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Culturally congruent care: Predictors of patient satisfaction among adult Mexican Americans

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CULTURALLY CONGRUENT CARE:

PREDICTORS OF PATIENT SATISFACTION AMONG ADULT MEXICAN AMERICANS

A Thesis

by

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Predictors of patient satisfaction among hospitalized adult Mexican Americans were examined in this pilot study. Acculturation as determined by the Acculturation Rating Scale for Mexican Americans-II (ARSMA-II), ethnicity of the nurse, age, gender, socioeconomic status, level of education and marital status were examined as predictors of patient satisfaction. Patient satisfaction was measured by the Patient Satisfaction Inventory (PSI). The pilot study was conducted in an acute care setting in the lower Rio Grande Valley, where 81 participants provided the data. The questionnaires were offered in both English and Spanish. Two qualitative questions were asked regarding the patients' perception of culturally sensitive nursing care. These questions were asked in the patient's language of choice. The independent demographic variables were not found to lessen or increase the level of patient satisfaction. Similarly, the ethnicity of the nurse and the level of acculturation were not found to lessen or increase the level of patient satisfaction. The qualitative questions revealed five categories related to culturally congruent nursing care.

DEDICATION

To the Friendship of Three.

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CHAPTER I

INTRODUCTION

As the twenty-first century approaches, health care providers must be prepared to deliver care to a growing number of culturally diverse clients. An increased understanding of culture is required as the number of minority populations grow. Knowledge of cultural diversity is essential in nursing. It is not only important to deliver culturally relevant care, but it is also important to perform cross cultural comparisons in order to recognize universal aspects of care (American Nurses Association, 1991). Nurses must recognize specific cultural factors affecting individual clients and take into consideration variances that may occur within the particular culture. The American Nurses Association (1991) supports the need for culturally sensitive nursing care and recognizes that ethnocentric approaches to nursing practice are inadequate in meeting health needs of diverse cultural groups.

Another concern in this age of consumer driven health care, where cost cutting and case management are now the norm, is identifying factors that affect patients' satisfaction. "In the current health care environment, the measurement of patient satisfaction, defined by some investigators as patients' perception of quality of care, has become important as hospitals compete for patients and struggle to control costs"

(Williams, 1997, p. 15). Many different studies have shown that patient satisfaction has a positive relationship with recovery, comfort, health behaviors, and compliance (Gardner &Wheeler, 1979; Keane McDermott, Chastian, & Rudisill, 1987; Kincey & Kat, 1984; Lauer, Murphy, & Powers, 1982). Patient satisfaction has been further conceptualized as a patient's perceived level of caring and its actual occurrence (von Essen & Sjoden, 1991). Understanding that patient perceptions of nursing care may affect satisfaction urged the researchers to explore these perceptions. Delineation of these perceptions may lead to improved patient outcomes and satisfaction.

Statement of Purpose

National projections from the United States Bureau of Census indicate that the ethnic group with the highest rate of increase will be those of Hispanic origin. Hispanics will increase to 97 million by 2050 (U.S. Bureau of Census, 1998). This increase is three and a half times the 1995 Hispanic population. Persons of Mexican American ethnicity were subjects in this study. The terms Hispanic and Mexican American were not used interchangeably within this study because of the wide variation of heritage and culture possible among Hispanics. Persons of Hispanic origin can include Mexican, Puerto Rican, Cuban, Central American, South American, and all other Latin American countries (Marin & Marin, 1991). It should be noted that persons of Hispanic origin might be of any race (U.S. Bureau of Census, 1998). It is estimated that 63.4% of the Hispanic population is Mexican American (U.S. Bureau of Census, 1998). The rapid growth of this population as well as the location of this study served to determine the population utilized for this pilot study. The purpose of this study was to identify predictors of patient satisfaction among adult Mexican Americans in an acute care

setting. This study also aimed to investigate the relationship between the level of acculturation and its effect on patient satisfaction in the adult Mexican American.

Examination of the empirical testing related to this study revealed a plethora of research that has studied patient satisfaction; "however, very few reports of application of this type of research to the Mexican American population exist" (Hennessy & Friesen, 1994, p. 32). Additionally, much research has been done on measuring the acculturation level of Mexican Americans and a number of researchers have considered whether acculturation stress may contribute to significant health problems (Cuéllar & Roberts, 1984; Montgomery, 1992a; Szapocznik & Kurtines, 1980). Montgomery (1992a) further suggests that an acculturation scale could be used to investigate a possible link between acculturation and health factors among Mexican Americans. To date, no studies have been found which examine the link between level of acculturation and patient satisfaction. Few studies have examined the effect of the ethnicity of the caregiver on the patient. One study examined this concept on mental health patients and revealed that matched ethnicity of caregiver and patient had a higher return rate to the program (Sue, Fujino, Hu, Takeuchi & Zane, 1991; Takeuchi, Sue,& Yeh 1995). The apparent lack of research that examines the relationship between caregiver ethnicity and patient satisfaction helped provide the rationale for this study.

Research Questions

The purpose of this study was to identify predictors of patient satisfaction among adult Mexican Americans in an acute care setting; specifically, this study will answer the following questions:

Quantitative:

1. Is there a relationship between age, gender, marital status, level of education, socioeconomic status or language of response and the patient's level of satisfaction with care?

2. Is there a difference between the patient's level of satisfaction with care as provided by a Mexican American nurse or a nurse of another ethnic background?

3. Does the patient's level of acculturation or generation removed from Mexico affect the patient's level of satisfaction with care?

Qualitative:

1. In what way did the nurse recognize cultural beliefs?

2. Was there any aspect of care that was culturally displeasing?

Significance of the Problem

A vast amount of research has been reported in the area of patient satisfaction; however, these studies have failed to offer any cultural delineation of subjects, leaving this area of research underdeveloped for minority populations, especially Mexican Americans. Research related to acculturation and its effect on patient satisfaction has the potential to significantly contribute to the nursing base of knowledge and further support or enhance Leininger's Theory of Cultural Care Diversity and Universality which was utilized in this study as the theoretical framework.

Hispanics were the fastest growing ethnic group in the United States in the last 10 years (Caudle, 1993). Hispanics make up 29.4% of the population of Texas, 87.3% of the population in Hidalgo County, and 91% of the population in the city of McAllen. The US Bureau of Census (1998) estimates that 63.4 % of all Hispanics are Mexican

American, therefore choosing Mexican Americans as the target population for this study was clearly supported. The geographic location of the study was a small city, McAllen, in the Lower Rio Grande Valley of South Texas, bordering on Mexico.

The demographic data of the region and the lack of research on Mexican Americans clearly support the importance of this study. In addition, Trevino and Ray (1987) point out that Mexican Americans receive the lowest level of health services of any ethnic group in the United States, and are reportedly the least satisfied with the care they receive.

