant regardless of bloodline or legal relationships. Transition and continuity

incorporated consistency in the treatment plan to the home setting when the patient is discharged from the hospital setting.

These seven dimensions of PCC of the Picker Institute were identical to those of Planetree and other groups such as social workers (Zimmerman & Dabelko, 2007) and those working with the underserved (Silow-Carroll, et al., 2006). However, the Planetree model also incorporated the physical environment, spirituality, and interventions using complementary therapies (e.g. massage, aromatherapy) (Frampton, 2009; Frampton, et al., 2008). The Planetree model is even more focused on the healing environment of care for the patient.

In a research report based on interviews with experts in the field of PCC, Silow-Carroll et al. (2006) presented components of PCC for underserved populations. Underserved populations are the elderly, uninsured, low income, ethnic and racial minorities, and immigrants. Core components of PCC for the underserved were identical to those of the Picker Institute including considering patient culture, traditions and language and assisting with navigation of the healthcare system. The researchers noted the importance of having knowledge of the patient's culture, yet treating the patient as an individual without stereotyping. Underserved groups have even greater barriers to PCC. Barriers to PCC in the underserved were problems recruiting minority physicians, difficulty hiring community members since they may not meet education or experience criteria, and lack of partnership development between patient and provider due to differences in language and culture. Recruiting minority physicians and hiring

community members is beneficial since they reflect the community's diversity and may be more sensitive to the patient's background and culture (Silow-Carroll, et al., 2006). Interestingly, the researchers noted that nursing was at the forefront of PCC since nursing curricula were already focused on patient comfort and communication (Silow-Carroll, et al., 2006).

       PCC and nursing research studies. The Robert Wood Johnson Foundation and the Institute for Healthcare Improvement (IHI) developed a national program entitled *Transforming Care at the Bedside* (Upenieks et al., 2008) which includes patient centeredness. Through this program, Upenieks and colleagues (2008) evaluated the use of innovations at the bedside and the subsequent change in vitality for bedside staff. The innovations were categorized into one of four domains: safety and reliability, patient centeredness, vitality (work environment), and value/lean (efficiency). To evaluate vitality, nurse managers were asked if an increase of vitality was noted on the unit at the end of the first year and again at the end of the second year of the program. Sixteen medical surgical units across the U.S. participated in the program. Findings indicated that an average of 26.6 innovations were tested over the 2 year program with a range of 6 - 43 innovations on each unit. Innovations related to the patient centeredness domain were the most common with all 16 units attempting patient centeredness innovations and an average of 10 innovations per unit. Innovations in the patient centeredness domain were low technology and included whiteboards at the bedside for patient/nurse communication, care maps, education materials, bedside report, shift introductions, pet

therapy, quiet times, and snack baskets. Not surprisingly, managers that reported their units had increased vitality in the first or second year also reported attempting more innovations compared to units that had no change in vitality.

However, in a follow-up report related to the *Transforming Care at the Bedside* initiative (Needleman et al., 2009), the authors collected data from hospital administrators from ten hospitals that implemented the initiative and reported patients likely to recommend the hospital, an outcome of PCC, only increased slightly since implementing the interventions and was not statistically significant (n=7 units reporting, 61% patients in 2005, 67% in 2006, 66% in 2007) (Needleman, et al., 2009). In addition, although managers perceived an increase in staff vitality (Upenieks, et al., 2008), less bedside nurses (n=9 units) in 2007 stated that they felt part of an effective team compared to 2005 (43% vs. 45%) (Needleman, et al., 2009). Likewise, voluntary nursing turnover rates (n=13 units) in 2007 were only slightly lower than 2005 (3.9% vs. 4%) although these decreased in 2006 (3%) and all years were much lower than the national average for medical-surgical units (8.4%) (Needleman, et al., 2009).

Wolf, Lehman, Quinlin, Zullo and Hoffman (2008) examined the impact of PCC nursing care on patient reports of satisfaction with nursing care and hospital satisfaction. The sample consisted of two small groups of patients undergoing bariatric surgery with 18 patients in each group. The groups were randomly assigned from a convenience sample. The control group received standard care from nurses (n=20) and the intervention group were cared for by nurses (n=6) who had 10 hours of PCC training which focused

on communication. The intervention group of patients received a preoperative phone call

by PCC nurses to identify patient expectations and concerns and answer questions.

Satisfaction was measured using the Schmidt Perception of Nursing Care Survey

(SPNCS) and the Baker and Taylor Measurement Scale (BTMS). The SPNCS has 15

items and four subscales (Seeing the Individual Patient, Explaining, Responding, and

Watching over) with scoring on a 5-point Likert type scale 1 (strongly disagree) to 5

(strongly agree) (Schmidt, 2004). The BTMS was reduced from the original 99 items to

seven items in three subscales-Purchase Intention (2 items), Quality of Service (2 items),

and Satisfaction with Service (3 items). The BTMS is scored on a 7-point Likert type

scale 1 (strongly disagree or poor) to 7 (strongly agree or excellent) (Baker & Taylor,

1997). The authors did not discuss the process of reducing the BTMS scale or the

reliability and validity of the new 7-item scale. Cronbach alpha values to measure

internal consistency as a form of reliability for the revised BTMS and the SPNCS were

not provided for the study. Findings indicated there were no statistically significant

differences between the groups in scores on the subscale or total scale of SPNCS and no

statistically significant difference between the two groups for overall satisfaction

measured on the BTMS. The published report did not include mean total or subscale

scores for the SPNCS or the total score for the BTMS for the groups. The authors did

note a statistically significant difference for two BTMS subscales, Quality of Service for

the PCC group (M=17.11 (4.56), range 2 to 14, p=0.03) and Satisfaction of Services for

the PCC group (M=11.44 (3.07), range 3 to 21, p=0.04). However, the reported Quality

of Service results (mean 17.11) did not reflect the possible range of 2 to 14 and cast doubt

on the mean reported for the Satisfaction of Services subscale as well. The mean values

appear to be reversed. Unfortunately, effect size was not published in the report and

cannot be calculated due to the limited statistical information in the article. The authors

noted limitations of the study were the small sample size and possible diffusion of the

PCC training to the other group of nurses. The non-significant findings could be the

result of the small sample size, a lack of sensitivity of the instruments, or perhaps the

nurses on the unit all provided PCC since the only training appears to be improved

communication. Unfortunately, the authors did not describe how nurses were selected to

participate in the training, if it was random assignment or volunteer. Nurses that

volunteered for the training may have been more eager to provide improved patient care

practices.

Poochikian-Sarkissian, Wennberg, and Sidani (2008) also examined PCC and

outcomes of care from the patients' and nurses' perspectives. The outcomes of care were

patient satisfaction, symptom experience, functional status, personal control, and self-

care. The sample was patients (n=14) and nurses (n=21) on a neuroscience unit at a

university-affiliated hospital in Canada. This is a small sample size for a quantitative

study and power analysis information was not provided. The PCC survey used was a

combination of scales from other tools and measured individualization of care (12 items),

patient participation in care (5 items), patient education and counseling (9 items), and

coordination of care (7 items). Nurses completed a nurse version of the PCC survey on

the level of PCC they provided. Patients completed surveys within 48-72 hours after

admission (Time 1) and again 1 week after discharge (Time 2). At Time 1 and 2 patients

completed a symptom experience measure (number of items not published), functional

status measure (number of items not published), self-care measure (13 items), and sense

of personal control measure (13 items). In addition, at Time 2, patients completed the

PCC survey including a respect and caring measure (7 items) and satisfaction with care

measure (5 items). Findings indicated that nurses perceived more PCC care given than

patients did on three of the eight subscales (patient participation in care, provision of

patient education, provision of patient counseling) and the same on one subscale

(provision of care according to preferences). Patients were only somewhat satisfied, with

a very low mean of 1.6 (SD 0.7), range 1 (poor) to 5 (excellent) (Hays, Nelson, Rubin,

Ware, & Meterko, 1990). Nurses and patients did not have the same perception of

delivery of PCC and even with PCC, the patient satisfaction levels were surprisingly low.

Perhaps the instrument was not sensitive enough or the combination of different

subscales affected the reliability and validity of the measures. Measures of reliability

(Cronbach alpha) were not provided for this study.

In 1999, Hicks et al. (2005) assessed the impact of race and ethnicity on

discharged hospital patients' satisfaction with care (physician and hospital staff).

Satisfaction was measured based on domains of PCC. Participants (N=2664; Whites

n=2379; Blacks n=261; Latinos n= 178, 36% English speaking) that had been

hospitalized for medical, surgical or obstetric services were mailed a survey three months

after discharge. The standardized survey from the Picker Institute was offered in both

Spanish and English and the survey asked participants to report problems in any one of 7

domains. The 7 domains were respect for patient preferences (4 items), coordination of

care (6 items), information and education (5 items), physical comfort (5 items), emotional

support (6 items), involvement of family and friends (3 items), and continuity and

transition of care (4 items) (Hicks, et al., 2005). In analysis, problem scores were divided

into quintiles and those having the most problems in the 7 care domains were in the

highest quintile. Researchers used logistic regression and adjusted for cofounders such as

race, ethnicity, age, sex, and education, among others. Findings indicated Blacks and

Latinos reported more problems compared to Whites (reference group) in the respect for

preferences dimension (Black odds ratio [OR] 1.82, 95% Confidence Interval [CI] 1.26-

2.62; Latino OR 1.98, 95% CI 1.31-3.00). In addition, Latinos in obstetric services

reported more problems compared to Whites in respect for preferences (OR 3.60; 95%CI

1.58-8.21). Unfortunately, group mean scores on the surveys were not provided in the

published report. Researchers noted differences in perception of care may be associated

with different racial and ethnic expectations (Hicks, et al., 2005). As noted previously,

respect is very important in the Hispanic culture and expectations may be different.

In a mixed method research study Tandon, Parillo, and Keefer (2005) examined

perceptions of patient-centered care in women that recently experienced prenatal care.

The purpose of the research study was (a) to determine prevalence of perceptions of PCC

in Hispanic mothers, (b) to determine differences in perception of PCC between Hispanic

and non-Hispanic mothers, and (c) to understand Hispanic mother's perceptions of PCC

by prenatal care providers. The researchers used semi-structured questions to interview

women in Palm Beach County Florida hospitals within 24-48 hours after delivery

regarding their prenatal care. The sample was Hispanic women (n=125, mean age 24.6

(SD 6.1) years) and non-Hispanic women (n=302, mean age 28.1 (SD 6.4) years; 197

non-Hispanic White, 73 non-Hispanic Black, and 32 Haitian). They were interviewed in

English or Spanish. The subjects were asked three "yes" or "no" questions to assess

patient-centeredness, (a) "Did doctors or nurses treat you with respect during your

prenatal care appointments?", (b) "Did other office staff treat you with respect during

your prenatal care appointments?" and (c) Did you have language or communication

problems with your doctor or nurse during your prenatal care appointments?" (Tandon, et

al., 2005, p. 314). This was the quantitative component of the study. If respondents

answered "No" to a question, then they were further asked to explain their "No" response

which was the qualitative component of the research study.

Findings were a smaller percentage of Hispanic women reported "Yes" to being

treated with respect from doctors and nurses compared to non-Hispanics (86% vs. 96%)

even when adjusted for education, age, insurance status, time in U.S., and initiation of

prenatal care (Adjusted OR= 0.29 (White 1.0 reference), 95% CI 0.10-0.86, p=.026)

(Tandon, et al., 2005). A smaller percentage of Hispanic women reported "Yes" to being

treated with respect from office staff (80% vs. 95%)(Adjusted OR= 0.29, 95%CI 0.12 -

0.73, p=.008). Not surprisingly, Hispanic women also reported more problems with

communication with doctors and nurses during the prenatal appointment compared to non-Hispanic women (27% vs. 5%)(OR= 3.30, 95% CI 1.40 - 7.76, p=0.006). When asked to explain why the perception of lack of respect from doctors and nurses, the Hispanic mothers commented health professionals were rushed and impersonal. When asked to explain lack of respect from office staff, Hispanic mothers commented the office staff was not friendly and not helpful and the mothers did not understand what the staff was saying to them. When asked about communication with health professionals, the Hispanic mothers commented that due to their lack of English, they did not understand instructions. Also, although the nurses and physicians tried at times to speak some Spanish, the mothers did not understand fully the instructions. Hispanic mothers also commented about not wanting to return for further visits due to the lack of respect and communication issues.

Unfortunately, acculturation level was not assessed and there was no mention of how many mothers were interviewed in Spanish. A limitation of the study not identified by the authors was measuring PCC with only three items- two respect items and a communication item. The definition used by the authors was the IOM definition of PCC as "a health care system that is responsive to the cultural and language needs, values, and preferences of the patient" (Tandon, et al., 2005, p. 313). The items did address respect and communication but not family engagement or friendly interactions which are Hispanic cultural priorities. Participation and collaboration were not measured either, although these are important components of PCC according to the Institute of Patient-and

Family Centered care (2010) and other PCC experts (Frampton, 2009; Frampton, et al., 2008; Gerteis, et al., 1993; Silow-Carroll, et al., 2006).

Summary PCC. Definitions and dimensions of PCC were very similar across the Picker Institute and Planetree organizations (Frampton, 2009; Frampton, et al., 2008; Gerteis, et al., 1993; Silow-Carroll, et al., 2006) and fields such as social work (Silow-Carroll, et al., 2006; Zimmerman & Dabelko, 2007). PCC fundamentally requires acknowledging the patient's beliefs and values when delivering care. Core concepts of PCC include respect, patient and family involvement in care and decisions, improved communication, and collaboration with the community. Trust is at the foundation of collaboration in the provider-patient relationship (Thorne & Robinson, 1988). The Picker Institute and Planetree organization have led initiatives to implement PCC in hospitals and patient care institutions throughout the U.S. The enhanced patient experience leads to improved patient outcomes and patient satisfaction. However, some nursing research studies did not report high levels of patient satisfaction, possibly due to inadequate design elements such as appropriateness of instrument and sample size (Poochikian-Sarkissian, et al., 2008; Wolf, et al., 2008). The findings need to be viewed with caution. Studies of PCC in the Hispanic population found Hispanics reporting a lower level of perceived PCC (Hicks, et al., 2005; Tandon, et al., 2005). This lower level could be attributed to the importance of respect in the Hispanic culture and the Hispanic patient's perceived lack of respect from providers. The following section discusses cultural competence, a necessary component in providing PCC to patients in the care experience.

Cultural Competence

Patient-centeredness and *cultural competence* are distinct, yet overlapping, concepts (Saha, Beach, & Cooper, 2008). Patient-centeredness and cultural competence share the same principles of respect, partnership, communication, and a holistic view of illness including the sociocultural context (Saha, et al., 2008). Both have the goal to improve health care quality while cultural competence is more specific to care delivered to people of different cultures and disadvantaged groups (Ngo-Metzger, et al., 2006; Saha, et al., 2008). Ngo-Metzger and colleagues identified the need for PCC for all people but that limited English proficiency (LEP), ethnic minority and low economic status (LES) persons are more vulnerable and affected by a lack of PCC. This lack of PCC can lead to decreased adherence to plan of care and can result in poorer health outcomes and healthcare disparities. The cultural competence movement resulted from efforts to bridge the gap between the White, middle-class, biomedical-minded providers and the immigrant patient (Saha, et al., 2008).

In a review of the literature related to cultural competence and quality of care, Ngo-Metzger and colleagues (2006) noted ethnic and racial minority, LEP, and LES patients perceived worse care experiences than patients that were White, English-speaking or those of a higher socioeconomic status. This difference in care experiences could be due to a discrepancy in patient expectations, provider bias, or communication issues (Ngo-Metzger, et al., 2006). The researchers provided a conceptual framework of culturally competent care from the patient's perspective (Ngo-Metzger, et al., 2006). Five

aspects of culturally competent care were (a) patient-provider communication, (b) shared

decision making and respect for patient preferences, (c) experiences leading to trust or

distrust, (d) experiences of discrimination, and (e) linguistic competence. These domains

are very similar to the dimensions of PCC and PCC's core concepts of dignity and

respect, information sharing, participation and collaboration (Frampton, et al., 2008). The

authors suggested further research is needed from the patient's perspective and the need

to include at risk populations such as LEP, LES, and low health literacy patients so

results of data collection are not skewed toward populations with higher socioeconomic

status (Ngo-Metzger, et al., 2006).

Transcultural nursing leaders (Giger, et al., 2007) and medical experts in health

disparities (Betancourt, et al., 2003) acknowledged the definition of cultural competence

has varied and still needed to be clarified. Cultural competence has been defined as a

process (Campinha-Bacote, 2002; Purnell, 2005) and as an end result of nursing care,

culturally congruent care (Leininger, 2001). Leininger (1967) wrote a pioneering article

that considered culture and nursing care. She eventually defined culturally congruent care

as:

> Those cognitively based assistive, supportive, facilitative, or enabling acts or
> decisions that are tailor made to fit with individual, group, or institutional cultural
> values, beliefs, and lifeways in order to provide or support meaningful, beneficial,
> and satisfying health care, or well-being services (Leininger, 2001, p. 49).

A definition from Orque, another leader in cultural competence, was "the nurse's

effective integration of the patient's ethnic cultural background into her [sic] nursing

process-based patient care" (Orque, 1983, p. 7). Orque's definition reflected cultural

competence as a process. Nursing researchers who have completed concept analyses of

cultural competence have rightly concluded that cultural competence is a process

(Burchum, 2002; Smith, 1998; Suh, 2004). The outcome of this process is culturally

competent care.

Following a review of cultural competence in the medical and public health

literature, Betancourt, Green, Carrillo, and Ananeh-Firempong (2003) stressed

distinguishing between sociocultural barriers and cultural barriers alone when examining

the increasing evidence of health disparities. The researchers' view of cultural

competence as a practical framework reflected a system's approach. They wrote:

> 'Cultural competence' in health care entails: understanding the importance of
> social and cultural influences on patients' health beliefs and behaviors;
> considering how these factors interact at multiple levels of the health care delivery
> system…; and, finally, devising interventions that take these issues into account
> to assure quality health care delivery to diverse patient populations (Betancourt, et
> al., 2003, p. 297).

This system's approach to cultural competence was similar to some nursing researchers

(Burchum, 2002; Purnell, 2005). In addition, researchers denoted interventions for

sociocultural barriers at three levels that incorporate cultural competence (Betancourt, et

al., 2003). At the organizational level, an intervention was to recruit ethnically diverse

physicians. At the structural level, data collection was viewed as a sociocultural

assessment of the patient population. At the clinical level, the researchers recommended

educating physicians in cultural competence, incorporating a combination of knowledge

related to specific cultures along with communication skills necessary to most effectively

interact with these groups. This emphasis on cultural knowledge and communication

skills in medicine was similar to a debate in the nursing literature which is discussed in the following section.

  Dimensions of cultural competence. Published definitions and characteristics of cultural competence in the nursing literature incorporated two main components: (a) cultural knowledge and (b) provider attitude during the patient interaction. Many transcultural nursing experts included cultural knowledge, among other factors, as necessary to provide culturally competent care (Campinha-Bacote, 2002; Giger & Davidhizar, 2004; Leininger, 1978; Purnell, 2005). However, stereotyping could be an issue when viewing the patient as a member of a cultural group with particular beliefs rather than as an individual (Dreher & MacNaughton, 2002) and could lead to a "recipe approach to patient care" (DeSantis, 1994, p. 711). Experts in medical academe identified cultural competence as a "skill set for more effective provider-patient communication" (Betancourt, Green, Carrillo, & Park, 2005, p. 501) and expressed dismay at a "recipe approach" of learning about different cultural groups (Betancourt, et al., 2005; *Culturally competent medicine: An American perspective*, 2008).

  Transcultural nursing experts acknowledged the importance of treating people as individuals (Andrews & Boyle, 1995; Campinha-Bacote, 2002; Giger & Davidhizar, 2004; Leininger, 1978; Purnell, 2005); yet, cultural knowledge of a group could lead to the identification of cultural differences between the nurse and the patient. This identification of differences is beneficial. According to DeSantis (1994), culturally competent nurses were open to differences in culture and view the patient as a teacher

and the nurse as a learner. This view of patient as culture educator for the provider was apparent in other transcultural nursing literature (Andrews & Boyle, 1995; Leininger, 2001; Purnell, 2005) as well as a research study of physicians (Shapiro, Hollingshead, & Morrison, 2002). In a concept analysis of cultural competence, Smith (1998) noted that although cultural knowledge was useful and was part of Smith's concluding definition, it was not an essential component of cultural competence. In research findings of nurses who cared for Mexican farm workers (Kim-Godwin, et al., 2006), knowledge was a component of cultural competence, although not the most essential component. Caring and sensitivity in the interaction were more important (Kim-Godwin, et al., 2006).

Provider attitudes such as openness, respect, and flexibility were important characteristics that contributed to cultural competence in health care (de Chesnay, Wharton, & Pamp, 2005). Researchers have identified provider attitudes in research studies and incorporated attitudes prominently in concept analyses of cultural competence (Burchum, 2002; DeSantis, 1994; Fernandez et al., 2004; Shapiro, et al., 2002; Warda, 2000). In research studies of patients' perceptions of care, the provider's attitude of listening and taking time was more important than cultural knowledge in encounters with Mexican American domestic abuse victims (Belknap & Sayeed, 2003) and English-speaking patients of primary care physicians and residents (Shapiro, et al., 2002).

Tucker and colleagues developed the term "cultural competence plus" (Tucker, Mirsu-Paun, et al., 2007, p. 610) which was patient-centered, culturally sensitive health care and included evaluating the patient's perception of receiving patient-centered,

culturally sensitive care (Herman et al., 2007). This approach presented the two concepts,

PCC and cultural competence, clearly as overlapping. In the discussion of their model,

the Patient-Centered Culturally Sensitive Health Care Model, Tucker and colleagues

(Tucker, Herman, et al., 2007) noted many culturally sensitive qualities, respect,

attention, and individualized care, were universal and not culture specific. However, the

patient needed the means to convey expectations and give feedback to the provider on the

patient's level of satisfaction with patient-centered, culturally sensitive health care. This

mechanism of feedback made this cultural competence plus. In addition to the

opportunity for the patient to express expectations and provide feedback, cultural

competence plus included (a) provider staff behavior and attitudes that were patient–

desired, (b) respectful policies and healthcare environment, (c) patient-provider

partnership, and (d) patient empowerment. In the partnerships, the provider should

display compassion and empathy and be responsive to patient values and needs, while the

patients should express their values, preferences, and needs. Patient empowerment is a

sense of control.

Tucker and colleagues (Tucker, Mirsu-Paun, et al., 2007) developed a measure to

use in the primary care physician office to measure patient-centered, culturally sensitive

health care from the patient's perspective. The researchers held 20 focus groups with

African Americans (n=52), Hispanics (n=45) and non-Hispanic White Americans (n=38);

most participants were low income (Tucker, Mirsu-Paun, et al., 2007). Using the results

of the focus groups, the researchers developed the Tucker-Culturally Sensitive Health

Care Inventory (T-CUSCHI). The T-CUSCHI contained three scales: (a) Provider

Behaviors and Attitudes, (b) Office Staff Behaviors and Attitudes, and (c) Center Policies

and Physical Environment Characteristics. The goal of the researchers was to develop a

tool for each group- African Americans, Hispanics, and non-Hispanic White Americans.

The researchers were unable to test the tool on Hispanics due to a small sample size, but

did carry out a pilot test with African Americans (n=88) and non-Hispanic White

Americans (n=91) to test those versions of the tool. The tools demonstrated test-retest

reliability (African American version 0.97-0.99; non-Hispanic White American version

0.97-0.99) and internal consistency (African American version Cronbach alpha 0.95 –

0.98; non-Hispanic White American version 0.92- 0.99) and the researchers concluded

these were helpful in assessing the patient perspective of culturally competent PCC in the

physician's office. This is important since PCC may lead to improved health outcomes,

increased adherence, and decreased errors due to communication problems (Tucker,

Mirsu-Paun, et al., 2007).

Tucker and colleagues (Tucker, Marsiske, Rice, Nielson, & Herman, 2011) used

the T-CUSCHI African American and Caucasian American versions in model testing of

the literature-based model Patient-Centered Culturally Sensitive Health Care. The sample

consisted of African Americans (n= 110, 25 men, mean age 51, range 18-85 years) and

Caucasian Americans (n=119, 39 men, mean age 55, range 20 to 89 years) with

hypertension who had clinic visits or responded to a television advertisement. Findings

indicated African Americans that rated the provider as more culturally sensitive was

associated with reporting perceptions of trust in provider, satisfaction with care, health promoting lifestyle, and dietary adherence, but not medication adherence. The researchers were unable to obtain data related to clinical outcomes on the sample. Limitations of the study were the small sample size which precluded using structural equation modeling, and some questions of instrument validity. The authors noted the high correlation among scale scores and noted possible overlap in the constructs of trust, satisfaction and cultural sensitivity.