Research indicates that "Mexican Americans are not a homogenous group; they vary considerably according to level of acculturation" (Cuéllar, Harris, & Jasso, 1980, p. 210). Understanding one's level of acculturation or being able to measure level of acculturation creates a cultural awareness which can significantly impact the care being given and the perception of care being received. Having a better understanding of what affects patient satisfaction among Mexican Americans could directly contribute to the knowledge base of nursing and in turn enhance nursing practice. The results of this convenience study can not be generalized to other populations. The only application that can be made is to the population being studied; however, this does not diminish the importance of the research. It is imperative that nurses become aware of and gain insight into the factors that affect Mexican American's perceptions of patient satisfaction, especially since they are the fastest growing ethnic minority. Through gaining an understanding of the predictors that affect patient satisfaction among Mexican Americans in one city in South Texas, it may be possible to educate nurses throughout the Lower Rio Grande Valley to provide improved, culturally congruent care. Ultimately,

understanding differences in perceptions of care may improve quality of care and patient satisfaction if applied to the education of new nurses, the practice of existing nurses, and further research.

Definitions

The following definitions guided the researchers throughout the study:

1. Mexican American: Ethnicity as defined by the subjects and the classification on their medical record.

2. Patient satisfaction: A fulfillment of the expectations and needs of hospitalized individuals from their perspective (Ryan, Collins, Dowd, & Pierce, 1995).

3. Culturally congruent care: The "cognitively based, assistive supportive, facilitative or enabling acts or decisions that are tailor made to fit with individual, group, or institutional cultural value, beliefs and lifeways in order to provide or support meaningful, beneficial and satisfying health care or well being services" (Leininger, 1991, p. 49).

4. Acculturation: The adaptation to the host culture (Choi, 1997, p. 81).

5. Nursing care: Care received by the patient from any healthcare provider they perceive to be a nurse.

Assumptions and Limitations

Several assumptions were recognized within this pilot study. Firstly, participants were able to use the tools and answered the questionnaires honestly. Secondly, a review of literature demonstrated that culture has an influence on behavior and perception, and that culturally congruent care is indeed good care (Leininger, 1991). Thirdly, it was assumed that the Patient Satisfaction Inventory (PSI), (see Appendix A) is a culturally

sensitive tool. Fourthly, comparable scores on the English and Spanish versions of the PSI have the same meaning.

Participant responses may have been affected by uncontrolled variables within the study, such as illness, gender, or age. The amount of time involved to participate in the study may have been a limitation. If a participant was tired or in pain, having to fill out two questionnaires, a demographic data sheet, and answer two qualitative questions could have affected some of the responses. The researchers delivered the questionnaires, asked the qualitative questions, and retrieved the questionnaires at the end of the day. This direct contact by the researchers may have affected the responses and could have created some bias within the study. The quantitative data collected were from highly structured self-administered questionnaires. The questions were listed in a specific order and had pre-designed responses, which leaves little opportunity for the subjects to explain or to qualify their answers.

Having the subjects identify their level of satisfaction of care based on one particular nurse from this hospitalization may have biased the study. The nurse may have been selected because he/she stood out for a variety of reasons, or he/she happened to be the last nurse that provided care. Lastly, a convenience sample was used and the results are only generalizable to this research sample of Mexican Americans living in the Lower Rio Grande Valley.

CHAPTER II

REVIEW OF LITERATURE

Theoretical Framework

For purposes of this study, Madeleine Leininger's Theory of Cultural Care Diversity and Universality was utilized as the theoretical framework. Madeleine Leininger's theory is a nursing theory that aims to improve client care. Leininger purports that nurses can provide culturally congruent care by gaining insight and understanding of another person's culture. Leininger further asserts that "if nurses fail to provide culturally based care, client satisfaction does not occur, recovery from illness is often delayed and clients often become uncooperative and/or non-responsive" (Leininger, 1996, p. 72). The Theory of Cultural Care Diversity and Universality has "come into relevance in nursing and is a valuable theory guiding nurses in their clinical practices to improve client care by providing culture-specific and culturally congruent nursing care" (Leininger, 1996, p. 72).

The Theory of Cultural Care Diversity and Universality has been used as a foundation to study approximately 55 cultures within and outside the United States. This theory was derived from the discipline of anthropology, then conceptualized to be relevant to nursing. The theory incorporates numerous aspects of culture through the use of Leininger's Sunrise Model. The Sunrise Model presents the different factors that need to be considered when attempting to gain a holistic picture of an individual and

understand what influences that person's well being (Alexander, et al. 1994, p. 425). The Sunrise Model is able to guide research through its ability to promote discovery of culture care values with respect to religious, philosophical, political, legal, technological, economic, educational, and health factors of clients (Leininger, 1996).

Leininger's Theory of Cultural Care Diversity and Universality guided the development of this study. Leininger (1991) states that cultural blindness and ethnocentrism by nurses can ultimately lead to a poorer quality of care provided to clients. Leininger further asserts that culturally congruent care is what makes clients satisfied that they are receiving "good care." Quality care is what clients seek most when they come for health care services (Alexander, et al., 1994). Even though Leininger does not discuss acculturation or specifically address the ethnicity of the nurse, her theory does contend that gaining insight to a person's culture and treating him/her in a culturally appropriate manner can only serve to enhance patient satisfaction. Patient satisfaction is known to have a positive relationship with recovery, comfort, health behaviors, and compliance (Lauer, et al., 1982).

Patient Satisfaction

Within the last decade, healthcare started viewing patients as customers. This expanded the scope of practice to attract consumers and fostered competition (Nash et al., 1994). Consumers are now critics of services, convenience, cost, and quality of healthcare. This shift has served to emphasize the need to provide high quality healthcare to increase patient satisfaction. Empirical evidence suggests that the study of patient satisfaction is imperative at this time due to the restructuring of the health care system. Consumer perception of quality will play a significant role in the providers' survival and

success, or failure (Bowers, Swan, & Koehler, 1994; Davis, & Bush, 1995; Ludwig-Beymer et al., 1993; Nash et al., 1994; Williams, 1997). For this reason, it is important for health care facilities and providers to monitor patient satisfaction because it is a managerially controllable variable affecting financial performance (Bowers, et al., 1994).

By investigating whether a patient is satisfied with the care received and the contributing factors that lead to satisfaction or dissatisfaction, health care providers can evaluate their own performance and alter areas indicated to be important by the consumer. This investigation will also give information on the provider's success at meeting patient's values and expectations. The personal nature of health care encourages patients to seek the highest possible quality of care they can receive. With market forces prompting hospital facilities to focus on promoting patient satisfaction, it is important to identify the level of satisfaction with services as well as factors that contribute to that satisfaction.

A considerable amount of the research done on patient satisfaction deals with perception of nurses and nursing care. Nursing care has been found to be the most significant variable influencing patient satisfaction in an inpatient setting (Larson & Ferktich, 1993; Lin, 1996; Nash et al., 1994; Williams, 1997). As a result of these findings, patient satisfaction is viewed as a means to assess quality of care while evaluating the effectiveness of nursing interventions (Williams, 1997). Nursing practice is patient driven and patient centered. For this reason Lin (1996) suggests evaluating the quality of nursing care because it supports the basis of the usefulness and effectiveness of nursing practice.

Factors such as age, gender, education, and race have been found to have an inconsistent relationship to patient satisfaction. Pascoe (1983) found that older patients reported a higher rate of satisfaction. This was supported by Cohen (1996) who studied the relationship of age, social class and self reported health status to level of satisfaction. Age was a correlate. Younger patients expressed lower levels of satisfaction than older patients. Effects of social class and health status were nonsignificant in this study. Younger patients have been found to value affective dimensions of care more than older patients (Brown, 1981; Latham, 1990). Gender based research indicated that male patients focused more on physical aspects of nursing care, while female patients focused more on the emotional aspects of care (Reimen, 1986; Weiss, 1984). Women were found to be more satisfied with care than men (Pandiani, Kessler, Gordon, & Domkot, 1982). In contrast, other studies have shown that demographic variables have no consistent relationships to patient satisfaction (Bader, 1988; DiStefano, Pryer, & Garrison, 1980; Fox, & Storms, 1981). In addition, a study by Avis, Bond, and Arthur (1997) yielded no association between patient age and gender with changing perspectives on their satisfaction with care.

Research by Hennessy and Friesen (1994) measured patient satisfaction among Mexican Americans and provided a good foundation to support this research study. Their pilot study explored Mexican American patients' perceptions of quality in relation to socioeconomic status and treatment setting. The sample consisted of 30 subjects from two hospitals divided among four socioeconomic groups. Raw satisfaction scores indicated that subjects of lower socioeconomic groups were less satisfied with care. There were no other significant differences. Since Mexican Americans form the largest

component of the Hispanic population in the United States, this population presents health care providers with a multitude of challenges that can only be met if health care providers are cognizant of consumer perceptions (Hennessy & Friesen, 1994).

Williams (1997) found that patients were more satisfied when they perceived nurses to be caring. Her study revealed that the greatest predictor of patient satisfaction was sensitive care. These findings support the view that patients value the affective aspect of nursing care over physical care (Bader, 1988; Brown, 1981; Reimen, 1986; Warren, 1988). Williams (1997) also found that physical care added a predictive value to sensitive care. This is congruent with other research studies that found that patients value technical skills, competency, and timely physical care (Cronin, & Harrison, 1988; Keane McDermott, Chastain, & Rudisell, 1987; von Essen, & Sjoden, 1991). Attributes that consumers used to evaluate health care services were communication, empathy, responsiveness, and reliability. These attributes were found to positively affect patient satisfaction (Bowers, Swan, & Koehler, 1994).

Although the research on patient satisfaction is plentiful, actual application to minority groups, especially Mexican Americans, is limited. To date there have been no studies done that attempt to link acculturation of Mexican Americans to patient satisfaction. The studies which have come close in attempting to link patient satisfaction with acculturation suggest that language, which is a large component of acculturation, affects health behavior and health care delivery, and may affect doctor-patient interactions (Deyo, Diehl, Hazuda, & Stern, 1985; Solis, Marks, Garcia & Shelton, 1990).

Empirical evidence reveals that at least 21 instruments have been developed and used to measure patient satisfaction since 1957 (Ryan, et al., 1995). There is a lack of

standardization among these tools. Kristjanson (1993) developed a tool to measure satisfaction with cancer care dimensions. Another tool developed by Cleary (1991) measured satisfaction with seven dimensions of care. Included were respect, coordination of care, information and education, physical comfort, emotional support, involvement of family and friends, and continuity. Different aspects of care are examined to measure patient satisfaction by these tools.

The Patient Satisfaction Inventory (PSI) was developed by Risser (1975) and revised for inpatient use by Hinshaw and Atwood (1982). The PSI was utilized to measure patient satisfaction in this study. This tool was chosen because of its comprehensive nature. It covers three areas of satisfaction in its subscales: professional-technical activities, trust, and educational activities. Professional-technical activities are behaviors that fulfill goal achievement functions including nurses' knowledge and technical abilities (Risser, 1975; Williams, 1997). The trust subscale is measured through verbal and non-verbal communication. Examples include interest in patient, sensitivity to people and their feelings, and listening to patient problems (Risser, 1975; Williams, 1997). The last subscale, educational activities, consists of information exchanged between patient and nurse such as answering questions and providing explanations (Risser, 1975; Williams, 1997).

Reliability and validity estimates were reported by Hinshaw and Atwood (1982) in five studies. Acceptable levels of both reliability and validity were demonstrated through successive estimates in these studies. The primary study by Risser (1975) was conducted to test the new tool in an urban clinical setting. A second study that utilized the PSI was conducted at the Arizona Health Sciences Center (AHSC) by Hinshaw. A

convenience sample of 57 patients on general medical-surgical units was used for the study. It aimed to assess patient satisfaction while replicating validity and reliability of the PSI. The third study was administrative research conducted at AHSC by Hinshaw and Atwood (1977). Its purpose was to assess the effect on staff and patients when staffing was changed from a mixed staff (licensed vocational nurses and registered nurses) to all registered nurses. The fourth study testing the tool's validity and reliability assessed changes in staff and patient outcomes when a new set of care comfort nursing standards were implemented. Data was gathered before the implementation and six weeks after the change. The fifth study using the PSI utilized a double-blind, quasi-experimental design to investigate the impact of teaching activities. Validity and reliability estimates were also obtained with a sample of 88 patients (Hinshaw & Atwood, 1981). The coefficient alpha for the PSI demonstrated a high degree of internal consistency, with the subscales of the instrument ranging from 0.36 - 0.96 within these studies (Hinshaw & Atwood, 1982; Williams, 1997).

Culturally Congruent Care

Culture is a learned pattern of behaviors and health beliefs that is passed down from generation to generation (Clinton, 1996). Nurses have been aware of the importance of culture since Florence Nightingale expressed her concerns regarding the aborigines of Australia (Nightingale, 1865). Interactions between the nurse and patient have the potential to be less than therapeutic if the nurse has ethnocentric beliefs about Western medicine, or his/her personality is defensive or less than tolerant (Bonaparte, 1979). It is a growing responsibility of every health care provider, specifically nurses, to be aware of their own bias and be open to learning about different cultures they encounter

every day. Individual responses within the nurse patient interaction are a compilation of socioeconomic, gender, and racial issues which are framed by values, beliefs and responses of individuals, families, and communities (Meleis, 1996).