Operational definition of cultural competence. After a review of the literature, an operational definition of cultural competence was developed incorporating provider attitude, cultural knowledge and the outcome of patient satisfaction. Cultural competence is a process of interaction with people of the same or different culture and incorporates communication skills, attitudes of openness, trust, respect and experiencing the patient as culture teacher in the encounter. The provider integrates culture into care through flexible, adaptive, problem-solving that results in quality care, patient satisfaction, improved health outcomes and provider's personal and professional growth. It requires a caring attitude, self-awareness, and cultural knowledge that is always developing.

The antecedents of cultural competence are (a) a caring attitude which is essential in nursing (Leininger, 1978), (b) self-awareness of one's own beliefs and values (Campinha-Bacote, 2002; Smith, 1998), and (c) knowledge of other cultures (Campinha-Bacote, 2002; Giger & Davidhizar, 2004; Leininger, 2001; Purnell, 2005; Smith, 1998; Suh, 2004). Of note, cultural knowledge is an important aspect of cultural competence;

however, as presented here, it is an antecedent. Cultural competence is a process,

therefore, as the provider incorporates an attitude of openness and a view of the patient as

culture teacher in encounters, cultural knowledge increases and the provider will

approach the next encounter more enriched than the last.

Consequences of cultural competence are (a) patient satisfaction with provision of

quality care (Leininger, 2001; Smith, 1998; Suh, 2004), (b) improved health outcomes

(Smith, 1998; Suh, 2004), and (c) provider personal and professional growth and

satisfaction (Smith, 1998; Suh, 2004). These consequences reflect the patient as the

recipient of care as the major focus of cultural competence. Since care is based on

culture, members of the cultural group are the best judge of whether care is good

(Andrews & Boyle, 1995).

The next section reviews research studies related to cultural competence in

general while later sections in this chapter review cultural competence and the Hispanic

population.

Cultural competence and research studies. In 2002, researchers (Betancourt, et

al., 2005) interviewed experts (n=37) in cultural competence from academe (medical

schools), managed care and government entities using structured interview questions.

Review of the interview transcripts revealed themes and recent trends in education,

policy and the practice of cultural competence. Experts in academe identified cultural

competence as the development of communication skills while government experts saw it

as an avenue for increased quality care access for all patients and managed care experts

saw it as improved outcomes and cost control. All experts noted a clear link between cultural competence and the elimination of healthcare disparities but acknowledged other factors also contributed to healthcare disparities. Academe experts reported little research on cultural competence interventions and outcomes and Betancourt and colleagues (2005) saw the emergence of cultural competence into the mainstream as an avenue to improve quality.

In the field of medicine, Shapiro, Hollingshead, and Morrison (2002) completed a qualitative study (content analysis) of beliefs about culturally competent communication in the doctor-patient interaction. Using focus groups, researchers interviewed five groups of physician faculty (n=24), three groups of physician residents (n=27), and two groups of patients (n=14). The patients were low-income and received care at the primary care community clinic in Irvine, California where the residents and faculty practiced. The patient groups were composed of 21% low-income non-Hispanic White, 14% Latino, 7% African, 7% African-American, and 50% Native American Indian. The physician groups were composed of 34% non-Hispanic White, 40% Asian and the remainder from other ethnic backgrounds. The findings identified from the focus groups were the physicians described culture communication in both culture-specific elements and generic terms while the patients emphasized generic skills and attitudes only. Patients did not refer to culture even when prompted by group facilitators and they discounted the need for ethnically matched providers. Physicians and patients both noted appropriate skill and attitude development was the key to successful communication. Faculty mentioned

patients should be viewed as culture educators; residents found it beneficial to treat the patient as an individual rather than generalizing based on ethnicity. Residents also mentioned the need to display respect, take time, develop trust, and give the patient a sense of control. These reflect components of PCC (Institute of Medicine, 2001). Patients stated they wanted a physician to listen carefully and display empathy, trust and respect. Researchers noted a limitation of the study was the small sample size of patients and the exclusion of non-English speakers. Unfortunately, the perceptions of non-English speaking patients were not shared in this study on culturally competent communication. However, based on these results, it appears that culturally competent communication encompasses the dimensions of PCC and does not focus on cultural specifics. In addition, this supports the importance patients and providers place in the role of trust in culturally competent care.

In a non-experimental, quantitative study, Fernandez and colleagues (2004) explored primary care physicians' self-reported Spanish language ability and cultural competence and the effect on their Spanish-speaking Latino patients' ratings on interpersonal care. Bilingual research assistants met face to face with Spanish-speaking Latino patients with diabetes (n=116) in San Francisco primary care clinics to administer the 22-item communication portion of the Interpersonal Processes of Care (IPC) in Diverse Populations instrument (Stewart & Napoles-Springer, 1999). No psychometric evidence was provided regarding the instrument. The patients' physicians (n=48) completed a 3-item questionnaire: one item related to language ability and two items

concerning cultural competence (Cronbach alpha 0.75). Findings indicated that if the

physician self-rated a higher level of Spanish-speaking ability and cultural competence,

the Spanish-speaking patient was more likely to report better interpersonal processes of

care. In bivariate analysis, a statistically significant finding was if the physician self-rated

Spanish language ability as *excellent/good* then the Spanish-speaking Latino patient was

more likely to rate the physician as optimal on *elicitation problems and concerns* (OR

4.3, 95% CI 1.75 to 10.56). In multivariate analysis when adjusted for physician

characteristics of ethnicity, gender and training and patient characteristics of age, gender,

years with diabetes, and years with physician, the adjusted odds ratio was even higher

5.25 (95% CI 1.59-17.27) for physician self-rating *excellent/ good* language ability and

likelihood of patient also rating an optimal level in *elicitation problems and concerns*.

The researchers recommended that Spanish language skills and skills in cross-cultural

communication be taught in medical school. Unfortunately, the study did not explore

cultural competence independent of language skills since English-speaking Latinos were

excluded. However, they did assess physician self-rated ability with other patient

population groups such as White, African American and Chinese and determined the

effects were population specific to Latinos and not just general communication skills.

Other researchers used the IPC to explore the client's perception of community

nurse's cultural competence and identify similarities between client and community nurse

perceptions of cultural competence in North Carolina using a quantitative descriptive

survey design (Starr & Wallace, 2011). Researchers used the Model of Culturally

Congruent Care (Schim, Doorenbos, Benkert, & Miller, 2007) based on Leininger's

theory of Culture Care Diversity and Universality (Leininger & McFarland, 2006) as the

theoretical framework. A convenience sample of clients from the health department was

recruited (n=69, mean age 25 (SD 7.8); 97% female; 61% non-Hispanic White, 25%

Hispanic, 12% African American; 75% prefer English, 22% prefer Spanish; 59% only see

RN at clinic). A convenience sample of nurses were recruited from the health department,

hospice, and home care agencies (n=71; gender not specified, mean age 47.5 (SD 9.4);

94% non-Hispanic White; 59% associate degree highest degree; 54% employed in health

department; 89% participated in cultural diversity training). To measure client perception

of community nurse's cultural competence, clients completed the Interpersonal Processes

of Care Survey: Short Form (IPC-18) (Stewart, Napoles-Springer, Gregorich, & Santoyo-

Olsson, 2007) available in English or Spanish (n=15 completed Spanish version). The

IPC-18 has 18 items to measure the interpersonal relationship between provider and

client; the researchers received permission to change the wording from *physician* to

nurse. The IPC-18 has 3 domains (a) communication (7 items), (b) participatory decision

making (2 items), and (c) interpersonal style (5 items). This only totals 14 items and no

further explanation was provided in the article about the additional four items. However,

based on a review of the IPC-18 (Stewart, et al., 2007), it appears the authors did not use

the four items in the interpersonal style domain related to disrespectful office staff.

Responses on the IPC-18 tool items are on a 5-point Likert-type scale, 1 (never) to 5

(always), with some items reverse scored. The scores are averaged and a higher score

indicates higher interpersonal processes of care. The IPC-18 had good internal reliability (Cronbach alpha =.84) in the study. To measure the community nurse's perception of cultural competence, the nurses completed the Cultural Competence Assessment tool (Schim, Doorenbos, Miller, & Benkert, 2003) based on Leininger's theory of Culture Care Diversity and Universality. The Cultural Competence Assessment tool has 25 items in two subscales: cultural awareness/sensitivity (11 items) and culturally competent behaviors (14 items). The cultural awareness/sensitivity subscale is scored on a 7-point Likert type scale, 1 (strongly disagree) to 7 (strongly agree) with some items reverse scored. The culturally competent behavior subscale is scored on a 7-point Likert-type scale, 1 (never) to 7 (always). The scores on each subscale are averaged and a higher score indicates higher cultural awareness/sensitivity or higher culturally competent behavior. In addition, the researchers provided one self-assessment of cultural competence item, scored on 5-point Likert-type scale, ranging from 1 (very incompetent) to 5 (very competent) and two diversity encounter items, one item to identify racial/ethnic groups and one item to identify special population groups (e.g. mentally ill, religious group, homeless) the nurse met in the last 12 months in the nurse's practice setting.

Findings indicated the clients rated the community nurses very high in all three domains (communication mean=4.46 (SD 0.6); participatory decision-making mean=4.04 (SD 1.2); and positive interpersonal style mean=4.59 (SD 0.72)) (Starr & Wallace, 2011). There were no statistically significant differences in mean scores based on independent sample t-tests between Hispanics (n=17) and other groups (n=52) or between those

completing the Spanish version (n=15) and those completing the English version (n=54).

The authors did not provide the mean scores of the separate groups or power analysis

calculations, however, the communication domain was the domain closest to approaching

significance for both the Spanish version users compared to English version users

(p=0.178) and the Hispanics compared to other groups (p=0.130). The community nurses

scored moderately high for cultural awareness/ sensitivity (mean=5.97 (SD 0.42)) and

moderate for culturally competent behavior (mean=5.21 (SD 1.01)) yielding overall a

cultural competence score that was moderately high (mean= 5.53 (SD 0.67)). On the one

self-rating cultural competence score, the nurses rated themselves moderately high as

well (mean=4.25 (SD 0.63)). The authors noted similarities in the client and nurse

perceptions of culturally competent care. However, in reviewing the table provided in the

article noting the similarities, nurses rated 57% for communication domain whereas

clients rated the nurses at over 90% on the communication items. In addition, the Cultural

Competence Assessment tool completed by the nurses included items related to culture

barriers and adaptation whereas the IPC-18 tool completed by the clients did not include

such items. The authors noted a limitation of the study was sampling only those persons

who had access to care and the nurses who volunteered for the study may have been more

likely to be interested in providing culturally competent care. The authors noted the lack

of clients from hospice and home care and provided a rationale as to why these clients

may have declined to participate. However, there was no mention of recruitment efforts

for these particular groups of clients in the published article. Additional limitations of the

study not addressed by the authors are related to the client sample recruited. First, there was a high number of female participants (97% of sample). The clients were recruited from the health department which provided many female-based services (prenatal care, family planning, Women Infants and Children (WIC)) yet some clients were recruited from general care (27% of client sample). Another limitation was 61% of the sample was non-Hispanic White. It seems for a study related to perceptions of cultural competence, the researchers should have oversampled from minority racial and ethnic groups. This study does provide some evidence that the client and nurse have similar perceptions of the nurse's cultural competence with clients rating the nurses highly in the community setting.

Summary Patient-Centered Care and Cultural Competence

PCC and cultural competence are overlapping concepts with cultural competence reflecting an approach of PCC for all groups, especially the more vulnerable, underserved groups. Cultural competence is not clearly defined in the literature with an ongoing debate related to the importance of knowledge of specific cultural groups in addition to provider attitude and communication skills. Both PCC and cultural competence should be evaluated from the patient's perspective and studies should not exclude LEP patients. An outcome of cultural competence and PCC is patient satisfaction and trust is an important component of both cultural competence and PCC. The next section discusses Hispanic culture including nursing research studies related to culturally competent care with Mexican American patients.

Hispanic Culture and Culturally Competent Care

Hispanics are the largest ethnic group in the U.S. and the Hispanic population is growing. In 2004, Hispanics were 14.2% of the total U.S. population and White non-Hispanics were 67.3% (U.S. Census Bureau, 2007). In 2010, Hispanics were 16% of the total population and White non-Hispanics were 64% (U.S. Census Bureau, 2010a). The U.S. government coined the term *Hispanic* which is defined as "a person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin regardless of race" (U.S. Census Bureau, 2007, p. 1). The terms *Hispanic* and *Latino* are often used interchangeably. Mexicans are by far the largest subgroup of Hispanics. In 2004, Mexicans were 9.1% of the total U.S. population and the next largest Hispanic subgroups were Puerto Ricans (1.4%) and Cubans (0.5%) (U.S. Census Bureau, 2007).

The U.S. Census Bureau collects data on people's race and ethnicity. The ethnicity option is Hispanic origin *No* or *Yes*, with additional *Yes* options to denote subgroups of Hispanics: Mexican, Puerto Rican, Cuban or *Other* (fill in the blank). The race options are *White, Black, Native American* or *Alaskan Native* and nine additional Asian or Pacific Islander categories (i.e. Japanese, Chinese) (U.S. Census Bureau, 2009c). In research with Hispanics, it is important to specify the ethnic sub-group such as Mexican since each sub-group has unique cultural characteristics and histories (Jani, Ortiz, & Aranda, 2009; Smedley, et al., 2003; Thomson, et al., 2006). The next section addresses Hispanic culture in general and then briefly addresses the differences between the three largest Hispanic subgroups: Mexicans, Puerto Ricans and Cubans. This is

followed by research studies related to Mexicans, the largest subgroup of Hispanics and the focus of this study.

Hispanic Culture Overview

Every person is a unique individual, however, for the purpose of culture discussion, it is necessary to deal in generalizations. Americans, Mexicans, Cubans, and Puerto Ricans all have great pride in their respective heritage and culture (Purnell & Paulanka, 2003c). Nevertheless, Hispanic groups such as Mexicans, Puerto Ricans and Cubans in the U.S. share several beliefs and values that are different from the dominant European American culture (referred to as American culture).

Components of Hispanic culture. Traditionally, Hispanics speak Spanish, are predominantly Catholic, and place a high importance on family (familism) (The National Alliance for Hispanic Health, 2001). Americans speak English, are predominantly Christian (i.e. Protestant, Catholic), and place a high value on the individual and independence (Purnell & Paulanka, 2003a). The Hispanic family is patriarchal and the extended family live together; the American family is egalitarian and adult children (over age 18) are expected to move out and become independent (Purnell & Paulanka, 2003c). *Compadrazgo* (fictive kin) is an important component of familism and social support in the Hispanic culture (Gill-Hopple & Brage-Hudson, 2012). *Compadrazgo* refers to kin relationships of extended family and friends that incorporate the same level of reciprocity and respect as the relationship between parent and child (Gill-Hopple & Brage-Hudson, 2012). Traditionally, the Hispanic culture values *machismo,* men as strong and confident,

while the dominant American culture has a perception of equal roles for men and women

(Purnell & Paulanka, 2003c). In the Hispanic culture, the older female in the family

provides health advice and the whole family visits the hospital and is involved in health

decisions (Purnell & Paulanka, 2003c). However, usually there is one person (older male,

husband) in the family who is the decision maker and this person can be helpful in

promoting the patient's adherence to the plan of care (Martinez-Schallmoser, MacMullen,

& Telleen, 2005). *Compadrazgo* (kin) provide social and emotional support in times of

illness and hospitalization (Gill-Hopple & Brage-Hudson, 2012; Martinez-Schallmoser,

et al., 2005). In the American culture, the individual may not even disclose health

information to another family member and individuals closely protect their privacy.

Other important components of the Hispanic culture that are different from the

American culture affect interpersonal relationships. The American culture is a low touch

society and people expect a spatial distance of 18 inches (Purnell & Paulanka, 2003a).

The Hispanic culture is a high touch society and includes (a) *personalismo*, a preference

for personal relationships not institutional ones; (b) *simpatia*, friendly, positive

relationships; (c) *confianza*, trust in others based on a close relationship as a family

member or friend; and (d) *respeto*, respect for others based on age and social standing

(Purnell & Paulanka, 2003b; The National Alliance for Hispanic Health, 2001). In the

American culture, individuals willingly share personal information with healthcare

providers; Hispanics may not share personal information with the healthcare provider

until they have established a relationship and develop trust (*confianza*) (The National Alliance for Hispanic Health, 2001).

Additional components of the Hispanic culture that affect health care are time perception, locus of control, and use of folk medicine. Hispanics view time as relative compared to the American value of timeliness to an appointment (Purnell & Paulanka, 2003a). Hispanics have a present orientation and external locus of control compared to Americans that have a future orientation and an internal locus of control (Purnell & Paulanka, 2003c). For this reason, in general, Hispanics may not be concerned about disease prevention since they live in the moment and illness is seen as out of their control and the will of God. However, in a grounded theory study with Mexicans, Warda (2000) identified a combination of internal and external locus of control which was coined *spiritual dualism,* a relationship with God but also individual control over one's own life.

Folk medicine has a prominent place in Hispanic culture. Although Americans also have folk medicine practices such as the use of herbal tea, Hispanics strongly believe in a mind, body, spirit connection (The National Alliance for Hispanic Health, 2001). Hispanics consult folk healers and spiritualists although there are variations among Hispanic ethnic groups (Purnell & Paulanka, 2003c). Mexicans consult the *curandero* (folk healer), *yerbero* (herbalist) or *sobador* (manipulation and massage) (Zoucha & Purnell, 2003) whereas Puerto Ricans consult *Santeros* (practitioners of *Santería*) for health promotion and personal growth and *espiritistas* (spiritualist) to communicate with spirits and evil forces (Juarbe, 2003). When Cubans are ill, they may include rituals from

Santería, an African-Cuban practice that combines African rituals with Catholic saints, and consult staff at *botanicas* (herb and religious shops) (Purnell, 2003). Mexicans and Puerto Ricans believe in the "hot and cold" theory of food related to illness (Juarbe, 2003; Zoucha & Purnell, 2003). Generally, "hot" illnesses are caused by vasodilatation and "cold" illnesses by vasoconstriction. An example of a "hot" illness is hypertension and it is treated with "cold" foods such as fresh fruit, fish, and dairy products. An example of a "cold" illness is pneumonia and it is treated with "hot" food such as cheeses, onions, liquor, and spicy foods (Zoucha & Purnell, 2003). Finally, Americans rely on over the counter medications or prescriptions obtained from healthcare providers and filled by pharmacists whereas members of the Hispanic communities also use *tiendas* (shops) or *bodegas* (shops) to purchase medications without a prescription such as antibiotics to treat their illnesses (Gentry et al., 2007; Larson, Dilone, Garcia, & Smolowitz, 2006; Purnell & Paulanka, 2003c).

Differences among Cubans, Mexicans and Puerto Ricans. Differences among Cubans, Mexicans and Puerto Ricans in the U.S. are related to immigration status, education and employment, and access to health care. Immigration status affects access to government programs, employment and health care. Puerto Ricans are U.S. citizens and can come and go freely; many come for economic and quality of life reasons (Juarbe, 2003). Many Puerto Ricans live in the northeastern part of the U.S and in large cities such as Chicago and New York (Juarbe, 2003). Since becoming a socialist country in 1959, Cuban immigrants have been warmly received by the U.S. government with unique

programs to assist them upon their arrival such as the Cuban Refugee Program (Purnell, 2003). Cubans emigrate to the U.S. for political and economic reasons and they are the largest ethnic group in Miami, Florida (Purnell, 2003). Mexicans emigrate for economic reasons with the more recent immigrants being poorer than those in previous waves of immigration (Zoucha & Purnell, 2003). Half of the over 5 million undocumented people in the U.S. come from Mexico (Zoucha & Purnell, 2003). Many Mexicans live in the south and west regions of the U.S. and 90% live in urban areas such as Chicago, New York and Los Angeles (Zoucha & Purnell, 2003). Of note, although Mexicans speak Spanish, in Mexico there are 500 dialects and 54 indigenous languages (Zoucha & Purnell, 2003).

Traditionally, in the American culture, education is highly valued (Purnell & Paulanka, 2003a). Level of education affects choices for employment and, consequently, level of income and access to insurance. Cubans in the U.S. have a median age of 41.0 years which is older than other Hispanics (Mexicans median age 25.7 years; Puerto Ricans median age 29.1 years) and slightly older than non-Hispanic Whites in the U.S. (median age 40.6 years) (U.S. Census Bureau, 2009a). Cubans and Puerto Ricans value education (Juarbe, 2003; Purnell, 2003). While Mexicans place value on education as well, other factors may be a higher priority, such as working to support the family. Education is not needed to obtain work in Mexico where the average level of education is fifth grade (Zoucha & Purnell, 2003). Mexicans have the highest percentage of people over age 25 without a high school diploma in the U.S. (46.5%) compared to Puerto

Ricans (28.4%), Cubans (25.9%) , Blacks (20.7%) and non-Hispanic Whites (11.1%)

(U.S. Census Bureau, 2009a). Consequently, Mexicans also have the lowest percent of

people that have finished college and have at least a baccalaureate degree (8.4%)

compared to Puerto Ricans (14.9%), Cubans (24.7%), Blacks (16.9%) and non-Hispanic

Whites (30.0%) (U.S. Census Bureau, 2009a). As additional evidence of the value Puerto

Ricans place on education, the literacy rate in Puerto Rico is 90%. Puerto Ricans are

more likely to be bilingual, learning English in school from kindergarten through high

school. Only 20.6% of Puerto Ricans in the U.S. do not speak English well compared to

Cubans (42.7%) and Mexicans (41.3%). The more educated are more likely to assimilate

and learn the language (Purnell & Paulanka, 2003c). Second generation Hispanics

(children of immigrants) are more likely to speak English and be more educated (Purnell

& Paulanka, 2003c).

In the U.S., Cubans tend to be self-employed entrepreneurs within the Cuban

community or employed in management, service or sales (Purnell, 2003; U.S. Census

Bureau, 2009a). Likewise, Puerto Ricans are employed in management, service and sales

(U.S. Census Bureau, 2009a). In general, Mexicans in the U.S. do not prefer the

leadership roles of management (Zoucha & Purnell, 2003), and are employed in service,

sales and unskilled labor such as construction or transportation (U.S. Census Bureau,

2009a). Only 3.5% of Mexicans in the U.S. are in agriculture or forestry jobs which

includes migrant farm work; however, this is much higher than non-Hispanic Whites

(0.5%), Cubans (0.3%) and Puerto Ricans (0.2%) (U.S. Census Bureau, 2009a). Between

2005 and 2007, Mexicans over the age of 16 years had the highest rate of employment (62.6%) compared to Cubans (56.3%), Puerto Ricans (54.2%), Blacks (54.4%) and non-Hispanic Whites (60.6%) (U.S. Census Bureau, 2009a). However, the percentage of families in poverty was higher among Mexicans (20.8%) than Cubans (11.3%) and non-Hispanic Whites (6.1%); however, Puerto Ricans (21.8%) and Blacks (21.8%) also had a higher percentage of families in poverty. Although Mexicans are more likely to have a job, it is for lower wages. Mexicans work to survive and place a higher value on family activities (Zoucha & Purnell, 2003). Mexicans had a median household income of $38,823 which is slightly more than Puerto Ricans ($37, 152) but less than Cubans ($42,909) and non-Hispanic Whites ($54,189) (U.S. Census Bureau, 2009a). Of note, it is considered taboo in the Mexican culture to discuss income (Zoucha & Purnell, 2003). For example, in the 2005 Health Information National Trends Survey (HINTS), a telephone survey, 37% of Latinos did not report income and 38% did not report age of arrival or years in residence in the U.S. (Andreeva et al., 2009).

All Hispanic groups face the same barriers to access to health care: language barriers, wait times, and bureaucracy (Juarbe, 2003; Purnell, 2003; Zoucha & Purnell, 2003). Other barriers to seeking treatment from doctors are cost and legal status (Larson, et al., 2006). Culturally appropriate interventions that may help are use of *prometoras* (community members that promote health) in educational interventions, a focus on family rather than the individual and bilingual offerings in both Spanish and English (Jani, et al., 2009). Generally, Cubans are the only Hispanic subgroup that uses preventive services

such as cancer screenings, immunizations, and prenatal care in the U.S. (Purnell, 2003).