Culturally congruent care, according to the National Academy of Nursing, is that which is sensitive to "issues related to diversity, marginalization, and vulnerability due to culture, race, gender, and sexual orientation" (Meleis, Isenberg, Koerner, Lacey, & Stern, 1995, p.4). Culturally congruent care is that which a transcultural nurse utilizes in his/her care of all patients. According to Leininger, the nurse must be educated to different cultures, and furthermore must possess an inner desire to know different cultures (Leininger, 1996). For culturally congruent care to flourish in the acute care setting, teamwork among health care providers is essential, along with tolerance and communication. Each patient is a unique individual and culturally a "product of past experiences, cultural beliefs and norms" (Giger & Davidhizar, 1995, p. 8).

Culturally competent care is now demanded by all patients and their advocates and should be included in the education of all nurses (Meleis, 1996). Technological advances, the information superhighway, and increased migratory patterns have led to changes in health care consumerism throughout the world. Minorities are speaking out about their heritage and demanding equal and sensitive care, while providing a picture of the social injustices and power struggles they experience (Meleis, 1996). These disparities are made worse because few nurses are minorities, and a large portion of the patients are minorities, resulting in obvious incongruities (Bushy, 1995).

In order to provide care that is culturally congruent by Leininger's definition the nurse must be involved in the process of becoming culturally competent (Campinha-

Bacote, 1991). Cultural competence, therefore, is defined as an ongoing awareness or seeking of knowledge and skill (Campinha-Bacote, 1991) with regard to age, gender, religion, physical ability, sexuality, education, economic power and the way people deal with each other (Bucher, Klemm, & Adepoju, 1996). Some theorists insist that Leininger's transcultural theory and definition of congruence neglects consideration of the positions of power and influence certain ethnic groups exert in society (Mulholland, 1995; Ramsden, 1990). In addition, theorists suggest that no nurse interaction can truly be objective, that every intervention involves a pre-learned mindset, values and uniquely depends on where it takes place (Poaschek, 1998; Ramsden, 1990).

Whatever definition of culturally congruent care is chosen, it is clear that culturally incongruent practices include any interaction which demeans, disempowers, or diminishes the cultural identity of any individual (Ramsden, 1990). Nurses should be educated to other cultures and must have the desire to learn about other groups (Leininger, 1992). Nurses must also recognize their own cultural groups' stereotypes and how these may unconsciously affect patient care. It may be the nurse who is seen as exotic to the patient, not the other way around (Ramsden, 1996).

Many studies fail to culturally delineate the subjects and therefore provide little to no understanding as to the affect a patient's culture can have on level of satisfaction with care (Bowers, et al., 1994; Larrabee, Ferri, & Hartig, 1997; Ludwig-Beymer et al., 1993; Nash et al., 1994; Williams, 1997). A limited amount of research has examined the impact of ethnic specific services on patient satisfaction. Ethnically specific programs for mental health patients have promoted a higher rate of patient compliance and continuation in the program as compared to main stream, non-ethnically specific mental

health programs. This response was particularly noted in Mexican Americans (Sue, et al., 1991; Takeuchi, Sue, & Yeh, 1995).

Acculturation

"The term acculturation generally refers to the transfer of culture from one group of people to another group of people" (Negy & Woods, 1992b, p. 224). A more common use of the term acculturation refers to "a process of change experienced by members of a minority group toward the adoption of the majority group's culture" (Negy & Woods, 1992b, p. 224). As a result of changing demographics in the United States, numerous studies focusing on acculturation have been accumulating (Negy & Woods, 1992a). Acculturation has been measured among normal populations as well as clinical populations. The normal, or non-clinical populations have included staff members at a state hospital and student populations (Cuéllar, Arnold, & González, 1995; Cuéllar, et al., 1980; Cuéllar & Roberts, 1997; Montgomery & Orozco, 1984; Smart & Smart, 1993; Solis, et al., 1990). The clinical populations have included hospitalized psychiatric patients and non-hospitalized patients seeking preventative services throughout the United States. Numerous scales have been developed to measure acculturation. These scales have been developed or modified primarily for use among Hispanics and/or Mexican Americans within the United States (Cuéllar, et al., 1980; Deyo, et al., 1985; Montgomery, 1992; Montgomery & Orozco, 1984). These acculturation scales measure language preference, ethnic identity, generation removed from Mexico, ethnicity of friends, and extent of direct contact with Mexico (Montgomery & Orozco, 1984).

The construct of acculturation is a well established standard for understanding intercultural variance in Mexican Americans (Cuéllar, Arnold, & Maldonado, 1995;

Padilla, 1995). The behavioral aspects of acculturation have been found in previous research to be significantly related to various behavioral and health indices (Gonzalez, & Cuéllar, 1983; Marin, & Marin, 1991; Negy, & Woods, 1992b).

There is a growing body of research revealing that cognitive measures such as values, attitudes, and beliefs also correspond with acculturation (Cuéllar, Arnold, & González, 1995; Domino, & Acosta, 1987; Marin, 1993). Specifically, Cuéllar, Arnold and González (1995), in a study including 379 subjects, examined relationships between the behavioral measure of acculturation and five theoretical cultural constructs. The cognitive constructs of acculturation examined in the study were shown to have the same potential as behavioral constructs of acculturation when examining illness experiences and help-seeking behavior. The clinical relevance of acculturation is introduced by Velasquez and Callahan (1992) who recommend that "level of acculturation of Hispanics should always be assessed as an integral part of a clinical evaluation" (p. 260).

The definition that is central to the construct of acculturation in this study is inherent in the Acculturation Rating Scale for Mexican American-II (ARSMA-II), (see Appendix A), "Acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups" (Cuéllar, Arnold, & Maldonado, 1995, p. 278). Throughout the development of the ARSMA-II, acculturation was seen as an interactive, developmental, multifactorial, multidirectional, and multidimensional process (Cuéllar, Arnold, & Maldonado, 1995).

The original Acculturation Rating Scale for Mexican Americans (ARSMA) and the revised ARSMA-II have had limited use with clinical populations. Cuéllar et al.

(1980) used the ARSMA on one of the few cited clinical populations. This study included a diverse population consisting of 222 subjects. Of the 222 subjects, 88 were hospitalized Mexican American psychiatric patients who spoke Spanish. The remaining 134 subjects were students or staff participating in an in-service training, 17 were Mexican, 104 were Mexican American, and the remaining 13 were non-Mexican American. This study revealed that the "ARSMA can be applied to non-clinical and clinical populations, to monolingual Spanish populations as well as bilingual, and to individuals of varying educational levels" (p. 209).

The ARSMA-II was used to examine the clinical population in this study. The ARSMA-II employs a bilingual format with both language versions (English and Spanish) on the same page. It is composed of a 30-item self-rating scale with an Anglo Orientation Subscale (AOS) and a Mexican Orientation Subscale (MOS). The AOS has 13 items and reveals an internal consistency score coefficient alpha of 0.83 (Cuéllar, Arnold & González, 1995). The MOS has 17 items and reveals an internal consistency score coefficient alpha of 0.88 (Cuéllar, Arnold & González, 1995). In addition to measuring level of acculturation, this scale is able to "differentiate five distinct types of Mexican Americans" (Cuéllar, et al., 1980, p. 199) (see Table 1).

Review of the literature has revealed that there is a positive correlation between acculturation and socioeconomic status (Negy & Woods, 1992a). It is inferred that acculturation and socioeconomic status are intricately intertwined. Negy and Woods (1992a) suggest that "research involving acculturation should account for socioeconomic status in order to clarify the specific influences of the two constructs in any given data

set" (p. 251). Socioeconomic status was included as an independent variable in this study.

Examination of the clinical relevance of acculturation was an underlying thread in this pilot study. Cuéllar, Arnold, and González (1995) assert that assessing acculturation should add meaningful dimensions to understanding the cultural differences that may have relevance in health seeking behavior, diagnostic assessment, and treatment of Mexican Americans. Scribner (1996) examined the clinical relevance of acculturation and found that Hispanics in the United States who practice more traditional ways of life tend to have better health outcomes than Hispanics who are more acculturated. Cuéllar et al. (1980) in their examination of both clinical and normal populations found that the ARSMA is a practical and suitable measure of acculturation in both populations and can be used as a cultural awareness scale for staff or patients. In addition to using the ARSMA as a cultural tool, Cuéllar et al. (1980) suggest that ones level of acculturation could be used as a moderator variable and that it would be "useful in matching the extent of cultural compatibility between consumers and providers of health care (p. 200).

Previous research has touched on the concept of examining attitudes, beliefs, and values in relation to acculturation; however, Negy (1993) states there is a lack of empirical research that relates acculturation to psychological processes. No research to date has examined level of acculturation and how it relates to patients' perception of satisfaction with nursing care.

Table 1

ARSMA-II Levels of Acculturation (Cuéllar, Arnold & Muldonado, 1995)

Acculturation Levels	Description
Level I	Very Mexican oriented
Level II	Mexican oriented to approximately balanced bicultural
Level III	Slightly Anglo oriented bicultural
Level IV	Strongly Anglo oriented
Level V	Very assimilated; Anglicized

CHAPTER III

METHODOLOGY

This pilot study used a quantitative and qualitative non-experimental approach. Both techniques were utilized to investigate the relationship between the independent and dependent variables and to identify any variance between level of acculturation of Mexican Americans and their satisfaction with nursing care. The independent variables include: the ethnicity of the nurse, age, gender, marital status, level of education, socioeconomic status, and level of acculturation of the patient. This research examined differences among Mexican American subgroups related to the dependent variable of patient satisfaction as measured by the Patient Satisfaction Inventory (PSI). This approach accounts for intracultural variations of Mexican Americans. Velasquez and Callahan (1992) support this approach suggesting that examining differences among subgroups is less popular in the literature but appears to be more appropriate for future research. Subjects were interviewed to obtain qualitative content related to their cultural experiences.

Approval to conduct this research study was granted by the University of Texas-Pan American Human Subjects Committee (see Appendix B). Permission was also obtained from the Hospital Ethics Committee to conduct research at the 400-bed acute care facility (see Appendix B). Approval to use the Acculturation Rating Scale for Mexican Americans-II (ARSMA-II) in English and in Spanish, was obtained in writing

from Sage Publications (see Appendix B). Similarly, written approval was granted from Aspen Publications to translate the Patient Satisfaction Inventory into Spanish and utilize it in both languages for the purpose of this study (see Appendix B).

The study involved a convenience sample of 100 adult Mexican American in-patients from four medical units at an acute care facility in the Lower Rio Grande Valley. Subjects were at least 21 years of age, the age of majority in the state of Texas. Both males and females that had been in the hospital for at least two days were included, allowing them time to have had experiences with more than one nurse.

The sample was comprised of individuals who declared themselves to be Mexican Americans. Participation of all subjects was voluntary. Written informed consent was obtained from each subject, followed by completion of an anonymous demographic questionnaire, the ARSMA-II, and the PSI. The two qualitative questions were asked prior to the questionnaires. All forms were available in both English and Spanish, including the qualitative interview. The three researchers collected data over a period of four weeks in September of 1998. Surveys were administered to 100 subjects. The subjects were given one day, approximately eight to ten hours to complete the tools. The researchers verbally administered the questionnaires when requested by the subject. The subjects were provided an envelope in which to place the finished questionnaires and data sheet. The envelopes were collected by one of the researchers at the end of the day. Drop boxes were available on each unit for patients that were discharged during the interim.

The demographic data questionnaire (see Appendix A) provided most of the independent variable data needed to conduct a Pearson's product moment correlation

analysis. Included in these variables were age, gender, marital status, socioeconomic status, educational level, and language. The last question on the demographic form asked the patient to think of a nurse that stood out in his/her mind, identify whether that nurse was Mexican American or Non Mexican American, and to remember this same nurse as they filled out the PSI. Nurse ethnicity was then included as an independent variable.

Researchers obtained lists of patients from the resource nurse in order to determine who met the inclusion criteria. All potential subjects were given an explanation and description of the study as well as an informed consent form (see Appendix B). Confidentiality of participant information in the study was stressed with all subjects. The subjects were informed that participation or non-participation in this study was purely voluntary and their decision would in no way affect their care.

Instrumentation

The ARSMA-II was available in both English and Spanish. The internal reliability was measured by means of a coefficient alpha, which was 0.87 for hospitalized subjects, indicating an acceptable level. Concurrent validity has been assessed on both the original ARSMA and the ARSMA-II. A Pearson product moment correlation of 0.89 was derived from both tools (Cuéllar, Arnold, & Maldonado, 1995). Several separate analyses have been conducted to assess the validity of the ARSMA-II, including: factor analysis, staff ratings, English versus Spanish scores, generation, and level of acculturation. The analysis differed only slightly between the clinical and non-clinical populations, thus supporting the validity of using the scale on clinical patients (Cuéllar, et al., 1980). The excellent reliability and validity of this instrument provided appropriate rationale for the use of the ARSMA-II in this pilot study.

The PSI was designed to measure levels of patient satisfaction, specifically as received from one nurse which the subjects have identified by ethnicity alone. The PSI is a 25-item Likert scale originally developed by Risser (1975) and revised for inpatient use by Hinshaw and Atwood (1982). The scale includes three dimensions of satisfaction: professional-technical, educational, and trust activities. The original scale developed by Risser (1975) was available in both English and Spanish but the revised scale by Hinshaw and Atwood (1982) was only available in English and needed to be translated into Spanish. When using a translated tool considerable care is needed to assure that any translation, whether culturally specific or not, achieves a level of language usage that is equivalent to the original source. This is essential to decrease the threat of between group difference (Berkanovic, 1980). Translation into Spanish and back translation was completed with the revised tool in order to fully utilize this instrument. The Spanish language version was originally translated by one of the researchers and translated back into English by a bilingual volunteer who had no previous connection with this research. The volunteer was not informed of the details or purpose of this study and was asked only to provide an English language version that achieved a level of idiomatic usage equivalent to the Spanish language version.