This is attributed to their experience with an excellent preventive service program in

Cuba (Purnell, 2003). In general, Puerto Ricans and Mexicans do not seek preventive

services such as early prenatal care and tend to require acute care in the emergency

department (Juarbe, 2003; Zoucha & Purnell, 2003). The Hispanic groups have slightly

different responses to pain. Cubans and Puerto Ricans are verbal and loud similar to

European Americans such as Italian Americans. Mexicans are more stoic which is similar

to another European American group, Irish-Americans (Purnell & Paulanka, 2003a).

Cubans take on the sick role easily and receive much attention from family whereas

Mexicans only seek care if they can no longer work (Purnell, 2003; Zoucha & Purnell,

2003). Mental illness carries a stigma in the Puerto Rican culture yet Mexicans consider

it similar to physical illness (Juarbe, 2003; Zoucha & Purnell, 2003).

Finally, in general, Hispanics, like African Americans, tend to mistrust

researchers (Jani, et al., 2009). Some researchers have noted Hispanics and African

Americans display extreme response patterns when answering survey questions (Dayton,

Zhan, Sangl, Darby, & Moy, 2006; Marín, Gamba, & Marín, 1992). Extreme response

refers to choosing the numbers at the ends of the continuum, for example choosing 1 or 4

on a 4-point Likert- type scale, rather than choosing the middle options 2 or 3.

Researchers recommended including some expectation type questions in surveys as

expectations are a factor that may affect survey response (Dayton, et al., 2006).

Expectations are based on attitudes, experiences and beliefs which may be shared by

racial/ethnic groups (Dayton, et al., 2006). Likewise, researchers should ensure that measures and interventions are culturally relevant (Jani, et al., 2009).

The next section reviews research studies related to cultural competence and care of Mexican American patients.

Mexican Americans and Culturally Competent Care

Culturally competent nursing care has been the subject of several qualitative studies related to Mexican Americans. The patient's perspective and their description of expectations in the healthcare encounter are most important since only the recipient of care can judge if it was culturally competent. In addition, one study discussed below is from the nurse's perspective when caring for the Mexican American patient.

In 1991, Stasiak (2001) completed a pioneering ethnonursing study of Mexican Americans and their use of folk medicine, based in Culture Care theory (Leininger, 2001) as the framework. Five key informants and 10 general informants were interviewed in either English or Spanish. Fourteen of the 15 informants were second generation Mexican American; all were from the Mexican American community within urban Detroit. Using qualitative analysis, Stasiak identified four themes: (a) involvement of family, (b) care, (c) importance of folk practices, and (d) significance of religion to promote healing. The first theme revealed caring involved family and *compadres* (close friends) with a lack of trust of strangers and medical professionals and in which the nurse demonstrated respect by speaking Spanish and using a formal address such as *Señor* or *Señora*. The second theme was "Care means 'everything or almost everything'" (Stasiak, 2001, p. 191). The

third theme was the importance of folk practices to promote healing and caring. The last theme was similar with all informants revealing the use of religion with folk care to promote healing. A key finding was most informants stressed the importance of the nurse speaking Spanish. Another finding was the importance of developing *confianza* (trust); however, due to shortened hospital stays this makes it more difficult to develop since *confianza* develops over time. This ethnonursing study included quantitative measures such as percent of informants whose comments contributed to a theme. The validity of the findings was only briefly addressed; saturation was listed among five of Leininger's qualitative criteria but without supporting statements. The other criteria were "credibility, confirmability, meanings-in-context, [and] recurrency" (Stasiak, 2001, p. 189). This study was important as one of the first related to Mexican Americans perceptions of health care.

Zoucha (1998) completed an ethnonursing research study focusing on Mexican Americans who have experienced professional nursing care in an outpatient surgery center in the southwestern U.S. Using Culture Care theory (Leininger, 2001) as a framework, Zoucha interviewed 15 key informants and 25 general informants in English or Spanish. The key informants were patients, the general informants were family that accompanied the patients (n=15) and healthcare staff (n=10) including six non-Mexican American nurses. Zoucha identified three themes. The first theme was Mexican Americans expected nurses to be friendly, respectful and personal. The second theme was characteristics of noncaring nurses as not listening, completing tasks in a rushed manner,

not attempting to communicate in Spanish and build a relationship with the patient, and

not showing respect for Mexican American patients. The third theme was the nurse must

earn *confianza* (trust) through time spent with the patient and becoming personal. The

patient would be more likely to ask questions once *confianza* was established. Lack of

confianza could lead to negative health outcomes for the patient. This is similar to

previous findings that the nurse should attempt to speak Spanish and earn *confianza*

(Stasiak, 2001). Similar to Stasiak (2001), Zoucha did not go into detail about the validity

of the study, but did note using Leininger's six criteria "credibility, confirmability,

meaning in context, recurrent patterning, saturation, and transferability" (Zoucha, 1998,

p. 38). This study was important since the focus was on nursing care specifically.

In another ethnonursing study using Culture Care theory as the framework,

Belknap and Sayeed (2003) explored domestic violence screening in Mexican immigrants

in the U.S. The researchers, using an interpreter, interviewed seven Mexican immigrant

women who had experienced abuse from intimate male partners and were receiving

outreach services. The women reported they had never been asked about their abuse

while in the healthcare setting. These themes revealed characteristics of the nurse or

doctor that would lead to confidence for Mexican American women in discussing abuse

issues. Themes were presence, taking time to listen, and showing an interest in the

client's life. These reflect qualities of *respeto* (respect), *personalismo* and *simpatia* which

can lead to *confianza.* Although culturally congruent care was a prominent concept in this

study, cultural knowledge was not mentioned. Unfortunately, the researcher used the

research questions as a framework to code the transcripts and develop the themes. This severely limited discovery of new themes from participants, the goal of an ethnonursing research study.

Clark and Redman (2007) completed an ethnographic research study of mothers of Mexican descent to explore their expectations of the U.S. healthcare system in the Rocky Mountain West. Researchers interviewed participants (n=28, Spanish speaking only n=13, English speaking only n=5, bilingual n=10) an average of 6.7 times over 19 months and the study lasted 5 years. The Los Angeles Epidemiologic Catchment Area (LAECA) acculturation rating scale was used to determine the women's level of acculturation to U.S. culture. Almost half the women were low acculturation to U.S. culture (46%), others were bicultural (25%) and the remainder was labeled acculturated (29%). Interviews were conducted in English or Spanish. Data analysis throughout the study process incorporated a systematic constant comparative method similar to classical grounded theory (Glaser & Strauss, 1967). Researchers identified nine categories with six categories overlapping for both acculturated and lesser acculturated women. The overlapping categories were: (a) *Individualized Care*; (b) *Expectations for Information and Health Education*; (c) *Relationship-Centered Health Care*; (d) *Convenient, User-Friendly Health Care*; (e) *Provider Characteristics*; and (f) *Understanding of the Health Care System*. These categories reflect dimensions of PCC – individualized care, information, coordination, continuity (Gerteis, et al., 1993). In interviews with the Mexican immigrant mothers, the researchers identified three additional categories: (a)

Cultural and Linguistic Expectations, (b) *Access and Financial Elements*, and (c) *Time*. These reflect barriers noted by all Hispanic groups (Purnell & Paulanka, 2003c) and similar to previous findings with Mexican American participants (Stasiak, 2001; Zoucha, 1998). All the Spanish-speaking mothers identified language barrier as an issue and some preferred a Spanish-speaking provider so they could advocate better for their child's care. The immigrant mothers referred to nurses and physicians as *buena gente*, good people, even though they spoke little Spanish. One limitation of this published study was the researchers relied exclusively on interviews and did not discuss observations in this ethnographic study. However, in general, the study was well done with repeated interviews and a comprehensive explanation of findings in the published report.

Warda (2000) completed a modified grounded theory study of Mexican Americans in the San Francisco area regarding their perceptions of culturally competent care. Four focus groups (n=22) were conducted in either Spanish or English; group sizes ranged from 4 to 7 participants. Three groups were composed of Mexican Americans who had received health care during the past year; the fourth group was composed of Mexican American nurses. Warda did not report the use of theoretical sampling to further explore the emerging concepts but noted the number of focus groups were determined at the beginning of the study and data saturation was not a goal. Warda developed a theory with two main components, *Culturally Congruent Care* and *Incongruent Care*. The core category was Valuation-Disregard Paradox: Patterns of Health Care Experiences which reflected Mexican Americans decision to seek health care and experience in seeking it

(Warda, 2000, p. 209). *Congruent Care* included the sub-categories of *valuing,*

personalismo (friendly relations), *cultural comprehension* (knowledge), and *system*

support. Provider technical skills were not important. The *Incongruent Care* sub-

categories were *discounting, system barriers,* and *blaming*. The outcome of congruent

care was enabling while the outcome of incongruent care was hindering.

Trust was mentioned in the *Congruent Care* category under the subcategory

valuing (Warda, 2000). Mexican American participants noted the importance of trust in

the healthcare provider relationship with the patient and the role of the nurse being

friendly (*personalismo*) to encourage the development of trust. A participant quote to

demonstrate *personalismo* provided by the author also demonstrated the importance of

trust:

> At first I remember that when I first started seeing the nurse, at first I didn't have confidence/trust (*confianza*) with her. There were things I could have shared, but I didn't....I could have avoided a lot of what happened to me....What made it possible for me to share private things with the nurse was that she made me feel comfortable. I felt that she could understand me. I don't know; it was as though she was seeing me as me, my own person, and was interested in my problem (Warda, 2000, p. 212).

This quote includes the importance of being nice, treating the patient as an individual,

listening and the development of trust allowed the patient to confide in the nurse that led

to better healthcare treatment. In discussion, Warda noted Mexican Americans prefer an

"atmosphere of trust and intimacy" in healthcare encounters (2000, p.221).

All groups, including the nurses, identified family support and obligation as an

area of importance for healthcare providers (Warda, 2000) which is similar to Stasiak's

(2001) findings. This value of family is very dominant in Hispanic culture and prevailed despite acculturation to U.S. culture. Other important concepts were *simpatia* (positive, friendly) and *personalismo* which were a preference for pleasant encounters with expressions of caring qualities and feelings. Mexican Americans preferred communication that was "pleasant, kind, human, respectful, professional, and sensitive" (Warda, 2000, p. 211) and a healthcare provider to speak Spanish. This focus on *personalismo* and *respeto* is similar to findings in previous research (Belknap & Sayeed, 2003; Zoucha, 1998). Warda acknowledged that all people regardless of culture would prefer positive interactions; however, the difference is that Hispanics want it more often and want to avoid negative encounters. This supports *personalismo* and *simpatia* as "generic cultural care value" for Hispanics (Warda, 2000, p. 222).

Regarding *Incongruent Care*, Warda (2000) found healthcare providers should acknowledge the importance of family in their care, respect their beliefs, and be aware of life circumstances that affect access to care for Mexican American patients. For example, hindering, an outcome of incongruent care, was due to personal factors such as language, access to care, and a lack of knowledge of the system, consistent with barriers to access to health care identified in the literature previously (Clark & Redman, 2007). *Discounting*, another sub-category of *Incongruent Care*, was defined as "failure to acknowledge client's perceptions" (Warda, 2000, p. 213). Asking the patient their perception of illness was a strategy suggested by Betancourt, Carrillo, and Green (1999) as well when communicating with patients that are from a different culture.

A new concept was *spiritual dualism* which was a relationship with God, but also the "individuals' power to exert control over their lives" (Warda, 2000, p. 216). This new concept was in contrast to previous literature regarding Hispanic culture that focused on fatalism and lack of control. Another new concept was *health care options*. Health care options were determined by the following factors: immigration status, health insurance, language, and knowledge of the health system. Barriers to care arose for patients with limited health system knowledge, monolingual in Spanish, and jobs with low income and no health insurance. Although there are methodological issues with this grounded theory study (saturation), the resulting theory is comprehensive, explained well, and key in filling a gap in the research related to Mexican Americans' perceptions of culturally competent care.

In a qualitative research study based on a phenomenologic approach in 2006, Jones (2008) interviewed emergency nurses related to their experiences caring for Mexican American patients in the Midwest. The opening interview question was "Share a story about an experience you had caring for a Hispanic patient in the past week and how did this patient's culture play a role in providing care to this patient?"(Jones, 2008, p. 201). Five nurses were interviewed, all White, non-Hispanic at least second generation American. One participant spoke some Spanish while the others spoke none or only a few words. The themes revealed were *Language Barrier, Continuity of Care,* and *Limited Knowledge of Hispanic Culture.* Similar to Warda (2000), immigration status impacted the use of follow-up care as revealed in the *Continuity of Care* theme. A key finding was

the participant who spoke Spanish discussed the establishment of a connection with her patients; none of the other participants discussed a nurse-patient relationship. This finding reflects the expectations noted in previous research studies that the nurse should speak Spanish and could earn *confianza* (Belknap & Sayeed, 2003; Stasiak, 2001; Zoucha, 1998). Jones recommended future research regarding the impact of the nurse's Spanish language ability on the nurse-patient relationship. Data saturation in interviews and an audit trail supported the validity of the study.

In another study from the nurse's perspective using a modified Delphi method, Kim-Godwin and colleagues (2006) identified the characteristics needed to provide culturally competent care. First, researchers asked health professionals with expertise in Mexican migrant care (n=17) to define culturally competent care and "the prerequisites of cultural competence in the domains of cultural sensitivity, knowledge, and skills" (p. 28). Unfortunately, providing these domains encourages responses that fall into these categories rather than relying on the experts to provide terms unencumbered. Researchers then mailed surveys to transcultural nursing specialists and health professionals including nurses that care for Mexican migrant farm workers. In the modified Delphi technique, researchers increased the sample size in the second round (first round respondents n=101; second round respondents n=153). Researchers identified 21 essential items from a total of 89 prerequisites. The items fell into four domains: caring, cultural sensitivity, cultural abilities, and cultural knowledge. The caring domain reflected patience in communications to help reduce the language barrier and being non-judgmental. The

cultural sensitivity domain included demonstration of respect for the client's culture. The cultural abilities domain incorporated outcomes of client satisfaction, utilization of services, and development of trust. The elements of *personalismo, respeto,* and *confianza* were evident as in previous research studies (Belknap & Sayeed, 2003; Stasiak, 2001; Warda, 2000; Zoucha, 1998). These outcomes of cultural abilities are important in quantitative studies of cultural competence since these are quantifiable. The cultural knowledge domain was the need to gather knowledge from individual clients. Of note, the cultural knowledge domain had only one item in the top 21 essential items so it was not labeled as "most essential" (Kim-Godwin, et al., 2006, p. 30).

An unusual finding in this study was fluency in Spanish was not rated highly by the participants (Kim-Godwin, et al., 2006). Researchers noted this finding was different than results from research studies of Mexican clients that "prefer nurses to use Spanish without using interpreters" (Kim-Godwin, et al., 2006, p. 32). However, the cited research studies (Stasiak, 2001; Zoucha, 1998) mentioned nurses speaking Spanish, but did not state in place of interpreters. There is a difference between Spanish conversation with the patient and family and fluency in Spanish. Likewise, bicultural providers were not highly rated. Of note, the participants were mostly non-Hispanic Whites but the majority spoke Spanish. The researchers recommended future research on Spanish fluency.

Summary Hispanic Culture and Culturally Competent Care

People of the Hispanic culture value family; warm, friendly interactions; and trust in relationships which is different from the individually oriented, low-touch American culture. Some variations among Mexicans, Cubans, and Puerto Ricans exist especially related to socioeconomic status and English language use. Throughout the research studies of Mexican Americans and culturally competent care, values of *respeto, personalismo* and *confianza* in the care encounter arise along with barriers to care such as language use, bureaucracy and immigration status. In addition, the nurse speaking Spanish contributes to displaying respect and earning trust in the encounter and involving family in care is likewise important. Many of these factors that contribute to culturally competent care also reflect PCC, respect, family involvement, trust, and ease in navigating the healthcare system.

Gap in the Research

Trust (*confianza*) is an important component of Hispanic culture, PCC and cultural competence. Establishing trust has been identified in research as a major factor related to culturally competent care from the perspective of Mexican American patients experiencing nursing care, yet no research has been done related to the development of trust in nurse-patient relationships with the Hispanic population. There is a need for foundational research related to the development of interpersonal trust in the nurse-patient relationship with Hispanic patients in the hospital setting. Although the hospitalized patient encounters more nurses over time compared to the outpatient setting,

the hospitalized patient has a longer encounter with the individual nurse in the hospital setting. Therefore, the likelihood of developing trust may be more prevalent in the hospital setting. Mexican American patients may develop trust in a different manner than non-Hispanic patients so it is important to explore this ethnic group specifically. In the following chapter, the research method will be discussed to answer the research question "How does interpersonal trust develop between the patient and the registered nurse in hospitalized adult Mexican American patients?".

CHAPTER THREE

METHODS

The focus of this study is the process of how Mexican American hospitalized patients develop trust in the nurses providing care to them. In this chapter methods used to conduct the study focus are outlined. The specific elements to be addressed are research design; setting and sample; recruitment of participants; data collection, management and analysis; rigor; and ethical considerations.

Research Design

A naturalistic design using qualitative research was used to answer the research question, specifically the classical grounded theory method (Glaser, 2001; Glaser & Strauss, 1967) was used. Grounded theory is used to explain social processes and the development of trust is a social process. Grounded theory uses the participant's frame of reference to know the phenomenon and reveal the participant's main concern (Glaser, 2001). The participants' expressions of their experiences leads to patterns that uncover the main concern and the current resolution of the concern, the development of trust for the Mexican American patient. This is an important concern because *confianza* (trust) is important to the Mexican American population and the development of trust is important for nurses since it is a main component of PCC and culturally competent care as detailed in Chapter 2.

Setting

This study was conducted in a hospital setting in the urban Midwest with a large number of Mexican Americans living in the area. Based on 2010 census data, 53.2% of adults in this city are Hispanic (U.S. Census Bureau, 2010b). Based on census estimates from 2009, 86% of Hispanics in this area identify as being Mexican (U.S. Census Bureau, 2009b). Based on the prior 2000 census, 43.1% of the people in this area speak a language other than English; however, of those that speak Spanish, 77.7% speak English well or very well (U.S. Census Bureau, 2010b). The hospital has 427 beds with an average daily census of 260-275 patients. The hospital has medical-surgical units including an orthopedic unit, a cardiac unit with cardiac surgery patients, an oncology unit, a neurology (stroke) unit, a pediatrics unit, an obstetrics unit, and an intensive care unit. In addition, the hospital has a separate skilled nursing facility rehabilitation unit and a separate but connected behavioral health unit. Although many rooms were designed as semi-private rooms, the administration decided to make the rooms private by assigning only one patient per room and opening additional units for overflow when needed to maintain the private room atmosphere. An exception was the obstetric unit which, during the course of this study, experienced an unusually high patient census and patients occasionally had to share a room. A breastfeeding room was made available to the researcher to conduct interviews with obstetric patients in a private setting as needed. According to a hospital representative, approximately 30% of medical-surgical patients and 80% of obstetric patients are Hispanic.

The hospital is a certified stroke center and a teaching hospital with residents from a nearby medical school and nursing students from several local nursing programs. While the hospital does employ licensed practical nurses, they only work in the outpatient clinic areas and not the inpatient areas. The hospital is a Magnet designated institution.

Sample and Sample Size

A purposeful sample of Mexican American adults from an urban area in the Midwest who were hospitalized on medical-surgical or obstetric units and within 1 or 2 days of anticipated discharge comprised the sample. Interviews were conducted while patients were hospitalized, rather than after discharge, since the experience with nurses was fresh in their minds and, based on a pilot study, the population was not easily recruited through follow-up contact after discharge. The inclusion criteria for this study were the participants must have been (a) English-speaking Mexican American adults, (b) hospitalized at least 48 hours to experience nursing care on a medical-surgical or obstetric unit, and (c) anticipated being discharged within 1 to 2 days. Exclusion criteria were (a) Hispanics who did not self-identify as Mexican origin, (b) patients who were cognitively impaired (e.g. dementia, confusion), or (c) patients who were admitted to a unit for treatment of a mental health condition.

Recruitment of Participants

Recruitment occurred in the hospital setting. Recruiting hospitalized patients for a research study required compliance with Health Insurance Portability and Accountability Act (HIPAA) of 1996 guidelines. The guidelines state that the researcher may not obtain

personal contact information about the patient from the hospital unless the IRB has

partially waived authorization requirements (U.S. Department of Health and Human

Services National Institutes of Health, 2004). For this reason, the researcher had hospital

employees first approach the potential participants to ascertain their interest in meeting

the researcher to learn more about the study.

To gain access to participants, a contact person at the hospital approached patients

who met the inclusion criteria, but not the exclusion criteria, and inquired if they would

like to talk to the researcher about possibly participating in the study. The contact person

provided the researcher with the name and room number of those patients agreeing to the

additional contact (see Appendix C Recruitment Materials) and the researcher met with

the potential participants to discuss the study and obtain consent (see Appendix D

Consent Form).

Data Collection

Data were collected through face-to-face interviews. Interviews were digitally

recorded with a cassette tape recorder as a back-up. The researcher interviewed

participants in their hospital room, which were private rooms, with the door closed or in

other private areas on the unit. When a staff member entered the room, the recorders were

turned off and the researcher stepped out of the room to allow the staff to provide care.

The interview resumed when care was completed and the participant agreed it was time

to resume. If it became apparent after the first couple of interviews that participants

seemed reluctant to discuss specifics about the nurse-patient relationship, then the

researcher was prepared to arrange for interviews after discharge using contact information provided by the participants. However, participants freely shared experiences, both positive and negative.

In a grounded theory approach the goal is to listen to the participant's concerns and not lead with a preconceived problem (Glaser, 2001). Before the interview began, the researcher engaged in casual conversation including personal disclosures to build trust and establish rapport (Ojeda, Flores, Meza, & Morales, 2011). To start the interview, basic demographic information was asked as an additional method to establish rapport. Basic demographic information collected included: age, marital status, children, years of school completed, years lived in the U.S., language preference at home, length of current hospitalization, previous hospitalizations, and if anyone in the family is a nurse or healthcare provider. Then the data collection commenced with an open-ended question, "Tell me about your experiences with nurses that have been caring for you thus far in the hospital". An interview guide was used to help the participant focus on the nurse-patient relationship (see Appendix B). After the basic question, to help the patient focus on trust, the patient was asked about *confianza* (trust) in the Mexican culture and any experiences of *confianza* with a particular nurse in the hospital. In this way, the participant focused on interpersonal trust rather than institutional trust in nurses. Participants were specifically asked about factors to develop trust with an individual nurse and barriers to developing trust with an individual nurse. The last question of the interview was always "Is there anything else you would like to add about trust and the nurse-patient relationship?".

Data Management

Participants were assigned a participant number and transcripts contained only this number to ensure confidentiality. The interviews were digitally and tape recorded and the digital file or cassette tape likewise only contained the participant number. The interviews were transcribed by a transcriptionist and the transcriptions were stored in a locked file cabinet in the researcher's private residence. Digital recordings and subsequent transcriptions were sent via a secure university website between the researcher and the transcriptionist. The transcriptionist signed a confidentiality agreement. The digital recordings were downloaded to a password protected computer and a back-up copy was stored on a CD and placed in a locked file cabinet in the researcher's private residence. The tape cassettes were also stored in a locked file cabinet in the researcher's private residence. The consent forms were stored in separate areas of a locked file cabinet in the researcher's private residence. To verify accuracy of transcription, the researcher listened to the audio recordings as she read the transcripts. The researcher replaced any identifying information such as names and locations with a pseudonym or the information was deleted if not needed to understand the context of the statement. In addition, the chair of the dissertation committee had access to the transcripts as needed via a secure university website.

Data Analysis

Data analysis in the grounded theory method is based on codes rather than description (Glaser, 2001). The focus of grounded theory is not on the level of detail of

descriptions but on the abstraction of concepts that generate theory. This abstraction of concepts develops through analysis of data. After each encounter with a participant, the researcher used constant comparison to analyze and code the data. Constant comparison is the method of "comparing incident to incident and then incident to concept for the purpose of generating categories and saturating their properties" (Glaser, 2001, p. 185).

Grounded theory in practice using constant comparison involves two levels of coding with data collection and analysis occurring concurrently. Using coding to develop a grounded theory was based on the process as outlined by Glaser (1978). In the first level of coding, open coding, the researcher reviewed the transcript of the interview going line by line using words, sentences, phrases, and passages to assign codes. The source of data was preserved by identifying participant number and page number for each code in the right margin of the paper. Open coding yielded theoretical memos, which are ideas, insights and theoretical hypotheses about the data and the emerging categories.