CHAPTER IV

ANALYSIS OF DATA

After the compilation of the demographic data as nominal and ordinal level data, descriptive statistics were used to measure central tendencies and breakdown of the demographic data to identify trends in the demographics of the population. Multiple linear regression and Pearson's product moment correlation were utilized to investigate predictability and relationships among these variables. Analysis with multiple linear regression was completed to investigate possible patterns of predictability between independent variables and the dependent variable. Outcomes of Pearson's product moment correlation were used to investigate whether a linear relationship (negative or positive) existed between each of the independent variables and the dependent variable and among the independent variables themselves (Burns & Grove, 1993).

Answers to the qualitative questions were analyzed and categorized into recurring themes or consistencies within the groups of data. Ultimately, understanding differences in perceptions of care may improve quality of care, patient satisfaction, education of new nurses, and practice of existing nurses. This chapter presents the results of the study relevant to each of the research questions.

The questionnaires were completed during September 1998. The patient population of the hospital for September was 2270. From this total, 2066 (91%) were identified as Mexican American. A total of 100 Mexican American adult volunteers

meeting the inclusion criteria were randomly selected from four of the hospital units. Following completion of the qualitative portion, the questionnaires were to be left with the subjects and retrieved that same afternoon or the following day, however, a majority of the questionnaires were completed with the researchers' assistance for reasons such as inability to read, eyeglasses not available, or at the patients specific request. Of the 100 questionnaires handed out, 83 were retrieved. Of these, 81 were complete enough to be entered as data. All of the data was entered via the double entry method to allow for easy verification of correct data. In order to not alter the analysis, the areas with missing data were left blank as opposed to being assigned zero as a placeholder.

Quantitative Results

Subjects

The subjects consisted of 42 male and 38 female Mexican American adults from 27-86 years of age. The average age of subjects was 55 years. The education level of the subjects ranged from elementary school to the completion of graduate school. Forty percent had only an elementary education. Of the remaining subjects, 37% finished high school, 15% completed college, and 8% had completed graduate school. Based on these figures, a total of 77% of the subjects had a high school equivalency or below, with only 23% of the total completing some for of post-secondary education. Of the total 81 respondents 60% were married, 28% had been previously married or widowed, and 11% were single. Of the subjects who answered the socioeconomic question, 82% earned below $20,000 per year. Table 2 illustrates the demographic characteristics of the sample.

Table 2

Demographic Characteristics

Subjects	Number	Percent
Gender		
Male	42	52.5%
Female	38	47.5%
Level of Education		
Elementary	32	40%
High School	29	37%
College	12	15%
Graduate School	6	8%
Marital Status		
Single	9	11%
Previously Married	23	28%
Married	49	60%
Socioeconomic Status		
Below $20,000	61	82.4%
$20,000-$30,000	5	6.7%
$30,000-$40,000	4	5.4%
$40,000-$50,000	3	4.0%
Over $50,000	1	1.4%

Language, Acculturation, and Generation Removed

Of the total respondents, 68% chose to answer in English and 32% answered in Spanish. When asked how many generations of their family had not lived in Mexico (generation removed), the majority (36.7%) indicated they were the first generation living in the United States. Of the remaining, 29.1% identified themselves as second generation, 22.8% as third generation, 6 % as fourth generation, and 5% as fifth generation. Table 3 illustrates the language of response and generation removed from Mexico.

The ARSMA-II has five levels of acculturation, ranging from very Mexican to very assimilated (Cuéllar, Arnold, & Maldonado, 1995). Based on the formula provided by the developers of the tool, each respondent was classified according to their answers on the ARSMA-II. Of the subject group 35% were considered Level I, or very Mexican, 26.3% Level II, or slightly Mexican bicultural, 31.3% were identified as level three, or slightly Anglo oriented bicultural, and 8% were identified as Level IV or strongly Anglo oriented. No subject was categorized in Level V, or very assimilated (see Table 3).

Ethnicity of the Nurse

Each subject was asked to complete the PSI based on one particular nurse who had cared for him or her. The subjects were asked if the nurse they chose was Mexican American or Non-Mexican American. Of the 81 respondents, 94% chose to answer this question. Of these, 56.6% of the nurses were identified as Mexican American and 43.4% identified as Non-Mexican American. Five of the respondents (6%) left the nurse ethnicity question blank. Table 3 illustrates the responses on the nurse ethnicity.

Table 3

Language, Acculturation, Generation and Ethnicity

Subjects	Number	Percent
Language of Response		
English	55	68%
Spanish	26	32%
Level of Acculturation		
Level I	28	35%
Level II	21	26.3%
Level III	25	31.3%
Level IV	6	8%
Level V	0	0%
Generation Removed		
First	29	36.7%
Second	23	29.1%
Third	18	22.8%
Fourth	5	6%
Fifth	4	5%
Ethnicity of the Nurse		
Mexican American	43	56.6%
Non-Mexican American	33	43.4%

Patient Satisfaction Inventory

The results from the PSI included a total score on three subscales: professional-technical, educational, and trust. A low score represents a high level of patient satisfaction. Accordingly, higher scores demonstrate a relatively lower level of satisfaction. The total scores ranged from 32 to 104. Scores can range from 25-125. Table 4 illustrates the results of the PSI total score and subscale scores.

Table 4

PSI and Subscales

PSI	Number of Questions	Range	Mean
Total	25	32-104	44.3
Professional-Technical Subscale	7	8-26	14.5
Educational Subscale	7	8-28	15.5
Trust Subscale	11	11-51	22.3

Quantitative Question One

Research question one was stated as follows: Is there a relationship between age, gender, marital status, socioeconomic status, level of education, or language of response and the patient's level of satisfaction with care? Multiple linear regression was used to investigate the predictive relationships between these independent variables and the dependent variable. The independent variables included: age, gender, marital status, socioeconomic status, language, and education level. The total score from the PSI was entered as the dependent variable. The same test was completed with each of the three subscales. No significant level of predictability was determined between these variables and patient satisfaction. Pearson's product moment correlation coefficient was used to

investigate the existence and the magnitude of relationships between the independent variables and the dependent variable. No significant relationships were revealed. No relationship was found between these independent variables and the patient satisfaction total score or the subscale scores. From these results, the answer to research question one is that no relationship exists between age, gender, marital status, socioeconomic status, level of education, or language of response and the patient's level of satisfaction of care.