In the second level of coding, axial coding, the researcher reviewed codes and grouped these into categories. The researcher defined categories in terms of substance and properties using theoretical memos to link categories together. The linked categories then formed a theory to explain the process. Through first and second level coding, the core category emerged and the researcher identified the core category which subsumed most of the categories characterized in the theory. Through the use of theoretical memoing, substantive codes from the first level of coding then led to theoretical codes (Glaser, 1978). Throughout data analysis, the developing concepts and patterns led the

researcher to use theoretical sampling (Glaser, 1978; Glaser & Strauss, 1967), focused

interviews with individuals to clarify aspects of a concept.

Ethical Considerations

The study received Institutional Review Board (IRB) approval at both the

academic institution, Loyola University Chicago, and the hospital (see Appendix A

Letters of Approval). In accordance with the IRB policy of Loyola University Chicago,

the researcher completed the IRB process at the hospital first.

Chapter Summary

In this chapter, the grounded theory method has been presented as appropriate for

this study. The process of sampling, data collection and analysis has been discussed.

Finally, ethical considerations have been addressed. In Chapter Four, further details of

the sample, participant recruitment, and data collection and analysis are discussed as well

as presentation of study findings and a discussion of methodological rigor.

CHAPTER FOUR

RESULTS

The purpose of this chapter is to present the study findings to explain the process of how trust develops in the nurse-patient relationship with hospitalized Mexican American patients and the nurses who care for them. First, a discussion of the sample, recruitment, data collection and analysis using the classical grounded theory methodology are presented. The presentation of the findings of the study follow and the chapter concludes with a discussion of elements used to demonstrate methodological rigor of the study.

Sample

Twenty-two English-speaking Mexican American adults who were hospitalized at least two days on an obstetric or medical-surgical unit and within 1 to 2 days of being discharged were interviewed in a face-to-face format. The participants were hospitalized in one hospital in an urban area of the Midwestern United States. The participants (16 females, 6 males) ranged in age from 19 years to 69 years with a mean age of 35.0 years. Nine participants were married and 13 participants were single. Four participants had less than 12 years of schooling and 12 participants had education beyond high school. Twelve participants were born in the United States and 10 participants were born in Mexico and arrived in the U.S. as children (age range at arrival to U.S., infant to 16 years old). Eight

114

participants preferred to speak English at home, nine participants had no preference and spoke both Spanish and English at home and five participants preferred to speak Spanish at home. Of the five participants who spoke Spanish at home, the researcher noted three with limited English proficiency (LEP) during the interviews, which were conducted in English. At the time of the interview, the number of days participants were hospitalized ranged from 2 days to 2 weeks. Nine participants were hospitalized on a medical-surgical unit and 13 participants were hospitalized on the obstetric unit. All but one of the participants hospitalized on the obstetric unit were admitted for childbirth. Of the 22 participants, 3 participants had no previous hospitalizations, 7 participants had been hospitalized before, but only for childbirth, and the remaining 12 participants had been hospitalized one or more times before the current hospitalization for reasons other than childbirth. Two participants were nurses (1 LPN, 1 RN) and ten other participants had family or extended family members who worked in healthcare environments (nurses, pharmacy technicians, nursing assistants/caregivers, physicians).

Recruitment

To recruit the sample of hospitalized patients, designated contact persons (nurses) employed by the hospital approached patients who met the inclusion criteria, but not the exclusion criteria. The contact person used scripting to ask the patient if they would like to meet the researcher and learn more about the study. If the patient agreed, the contact person then called the researcher and provided the patient's name and room number or provided these in person when the researcher arrived at the hospital. The researcher met

with the potential participants to discuss the study, answer any questions and, if they agreed to participate, obtain informed consent.

Twenty-nine potential participants were identified by the contact persons. Of these, 22 participants completed the consent process and were interviewed for the study. Of the remaining seven persons contacted and not participating, one Hispanic male was excluded by the researcher from participating because he was not of Mexican descent. Two female patients admitted for childbirth declined after receiving further information about the study from the researcher. The other four did not speak to the researcher about the study due to timing conflicts. One male was to be discharged from the hospital before the researcher could arrive to discuss the study; one male patient declined because he had visitors in the room each time the researcher returned to discuss the study; and two female patients admitted for childbirth declined to discuss the study because they were waiting for their ride home after being discharged.

Participants who had family members present chose to have their family members remain in the room during the interview process. Family members were informed of the recording devices and family member statements were not used as data. The participants received a $20 gift card as a token of appreciation at the completion of the interview.

Data Collection and Analysis

In the classical grounded theory methodology, data collection and data analysis occur concurrently (Glaser & Strauss, 1967). For purposes of clarity, data collection will be discussed and then data analysis.

The researcher conducted face-to-face interviews with the participants at the time the study was explained, informed consent was obtained, and the consent document was signed. Interviews took place in a private setting in the hospital and the duration of the interview ranged between 9 minutes and 38 minutes. Data collection occurred over a four month period, spanning August 2011 through November 2011.

Interviews were audio recorded using a digital recorder, with a cassette recorder as a back-up. When hospital personnel entered the room, the interview was stopped and recorders were turned off, and the researcher stepped out of the room. The interview resumed when hospital personnel completed care and left the room and the participant agreed to continue the interview.

Interviews were conducted in a conversational style using the tree and branches approach, with main questions and follow-up questions for further exploration and depth and probes to keep the conversation focused or as needed for clarification (Rubin & Rubin, 2005). The researcher asked basic demographic questions at the beginning of the interview and then used an interview guide to focus the interview on the nurse-patient relationship. To ensure the focus was on experiences with a registered nurse rather than other hospital personnel (e.g. nurse's aides, physicians), questions were asked to clarify the role of the person being discussed with the definitive role of nurse as administering medications (Did the person just get your blood pressure? Did the person give you medicine?). Of note, licensed practical nurses are not assigned care responsibilities in the inpatient areas. If the person was someone other than a nurse, the participant was

redirected to focus on experiences with a nurse. Participants readily discussed their experience including specifics about both positive and negative interactions with individual nurses.

During the interview, the researcher took brief notes to assist with follow-up questions and at the completion of the interview to assist with recall of key points and write memos. After several interviews, a pattern and relationships between concepts, hypotheses, emerged. At the end of subsequent interviews, participants were asked focused questions related to the emerging hypotheses to elicit their feedback. Using focused questions for the purpose of clarifying properties of categories and relationships is a form of theoretical sampling (Glaser, 1978; Glaser & Strauss, 1967).

Thirteen of the first 14 participants were admitted to the obstetric unit. Concurrent data analysis along with data collection indicated the need to interview other groups to broaden the scope of the population and explore similarities and differences in perceptions (Glaser & Strauss, 1967). This was another aspect of theoretical sampling. Through theoretical sampling, the researcher focused on the recruitment of participants who were hospitalized for medical-surgical issues, on units in the hospital other than the obstetrics unit, and male participants. These additional patient types and care areas were chosen to explore if there were similarities and differences in the nurse-patient relationship in diverse situations other than childbirth, in which the patient is basically healthy. Recruitment was focused on including male patients to explore if there were similarities and differences in perceptions of trust in the nurse-patient relationship based

on gender. These similarities and differences would be used to expand on properties of categories (Glaser, 2001). Data collection continued until saturation occurred, indicating no new relevant categories or new properties to existing categories emerged.

Three minor issues arose during the data collection process. These minor issues were clarity of English language use by LEP participants, an inaudible interview recording, and one participant in poor health with very brief answers. The three participants who were LEP participated fully in the interviews and shared their experiences, although the English vocabulary used by the participants was more limited. The researcher repeated the LEP participant's responses throughout the interview to confirm the researcher understood the meaning of the statements and ensure the transcriptionist could clearly hear the English words that were spoken with an accent. Although interviews were conducted primarily in English, one LEP participant used Spanish words and phrases at times. This was not an issue since the researcher speaks Spanish, the participant's daughter who is bilingual was present and assisted with vocabulary as needed, and the transcriptionist is a bilingual Mexican American so Spanish phrases were accurately transcribed along with English translations. At the conclusion of the interview with the LEP participants, the researcher asked if the participant would like to make any additional comments in Spanish. The LEP participants did not add any additional comments beyond what was already said in English. The second issue was the inaudible digital recording of one participant and the failure of the cassette back-up. Due to the poor audio quality, it was impossible to accurately

transcribe the interview. For this participant, data analysis was based on memos derived from field notes alone and did not include line by line coding of a transcript. The third issue was one participant was in poor health at the time of the interview which may have limited his ability to contribute fully. This participant had limited responses to questions with minimal detail. However, since "all is data" (Glaser, 2001, p. 145), the transcript was analyzed and coded and is part of the data for this study.

After each interview and transcription, the researcher compared the transcripts to the audio recording to ensure accuracy of transcription and changed any names of people or places to pseudonyms in the transcripts. At the beginning of data collection, the researcher compiled a list of words used to characterize culturally competent care, patient-centered care and trust to heighten theoretical sensitivity. This list of words was then set aside and not reviewed again during data collection/data analysis. By setting the list aside, terms and phrases had to work their way into the conceptualization of the trust development process through the data.

Data analysis was done using the constant comparison method. Using the inductive approach, the researcher completed the first level of coding, known as open coding, going line by line and coding through writing key words or phrases in the margins of the transcripts. These key words and phrases used the participant's phrasing to the extent possible. The lines and phrases were then cut and pasted to code sheets with the same key words used. The codes had positive and negative phrasing, for example, one code was "asking me my needs" and another code was "not asking me". As additional

interviews were completed and transcripts coded, these codes were compared to previous

codes and were added to existing codes, codes were revised, or additional codes were

created. Data that did not generate a code was placed in the *miscellaneous* category and

reviewed again at the completion of coding of all transcripts to ensure codes were not

missed.

The researcher wrote theoretical memos as transcripts were coded. These

theoretical memos included associations between codes, questions about definitions of

codes and relationships, and a variety of insights related to codes and the emerging

model. Throughout the data collection and coding process, the researcher reviewed and

referred back to the memos written and added additional memos. As the relationships

between codes emerged to form hypotheses, the researcher used theoretical sampling by

adding additional questions to subsequent interviews to elicit participant perceptions of

the emerging hypotheses. Using the theoretical memos, the researcher proceeded to the

second level coding, axial coding, to place the codes into categories based on these

memos. The researcher used positive and negative codes, and those formed a category

that had range. For example, "asking me my needs" and "not asking me" contributed to

the property *coming in and asking*, part of the category *Taking Care of Me*. In axial

coding, the researcher reviewed the theoretical memos derived from the data during open

coding. During axial coding, codes fell into categories and the relationship between the

categories was elicited from the theoretical memos. The model of the process of trust

emerged through this process of axial coding. After the model of the process was in

place, the researcher reviewed all the transcripts in their entirety to see if the model fit with the data. With this additional review of the transcripts, memos and the model, and further reflection, the core category emerged. The wording for the core category is derived from phrases mentioned over and over by participants and is the essence of the process of developing trust in its entirety.

At the completion of coding, the researcher had compiled 217 unique codes. These codes were then collapsed into clusters of similar codes, and through axial coding into a core category and eight categories with properties. The properties of the categories have explanatory power for the categories. The categories were sequenced in time and linked together in a model of the development of trust that indicates a beginning, middle, and end point in the process as well as outcomes of the process. The endpoint of the process was the development of trust. However, the participants gave additional information about the consequences of the development of trust which allowed for the conceptualization of the outcomes of the process and adds to the explanatory power of the model.

The next section presents the model, core category and categories generated from the data that conceptualize the process of developing trust in the nurse-patient relationship.

Findings

The following findings answer the research question "How does trust develop in the nurse-patients relationship with Mexican American patients?" and explain the basic

social process of developing interpersonal trust. In this section, first the process and model are presented and then the core category and eight categories are defined including their properties. Participant quotes are provided to illustrate the findings. The core category is Making Me Feel Comfortable, and the eight categories are *Having Needs, Relying on the Nurse, Coming Across to Me, Connecting, Taking Care of Me, Feeling Confianza (Trust), Confiding in the Nurse,* and *Taking Away the Negative.* In this presentation of findings the Core Category is capitalized, the *Categories* are capitalized and italicized, and *properties* of the categories are not capitalized but are italicized. Participant quotes are provided to support the category descriptions. Each quote is followed by a series of numbers in brackets which represent the participant number and page number of the transcript, for example, [8.21] indicates participant number 8, transcript page number 21.

Process and Model

Based on the data, the process of developing trust in the nurse-patient relationship depends on the nurse's ability to make the patient feel emotionally comfortable so if the need arises, the patient will confide in the nurse and ask for help. The process is illustrated in the model (see Figure 1). The process begins with the patient having a need (*Having Needs*) and relying on the nurse (*Relying on the Nurse*) to address the need. The manner in which the nurse responds and comes across to the patient (*Coming Across to Me*), demonstrates caring (*Taking Care of Me*), and connects with the patient (*Connecting*) can lead to the patient feeling comfortable with the nurse. In feeling
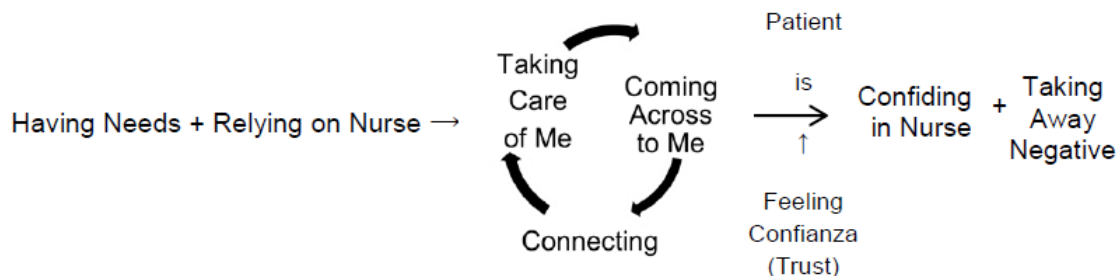
Having Needs + Relying on Nurse → Taking Care of Me → Coming Across to Me → (is) → Confiding in Nurse + Taking Away Negative

Patient

Feeling Confianza (Trust)

Connecting

Figure 1 Model of the development of trust in the nurse-patient relationship with Mexican American patients (provided in Chapter 5 as well).

comfortable, the patient is willing to trust (*confianza*) (*Feeling Confianza*) the nurse which leads to confiding in the nurse (*Confiding in the Nurse*) and the patient not wanting the nurse to leave at the end of the shift. In addition, when trust develops, the positive interaction can take away previous negative experiences or feelings (*Taking Away the Negative*).

Conversely, during the interaction cycle of *Coming Across to Me, Taking Care of Me,* or *Connecting,* anytime there is a negative element, this element halts any further development of trust. If the nurse comes across as negative or does not seem to care about the patient, the patient feels uncomfortable and may feel like a bother, will not develop trust, will not ask for help, and will wait until the next shift.

Development of trust with a nurse is a cyclical process that starts again with the next shift, depending on how the nurse chooses to interact with the patient and how the patient perceives this interaction.

Core Category: Making Me Feel Comfortable

The core category encompasses all the categories of the process and has "grab" and explanatory power (Glaser & Strauss, 1967, p. 95). Making Me Feel Comfortable emerged from the data as the core category in the process of developing trust in the nurse-patient relationship. In the nurse-patient relationship, as the nurse addresses the patient's needs, the interactions can be either positive or negative. Through positive interactions with the nurse (talking, helping, connecting), the patient feels comfortable with the nurse. This feeling comfortable is a state of being rather than physical comfort. When the patient feels comfortable, the patient feels *confianza* (trust) and is willing to confide in the nurse. The term "making me" reflects the key role the nurse has in the patient reaching this state of being. It is the nurse's actions which direct whether the interaction will be perceived as positive or negative. Participants used the phrase "making me feel comfortable" to refer to a feeling of ease with the nurse. When the patient achieves this feeling of comfort with the nurse, it indicated trusting in the nurse and a willingness to confide in the nurse. One participant described the process:

> And then there's some that actually come in, oh, hi, how's your day, blah, blah, blah, and you start, oh, hey. And then, you know, sometimes they start telling you about oh, you know, when I was in the emergency -- they -- they try to make you feel like comfortable, and then they start making comments and it makes you feel more comfortable, and then that's what makes you also be like, oh, I could ask her for anything 'cause she's being nice and she makes me feel comfortable [13.14-15].

The core category Making Me Feel Comfortable encompasses the eight categories in the model. The eight categories are *Having Needs, Relying on the Nurse, Coming Across to*

Me, Connecting, Taking Care of Me, Feeling Confianza (Trust), Confiding in the Nurse,

and *Taking Away the Negative*. These eight categories and their properties are discussed

in the following sections.

Having Needs

The beginning stage of the process of developing trust starts with the patient

Having Needs. Having Needs reflects the patient *being in a vulnerable position* by

having a specific need such as pain relief or by virtue of being hospitalized. Every

hospitalized patient has needs during the hospitalization. One participant described a

common situation in the hospital, pain:

> I mean, I kind of messed up yesterday, 'cause I let the pain get a little too far out
> of hand. She [nurse] said, "You know, you've got to let us know you got pain
> right away," 'cause I didn't want to bother them, 'cause I heard beepers going off
> all day. But she said, "That's what we're here for, for you to bother us." So that
> was nice to know [18.7].

Another participant echoed a similar need:

> I think, to me, it was more because of what was important to me was because I
> was in pain, so that was the one thing that I kept focusing on, was just that I was
> in pain; I was hurting [8.27].

Both these statements reflect the patient's vulnerable position, being in pain, and the need

for pain relief. The patient relies on the nurse to address the need.

Relying on the Nurse

In the *Relying on the Nurse* category, the patient relies on the nurse to respond

and help meet the patient's needs. The nurse is in the key position to help the patient who

is in a vulnerable position. As one participant stated, "nobody is going to help me but her.

I'm kind of relying on her to help me feel better, and that's a big thing with trust" [8.27].

Relying on the Nurse includes *having expectations of nursing care/hospitalization*. These expectations include the nurse's role as helping, of being there more than the doctor, having competence in providing care, and the patient choosing a particular hospital because of the nurses. For example, with regard to the nurse being there more than the doctor, one participant stated:

> So it's mostly like -- I would say the nurses would have to be like, in some way, like comforting you here, 'cause they're the -- they're the only ones that know what's going on with the doctors. I mean, 'cause they're, I guess, they're -- the middle person I would say. They're the middle person between you and the doctor, because the doctor is not here like 24/7, or she's [doctor] not going to be here with you like the whole day. The nurse is the one that's actually here with you, and taking care of you [12.18-19].

This role of the nurse as the "go between" as well as the main provider of care was echoed by other participants as well. Given the nurse's role of "middle person" between patient and doctor, patients expect the nurse to have a certain level of knowledge and technical competence. When the nurse did not meet this expectation of competence, the participants openly discussed these negative experiences of relying on the nurse and being disappointed with the results. For example, one participant who did not receive stronger pain medication for eight hours due to an apparent oversight by the nurse, stated:

> She should know, this is where she works, she sees this every day, so she should know…. So why aren't you double checking, or seeing? I mean, this is what you do every day. You should know. So it's kind of bothering. And the other one [next nurse] knew right away [8.25].

This same participant noted choosing a hospital based on expectations of nursing care, she stated:

>Maybe because I've been in the hospital a couple of times, but I could tell … the nurses were nice, I liked them. But this time … I'll be like, no, I don't want to go to that hospital. That one doesn't have nice nurses. And that's the people that you see 24 hours a day for five days, so they're the ones you're going to be with that whole time. The doctor, you see maybe two times, or she [doctor] comes in for five minutes. The nurse, you're with nine hours, nine hours, nine hours [8.32].

This participant noted the "nice nurses" which is a statement about nurses in general on the unit which is the basis for expectations of care. This participant alluded to having the nurse nine hours which would indicate the individual nurse-patient interaction and relationship on a nursing shift. In developing interpersonal trust, the focus is on the interaction with a specific nurse. The next stage in the process of developing trust in the nurse patient relationship reflects the interaction with a particular nurse during the shift.

The *Having Needs* category combines with the *Relying on the Nurse* category and both proceed to interactions with the nurse in the middle stage with the *Coming Across to Me, Taking Care of Me* and *Connecting* categories occurring in the process.

Coming Across to Me

The next stage of the process of developing trust reflects an interacting cycle between the nurse and the patient and has three categories: *Coming Across to Me, Taking Care of Me* and *Connecting*. These categories have range in positive and negative directions. The *Coming Across to Me* and the *Connecting* categories are more attitudinal, affectively-driven responses compared to the category *Taking Care of Me* which is a more action-driven response.

Coming Across to Me includes the properties *making a first impression*, *responding,* and *talking*. *Making a first impression* occurs at the nurse's first interaction

with the patient; *responding* and *talking* occur as the nurse interacts with the patient

throughout the nursing shift. *Making a first impression* includes positive characteristics

(friendly, nice) or negative characteristics (rude) as well as the manner in which the nurse

goes about his/her job. The participants provided many comments on the importance of

the first impression and that they "can tell the way the nurse is." Participants commented

on the nurse's attitude as being positive or negative. For example, one participant who

developed trust with a particular nurse stated, "As soon as she came in, with a smile on

her face; you know, it's just her attitude. You can just feel, you know -- she just gave

you that vibe" [19.9]. Another participant commented on the positive and negative range

in making a first impression depending on the nurse:

> But you could tell also by the face, like if, just by coming in, you can tell, oh,
> she's not nice. ...like if she just comes in here and gives you a face, and you'd be
> like, oh, we're going to have problems. And if she comes in here all smiling and
> stuff, it's like, oh, she's going to be nice [13.16].

Another participant stated simply, "I don't know. Only I see the eyes, their face, and I say

these are good" [22.21]. Positive characteristics were having a smile, being nice, being

friendly, and being outgoing. Negative characteristics were having a "mad face," being in

a bad mood, being rude, and being mean. The nurse who comes into the room without a

smile made an impression on one participant who stated:

> Yeah, like if they -- if they look like they're mad already, it's hard, 'cause it's like
> a wall up already, so it's hard to -- to tell her I need this, or I need -- I need
> anything, because, I don't know, I feel like do they get mad? I don't know [9.8].

The facial expression was perceived by the patient as a barrier to further interactions with

the nurse including asking for assistance. Perceiving the nurse as being rude or having a

negative attitude was the main barrier to developing trust. One participant stated:

> I don't see any like any barriers, except, you know, like the same thing, her
> attitude; if she seems like she don't care, then I'm not going to trust her with the
> baby, or myself, or ask her any questions or anything like that [5.9].

This sentiment of the nurse being rude as a barrier to trust was echoed by many

participants. The nurse being rude or having a negative attitude leads to the patient

feeling uncomfortable and not wanting further contact with the nurse.

Another component of the property *making a first impression* was the nurse's way

of going about the job. The participants commented on whether the nurse seemed to like

the job or if the nurse was simply doing the job. One participant stated, "So I think those

simple things from her are already barriers to see if she's going to be a nice nurse and she

likes her job, or she's just here to do her job and then leave" [8.20]. The patient seems to

perceive the nurse's underlying motives, positive and negative, during care interactions.

This perception is evident in the *Taking Care of Me* category discussed later.

Another property of the *Coming Across to Me* category is *responding. Responding*

includes the way the nurse talks to the patient and the way the nurse answers the patient,

which incorporates both tone and content in the response. The nurse's responding to the

patient's inquiry is the gateway to trust developing. *Responding* has range in both

positive and negative directions. Positive responses include explaining and

understanding. Negative responses include giving attitude, judging, and "telling me what

to do". The participants provided numerous examples of both negative and positive

responses from a nurse. When one participant was asked what *prevents* her from

developing trust with a particular nurse, she stated:

> I guess the way they answer when you ask them for something. Like the first
> time you ask them for something, and that way you know -- like I asked her, the
> first thing was: Am I going to get a pain medicine? What time am I going to get
> it? Is it coming up?...So just by asking her: Is my pain medicine coming up?
> She's -- she was just like, oh, it's every six hours. Okay. I don't know every six
> hours, so is it two hours from now, or I'm going to bring it to you soon? ….
> Like, just easy stuff like that, she's already not giving me a good response and
> being nice, and I already know, okay, well, she's not going to be good. Oh, great,
> and then these nine hours are not going to be good [8.19-20].

This statement reflects the importance of the nurse understanding the patient's vulnerable

position when responding, and the content of the nurse's response. Another participant

provided examples with two different nurses; one was a positive response and the other a

negative response. When asked if she was able to develop trust with a particular nurse,

the participant related the positive response:

> With one of them; her name is MARY [name changed] also. She -- like I was
> able to talk to her about like breast feeding and questions concerning the baby,
> and she was explaining to me very good. When I call other nurses, they don't
> explain it very good, but with her, it was more -- she was more open, like trusting
> in her [14.4].

The same participant described a negative response from a different nurse:

> Just some nurses, it's kind of hard to trust them, just the way they are ….Just --
> just the way they like react towards, when you ask them something, just the way
> they answer back to you. It's important because you're like asking them for
> information or you have a question about something, and they just answer back
> with like an attitude…. I'm like trying to explain to her why I wasn't doing
> [something], but I -- she got bothered by what I told her, and she just like walked
> out [14.10-11].

The way the nurse responds to the patient can lead to trust or to no trust. With the development of trust, a patient would be willing to confide in the nurse. One participant described:

> Like in the beginning, you know, I was still quiet, I was a little shy; I didn't really want to ask her for much. But as I saw how she was towards me, like it made me confide in her that, you know, she wasn't gonna be smug about stuff, or just like brush me off, or just do this as her job. She really took her time to make sure that I was comfortable, that I was okay, that I felt good, and that the baby was okay. And that's what really helped me [2.41].

The way the nurse responded to the patient's inquiry was the gateway to developing trust.

Where responding is the gateway to trust, talking is the *key* to developing trust. *Talking,* another property of *Coming Across to Me,* is similar to the property *responding* but includes talking personally and talking to the patient. The importance of talking was mentioned over and over by participants. For example, when one participant was asked how the relationship with the one nurse whom she trusted was different than the nurse she had the previous day, the participant simply stated, "She talks to me [laugh]" [1.12].

Talking is a way for the patient to become familiar with the nurse and for the nurse to demonstrate seeing the patient as a person. In a sentiment echoed by many participants when asked what helps to develop trust, one participant stated, "Talking; if -- if I can talk to them and they'll talk to me, just normal, like -- like if we're good friends, then I would start trusting them" [2.29]. Another participant echoed similar sentiments about the importance of talking, yet acknowledged the line between the nurse's role and friendship:

> The other thing they start to talk to you to make some comfort, and you know when the people are happy, or feel happy for you, or they wanna make some friend. I feel good about that. 'Cause sometimes like the other nurse come in and just ask you, I mean, simple question like how you feeling, you need some more pillows? If I say, yes, I'm okay, and then they walk away. I mean, that's -- the nurse job, right. It's not -- they [sic] job make some friend for every patient, I mean, but that's okay [3.21].

Talking led to the patient feeling comfortable. In contrast, *not* talking to the patient will lead to the patient feeling uncomfortable. One participant described an experience with a nurse who did not talk:

> Well, there was like one that [put up a barrier]-- this one particular nurse, and they came in and never said anything. So just her alone kind of put me not at ease, and it wasn't that she probably was doing her job any differently outside of speaking; everything she did was just as good, 'cause she changed the IV in the same manner as everybody else, and she took blood in the same manner as everybody else. But she never had anything to say, so it was kind of just like an uneasy time when she was in the room [21.16].

Talking includes talking about non-health issues, encouraging and, for some patients, speaking Spanish occasionally. Talking about non-health issues with the nurse was important for the patients in developing trust. One participant explained:

> You can get closer to her just by her doing something like that …you trust again, because she's talking personally about herself, and about you, and then you trust them again. You trust them and you respect them, because they're not treating you like a clown; they're treating you like a person. That's what I like [17.30-17.31].

The patient and the nurse connect through talking. Talking leads to the patient feeling comfortable and at ease which leads to the patient confiding in the nurse, an outcome of trust. Another participant noted the importance of the nurse talking to put him at ease during treatments, a form of encouraging:

> Yeah, because it just seems like if they come in and start poking you and don't say anything … it's just so much more coldness compared to coming in, you know, this might hurt a little bit, and let me know if it does; that kind of thing just eases the tension…. It helps, even if it's just words; it just seems to help [21.20-21].

This simple act of talking during care interactions had a positive effect on patients. For some patients, talking in Spanish led to a feeling of comfort and trust. For example, when one participant who was LEP was asked what helped her develop trust in one particular nurse more than another, she replied:

> Because she speaks Spanish so I can talk more with her, because my English not good, so I'm -- I'm prefer don't ask many questions because I don't know how to say things -- so she speaks Spanish and she put me attention [sic] when I'm talking, and that's why I have more *confianza* with her [11.6].

This same participant went on to note that her mother who spoke only Spanish had many questions for the nurse and the patient was relieved she did not have to translate for her mother. Speaking Spanish to patients with limited English proficiency or who are monolingual in Spanish seems understandable. However, another participant who was fluent in English also noted the comfort of speaking Spanish. She stated:

> You obviously know when someone doesn't -- you know, because of our accent, she knows that she could speak Spanish to us, you know. So she was really nice to just speak Spanish to us, even though we were talking, you know, she could speak to us in English, she knew that we felt more comfortable talking in Spanish. So it was nice of her [7.11].

Although speaking Spanish to the patient, or for the benefit of family present, was important for some participants, they also noted it was not important that the nurse be Hispanic. As one participant stated, "I don't think it depends on the race; it just depends on how well they treat you" [13.21].

Talking and responding contribute to connecting with the nurse. *Connecting* is the next category in the middle stage of developing trust.

Connecting

Connecting is another affectively-driven category in the interaction cycle with the nurse. *Connecting* reflects the feeling the patient gets when experiencing positive interactions with the nurse in *Coming Across to Me* and *Taking Care of Me*. These categories are cyclical and build on each other. One participant explained, "I guess just the way they come -- they come at you. Like there's some that just their attitude isn't very nice. And there's some that right away like you can connect with them" [14.6]. Most participants identified one nurse they established a connection with which led to trust. For example, one participant stated, "I mean, everybody else has been nice, but with her it had to -- it felt different" [12.7]. Another participant echoed similar feelings, stating, "I felt like, I don't know -- I felt more comfortable and more attached to her" [13.35]. This connection was a feeling the patient perceived as mutual between patient and nurse. One participant described connecting with her nurse even though there was a slight language barrier due to the nurse's English speaking abilities:

> I really connected with her even though we didn't have -- sometimes the things that I was trying to see what she was trying to tell me, 'cause her [Asian nurse's] accent was thick, but that still didn't bother me, like, oh, I don't even know what she's saying, so I don't want to bother with her. It was still like I was still attentive, she was still attentive to me, and I -- I liked it. [8.24]

A couple participants did not have a specific situation arise that led to trust with an individual nurse and noted no "special" connection with any nurse while other

participants noted they trusted all the nurses on the unit who cared for them. When two older male participants were asked if they developed a "special" connection with a particular nurse, they interpreted the phrase to mean a *romantic* connection and quickly mentioned their wife or girlfriend at home. Reasons participants mentioned for no connection with a nurse were not spending enough time with the nurse or not relying on the nurse for a specific need. These reasons reflect the influence the nurse's personal level of engagement has on *Connecting* with the patient. For example, one participant explained not connecting with the nurse on the unit because she only stopped in the room for 5 minutes a couple of times during the shift, yet, another participant was able to connect with a nurse who merely transferred her from one unit to the other due to the personal level of engagement demonstrated by the nurse toward the patient. The patient's ability to engage with the nurse also impacts *Connecting*. The patient may not be in a position physically to reciprocate in this mutual connection. One participant explained, "I didn't really -- I didn't really interact with them that much the first couple of days. I mean 'cause I was pretty sick" [1.17].

A few participants experienced negative interactions with the nurse and rather than connecting with the nurse and going on to the *Feeling Confianza* (trust) stage, the participants described *feeling like a bother*. *Feeling like a bother* is discussed in the *Feeling Confianza* section.

Coming Across to Me and *Connecting* refer to affective aspects of addressing a patient's needs. The next section addresses *Taking Care of Me*, a more action-oriented response.

Taking Care of Me

In the interaction cycle with the nurse, *Taking Care of Me* reflects the nurse's more action-oriented response to the patient's needs and demonstrates the patient relying on the nurse to meet those needs. Properties of the *Taking Care of Me* category reflect being attentive and include *being very helpful, coming in and asking,* and *showing care*. The nurse who is helpful, demonstrates caring and comes in to check on the patient often makes the patient feel comfortable. *Being very helpful* reflected going beyond the nurse's needs to "get the job done" and instead focusing on the patient's needs. One participant explained:

> It's like with the nurse that's more helpful, more ask about what *you* want, or what *you* need, or how *you* feel, instead of just saying like, okay, I'm here to do this, this is what's going to get done, and that's it [4.10].

This willingness to help the patient in whatever is needed is important for the patient to develop trust with the nurse. In contrast, a barrier to trust development is the nurse being perceived as unwilling to help. When asked about barriers to developing trust, one participant responded:

> Probably if they don't -- they don't really seem like they want to help; like they just want to get their job done. Like I just -- oh, okay, I'd just rather just cut it off there, just let them know what I need and that's all, and not really go further with it and see if, you know, they can help me with something else, or if I can ask them for something, or ask them a question that I might want to know something about [2.36].

The nurse who is not willing to help will not be asked again for a smaller or larger need. In willingness to help, the patient seems to perceive the nurse's underlying motives during care interactions. For example, one participant described a nurse who was willing to help, and stated:

> So if it's any smallest thing, if I want a pillow, I'm going to ask her 'cause I know she's going to enjoy bringing me the pillow and making me feel good, versus oh, I'm going to ask her for a pillow and she's going to give me attitude. I'll just stay with no pillows then, 'cause I don't want to bother her, or I don't want to talk to her [8.23-24].

According to the patient, this nurse enjoys helping and the patient is then willing to ask the nurse for assistance with other things without feeling like a bother. In contrast, the patient feels threatened when the nurse is unwilling to help. One participant stated:

> When they do it [lifting me], they do it with how do we say, *mala gana* [reluctantly]…They're doing it because they have to, you know… [Instead of] With a smile on their face, yeah; you know, you're frowning, and you're just shoving, you know. So when they get that that sense, like I said, it's war, because, you know, then you just put you on your guard [15.16].

In this instance, the patient is wary of the nurse and, for this participant, confrontation may ensue. Other participants noted "letting it go" and not wanting contact with the nurse who seemed unwilling to help.

Another property of *Taking Care of Me* is *coming in and asking* which reflects the basic nursing action of checking on the patient throughout a nursing shift. The patient distinguishes between the nurse who comes in and asks as being attentive and caring about the patient compared to the nurse who comes in and leaves without asking. For example, when asked if any particular incident led to the feeling of trust, one participant

responded, "Maybe just my first nurse, with her, because she seemed more concerned

about me. Like she asked more questions, came in more often, pretty much it" [10.9].

The importance of coming in and asking versus coming in and leaving were echoed by

another participant. When asked what a particular nurse did to help develop trust, the

participant responded:

> I think the most part was her keep checking in on me, 'cause a lot of times, I
> know it's busy, too, but a lot of times they forget and don't come back in. … So
> I kind of understand 'cause I know they have a lot of patients, but it doesn't make
> me feel nice to have to keep calling them for stuff, versus the one, that one nurse,
> I'm sure she had a lot of patients, too. She kept coming in and insisting, like what
> do you need help with? Is your pain okay? Doing -- do you need help going to
> the bathroom? Then it makes me feel good like she cares, versus the other ones
> [8.12].

Coming in and asking demonstrated caring about the patient. Coming in and leaving is

the negative component and indicates not spending time in the room or being open to the

patient. One participant observed:

> And then -- and then some of the nurses, when they come in, they come in in such
> a hurry that you don't want to ask them questions, you don't want to start a
> conversation with them because you feel that they're in a hurry, you know
> [15.22].

Coming in and leaving inhibits interaction between the nurse and patient and will not lead

to trust.

Similar to *being very helpful*, the property *showing care* is action-oriented.

Showing care includes caring more and going the "extra mile." The patient appreciated

the nurse who did extra and this contributed to the patient developing trust in the nurse.

One participant stated:

> I think the nurse I have right now is the one that I trusted the most. She's very easy going, she kind of like demonstrates that she cares a little more, so I guess maybe that shows -- it makes you want to trust her. The other ones, I guess, seem like they're here to do their job and try not to get as close to the patient as, you know, the rest. For example, I had cereal earlier, and I was [off the unit], so my milk got warm, …she went and got me a new milk and a new cereal since mine had already gotten warm, so I thought that was a nice gesture [1.7-8].

This simple action was perceived as the nurse caring more than other nurses. When another participant was asked about barriers to developing trust, she described an incident in which she perceived the nurse as not caring. The participant stated:

> Like I would -- I had asked a lady [nurse], that lady for ice, and she -- I had to ask her for the ice for like three times, you know, 'til my sister had to get up and go get it for me, 'cause she just wouldn't care. That's what it feels like, they -- like they don't care, you know, when they're being rude like that….Yeah, it seemed like she didn't care. And it seemed like she was just there to do her job and leave, you know. She wouldn't do a little extra, or try to make you comfortable. You know, it was just like I'm here to do this and that's it [7.15].

Not following through on a patient need was perceived as not caring. This negative interaction will not lead to trust developing. Caring more and going the extra mile leads to the patient feeling comfortable. Many times this "extra mile" was simply a nice gesture toward family present, while other times the "extra mile" was acting on a patient's concern that a previous nurse dismissed. For example, one participant developed trust with the nurse who followed through with getting a medication changed which was causing nausea; the previous nurse had insisted the patient take the medication. Another participant described her experience with a nurse she trusted and the attention provided to family present. She stated, "So it wasn't just me, the patient, that she was caring about. It was whoever else was here she was caring about, and being attentive to them also. She

didn't have to do that" [8.25-26]. In this situation, the nurse simply provided a blanket to a family member. The patient realized the nurse is doing extra and by making the family physically comfortable, the nurse makes the patient feel comfortable emotionally.

The categories *Coming Across to Me* and *Taking Care of Me*, in the words of participants, incorporate "simple stuff" which can lead to the patient feeling comfortable and willing to trust the nurse. Participants noted greeting the patient, responding positively to questions, and acting on requests as "simple stuff." When asked what helps to develop trust in a particular nurse, one participant responded:

> I would say probably their attitude, how they come about when they first come in the room and, you know, greet you and -- and answer your questions, see if they give you time, you know, or they say they'll be right back and they don't come back, or, you know. Simple stuff like that, I would -- I would say would build my trust [5.8].

Through these simple actions, the nurse engages in a positive interaction with the patient. This positive interaction leads to making the patient feel comfortable and the next stage, *Feeling Confianza (Trust)*.

Feeling Confianza (Trust)

Depending on how the nurse reacted in the interaction cycle, *Coming Across to Me, Taking Care of Me*, and *Connecting*, the patient may at some point be *feeling confianza (trust)* with the nurse and be willing to trust. This category has range in both positive and negative directions. If the nurse is positive in interactions with the patient (e.g. talking, attentive), this leads to the patient feeling comfortable and willing to trust. If the nurse is negative in interactions with the patient (e.g. rude, not helpful), this leads to

the patient feeling uncomfortable and not willing to trust and the patient possibly feeling like a bother. *Feeling Confianza* includes properties of *making me feel good* and *feeling like family*, and also not *feeling like a bother.*

The property *making me feel good,* similar to the core category Making Me Feel Comfortable*,* reflects the comfort on an emotional level the patient feels with the nurse when the patient feels *confianza* (trust). *Making me feel good* includes feeling comfortable to ask and comfortable to trust. When asked how the relationship is different with the nurse whom she established trust, one participant explained:

> When I trust them, it's easier for me to ask them when I need something, when I have a need; it's easier to tell them, you know, oh, I need this, and -- and they seem like, you know, they -- they're happy to help me, and so it makes me feel good, too. It makes me feel like -- like -- like welcomed; like I say, it makes me feel okay [9.12].

This welcome feeling was echoed by another participant who had been hospitalized several times within the span of a month. The participant stated, "And I think it's been like that every stay. There's always been at least one nurse, or two nurses, that actually made a difference, who made me feel at ease" [19.17]. As this participant noted, this feeling comfortable reflects a unique situation of interpersonal trust with a specific nurse as opposed to institutional trust with nurses in general.

Another property of *Feeling Confianza* is *feeling like family*. Several participants made comments related to feeling like a family member was caring for them and the comfort level that gave them. For example, one participant stated:

> And these people, for me not to know them, you know, they almost felt like they were like your mother or sister or brother would care for you. In a sense, it's

strange, you know. I guess they've been there like that, especially her, more than I could've imagined, you know [21.8].

Another participant echoed this *feeling like family* that occurred as a result of positive interactions with a particular nurse. The participant stated:

Well, either she help me with the baby and she hold the baby, too, and then she change the diaper, too, for her, and she tell me like the baby is beautiful. I don't know, I feel like -- like part of the family, like something comfortable, they talking to you and they like the babies and everything [3.11].

Feeling like family reflects the importance family has in the Hispanic culture. For the patient to feel that comfortable, to feel like family with the nurse, is a sign of the development of trust.

In contrast, although participants did not explicitly state *not* feeling like a bother; they talked about the negative feelings that come from *feeling like a bother*. When the interaction with the nurse is negative, the patient will feel uncomfortable and even *feel like a bother*. *Feeling like a bother* also has roots in Mexican culture as one participant noted:

But I think that with the one that I really, really liked, that I really felt comfortable asking her for help, 'cause I -- I don't know if it's like just Mexicans that don't -- but we don't really like to ask for help or to bother people to help us [8.14].

Several of the participants mentioned self-reliance and not wanting to impose on the nurse for things they can normally do themselves. As noted in the beginning stage, the hospitalized patient is in a vulnerable position and has to rely on the nurse for help. Another example of *feeling like a bother* was a participant who felt uncomfortable when the nurse caring for him did not speak to him. He stated:

> I wouldn't say that I had a rude nurse, but just the one that was just kind of quiet, I would've been a little more hesitant, to where if I did want something, I would have felt like I was bothering her, to where somebody else that was always asking me if I needed something and wanted something, I'd have been more quick to ask her for help or ask her for something, because she was already offering her assistance; as to where the other one didn't really say much, I would've been more hesitant to ask her for help [21.24].

In a negative interaction when the patient feels like a bother, the patient may be hesitant to ask for help as this participant noted or, as another participant explained, may simply shut down:

> I had asked her only – only, you know, to change my pad. She was very smug about it, like, well, she told me that she changed your pad three hours ago. Like that, I'm like, okay, I'm sorry. Did I bother you? ….So that's -- that's what it kind of like, oh, I'm not going to bother her. If I need something, I'll just see what I can do about it, but it -- it really like kind of like shuts me down [2.24].

In the situation where the patient feels like a bother, they will not ask the nurse again for help with something or confide in the nurse.

This feeling uncomfortable or *feeling like a bother* has a negative effect on the patient. For example, when asked to share any additional comments about the nurse-patient relationship and development of trust, one participant shared:

> You [the nurse] don't realize that you make the person feel small when you come in here mean. You know, you make them feel not good. Like the one nurse, she made me feel horrible and I was in a lot of pain; not only just because of the pain, but you're -- you're here to help me, and I'm relying on you, and you're treating me like this, so it makes me feel worse. Not only my pain, but you're making me feel worse inside, like I'm nobody [8.30].

This powerful statement demonstrates the impact the nurse can have in a single negative interaction not only in developing trust, but on the patient's well being in general.

On the other hand, when the patient has a positive interaction with the nurse and develops trust, outcomes are *Confiding in the Nurse* and *Taking Away the Negative.* These outcomes of developing trust are two separate categories and discussed in the next sections.

Confiding in the Nurse

When trust occurs the patient is more willing to confide in the nurse. This confiding in the nurse includes sharing something personal, asking for help, and *allowing* the nurse to help. If the patient had a negative interaction with the nurse, trust will not occur, the patient will not want further contact with the nurse, and will not ask for help.

Confiding in the nurse includes sharing something personal. One participant explained what feeling *confianza* and confiding mean:

> There might be some situations where …it's kind of more personal, like it's not something you would want to go and tell everybody like this is how I'm feeling, or this is what's happening to me, because it might be a little bit embarrassing, that's somebody I would go to. I probably wouldn't tell the other nurses for the same reason that I haven't received that like feeling of them really wanting to help me …and maybe those would be like looking at me kind of funny … when the other one would be more like a Mom relation -- like she's just going to be there to help you, whatever you need, whatever she could do for you, she's just going to do it, no questions asked, or no like judging, or -- 'cause that's what I think, it's the judging part [4.14-15].

In order to confide in the nurse, the patient had to have a comfort level like that with family (mother), indicating no judging. Another participant confirmed the ability to ask for help when trust is established, alluding to judging as well. The participant stated:

> Just by having that trust in them, you might be more willing to maybe have them look at something else that might be ailing you, knowing that they're going to do their best to help you with it, and confide in them with it, as to where if you felt

they were looking at you funny, or didn't have much to say, you might be more hesitant to tell them something [21.23].

The patient is taking an important step when the patient is able to confide in the nurse which demonstrates the vulnerable position of the patient. Confiding and trust can lead to a feeling of safety when the patient is in this vulnerable situation. For example, one participant stated:

I really connected with her, like we were -- we -- it was like having my cousin take care of me. It was -- it was -- it was nice. She was really nice, so, it was comforting to know that she actually cared; that you could tell that she cared. It wasn't just like her job that she was doing. And it -- so it made me comfortable, to trust her and confide in her that she was going to be okay, and anything I would ask her for, she was like, don't worry. I -- I have, you know, I have your back [2.40-41].

The nurse "has your back" is a powerful statement about the effect of a positive interaction and establishing trust has on the patient. *Confiding in the Nurse* also includes asking for help and allowing the nurse to help.

The participants spoke of asking for help if they established *confianza* and trusted the nurse. For example, when asked about *confianza* and a particular nurse, one participant stated:

Her name is ANNA [name changed]…she was really, really nice; she was like very, very wonderful. She -- she'd come to me and talk to me like -- like if she knew me. … and anything that I needed, she'll do it right away for me. She'll like come, if I press the button, if I needed something, or she'll just come and see like how I was doing. She'd be coming to see if I needed anything, …or she'll be just asking a lot of questions, like how I was doing, and -- and it really felt like I really can trust her, with like asking her anything. Or if I asked her something like really like personal, like at least for me, she'd be -- she'd be answering like she had no -- no problem answering any questions that I had. And so it was really -- it was really nice [12.6-7].

This participant describes how she was able to establish trust with her nurse and the outcome of confiding in the nurse and asking for help. This description has elements of *Coming Across to Me* (e.g. nice, talking personal, responding to needs) and *Taking Care of Me* (e.g. helpful, coming in and asking). This led to the patient feeling trust, asking for help and ultimately to confiding in the nurse. As mentioned previously, the patient does not like to impose on the nurse and feel like a bother, but when trust is established, this feeling of imposing is discarded and the patient will allow the nurse to help, another form of *Confiding in the Nurse*. One participant stated:

> [The nurse said] If you have to go to the bathroom, I'll come and I'll help you, 'cause I didn't want -- I'm like, no, I can just do it by myself, like go to the bathroom, I don't want to bother her; feel weird that she has to help me. But I trusted her to be like, okay, you can help me to the bathroom, instead of I'm like imposing on her, even if she's like, that's my job; I'm here to help you. So she was really nice, that made me feel comfortable around her and be able to trust her and not feel like guilty, or I'm bothering you, or something [8.14-15].

Allowing the nurse to help indicates accepting assistance while hospitalized is a difficult position to be in for these patients. *Confiding in the Nurse* includes not only asking for help but also allowing the nurse to help. This same participant explained she would not ask for help from another nurse with whom she had a negative interaction and did not trust. She stated:

> Than the other one, I didn't even want to ask her for anything anymore, 'cause I already seen she was not being helpful, or like I didn't trust her, so I didn't really even want to ask her for nothing anymore, 'cause then I knew she was going to come in here and like not be willing to help, or not be nice. So I just didn't want to, like have any kind of involvement with her [8.15].

A negative interaction with the nurse led to the patient not asking for help. This is a major

patient safety concern. Other participants echoed similar sentiments related to not asking

for help if they had a negative interaction with the nurse. That being said, however, some

patients may be in a position in which they must ask for help. One participant who was

confined to bed stated:

> No, I still would talking [sic] to her, you know. I don't care if she really likes me
> or not. The only thing that I want is that she help me what I need…. And when
> she [daughter] gets to the hospital, I tell them the name, I don't want that person
> in here [22.35-36].