Quantitative Research Question Two

Research question two was stated as follows. Is there a difference between the patient's level of satisfaction with care as provided by a Mexican American nurse or a nurse of another ethnic background? Multiple linear regression was utilized to examine the relationship between the ethnicity of the nurse as an independent variable and patient satisfaction as the dependent variable. The results revealed that there was no significant difference in the perceived level of satisfaction among those subjects cared for by a nurse of Mexican American ethnicity and a nurse of Non-Mexican American ethnicity. Pearson's product moment correlation coefficient was used to investigate the existence and the magnitude of relationship between the nurses' ethnicity and patient satisfaction. No significant relationship was revealed between nurse ethnicity and the total PSI scores or the subscale scores. From these results, research question two can be answered as follows: for this population there is no difference between the patient's level of satisfaction with care as provided by a Mexican American nurse or a nurse of another ethnic background.

Quantitative Research Question Three

Research question three was stated as follows: Does the patient's level of acculturation, or generation removed from Mexico affect the patient's level of satisfaction with care? Multiple linear regression was utilized to examine the relationship between the levels of acculturation and the generation removed from Mexico as the independent variables and patient satisfaction as the dependent variable. From this analysis, it was determined that these two variables held no predictive value with patient satisfaction in this population. Pearson's product moment correlation coefficient was used to investigate the existence and the magnitude of relationships between the level of acculturation or generation removed from Mexico and patient satisfaction. No significant relationships were found with the total PSI scores or the subscale scores. From these results it can be answered that the patient's level of acculturation, or generation removed from Mexico does not affect the patient's level of satisfaction with care among this sample population.

Table 5

Multiple Linear Regression: Independent Variables as Predictors of PSI Scores

PSI Score as Dependent Variable	R	R Square	Adjusted R Square	Standard Error
PSI Total	.411	.169	.033	13.21
Professional-Technical	.416	.173	.038	3.77
Educational	.377	.142	.001	3.89
Trust	.458	.210	.080	6.46

Relationships Among Independent Variables

There was a small positive relationship between socioeconomic status and level of acculturation. This is noted by 92.5% of the subjects having an acculturation Level III or below, and 82.4% of them making $20,000 dollars or below per year. Negy and Woods (1992a) support these results, suggesting that the more acculturated subjects often come from backgrounds with a higher standard of living. Socioeconomic status and acculturation level are intricately interwined. These researchers also suggest that when studying acculturation level you need to account for socioeconomic status to clarify the specific influences of the two constructs. A moderate positive correlation between the level of acculturation and the generation removed from Mexico was revealed. Of the respondents, 35% were Level I on the ARSMA-II scale and 36.7% were the first generation in the United States. These results are similar to findings by Cuéllar et al. (1980). In addition, a moderate positive relationship between socioeconomic status and educational level was revealed. This is noted by the 82.4% of individuals with incomes below $20,000 annually and the high percentage, 77.5%, that have only a high school education or less. Another moderate positive relationship was found between the level of acculturation and educational level. Findings revealed that 92.5% were Level III in the acculturation scale or below, which directly corresponds with the low level of education of this survey population.

A moderate negative relationship was found between age and level of education. An inverse relationship was noted with the level of education decreasing as age increased. Also, a moderate negative relationship was found between language and both acculturation and generation removed from Mexico. The large number of Spanish

responses correlated with lower levels of acculturation and lower generation removed from Mexico.

Summary of Findings

The independent variables were not predictors of patient satisfaction with care in this particular population. No significant relationships were revealed. These results are similar to findings of previous studies which were unable to determine any predictors of patient satisfaction (Avis, Bond, & Arthur 1997; Bader, 1988; DiStefano, Pryer, & Garrison, 1980; Fox & Storms, 1981). Table 5 illustrates the results of the multiple linear regression. In addition, no relationship was found between the independent variables and the patient satisfaction total score or the subscale scores. Significant relationships were identified between several of the independent variables. Correlation results are depicted in Table 6.

Qualitative Results

For the qualitative aspect of the study the researchers asked two questions. The qualitative data was collected before having the subjects complete the PSI and the ARSMA-II. A short interview was conducted at the bedside with each subject, and the responses were recorded on paper verbatim by the researchers. Analysis of the data was conducted once all data was gathered. The three researchers reviewed the qualitative data and began searching for recurring themes. The responses were categorized and tallied. Themes were categorized by the researchers and compared with the narrative notes to ensure that they were congruent. All three researchers read and agreed on the categorization of the responses that were obtained.

Qualitative Research Question One

The first qualitative question was stated as follows: In what way did the nurse recognize cultural beliefs? Five major themes were identified from the answers to the first question. In order of frequency they are (a) attitude, (b) communication, (c) equality, (d) respect, and (e) attention.

The first and most recurrent theme in the data was the nurses attitude, being perceived as nice and friendly. One subject stated that they "treated me nice, and are very polite." Comments like this and "everyone treats me nice" were the most recurrent during analysis of the qualitative data. The second most common theme that emerged was the nurse's ability to communicate with the subjects. Related to this was being able to communicate in the same language (Spanish). The subjects perceived this as an indicator that they were receiving culturally congruent care. A subject answered "They speak to me in Spanish, that is nice to have." One subject stated "The way I speak, mix English and Spanish, they respect that." Communication was also important to one subject who stated "The nurse talks to me a lot, makes you feel you're not at the hospital. That's the way Mexican Americans are. That's the way mom raised me to be." Another subject stated that the nurses "try to talk Spanish even though it is not good." He stated he appreciated that effort.

The third most common theme that was revealed by a large number of subjects was that of equality, "being treated no different." Receiving culturally sensitive care was perceived by the subjects to mean being treated no differently than anybody else. The subjects revealed that culturally congruent nursing care to them meant being treated equally. One subject responded "They treated me like everybody else even though I

didn't have any money." Another subject reported that they were "just treated like any other patient."

Being treated with respect and politeness was the fourth most frequent theme that emerged from this sample population. A subject stated "Often the nurses are the same religion or ethnicity as me, but if not, it doesn't matter because I've been treated with respect." Another subject said "They respect the elderly and there are no superior or inferior relationships." One subject stated the nurse "Respects what I am. I respect them for protecting me." This theme also involved being polite and "speaking with manners." The last theme, which occurred less frequently than the previous categories, was the nurse paying attention to the subject. This was reflected in one subject's response "They are attentive when they assist with my care." Another subject stated "they care for me and pay attention to what I need."

Qualitative Research Question Two

The second question was stated as follows: Was there any aspect of care that was culturally displeasing? The most common response to the second question was that there were no events that the subjects found to be culturally displeasing. The subjects often stated that they were satisfied with their nursing care. Negative recurrent themes did not emerge from the data on this question; however, some singular responses to the first question indicated that culturally displeasing care was occasionally experienced by the subjects. This included not having coffee brought, the nurse not closing the door, or not turning the light off. One subject stated "The nurse didn't respect my privacy. She has a short temper, and saw me less than educated. I think because she was Anglo and I am Mexican." One subject who had surgery during this hospital admission stated, "One

nurse failed to help me get up after surgery and was very rude, she was white. She said there wasn't going to be someone there to help me all the time." The qualitative data supported the quantitative data in that it revealed that as long as subjects perceived they were treated nicely and with respect they were satisfied with care.