So although the patient would continue contact with the nurse, it is only because she has

no other options at the time. Other participants echoed similar sentiments of not wanting

further contact with the nurse if they had a negative interaction. *Confiding in the Nurse*, a

positive outcome of establishing trust, includes sharing something personal but also

asking for help and allowing the nurse to help. Another positive outcome of developing

trust is *Taking Away the Negative* which is discussed in the next section.

Taking Away the Negative

When trust occurs, the positive experience can take away previous negative

experiences. *Taking Away the Negative* primarily reflects removing negative feelings

about an experience but also includes removing a negative physical outcome that the

patient perceives as avoidable. One participant explained:

> It makes you that much more comfortable, knowing that somebody's caring,
> actually caring for how you feel or what you need; it kind of takes away the --
> almost the pain, or the sorrow, or the hurt or the sympathy that you feel at the
> time, because here you've got somebody that you don't even know coming in and

consistently making sure you're all right, so I think it definitely has something to do with benefiting how you feel [21.10].

Another participant echoed similar sentiments:

I think all the negatives, you know, that I've experienced all month were probably taken away with all the -- with all the positives, you know. AMY [name changed], I was in the hospital a week, and if I had any negative stuff happen then, the last two days that I was here that she actually took care of me on her shift, made me forget anything that was happening [19.16].

In these two examples, "taking away the negative" refers to removing negative feelings about the hospital experience. However, *Taking Away the Negative* also refers to removing an actual negative outcome rather than negative feelings. One participant who developed trust with a nurse had a negative birthing experience after the nurse left for the day. The oncoming nurse did not check on the patient or respond to the call light and the patient began to push without hospital personnel in attendance. The participant stated:

Well, because -- maybe because she [trusted nurse] left, I felt, seriously that if she would have been there, maybe she would've kept going in there and checked up on me, or if I would've told her, Oh, you know, I think I want to push, because I called them and they got there late [13.33].

As this participant noted, she would have told the other nurse with whom she developed trust but the nurse on the next shift was not as attentive to the patient. Trust develops between a nurse and a patient during the nursing shift. For this reason, when the nurse leaves for the day, the patient is left with developing trust with the oncoming nurse. Evidence of the cyclical process in developing trust is discussed in the next section.

Cyclical Process

The process of developing trust in the nurse-patient relationship is cyclical and begins again at the start of the next nursing shift. When experiencing positive interactions and trust, the patient will not want the nurse to leave at the end of the shift. If the nurse responds in a negative way, trust does not develop, and the patient will wait until the next shift hoping for a "good" nurse. For example, one participant who developed trust with the nurse stated:

> The other ones were nice, too, but that's the one that I really remember, that I wished she wouldn't leave, or that I trusted, versus the other ones, or the ones that gave me bad experiences [8.13].

Not wanting the nurse to leave or choosing this nurse again was echoed by several participants. In contrast, *wanting* the nurse to leave due to having a negative interaction was mentioned by another participant who stated simply, "Yeah, so once she left, I felt -- I felt good" [9.15]. Having a negative experience with the nurse led to feelings of not wanting contact with the nurse and waiting for the next shift for a "good nurse." One participant explained:

> Because if they're here, and like maybe they're having a bad day and whatever, I'm here to get treated and she's really not answering me. I'm like, okay, well, then, obviously, I'm going to wait for the next nurse, to see what's her day going, or how like she's reacting to me or something like that. I would say that's -- that's how I see it [12.19].

Waiting for the next nurse indicates this is a cyclical process and is further evidence that the trust examined is interpersonal trust on an individual level between the nurse and the patient rather than institutional trust. Waiting to see the nurse's response is evidence that

it is the nurse who directs whether the interaction will be positive and lead to trust or negative and not lead to trust in the nurse-patient relationship with hospitalized patients.

Assessing Trustworthiness of Study

In the grounded theory method, participants share information that they deem relevant to the phenomenon under study. The grounded theory method results in a theory grounded in the participants' frame of reference. The theory emerges from the data and theoretical memoing serves as the researcher's decision trail. The theory that was generated has "grab" and demonstrated fit, work, relevance and modifiability (Glaser, 1978). In addition, this study met the criteria to establish the trustworthiness of the study and methodological rigor. The criteria for trustworthiness are credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). These criteria are addressed in this section along with the grounded theory components to evaluate a theory.

Credibility refers to "the reconstructions that have been arrived at via the inquiry are credible to the constructors of the original multiple realities" (Lincoln & Guba, 1985, p. 296). Basically, the findings represent the participants' realities (Lincoln & Guba, 1985). Credibility was evidenced by data saturation of the categories. Member checking, bringing concepts back to participants to verify, is inappropriate in grounded theory due to the raised level of abstractness of the concepts (Glaser, 2001).

Confirmability is defined as "the extent to which the data and interpretations of the study are grounded in events rather than the [researcher's] personal constructions"(Lincoln & Guba, 1985, p. 324). Confirmability was established through an

audit trail including when events occurred (e.g. interviews, data analysis) and theoretical memos which connect data to categories and categories to each other to form the model.

Dependability, referred to as the criterion *reliability* in quantitative designs, is demonstrated through both the process of the study and the product (findings) of the study (Lincoln & Guba, 1985). According to Lincoln and Guba (1985), dependability is demonstrated through an audit trail and not having early closure due to practical matters. The researcher kept an audit trail including a journal and concluded data collection when categories and properties were saturated and no new findings emerged. Dependability was also demonstrated as the resulting theory makes sense, fits and works. The categories fit with the data and the theory works. Glaser writes, "By *work*, we meant that a theory should be able to explain what happened, predict what will happen and interpret what is happening in an area of substantive or formal inquiry"(Glaser, 1978, p. 4). This theory works because it is clear and the user of the theory can use it to predict what will happen in a given situation. For example, if a nurse is open to connecting with the patient and approaches the patient for the first time with a smile on his/her face and engages the patient in small talk before beginning a nursing task, it is more likely the patient will feel comfortable with the nurse and establish trust. The researcher verified codes and reviewed the theory that developed with a mentor in grounded theory and considered alternative explanations that arose.

Transferability refers to findings being applicable in other situations as judged by the reader of the study (Lincoln & Guba, 1985). Sufficient description and range in

categories assist the reader in making this judgment (Lincoln & Guba, 1985). In this study, categories were clearly described and had range. Transferability was demonstrated by the findings being abstract and the ability to apply these across time. The findings are transferable to similar conditions as those in this study, the obstetric and medical-surgical type units in a hospital setting. The concepts developed in grounded theory are conceptual rather than descriptive since the goal of grounded theory is the explanation of a basic social process rather than the rich description of a phenomenon. The resulting theory has relevance and is modifiable (Glaser, 1978). The theory has relevance to other patient populations within the hospital setting and is modifiable based on future research with other conditions (i.e. Spanish-speaking patients) in the hospital, or other nursing settings and beyond. For example, the theory may be modified with future research with monolingual Spanish-speaking patients who may place even more importance on the ability of the nurse to speak Spanish.

Chapter Summary

In this chapter, the model of how trust develops in the nurse-patient relationship, the core category Making Me Feel Comfortable, and the eight categories and their properties were presented. The participants' quotes provided supporting descriptions of the categories that explain the process of developing trust. The chapter concluded with a discussion establishing the trustworthiness and methodological rigor of the study and the fit, work, relevance, and modifiability of the theory generated from the data. In the next chapter, the findings are discussed as they relate to previous literature, new contributions

to nursing knowledge, and implications for clinical practice, nursing education and

research.

CHAPTER FIVE

DISCUSSION

The purpose of this chapter is to discuss the key findings of the grounded theory

study of the development of trust in the nurse-patient relationship with hospitalized

Mexican American patients and how these relate to previous findings in the theoretical

and empirical literature. First, the model and core category are discussed, then the eight

categories are discussed along with previous literature findings and the unique findings

from this research study. The chapter concludes with a discussion of limitations and

strengths of the study and implications for nursing practice, education and future

research.

Model

The process of developing trust in the nurse-patient relationship begins with the

hospitalized patient having a need and relying on the nurse (see Figure 1).
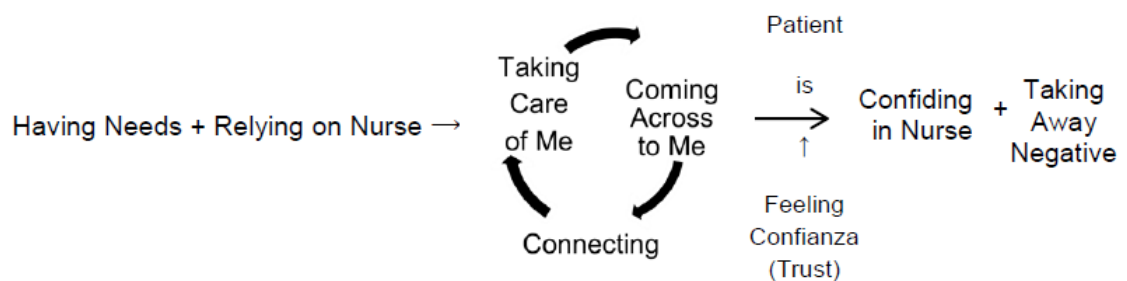

Figure 1 Model of the development of trust in the nurse-patient relationship with
Mexican American patients (from Chapter 4).

In the middle stage, the nurse and patient interact as the nurse addresses the patient's need through the *Coming Across to Me, Taking Care of Me,* and *Connecting* categories. The way the nurse approaches the patient directs whether the interaction will be positive or negative. If the nurse is positive and comes across to the patient as friendly, demonstrates caring, and connects with the patient this leads to the patient feeling comfortable with the nurse. In feeling comfortable, the patient is willing to trust the nurse, confide in the nurse and the patient will not want the nurse to leave at the end of the shift. If the nurse is negative in the interaction or does not seem to care about the patient, then the patient feels uncomfortable and may feel like a bother, will not develop trust, will not ask for help, and will wait until the next shift hoping for a "good" nurse. Outcomes of the development of trust are the patient will confide in the nurse and the positive interaction can take away previous negative experiences or feelings. If trust does not develop, the patient may feel like a bother and may not want further contact with the nurse.

The development of trust with a nurse is a cyclical process that starts again with the nurse on the next shift and depends on how the nurse chooses to interact with the patient. This cyclical process is further evidence that the trust examined in this study is interpersonal trust on an individual level between the nurse and the patient rather than institutional trust with nurses in general. Waiting to see the nurse's response is evidence that it is the nurse who influences whether the interaction will be positive and lead to trust or negative and not lead to trust.

The model of the development of interpersonal trust between the nurse and the hospitalized patient which emerged in this study was similar to the stages of initiation of trust between persons attributed to Luhman in the theoretical literature (Carter, 2009) and Hupcey et al. (2000) in a grounded theory study of trust between healthcare providers and hospitalized patients. In this study, the beginning stages of *Having Needs* and *Relying on the Nurse* was similar to Luhman's first stage Initiation which incorporated risk and vulnerability. Likewise, the expectations for nursing care in the Relying on the Nurse category were similar to the Hupcey et al. (2000) stage Entering the System which included expectations of the institution (hospital). In this study, the middle stage of interacting with the nurse which included *Coming Across to Me, Taking Care of Me* and *Connecti*ng was similar to Luhman's second stage of familiarity and communication which included assessment of personality and role expectations and the Hupcey et al. (2000) Interacting stage which included inhibiting and facilitating behaviors. The facilitating behaviors and some inhibiting behavior noted by Hupcey et al. (2000) were similar to findings in this study. However, the inhibiting behavior of having different caregivers noted by Hupcey et al. (2000) was not a finding in this study since this study focused only on the nurse-patient relationship rather than hospital-based healthcare providers in general as was the case in the Hupcey et al. (2000) study. In this study, the category *Feeling Confianza (Trust)* was similar to Luhman's third stage of mutual trustworthiness with some noted differences. In this study, the mutuality of the trust was not explored since the focus was the patient's perception of trusting the nurse and not the

nurse's perception of developing trust with the patient. Another difference was the balance of power. In Luhman's model, the power imbalance was stabilized, whereas, in this study of the nurse-patient relationship with hospitalized patients the power imbalance remained. This continuing power imbalance in the hospital setting is evident because, in the hospital, the patient is even more vulnerable and relies on the nurse for even basic needs. In the Hupcey et al. (2000) study, the final stage was the Evaluating stage which included general trust of individualized providers, global trust, rebuilding trust, and forms of distrust but seemed to reflect patient satisfaction which was different than findings in this study. Of note, in a recent model testing study of the Patient-Centered Culturally Sensitive Health Care Model with non-Hispanic Blacks and Whites, the authors noted some overlap in the constructs of trust, satisfaction, and cultural sensitivity (Tucker, et al., 2011). In this study, participants did not mention distrust, but rather no trust developing. Not developing trust is different than *dis*trust. If the patient does not develop trust, then there is simply no interpersonal trust with the nurse yet the patient may continue to trust the nurses in general (institutional trust). However, without interpersonal trust, the patient will not feel comfortable, not confide in the nurse and will be more hesitant to ask for help.

In this study, the outcomes of trust emerged from the data as well. The patient outcomes of interpersonal trust with the nurse were *Confiding in the Nurse* and *Taking Away the Negative*. The core category and categories in the model are presented in the next sections along with how the findings relate to previous literature.

Core Category

Making Me Feel Comfortable emerged from the data as the core category in the process of developing trust in the nurse-patient relationship with hospitalized patients. Participants used the phrase "making me feel comfortable" to refer to a feeling of ease with the nurse, a state of being rather than physical comfort. When the patient feels comfortable, the patient feels *confianza* (trust) and is willing to confide in the nurse. The term *making me* reflected the key role the nurse played in the patient reaching this state of being. It was the nurse's actions that directed whether the interaction would be positive or negative. The nurse making the patient feel comfortable was noted in a previous study related to trust in the nurse-patient relationship in an immunization clinic with Mexican American mothers (Keller, 2008) and it was briefly mentioned in another study of elderly clients in the homecare setting (Trojan & Yonge, 1993). Similarly, in a qualitative field study of adherence to treatment of home-based patients with leg ulcers in Belgium, the patients revealed trust/feeling safe with the nurse (Van Hecke, et al., 2011). In another study of culturally competent care (Warda, 2000), a quote by a participant related to the importance of *personalismo* also included the notion of the nurse making the patient feel comfortable and *confianza* (trust), however, the author did not address the issue of feeling comfortable in discussing trust.

An important finding in this study is the emphasis on the nurse's actions directing whether trust developed or not. In the theoretical literature related to trust (Carter, 2009) and previous empirical research related to culturally competent care with Mexican

Americans in the community (Stasiak, 2001) and in an outpatient surgery center (Zoucha, 1998), findings indicated the nurse must earn trust. Likewise, in this study, the nurse earned trust through simple, positive actions and the nurse was responsible for the development of trust in the nurse-patient relationship. Similar findings of the provider's actions directing whether trust was established or not were reported in a previous study of hospitalized patients and care providers (Hupcey, et al., 2000). Contrary to previous findings (Stasiak, 2001), *confianza* can develop in a relatively short period of time in the hospital setting according to participants in this study.

Perhaps due to the power imbalance and vulnerability in the hospital setting, the patient is more open to trust and, as evidenced by the findings in this study, it is the nurse's actions that dictate whether trust will occur. In the theoretical literature, the power imbalance was noted with the nurse being in a position of power and the patient being in a vulnerable position (Carter, 2009; Sellman, 2007). Likewise, previous studies noted a power imbalance occurred when the patient was admitted to the acute care (hospital) setting but when the patient returned home the power balance was restored in the nurse-patient relationship in the home care setting (Trojan & Yonge, 1993) and the physician-patient relationship in the primary care clinic setting in the U.S. (Thorne & Robinson, 1988).

The core category Making Me Feel Comfortable reflects the basic social process of developing trust and encompasses the eight categories *Having Needs, Relying on the Nurse, Coming Across to Me, Connecting, Taking Care of Me, Feeling Confianza (Trust),*

Confiding in the Nurse, and *Taking Away the Negative*. These eight categories and their properties are discussed in the next sections along with how these relate to previous literature.

Categories

Having Needs and Relying on the Nurse

In the beginning stage of developing trust, the patient has needs and relies on the nurse to meet those needs. The category *Having Needs* indicated the patient had basic needs such as pain relief and was in a vulnerable position due to being hospitalized. Due to the vulnerable position, the patient's needs had to be addressed by another person. The other person the patient relied on was the nurse caring for the patient during that shift.

The category *Relying on the Nurse* encompassed the expectations the patient had for nursing care including nursing competence and the nurse being present more than the doctor. *Relying on the Nurse* indicated the vulnerability of the patient in the hospital setting.

Previous theoretical literature related to the concept of trust indicated four key components were present for trust to occur: need, risk, vulnerability, and familiarity (previous experience) (Baier, 1986; Bell & Duffy, 2009; Hupcey, et al., 2001; Sellman, 2007). Additional components for trust were good will (Baier, 1986; Sellman, 2007) and expectations for future behavior (Hupcey, et al., 2001; Sellman, 2007) which could be subsumed under familiarity with an institution. Need and vulnerability were clearly evident in the *Having Needs* category. Risk, vulnerability, and expectations of care were

evident in the *Relying on the Nurse* category. In relying on the nurse, the patient had

expectations for nursing care and was in a vulnerable position which included risk that

the nurse caring for the patient on that shift would be attentive and competent in

addressing the patient's needs. Regarding risk, although the patient did not take a risk in

choosing the nurse who would provide care on the shift, according to Baier (1986),

people are vulnerable to another's ill will which would result in risk. Likewise, in the

Hupcey et al. (2000, p. 234) study, patients noted interpersonal trust developed with the

nurse who addressed a "critical need." In this study, technical competence of the nurse

was noted but in a limited manner, with interpersonal skills more important. Likewise,

the competence of the provider was only mentioned in a limited manner in previous

research related to trust in the hospital setting (Hupcey, et al., 2000), in the physician-

patient relationship (Mechanic & Meyer, 2000; Skirbekk, et al., 2011) and the

rehabilitation ward for patients with lower limb amputations in Australia (Manderson &

Warren, 2010). Likewise, in a study of cultural competence with Mexican Americans,

provider technical skills were not important (Warda, 2000). However, in a qualitative

field study of patient adherence to leg ulcer treatment, the technical competence of the

nurse was an important factor in trust development (Van Hecke, et al., 2011).

Another expectation of nursing care noted in this study of hospitalized patients

was the nurse being there at the bedside more than the doctor and serving as a "middle

person." Although this function of the nurse was not mentioned in the trust literature or

previous studies with hospitalized patients (Hupcey, et al., 2000), the nurse as the

mediator between the doctor and the patient was a component of communication in patient-centered care (PCC) (Gerteis, et al., 1993).

The components of familiarity and good will (Baier, 1986; Sellman, 2007) were evident in the middle stage *Coming Across to Me, Connecting* and *Taking Care of M*e discussed in the next section.

Coming Across to Me, Connecting, and Taking Care of Me

Following the beginning stage, the middle stage of trust development reflected the interaction of the patient with the nurse, with a focus on meeting the patient's needs. *Coming Across to Me* and *Connecting* were the affectively-driven components of this interaction cycle whereas *Taking Care of Me* was the action-driven component. *Coming Across to Me* included the nurse making a first impression, the way of going about the job, responding to the patient's inquiries, talking personally and, for some patients, speaking Spanish. *Taking Care of Me* included the nurse being helpful, coming in and asking, and showing care. *Connecting* was a mutual feeling of connection between the patient and the nurse, according to the participants, who noted mutual attentiveness when describing connections. When the patient connected with the nurse, the patient may go on to feeling *confianza* and willing to trust the nurse. If the patient did not connect with the nurse, the patient may feel like a bother and not develop trust with the nurse. The nurse's actions directing the development of trust may reflect the importance of connecting between the nurse and the patient needed for trust to develop

In *Coming Across to Me* and *Taking Care of Me*, the patient perceived the nurse's intentions as positive or negative. If the nurse was perceived as providing a positive atmosphere, talking personally, being helpful, caring more and going the extra mile, this indicated positive interactions and intentions. These positive intentions reflected good will. In addition, particularly in the *showing care* property of *Taking Care of Me*, this demonstrated caring *about* rather than caring *for* the patient, another reflection of good will and a component of trust (de Raeve, 2002). Caring was noted as an important aspect of trust in the nurse-patient relationship on a rehab unit in Australia (Manderson & Warren, 2010) and the physician-patient relationship in the U.S. as well (Mechanic & Meyer, 2000). In the theoretical literature, good will was the noted difference between reliance and trust (Baier, 1986; Sellman, 2007). Likewise, in this study and as represented in the model, participants indicated they may rely on the nurse to meet their needs, but it was the positive interaction (good will) with the nurse that led to trust developing. Although other empirical studies related to trust did not mention good will specifically (Hupcey, et al., 2000; Mechanic & Meyer, 2000), researchers noted the patient testing to see if the provider was "looking out for [the patient's] best interest" (Hupcey, et al., 2000, p. 234) which is synonymous with good will.

Making a first impression, a property of *Coming Across to Me,* reflected the nurse's personality and attitude and included being friendly and nice. Personality was important in trust development according to the theoretical literature (Carter, 2009). The first impression and approaching with a social intent rather than task were important in

studies related to the nurse-patient relationship with homecare nurses and elderly clients

(Trojan & Yonge, 1993) and with Mexican American mothers in an immunization clinic

(Keller, 2008). Likewise, being friendly and positive relations (*personalismo, simpatia*)

were important for culturally competent care and establishing *confianza* (trust) (Belknap

& Sayeed, 2003; Stasiak, 2001; Warda, 2000; Zoucha, 1998). A positive attitude of

caring and respect is part of PCC (Gerteis, et al., 1993) and provider attitude was

important to provide culturally competent care (Belknap & Sayeed, 2003; Burchum,

2002; DeSantis, 1994; Fernandez, et al., 2004; Kim-Godwin, et al., 2006; Shapiro, et al.,

2002; Warda, 2000).

Demonstrating range in the category *Coming Across to Me*, being rude or "having

a mad face" was noted as not leading to trust development in this study. This was similar

to the findings of a qualitative descriptive research study of the perceptions of newly

graduated nurses in Australia and developing trust with hospitalized patients which found

bringing negative issues to work would impact the nurse's ability to communicate with

the patient (Belcher & Jones, 2009). The nurse must be emotionally available to interact

with the patient.

Responding, a property of *Coming Across to Me* referring to the nurse's response

to the patient's inquiry, was the gateway to trust developing and incorporated the positive

intentions noted with good will. In this study, the patients were open to give trust but it

was the nurse's response to the patient's initial question that could lead to trust. If the

response was judgmental, this could lead to the patient shutting down and no trust

developing. *Responding* was similar to the testing by patients noted in other studies in which the patient made an initial inquiry to gauge the provider's response (Hupcey, et al., 2000; Mechanic & Meyer, 2000; Thorne & Robinson, 1988). Similarly, *responding* was the nurse's initial reaction to a patient inquiry. As in this study, not being responsive to patient concerns inhibited trust development in previous studies (Hupcey, et al., 2000; Trojan & Yonge, 1993) while listening and being non-judgmental facilitated trust development (Mechanic & Meyer, 2000). Likewise, in studies of culturally congruent care with Mexican Americans, discounting and not acknowledging the client's perceptions led to incongruent care while kind, positive communication (Warda, 2000) including being non-judgmental (Kim-Godwin, et al., 2006) led to culturally congruent care. Responding was also noted as a component of the patient's perception of nursing care in a grounded theory study with hospitalized patients (Schmidt, 2003).

Talking, another property of *Coming Across to Me,* was the key to developing trust. Talking personally included seeing the patient as a person and led to familiarity with the nurse. Familiarity was an important component of trust in the theoretical literature (Baier, 1986; Carter, 2009; Sellman, 2007). Likewise, the findings in this study of talking personally and seeing the patient as a person were supported in empirical research related to trust in the patient-provider relationship (Hupcey, et al., 2000; Mechanic & Meyer, 2000; Skirbekk, et al., 2011; Thorne & Robinson, 1988) and trust in the nurse-patient relationship (Trojan & Yonge, 1993; Van Hecke, et al., 2011) as well as the patient's perception of nursing care (Schmidt, 2003). In studies of culturally

competent care with Mexican Americans, spending time and becoming personal through talking led to *confianza* (trust) or confiding in an outpatient surgery setting (Zoucha, 1998) and domestic abuse outreach setting (Belknap & Sayeed, 2003).

Another component of *talking* in this study was the nurse speaking Spanish. The nurse speaking Spanish was also noted as important in culturally competent care which led to trust in a study of Mexican American mothers in an immunization clinic (Keller, 2008). The importance of the nurse or healthcare provider attempting to speak Spanish as a sign of respect, to become more personal or to establish a connection was also noted in other research studies related to culturally competent care with Mexican Americans (Jones, 2008; Stasiak, 2001; Warda, 2000; Zoucha, 1998) and a study of perceptions of discrimination of Mexican American parents of deceased seriously ill children (Davies, Larson, Contro, & Cabrera, 2011). The level of Spanish language ability was not specifically mentioned by participants in this study; in a previous study of cultural competence, fluency in Spanish was not rated high (Kim-Godwin, et al., 2006). In this study, a participant established trust with the nurse who spoke Spanish because the nurse could better explain her newborn's health problem. This was similar to findings in a study of Mexican immigrant mothers' expectations for child health care (Clark & Redman, 2007), which indicated the need for the provider to speak Spanish so the mother could better advocate for the child's health. The ability to explain health conditions would indicate a high level of Spanish speaking ability and perhaps fluency in Spanish. In the Jones (2008) study, the emergency room nurse who spoke only some Spanish

resulted in a connection between nurse and patient and led to the patient appearing more relaxed. Likewise, in this study, participants noted speaking Spanish with the nurse made them feel comfortable. Future research is needed with limited English proficiency and monolingual Spanish-speaking Mexican Americans to determine the impact of varying degrees of the nurse's Spanish language ability.

The *Taking Care of Me* category reflected nursing actions of being helpful, showing care including going the extra mile, and coming in and asking. Some of these actions may be specific to a hospital setting. Findings in this study were similar to the findings of another study in a hospital setting which noted taking action and going the extra mile facilitated the establishment of trust (Hupcey, et al., 2000; Morse, 1991). In contrast, going the extra mile was not mentioned in the study of trust in the homecare setting (Trojan & Yonge, 1993) or the clinic setting with primary care physicians (Thorne & Robinson, 1988).

In the *Connecting* category, the connection between the nurse and the patient is the key to a nurse-patient relationship. Although the connection was a mutual connection, participants in this study noted it was the way the nurse approached the patient that led to the connection, indicating the nurse's major influence in establishing a connection. Also, the patient had to be cognitively available (i.e. alert) to reciprocate, as one participant noted being too sick to interact with the nurse early in her hospitalization. The participant was not cognitively available to reciprocate. The amount of time spent with the nurse was a factor for some patients as well. Previous research studies of

experienced nurses have noted the nurse's role in developing the connection (Morse, 1991) and even newly graduated nurses realized their role in developing rapport with the patient (Belcher & Jones, 2009). In a study of trust between the healthcare provider and hospitalized patient (Hupcey, et al., 2000, p. 235), "clicking on a personal level" was mentioned as part of facilitating behaviors to establish trust. Likewise, in a study of emergency nurses caring for Mexican American patients, from the nurse's perspective, the one nurse who spoke Spanish was the only nurse who mentioned connecting with a patient and alluded to the nurse-patient relationship (Jones, 2008). However, in a previous study of the nurse-patient relationship and trust (Trojan & Yonge, 1993), Connecting was a category but it was described by the authors as becoming familiar in getting to know each other rather than as a mutual connection.

Finally, the patient and nurse being connected was addressed in a grounded theory study which provided foundational research related to the development of the nurse-patient relationship (Morse, 1991). Through interviewing Canadian nurses (n=44) both in their role as a nurse and, for some, their role as a patient, Morse (1991) identified four types of nurse-patient relationships: Clinical, Therapeutic, Connected, and Over-involved. The characteristics of the Connected relationship were very similar to findings in this study and the outcome of the Connected relationship was patient trust to confide in the nurse which went beyond trust in nursing competence noted in the Clinical and Therapeutic relationship types (Morse, 1991). Trust in nursing competence reflected institutional trust in nurses. In the Connected relationship the nurse saw the patient as a

person first and patient second, the patient's concerns were primary with treatment

concerns as secondary, the time spent with the patient was lengthy or the patient's needs

were extensive or in crisis, and it was noted the nurse "goes the extra mile" (Morse, 1991,

p. 457). These findings were similar to findings in this study of seeing the patient as an

individual and the patient relying on the nurse to meet needs. In the Morse study (1991),

the patient was grateful and the nurse felt her or his care made a difference. In this study,

patients noted being grateful and, according to the patients, the nurse's care made a

difference as evidenced by the *Taking Away the Negative* category. In the Connected type

relationship, the relationship ended at the end of the shift or discharge which interfered

with development of the nurse-patient relationship since it had to begin again with the

oncoming nurse (Morse, 1991) which was similar to findings in this study of the cyclical

nature of interpersonal trust with the nurse.

In addition, in the Morse (1991) study, Negotiating the Relationship was the core

category and started with the nurse assessing and then responding to the patient as a

person and looking for common ground. Assessing the patient was not physical

assessment but more of an emotional assessment, Morse wrote:

> The nurse evaluates the patient's personal needs and support system, assesses the
> patient as a person, and *consciously chooses* whether or not to make an emotional
> investment in the patient, or whether to just do her job. The nurse will look for a
> personality 'click' and determine if she can work with the patient (emphasis
> added) (p.461).

The assessment indicated the strong influence the nurse has in the situation in

determining whether to connect with the patient, similar to this study of either a positive

or negative interaction, and the responding was similar to talking personally in this study.

The author further stated after the mutual connection was established, the patient "trusts

the nurse to make the right decisions about care, relinquishes vigilance and relaxes"

(Morse, 1991, pp. 461-462). Again, very similar to this study in which after the

interaction and trust develops, the patient feels comfortable. As a matter of fact, the quote

provided by Morse noted "And I felt so comfortable.... I felt very good with that nurse on

[the shift]" (p.462). Of note, the connection was mutual between nurse and patient and

the connection was not possible with unconscious patients or psychiatric patients (Morse,

1991). This also reflects a finding in this study that the nurse could not have a mutual

connection with a patient who is not cognitively available to reciprocate. In the Morse

study, a connection with the parent of a hospitalized child was provided so one could

assume a connection could be made with family members of unconscious adults as well.

Noted outside factors influencing the development of the connection were the nurse

experiencing burnout and not wanting to invest emotionally in a relationship or the

patient was undesirable (no further explanation provided) (Morse, 1991). Likewise, in

this study, the participants noted the nurse with a "mad face" being a barrier to trust

developing. However, in the Morse study, if the nurse was rejected by the patient, the

patient was manipulative in "attempting to ensure nursing care" through gift giving,

demanding, and nagging (Morse, 1991, p. 462). In contrast, in this study of interpersonal

trust, if the patient was not accepting of the nurse, the patient was not manipulative, as in

the Morse study. Instead, in this study, if the patient had an issue with the nurse, the

patient wanted to let the issue go and did not want further contact with the nurse except one patient who noted "it's war". This may be a difference based on the cultural values of Hispanics since in general they want positive relationships and wish to avoid negative ones.

Feeling Confianza (Trust)

If the nurse was positive in interactions during the middle stage and connected with the patient, this led to *Feeling Confianza (Trust)*. *Feeling Confianza* was the willingness to trust the nurse and included feeling good and feeling like family. If the nurse was negative in interactions with the patient, instead of feeling *confianza*, the patient could feel like a bother and not want further contact with the nurse.

Feeling like family, a property of *Feeling Confianza*, was an important finding and may be unique to Mexican American and Hispanic patients. *Feeling like family* reflected the patient's feeling of comfort in the nurse which was similar to the feeling of having a family member caring for the patient in the hospital. Feeling like family was not a finding in previous research studies related to trust with hospitalized patients (Hupcey, et al., 2000; Manderson & Warren, 2010; Morse, 1991) or in the outpatient setting (Thorne & Robinson, 1988; Trojan & Yonge, 1993). However, in a phenomenological study of the development of trust between school nurses and high school students in Connecticut, the author noted setting-based and nurse-based factors in the development of trust were a sense of family and a surrogate mother role (Summach, 2011) which could be attributed to the long term contact and the adult-child relationship. In this study,

feeling like family more likely reflected the importance of family in Hispanic culture and

confianza as based on trust with family and close friends (Purnell & Paulanka, 2003c).

Therefore, it makes sense that a patient would assign a family role to a nurse with whom

the patient developed trust ("like your mother or sister or brother would care for you"

[21.8]). The importance of family in care of Mexican Americans has been noted in other

studies of cultural competence (Stasiak, 2001; Warda, 2000) as well as literature related

to *compadrazgo* (kinship) and social support in the Hispanic culture (Gill-Hopple &

Brage-Hudson, 2012; Martinez-Schallmoser, et al., 2005). Given their value for privacy

(Purnell & Paulanka, 2003c), this feeling of comfort with family providing care may not

be shared by Anglo-Americans, and is an area for future research.

Demonstrating range in the *Feeling Confianza* category, if the interaction was

positive, the nurse earned the patient's trust. The nurse earning trust was similar to the

theoretical literature related to trust (Carter, 2009) and findings in research studies related

to cultural competence and Mexican Americans (Stasiak, 2001; Zoucha, 1998). If the

interaction with the nurse was negative, the patient did not develop trust and did not want

contact with the nurse and may be feeling like a bother. Not developing trust was similar

to the theoretical literature which noted the decision to withhold trust or even to mistrust

(Carter, 2009). In a grounded theory study of hospitalized patients and the development

of trust with healthcare providers, findings indicated distrust when a negative encounter

occurred and the patient becoming angry and vigilant while receiving care (Hupcey, et

al., 2000). Distrust of the nurse was not mentioned by participants in this study, rather

they referred simply to trust not developing. In this study, the participants did not

mention becoming angry. The participants stated they shut down, felt like a bother and

waited until the next shift. This reaction of shutting down and feeling like a bother, rather

than anger, is a unique finding in this study. This could be a cultural difference which

reflects the Hispanic value of positive relations (*personalismo, simpatia*). In a study of

culturally competent care, Warda (2000) noted Hispanics avoid negative encounters. In

addition, feeling like a bother may reflect the cultural value of Mexican Americans of

doing for themselves and not imposing on others. This cultural value was mentioned by

participants and, based on previous literature, it is obvious that Mexican Americans are

hardworking (highest rate of employment) (U.S. Census Bureau, 2009a), do not readily

take on the sick role and only seek care if they cannot work (Purnell & Paulanka, 2003c).

Future research with non-Hispanics is needed to determine if feeling like a bother is

indeed a unique cultural value of Mexican Americans or a common value shared by

hospitalized adults regardless of ethnicity.

Confiding in the Nurse and Taking Away the Negative

The outcomes of developing trust in the nurse patient relationship were *Confiding*

in the Nurse and *Taking Away the Negative*. The patient who developed trust with the

nurse felt comfortable and was willing to confide in the nurse which included sharing

personal concerns, asking questions, and allowing the nurse to help. In addition, the

positive interaction which led to trust also led to the patient putting aside negative

feelings about previous experiences. Similar to the *Taking Away the Negative* category in

this study, in previous literature related to trust, Hupcey et al. (2000) noted the change

from negative feelings to positive feelings with a positive interaction with the care

provider. Outcomes of trust noted in a concept analysis of nurse-patient trust were self-

fulfillment from the patient's perspective and positive relationships from the nurse's

perspective (Bell & Duffy, 2009). In this study, only the hospitalized patient's

perspective was explored and although the participants did not mention self-fulfillment

they did note a positive relationship with the nurse in both the *Taking Away the Negative*

and *Confiding in the Nurse* categories. Part of *Confiding in the Nurse* in this study was

allowing the nurse to help. This finding is similar to the findings in a study of trust

between homecare nurses and patients where the Helping stage was noted as the patient

allowing the nurse to help (Trojan & Yonge, 1993). *Confiding in the Nurse* also included

sharing personal concerns or asking questions of a personal nature. Confiding in the nurse

or provider was not mentioned in previous studies related to trust in the U.S. (Hupcey, et

al., 2000; Thorne & Robinson, 1988; Trojan & Yonge, 1993) but a study in Norway

referred to patients being more open to share with the physician when trust was

established (Skirbekk, et al., 2011). Similarly, in a study of culturally competent care in

an outpatient surgery setting with Mexican Americans, Zoucha (1998) noted that the

patient would be more likely to ask questions if *confianza* (trust) was established and a

lack of *confianza* could have negative health outcomes, although no elaboration was

provided. Confiding in the nurse is an important finding in this study and the findings

provide a more in-depth explanation with supporting evidence of the importance of

confianza and the outcome, confiding in the nurse. *Confiding in the Nurse* is discussed further in the Unique Findings section.

Cyclical Process

In this study, the cyclical process of the patient developing interpersonal trust with the nurse was identified and attributed to changing nurses with the change of the nursing shift. The cyclical process is further evidence that the trust examined in this study was interpersonal trust with a particular nurse. This study is unique in that it truly reflects interpersonal trust development between the nurse and the hospitalized patient and not institutional trust. Establishing interpersonal trust contributes to institutional trust in general (Hupcey, et al., 2000).

In summary, the key findings of this study align with the findings from previous literature. The key similarities are listed on the next page along with the figure of the model (see Figure 1).
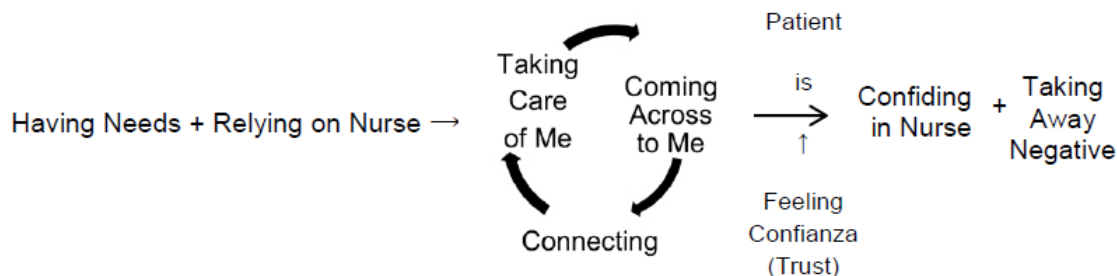
Figure 1 Model of the development of trust in the nurse-patient relationship with Mexican American patients.

1. *Having Needs* and *Relying on the Nurse* reflect vulnerability, risk, and power imbalance (Baier, 1986; Sellman, 2007); expectations of care (Hupcey, Penrod, & Morse, 2000)

2. *Coming Across to Me* includes *responding* which is similar to testing (Hupcey, Penrod, & Morse, 2000; Thorne & Robinson, 1988) and *talking* personally (Hupcey, Penrod, & Morse, 2000; Thorne & Robinson, 1988; Trojan & Yonge, 1993; Zoucha, 1998)

3. *Connecting* includes the perception of a mutual connection (Morse, 1991)

4. *Taking Care of Me* includes going the extra mile (Hupcey, Penrod, & Morse, 2000)

5. *Feeling Confianza* includes *feeling like family, like a bother* (unique findings)

6. *Confiding in the Nurse* reflects allowing the nurse to help (Trojan & Yonge, 1993)

7. *Taking Away the Negative* reflects changing to positive feelings (Hupcey, Penrod, & Morse, 2000)

8. *Making Me Feel Comfortable* (core category) reflects the nurse's key role in earning trust (Carter, 2009; Stasiak, 2001; Zoucha, 1998)

Other Findings

The findings in this study reflect the Hispanic values of *personalismo* (personal relationships), *simpatia* (friendly, positive relations) and the importance of family (familism) in the development of *confianza* (trust). However, surprisingly, participants did not really mention *respeto* (respect) in the development of trust. Participants noted being treated as they should be but only one participant specifically mentioned respect being important for trust to develop and he did not attribute this to his Mexican ethnicity, but rather to growing up in an Italian neighborhood. However, being seen as a person and not as a patient does indicate a certain level of respect.

Of note, there were similarities but no differences found in the development of trust based on gender of the patient or reason for hospitalization (childbirth vs. medical-surgical issues) which were considerations for theoretical sampling. Gender of the nurse did not emerge from the data as relevant. In one of the last participant interviews, a participant alluded to being cared for by a male nurse. The researcher used more in-depth questioning to ascertain any similarities or differences with care or connecting with a male nurse particularly since the participant was male. The participant noted no differences in care or ability to connect with a male nurse except perhaps it may be easier to bond through talking. However when, the participant mentioned specific names of nurses with whom he developed a connection or established *confianza*, the male nurse was not mentioned.

Unique Findings

This study had similar findings to other grounded theory studies of interpersonal relationships between patients and primary care providers (Thorne & Robinson, 1988) and hospitalized patients and nurses (Morse, 1991) as well as trust and the nurse-patient relationship in the home care setting (Trojan & Yonge, 1993) and establishment of trust between care providers and hospitalized patients (Hupcey, et al., 2000). However, a few differences were also found and some important unique findings were revealed, namely, feeling like family and feeling like a bother, which have been discussed, and the outcome, *Confiding in the Nurse*.

Confiding in the Nurse is an outcome of interpersonal trust with Mexican American hospitalized patients and an important finding in this study. In a study of culturally congruent care with Mexican Americans, a participant quote referred to confiding but it was not addressed by the author (Warda, 2000). A possible explanation could be in this study the interview question asking about *confianza* provided an opportunity for a more in-depth response by participants, related to their confiding in the nurse. According to some of the participants, *confianza* also meant sharing something personal. According to literature on the Hispanic culture, Hispanics will not share personal information with the healthcare provider until they develop trust (The National Alliance for Hispanic Health, 2001). Zoucha (1998) noted negative health outcomes if trust does not develop but did not elaborate. According to participants in this study, if trust develops, the patient is more open to discuss personal concerns and ask for help

from the nurse which could lead to further care and positive health outcomes. But more importantly, if trust does not develop or the patient feels like a bother, the patient will "shut down" and not want contact with the nurse, may not ask for help or share personal concerns. The patient shutting down and not asking the nurse for assistance are major patient safety and quality care concerns and could lead to negative health outcomes for the patient. Further research is needed with non-Hispanic groups to determine if confiding in the nurse is an outcome with those groups as well.

Limitations

A potential limitation of the study was the recruitment of English-speaking participants. It is possible, due to acculturation and the lack of a language barrier, that the development of trust may be different for English-speaking Mexican Americans compared to those who do not speak English. However, Mexican Americans tend to retain their values and beliefs even as they acquire English language skills (Luna, 2003; Warda, 2000). For example, in a study related to health care beliefs, acculturated (Anglo culture) Mexican Americans had similar health beliefs as those less acculturated (Hispanic culture) (Rogers, 2010). The use of interpreters during the interview process and the translation of transcripts add a layer of complexity to the language. In qualitative research, the nuances of the language are important (Ojeda, et al., 2011). As a novice researcher using the grounded theory methodology for the first time, it was important to focus on the nuances of the language as spoken by the participants directly without the added complexity of a second language. Future research to confirm the model with

Mexican Americans who are limited English proficiency or monolingual in Spanish is needed.

A difficulty in participant recruitment was the relatively young age of the Mexican American population in the U.S. (Mexicans median age 25.7 years old compared to non-Hispanic Whites median age 40.6 years old) (U.S. Census Bureau, 2009a). Persons in their mid-twenties tend to be healthy and less likely to be hospitalized except for childbirth. Therefore, the sample was largely female and experiencing childbirth. However, through theoretical sampling, non-obstetric patients were also recruited which added depth to the emerging categories in the grounded theory and reflected the perspectives of a variety of hospitalized Mexican American patients, rather than only the obstetric patient's perspective.

Finally, some may consider the hospital setting for interviews as a limitation of the data collection method because they assume the patients may not be free to make negative comments (Robinson, 2000). Interviewing participants while still hospitalized was done primarily because in a previous pilot study this population did not respond to a follow-up survey after hospital discharge (Jones, 2010). Participants were interviewed in private and the interview was immediately halted if someone entered the room. The participants openly discussed both positive and negative experiences with particular nurses in detail without hesitation, which leads to the conclusion this was not a major limitation in this study. Also, the grounded theory methodology would correct for this

limitation to some extent since the categories would not have been saturated and reflected such a range of both positive and negative characteristics in the properties.

Implications for Nursing Practice and Nursing Education

Through the use of the grounded theory methodology, a theory emerged which will contribute to nursing knowledge related to the establishmet of trust in the nurse-patient relationship while caring for Mexican American adults. The emerging theory is useful for nurses caring for Mexican American patients and nursing faculty in teaching about nursing interactions with Mexican American patients. The importance of establishing interpersonal trust with Mexican American patients cannot be overstated as it pertains to patient safety and quality care. The patient who developed trust with the nurse was more willing to confide in the nurse and ask for help. However, more importantly, the patient who had a negative interaction with the nurse shuts down and will not ask for assistance. A patient safety example is the patient who is in a weakened condition and needs help to ambulate to the bathroom. The Mexican American patient may feel like this is an imposition on the nurse. If the patient develops trust with the nurse, the patient would be more likely to ask for help, whereas, the patient who does not develop trust would likely not request help and potentially fall. An example of a quality care concern would be the implications of the patient confiding in the nurse about a new onset of pain or choosing not to confide in the nurse and waiting until the next shift which would delay the assessment and treatment of the new pain. Both of these examples, a fall while ambulating alone or delaying the assessment or treatment of new pain, could lead to

increased complications for the patient and a prolonged hospitalization. The nurse

engaging in positive interactions is especially important with Mexican American patients.

In nursing programs and in training hospital nurses and other personnel, being friendly,

smiling, responding in a positive manner and talking personally along with self-

disclosure with the Mexican American patient is important to develop trust. The nurse

should be open to connecting and prepared emotionally to connect with the patient. One

might ask if a "warm" personality can be taught. A widely used fundamental nursing

textbook notes the importance of developing trust with the patient through warmth,

competence, honesty and consistency (Potter & Perry, 2001). A widely-used nursing

textbook related to interpersonal relationships even provides a checklist of sorts which

includes many of the findings from this study such as seeing the patient as unique,

smiling, and active listening to name a few (Arnold & Boggs, 2011). This book even

provides a section on the Hispanic population and notes the necessity to engage in small

talk before beginning care (Arnold & Boggs, 2011). In the hospital setting, nursing

orientation and other training should include the importance of these communication

skills. Many hospitals have implemented hourly rounding with scripting for nursing staff

to use before leaving the room (e.g. "Is there anything else I can do for you, I have the

time") which reflects *coming in and asking*. In addition, given the importance of family

in the Hispanic culture, the nurse should take the extra moment to check that visiting

family members' simple needs are met as well. In the words of the participants, it's the

simple stuff.

As noted in this study, even patients who speak English appreciated the nurse speaking Spanish to make them feel more comfortable. The nurse speaking Spanish is recommended to help establish rapport in basic social context (conversational Spanish). However, if the nurse is not fluent in Spanish, it is important to use interpreters for communication related to patient care to avoid miscommunication that could contribute to errors (Diamond & Jacobs, 2010).

Implications for Future Research

Based on the results of this grounded theory study, future nursing research is needed with limited English proficiency and monolingual Spanish-speaking Mexican Americans to confirm or modify the model. It is anticipated that the nurse's Spanish language ability will be even more important for those populations than it was in this study. In addition, research with non-Hispanics is needed to identify any similarities and differences with the current findings. Another possible direction for future research includes the development of an empirically derived tool to assess trust development in the nurse-patient relationship from the Mexican American patient's perspective. Previous qualitative research studies with non-Hispanics outside the U.S. indicated patients may be more willing to adhere to the treatment plan if the patient developed trust with the nurse (Belcher & Jones, 2009; Van Hecke, et al., 2011). Research to determine the impact of interpersonal trust with the nurse and adherence to the treatment plan by Mexican American patients would be another area of future reseasrch.

In summary, the findings in this grounded theory study of the development of interpersonal trust between the nurse and hospitalized Mexican American patient were similar to findings in previous literature related to the establishment of trust, nurse-patient relationships, patient-centered care, and culturally competent care. In addition, unique findings from this study included the patient feeling like a bother, feeling like family and confiding in the nurse. These unique findings may be attributed to Hispanic cultural values. A major limitation of this study was including only English-speaking Mexican Americans. Further research is needed to test the model with limited English proficiency and monolingual Spanish-speaking Mexican Americans as well as non-Hispanics in the U.S.

Conclusion

The establishment of interpersonal trust between the nurse and Mexican American patient is important when providing patient-centered and cultually competent care in the hospital setting. In this grounded theory study, the model that emerged from the data conceptualizes how trust develops between a nurse and the hospitalized Mexican American patient. This model is useful for nurses who provide care to Mexican Americans who are part of a growing segment of the U.S. population.

This is the first time trust has been examined from the perspective of hospitalized Mexican American patients. The Hispanic culutural values of *personalismo*, *simpatia* and familism along with the Mexican cultural value of doing for oneself were evident in the emerging categories. These cultural values impact the devleopement of trust in the nurse-

patient relationship and can have an impact on patient safety and quality care. As

important as it is to develop trust, not developing trust can lead to the patient not asking

for help and not wanting further contact with the nurse. To develop trust with the

hospitalized Mexican American patient, first, the nurse needs to be emotionally available

to connect. Second, the nurse needs to walk in the room with a smile, chat with the

patient and family present, and then ask the patient and family "What do *you* need?". In

the words of the participants, simple stuff.

APPENDIX A:

LETTERS OF APPROVAL

VANGUARD
H E A L T H | C H I C A G O

April 19th, 2012

Sharon Jones, RN, MSN
9491 Church Street
Bridgman, MI 49106

RE: **110501B: Development of Trust in the Nurse Patient Relationship with Mexican American Patients**

Dear Ms. Jones,

The request for continuing review of the above mentioned study was reviewed at the 4/19/2012 meeting of the Vanguard Health Chicago Institutional Review Board.

The members voted to approve the study for a period of one year. Permission is granted to conduct the research as described in your application effective immediately.
Number of subjects approved for this site is:

The study is next subject to continuing review on or before 4/18/2013, unless closed before that date.

Amendments: any changes to the approved protocol, informed consent document, additions/deletions to personnel, recruitment and advertisement must be approved by the Vanguard IRB prior to implementation.

All serious unanticipated adverse effects must be promptly reported to and approved by the Institutional Review Board. All fatal or life-threatening events that are related to study and occur at the approved site must be reported to the IRB within 48 hours, even if all the information is not available. Follow-up written notification must be submitted within 10 working days. All other serious adverse events that are related to study and occur at the approved site must be reported within 10 working days. It is the responsibility of the investigator to ensure that written notification of such adverse events is submitted to the IRB. The investigator must complete the IRB approved research study Serious Adverse Event Report Form and attach any additional information necessary in evaluating the report (i.e. laboratory reports or supplemental information).

Please contact Marija Nikin (708-763-6238; fax 708-783-0968; email: mnikin@vhschicago.com) if you have any questions or require further information.

Sincerely,

Steven Nemerson, M.D., MSE, MBA
Vanguard Health Chicago IRB Chairman

VANGUARD
HEALTH SYSTEMS

July 6, 2011

Sharon Jones, RN, MSN
9491 Church Street
Bridgman, MI 49106

RE: Our meeting of 6/16/2011 regarding study number **110501B**: Development of Trust in the Nurse Patient Relationship with Mexican American Patients

Dear Sharon Jones:

Thank you for your response to requests from a prior review of your application for the new study listed above. This type of response qualifies for review under FDA and NIH (OHRP) regulations.

This is to confirm that your application is now fully approved. The consent dated 5/30/2011 is approved.

You are granted permission to conduct your study as most recently described effective immediately. The study is subject to continuing review on or before 6/16/2012, unless closed before that date.

Please note that any changes to the study as approved must be promptly reported and approved. Some changes may be approved by expedited review; others require full board review. Contact Diane Palmer (708-783-3414; fax 708-783-0968; email: dpalmer@macneal.com) if you have any questions or require further information.

Sincerely,

Steven Nemerson, M.D., MSE, MBA
Vanguard-Chicago Market IRB Co-Chairman

Loyola University Medical Center
Institutional Review Board
for the Protection of Human Subjects
2160 South First Avenue
Maywood, IL 60153

07/28/2011

NOTICE OF FULL APPROVAL OF A RESEARCH PROJECT

Investigator	**Schmidt, Lee**
LU Number	**203697**
Title	**Development of Trust in the Nurse Patient Relationship with Hospitalized Mexican American Patients**

Date of Initial Review	07/28/2011
Type of Review	**Expedited**
Action of Initial Review	**Full Approval**

IRB Findings	**1. The study is of minimal risk and qualifies for expedited review 45CFR46.110, b-1, HHS Secretary Category #7).**
	2. Loyola is not a performance site for this research.

Informed Consent Document required? **YES**

# of Participants	**20**
Participants Compensated?	**YES**

Amount ($)	**20**
Compensation Schedule	**End of participation**

IRB Number	**203697072811**
Date of Approval	**07/28/2011**
Frequency of Review	**Annual**
Date of First Review	**07/28/2012**

Conditions of Approval	None.
ITEMS SUBMITTED FOR REVIEW	

- **07/18/2011 203697.053011**
- **07/18/2011 MacNeal Hospital IRB approval letter**
- **07/18/2011 Sample Interview Questions**
- **07/18/2011 Recruitment script**
- **07/22/2011 Dissertation Proposal Trust (111 pages)**
- **07/26/2011 Research Protocol (6 pages)**
- **07/27/2011 Dissertation Proposal Approval Ballot**

YOU HAVE FULL APPROVAL AND YOUR PROJECT MAY BEGIN.

The following is for your information and will help you meet local and federal IRB requirements.

1. You must use the final IRB-approved version of the Consent Document. Spelling and grammatical changes may be made as necessary, but any other changes require prior review and approval.

2. You are required to maintain complete records of this project. Any changes in the protocol and the Consent Document must receive prior IRB approval. Use the online Research Portal's Project Amendment form to report changes. A change to the protocol necessary for the immediate safety and welfare of a

research participant may be implemented prior to IRB review and approval.

3. Federal Regulations require that projects undergo periodic review
of research activity at least once a year. This review must be substantive.
The frequency of review and next scheduled date of periodic review for your project
can be found under the "Annual Review" tab in the Research Portal's IRB section.
You will receive notification 4-8 weeks prior to the scheduled date of review.
At that time, you must provide information regarding the status of the project.
If the information is not received, the project will be suspended.
It is important that you not let approval lapse.

4. The IRB must be notified any time that the project temporarily or permanently
stops enrolling participants along with the reason. Use the online Closure form to
submit these notifications.

5. Any notices or advertisements soliciting participation must receive prior IRB approval.
Use the online Amendment reporting form.

6. The IRB must be notified PROMPTLY of all serious and any unanticipated adverse events
associated with the project (or the device or the drug). This includes any notification
received of adverse events occurring at other performance sites. Further guidance on
adverse event reporting may be found at the Office for Human Research Protections web site;
http://www.hhs.gov/ohrp/policy/AdvEvntGuid.htm#Q5

Reportable events include, but are not limited to:
a) a serious adverse event (including events that produce injury or death, an event
   leading to hospitalization or lead to prolongation of a current hospital stay);
b) the enrollment of a patient on a study that is no longer enrolling participants;
c) pregnancy occurring on the study where the study excludes pregnancy;
d) any patient reporting a billing problem as a result of project participation;
e) any participant who has voiced a complaint about some aspect of the project
or the consent document;
f) any unanticipated, untoward, or unexpected adverse event not covered above including
   rare adverse events or adverse events that occur at an unexpected rate
g) protocol deviations
h) investigational drug/device brochures, revisions

Adverse Protocol Events are reported through the online Research Portal.

7. The IRB may suspend the project to new participant enrollment or may suspend the
participation of current subjects if there is a perceived safety and/or regulatory issue.

8. Prospective consent must be obtained from all research participants.

9. The IRB may review your records relating to this project, including signed consent documents.

10. The Institutional Review Board of Loyola University Medical Center is appropriately
constituted and has been granted Federal Wide Assurance Number FWA00009471.

11. If you are unsure of your reporting requirements or of what is expected of you
during the conduct of this research, please call the IRB Office (708-216-4608) or
Dr. Kenneth Micetich (708-327-3144).

12. The Loyola Institutional Review Board is appropriately constituted as stipulated in
45cfr46 and is compliance with Good Clinical Practice Guidelines insofar as those guidelines
are consistent with the U.S. Food and Drug Administration regulations (21 CFR Parts 50 and 56)
and the Department of Health and Human Services regulations (45 CFR 46) pertaining to the
protection of human subjects in research.

Elaine Fluder
Director
Human Research Protections Program
Loyola University Health Sciences Division

APPENDIX B:

INTERVIEW GUIDE

Sample Main questions to focus interview

1. Tell me about your experiences with the nurses that have been caring for you thus far in the hospital.

2. In the Mexican culture, people use the term *confianza* to refer to trust or confidence, can you tell me about *confianza* and any experiences with a particular nurse you had so far in the hospital?

3. What helps you to develop trust in a particular nurse more so than with another nurse?

4. What barriers are there to developing this trust with a particular nurse?

APPENDIX C:

RECRUITMENT MATERIALS

Recruitment Script [printed on 3x5 pale yellow cards]

Sharon Jones, a graduate student at Loyola University, is interviewing patients for a research study. Sharon interviews you in your hospital room for about 30 minutes to an hour. Are you interested in talking to Sharon to learn more about the study? Saying "Yes" means you want more information and is not a commitment to be in the study. **Thank you.**

□ YES, I want to learn more about the study

Patient Name _____

Unit/Room number_____

APPENDIX D:

CONSENT FORM

XXXXX Hospital

Consent to Participate in a Research Study

Protocol No.: **110501B**
Title of Study: **Development of Trust in the Nurse Patient Relationship**
with Mexican American Patients

Principal Investigator: **Sharon M. Jones, RN, MSN**

Address: **9491 Church St.**
Bridgman MI, 49106
Phone: **(269) 405-3679**

Introduction
You are being asked to take part in a research study. Once you have read the following information, the researcher will review this information with you. Ask as many questions as you need to feel sure about deciding whether or not to take part. Participation is entirely voluntary and refusal to take part in the study will not affect your medical care or benefits you are otherwise entitled to.

What is the purpose of this study?
The purpose of this study is to explore the relationship and trust between Mexican American patients and the nurses that care for them in the hospital.

How many people will take part in the study?
About 20 patients will take part in this study at XXXXX Hospital.

Description of the study
If you decide to take part in this study, you will participate in an interview that will last about 30 minutes to 1 hour.

This research study is for a doctoral dissertation, a graduate school project. If you agree to participate in this study, you will be asked to share your recent experiences with the nurses caring for you in the hospital. Your responses will be tape recorded. This will take about 30 minutes to an hour. If your family members are present, they can remain in the room if you prefer. Any statements they make will not be included in the study. You can tell the researcher at any time to not include a portion of the conversation or ask the

researcher to turn the tape recorder off. If you request something to not be included, then it will not be used for the study. The researcher will listen to the recordings and have a typist type the conversation so it can be read later for better understanding. You can stop participation at any time and if you choose to not be included in the study, and all information, including any record of what you said, will be destroyed and will not be part of the study. Your privacy will be protected to the greatest amount allowed by law. A number will be used to refer to you, instead of your name in the recordings, typed records and any papers or reports. The typed records will be seen by the researcher and the chairperson of the dissertation committee. Any identifying information you mention will be removed from the transcripts or a pseudonym will be used. In publications or presentations some quotes will be used but identifying information will not be included and only a participant number will be used.

What side effects or risks can you expect from being in the study?
Being in this study does not involve any expected risk or harm to you; the only harm may be emotional if you have bad feelings about your illness or being hospitalized. Being in this study will not affect how you are treated at the hospital.

Potential Benefits
It is possible that you may not benefit from taking part in this study. The knowledge gained from your participation might benefit others in the future.

ALTERNATIVE OPTIONS: Alternatives are not applicable to this study.
What are the costs for taking part in this study?
There is no cost to you to be part of this study.

You will receive a $20 gift card at the completion of the interview as a token of appreciation.

Who can answer your questions about the study?
If you have any questions about the study, you should contact the researcher Sharon M. Jones at **(269) 405-3679** or Lee Schmidt, chairman of dissertation committee at **(708) 216-3573**.

If you have any questions about your rights as a research subject, you should contact the Human Investigation Committee: The Institutional Review Board of XXXXX Health Services Corporation at **(xxx) xxx-xxxx**.

WITHDRAWAL FROM STUDY:
You can withdraw from the study at any time for any reason, without penalty or loss of benefits you are normally entitled to.

It is important that you let the researcher know if you do decide to withdraw from the study.

Your name, picture, or any personally identifying information will not be used in any publication or advertisement resulting from this study. All paper and recordings will be kept by the researcher in a locked file cabinet only accessible by the researcher and the dissertation chairperson.

Consent to participate / Authorization

I have asked any questions about this study and all such questions have been answered to my satisfaction. I can end my participation in this study at any time without penalty, loss of benefits, medical care or affecting my medical care. I have not given up any of my legal rights as a research participant.

I have read the information in this Informed Consent Form and will receive a signed copy. I volunteer to participate in this study based on this information.

Signatures

_____   _____   _____
Patient's Printed Name   Patient's Signature   Date

_____   _____   _____
Witness (if applicable)   Witness (if applicable)   Date
 Printed Name   Signature

_____   _____   _____
Person Obtaining Consent   Person Obtaining Consent   Date
Printed Name   Signature

APPENDIX E:

TABLES OF RESEARCH STUDIES

Table 1

Trust and Patient-Provider Studies

Reference and Country	Method and Sample	Findings
Chavez, Wampler, & Burkhart, (2006) USA	Quantitative, descriptive; survey, face to face format Migrant seasonal farm workers (n=555, 99.9% Mexican origin) Spanish-speaking	Migrant farmworkers reported low levels of trust for Whites and Mexican Americans in the community.
Hupcey & Miller (2006) USA	Qualitative descriptive; interview Adult community members (n=32)	Interpersonal trust included being honest, feeling relaxed and having no concerns. Trust in healthcare providers required the provider to provide competent care, to have communication skills, and to have the patient's best interest.
Hupcey, Penrod, & Morse (2000) USA	Grounded theory (classic); interview Hospitalized patients with chronic conditions (n=50, 5 minority participants)	Model with three stages to establishing and maintaining trust and a fourth category, the *Changing Nature of Trust.* Three stages: (a) *Entering the System*; (b) *Interacting with Providers* included facilitating behaviors and inhibiting behaviors; (c) *Evaluating.* Core category: Meeting Expectations.

Table 1 (continued)

Reference and Country	Method and Sample	Findings
Mechanic & Meyer (2000) USA	Qualitative descriptive; interview Patients with breast cancer (n=30), Lyme disease (n=30), and mental illness (n=30) (n=90 total, predominantly female and non-Hispanic White)	The most prominent concept for interpersonal competence was listening; other concepts were concern, compassion, and caring.
Sheppard, Wang, Harrison, Feng, Huerta, & Mandelblatt (2008) USA	Quantitative, cross-sectional, non-experimental; Survey; Latina women (n=166; 11% Mexican) Spanish or English versions	The best predictor of mammography adherence was patient satisfaction with the physician. Trust in the physician was a predictor for high patient satisfaction in the provider but trust was not a statistically significant predictor of mammography adherence.
Skirbekk, Middelthon, Hjortdahl, & Finset (2011) Norway	Qualitative descriptive; Videotaped consultation, review with physician/patient dyad, and interview separately Ethnic Norwegian physician (n=8) and patients (n=16 aged 50-75 years old)	Findings indicated two types of interpersonal trust, *Limited Mandates of Trust* and *Open Mandates of Trust*.
Sohler, Fitzpatrick, Lindsay, Anastos, & Cunningham (2007) USA	Cross-sectional, correlational; survey Low-income HIV patients in community (n=380; 59.5% Black, 32.6% Hispanic, 7.9% non-Hispanic White) English or Spanish speaking	Racial concordance was not statistically significantly associated with increased trust in provider; mistrust in institution was significantly lower for patients with a racially concordant provider.

Table 1 (continued)

Reference and Country	Method and Sample	Findings
Thorne & Robinson (1988) Canada	Grounded theory (classic), interviews Chronically ill patients and their family members (n=77)	Patient-provider relationship is three stage process, trust has prominent role. Stages: blind trust, distrustful [disenchantment] stage, resolution with guarded alliance. No core category provided.
Weaver (2006) USA	Quantitative secondary data analysis Hispanic Americans (n=979; 60% Mexican origin); non-Hispanic Whites (n=16,202) English-speaking only	Hispanic Americans reported lower levels of trust in people compared to non-Hispanic Whites.

Table 2

Trust and Nurse-Patient Studies

Reference and Country	Method and Sample	Findings
Belcher & Jones (2009) Australia	Qualitative descriptive; interviews Newly graduated Bachelor of Science in nursing (BSN) nurses who completed first year in an internship-type program in a hospital setting (n=7)	Building rapport was important in trust development with the patient. Outcomes of trust development from the nurse's perspective were (a) increased self-esteem as a new nurse, (b) increased job satisfaction, and (c) the patient being more accepting of care.
Keller (2008) USA	Qualitative descriptive; semi-structured interviews grounded theory for analysis Mexican American mothers attending health clinic for their child's immunizations (n=12) English or Spanish speaking	Explored culturally competent care and the nurse-patient relationship, three themes emerged: *Trust in the Nurse, Building Confidence in the Mother and Child,* and *Language Concordance.*
Radwin, Washko, Suchy, & Tyman (2005) USA	Development of tool based on previous grounded theory study with cancer patients	Developed the Trust in Nurses Scale as part of an instrument of four scales to measure oncology nursing care, other scales were Fortitude, Optimism, and Authentic Self-Representation.

Table 2 (continued)

Reference and Country	Method and Sample	Findings
Trojan & Yonge (1993) Canada	Grounded theory (Strauss & Corbin); interviews Home care nurses (n=7) and elderly clients (n=6)	The stages for establishing trust identified were *Initial Trusting, Connecting, Negotiating,* and *Helping.* Core category: Trusting, Caring Relationships.
Van Hecke, Verhaeghe, Grypdonck, Beele, & Defloor (2011) Belgium	Qualitative field study, thematic analysis to develop a theoretical framework; field observations during nursing intervention (teaching) and semi-structured interviews following 12-week intervention program Home care patients with leg ulcers (n=26)	Interpersonal trust in the tissue viability (wound care) nurse was the central factor in the patient adherence to the nursing intervention.

Table 3

Patient-Centered Care Studies

Reference and Country	Method and Sample	Findings
Hicks, Ayanian, Orav, Soukup, McWilliams, Choi & Johnson (2005)	Quantitative, descriptive; mailed survey 3 months after discharge Patients hospitalized for medical, surgical or obstetric services Participants (N=2664; Whites n=2379; Blacks n=261; Latinos n= 178) English or Spanish	Findings indicated Blacks and Latinos reported more problems compared to Whites in the respect for preferences dimension.
Poochikian-Sarkissian, Wennberg, & Sidani (2008) Canada	Pre-Post test design; surveys admission and after discharge Patients (n=14) and nurses (n=21) on a neuroscience unit	Nurses and patients did not have the same perception of delivery of PCC and even with PCC, the patient satisfaction levels were surprisingly low.
Tandon, Parillo, & Keefer (2005) USA	Mixed method, Interview, Semi-structured questions Hospitalized women 24-48 hours after childbirth, Hispanic women (n=125) and non-Hispanic women (n=302, 197 non-Hispanic White, 73 non-Hispanic Black, and 32 Haitian). English or Spanish	Compared to non-Hispanic women, a smaller percentage of Hispanic women reported being treated with respect from doctors and nurses or office staff. Hispanic women reported more problems with communication with doctors and nurses during the prenatal appointment compared to non-Hispanic women.

Table 3 (continued)

Reference and Country	Method and Sample	Findings
Wolf, Lehman, Quinlin, Zullo & Hoffman (2008) USA	Quantitative, quasi-experimental, post-test design; surveys Patients undergoing bariatric surgery, control group standard nursing care (n=18), intervention group cared for by nurses who had PCC training (n=18)	No differences between the groups on perceptions of nursing care or overall patient satisfaction.

Table 4

Hispanics and Culturally Competent Care Studies

Reference and Country	Method and Sample	Findings
Fernandez, Schillinger, Grumback, Rosenthal, Stewart, Want, Perez-Stable (2004) USA	Non-experimental, quantitative; survey, face to face format Latino clinic patients with diabetes (n=116) and patients' physicians (n=48) Spanish-speaking (patients)	If the physician self-rated a higher level of Spanish-speaking ability and cultural competence, the Spanish-speaking patient was more likely to report better interpersonal processes of care (Interpersonal Processes of Care Survey: 22 item communication portion).
Shapiro, Hollingshead, and Morrison (2002) USA	Qualitative descriptive, content analysis; focus groups Five groups of physician faculty (n=24), three groups of physician residents (n=27), and two groups of low-income clinic patients (n=14; 21% non-Hispanic White, 14% Latino, 7% African, 7% African-American, 50% Native American Indian) English only	Physicians described culture communication in both culture-specific elements and generic terms while the patients emphasized generic skills and attitudes only. Physicians and patients both noted appropriate skill and attitude development was the key to successful communication.

Table 4 (continued)

Reference and Country	Method and Sample	Findings
Starr & Wallace (2011) USA	Quantitative descriptive; survey Health department clients (n=69; 97% female; 61% non-Hispanic White, 25% Hispanic, 12% African American) and nurses from health department, hospice, and home care agency (n=71; 94% non-Hispanic White) English or Spanish	The clients rated the community nurses very high in all three domains of Interpersonal Processes of Care Survey: Short Form (IPC-18) (communication, participatory decision-making and positive interpersonal style). The community nurses scored moderately high for cultural competence.

Table 5

Mexican Americans and Culturally Competent Care Studies

Reference and Country	Method and Sample	Findings
Belknap & Sayeed (2003) USA	Ethnonursing; interview Mexican immigrant women receiving outreach services for domestic abuse (n=7) Spanish	Themes revealed characteristics of the nurse or doctor that would lead to confidence for Mexican American women in discussing abuse issues. Themes were presence, taking time to listen, and showing an interest in the client's life.
Clark & Redman (2007) USA	Ethnography; interview; data analysis constant comparative method similar to classic grounded theory Mothers of Mexican descent (n=28, Spanish speaking only n=13, English speaking only n=5, bilingual n=10) English or Spanish	Expectations of U.S. healthcare system. Nine categories with six categories overlapping for both acculturated and lesser acculturated women. The overlapping categories were: (a) *Individualized Care*; (b) *Expectations for Information and Health Education*; (c) *Relationship-Centered Health Care*; (d) *Convenient, User-Friendly Health Care*; (e) *Provider Characteristics*; and (f) *Understanding of the Health Care System.* Three additional categories for less acculturated, immigrant mothers: (a) *Cultural and Linguistic Expectations*, (b) *Access and Financial Elements*, and (c) *Time*.

Table 5 (continued)

Reference and Country	Method and Sample	Findings
Jones (2008)	Qualitative with phenomenological approach; interviews Emergency nurses (n=5)	Themes revealed were *Language Barrier, Continuity of Care,* and *Limited Knowledge of Hispanic Culture.* Key finding was the participant who spoke Spanish discussed the establishment of a connection with her patients.
Kim-Godwin, Alexander, Felton, Mackey, & Kasakoff (2006)	Modified Delphi study, mailed surveys Transcultural nursing specialists and health professionals including nurses that care for Mexican migrant farm workers (first round respondents n=101; second round respondents n=153)	Identified characteristics needed to provide culturally competent care, found 21 essential items that into four domains: caring, cultural sensitivity, cultural abilities, and cultural knowledge.
Stasiak (2001) USA	Ethnonursing; interviews Mexican American community members in urban Detroit (n=5 key informants, 10 general) English or Spanish	Study of Mexican Americans and their use of folk medicine, found four themes: (a) involvement of family, (b) care, (c) importance of folk practices, and (d) significance of religion to promote healing.

Table 5 (continued)

Reference and Country	Method and Sample	Findings
Warda (2000) USA	Modified grounded theory; focus groups Four focus groups (n=22); three groups were composed of Mexican Americans who had received health care during the past year; the fourth group was composed of Mexican American nurses. English or Spanish	Developed a theory with two main components, *Culturally Congruent Care* and *Incongruent Care*. Trust was a component of congruent care in the valuing subcategory. Core category: Valuation-Disregard Paradox: Patterns of Health Care Experiences.
Zoucha (1998) USA	Ethnonursing; interviews Mexican American patients in outpatient surgery center (n=15 key informants) and patient family members (n=15) and healthcare staff (n=10; including 6 non-Mexican American nurses.) English or Spanish	Three themes identified: (a) expect nurses to be friendly, respectful and personal, (b) characteristics of noncaring nurses, and (c) the nurse must earn *confianza* (trust).

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