Table 6

Pearson's Product Moment Correlation: Independent Variables and Patient Satisfaction

	Age	Education	Gender	Socioeconomic Status	Language	Nurse Ethnicity
Education	-.446					
Gender	.048	-.033				
Socioeconomic Status	-.169	.417	-.078			
Language	.230	-.397	.249	-.291		
Nurse Ethnicity	-.163	.161	-.073	.094	-.331	
Marital Status	.221	-.279	-.310	.130	.122	-.198
Generation Removed	-.272	.148	-.017	.165	-.514	.189
Level of Acculturation	-.264	.444	-.126	.379	-.628	.222
Total PSI Score	-.138	.069	.085	-.197	-.061	.024
PSI-Professional-Technical	-.072	-.017	.202	-.190	.059	-.114
PSI-Educational	-.161	.161	-.046	-.133	-.145	.098
PSI-Trust	-.136	.050	.081	-.201	-.067	.052

Table 6 (continued) Pearson's Product Moment Correlation: Independent Variables and Patient Satisfaction

	Marital Status	Generation Removed	Level of Acculturation	Total PSI Score	PSI-Professional-Technical	PSI-Educational
Education						
Gender						
Socioeconomic Status						
Language						
Nurse Ethnicity						
Marital Status						
Generation Removed	-.231					
Level of Acculturation	-.140	.571				
Total PSI Score	-.208	-.052	.054			
PSI-Professional-Technical	-.244	-.127	-.062	.871		
PSI-Educational	-.198	-.198	.132	.888	.687	
PSI-Trust	-.156	-.156	.062	.952	.744	.769

CHAPTER V

CONCLUSIONS, IMPLICATIONS, RECOMMENDATIONS

As hospitals compete for patients in this age of consumer healthcare it is imperative to examine what predicts patient satisfaction with care, specifically nursing care. Gaining insight into the predictors of patient satisfaction will serve to improve nursing care and healthcare in general. Much research suggests that one way to enhance patient satisfaction is by providing culturally sensitive care. Leininger's Theory of Cultural Care Diversity and Universality asserts that by providing culturally specific care client care can be improved (Leininger, 1996). The American Nurses Association (1991) mandates that nurses must recognize specific cultural factors affecting individual clients and take into consideration variances that may occur within a particular culture. In order to provide culturally sensitive care, one must first examine the specific culture and the cultural constructs that influence patient satisfaction.

Mexican Americans were the targeted population in this study due to the limited amount of research on patient satisfaction done with this population. Also, Mexican Americans are the most rapidly growing minority in the United States. Examining the predictors of patient satisfaction among Mexican Americans serves to increase the knowledge base and to identify areas for further research with this population. Conclusions for this pilot study, implications of the findings, and recommendations for further research will be offered within this chapter.

The independent variables were not predictors of patient satisfaction in this particular population. No significant relationships were revealed. These results are similar to findings of previous studies which were unable to determine any predictors of patient satisfaction (Avis, Bond, & Arthur 1997; Bader, 1988; DiStefano, Pryer, & Garrison, 1980; Fox, & Storms, 1981). There were no predictors of satisfaction within this population, however, many of the independent variables were found to have relationships which is supportive of previous research in this area.

Administration of Questionnaires

The time involved completing the questionnaire proved to be a limitation to this study. Most of the subjects were willing to participate only if one of the researchers read the questions; therefore, researchers personally administered the majority of the questionnaires. Even though the Likert-style questionnaires were highly structured with pre-designed answers, this direct contact with the researchers could have biased the responses. Hospitalized subjects often have a decreased desire, ability, and energy to participate in research. Further research with this population might include having a neutral person help the subjects complete the questionnaires.

Socioeconomic Status

The research revealed that 82.4% of this population earned $20,000 or below annually. The income levels below $20,000 could have been delineated further. The $20,000 figure did not identify those making minimum wage, or those who were destitute. The range for those making minimum wage would be approximately $10,000 to $11,000 per year. Hispanics nationally are two and one half times more likely to live below poverty level than any other group (Council of Scientific Affairs, 1991). Further

delineation of socioeconomic status may have revealed more significant results related to patient satisfaction. Hennessy and Friesen (1994) assert that people of a lower socioeconomic class reportedly are less satisfied with nursing care. Future research should include narrower categories of socioeconomic status, more specifically those below $20,000, and also include the number of members in the household in order to identify those subjects living below poverty level.

Marital Status

Several subjects revealed they were widowed, but this was not a category included in the demographic data. This may have been a bias related to the age and developmental level of the researchers. In retrospect, the area of previously married people which was primarily to include separated and divorced subjects could have been delineated further to include those who were widowed. For the purposes of data entry, those who identified themselves as widowed were entered in the previously married category. This particular subgroup in the study was not appropriately identified. Accurate assessment of the widowed population may have resulted in significant findings related to patient satisfaction. Identifying the widowed population in future research is recommended.

Ethnicity of Nurse

It is assumed that those subjects who did not indicate the ethnicity of the nurse on the questionnaire based their answers to the PSI on their nursing care in general. Seventy-six respondents identified the ethnicity of the nurse and answered the PSI accordingly. Determination of nurse ethnicity was based solely on the subjects' opinions. The ethnicity of the nurses on the four units used in the research was 62% Mexican

American, 19% Philippino, 12% Canadian, 5% Ango American, and 2% other. The list of nurses' ethnicity was provided by the nurse managers of these units, not by the nurses themselves.

The majority of nurses, 80%, in Texas are of Anglo or Euro-American background according to the Board of Nurse Examiners (1998); however, the majority of nurses in this pilot study, 62%, were Mexican American. This differentiates the lower Rio Grande Valley's demographics from most others in the state. The difference in demographics of the nursing population in the geographic region compared to the nursing population in the state could have biased the results. Patient satisfaction may not have been influenced by the ethnicity of the nurses in this study because the largest percentage of the nurse population was of the same ethnic background as the patients. This could be an area for further research in a different geographical location.

Patient Satisfaction Inventory

Two controversies surrounding the use of the PSI include its cultural applicability and the use of a translated version. Most studies that have utilized the PSI have failed to offer any cultural delineation of the subjects, raising some uncertainties with its cultural applicability with the Mexican American population. Further research in this area should include validation of this tool among Mexican Americans. The original PSI was available in Spanish; however, the revised version was not. This resulted in the need to translate and back translate this tool. The use of the translated PSI raised some significant issues concerning comparability and reliability of the English and Spanish responses. No pilot test of the tool was conducted to test the reliability and validity of the Spanish translation and applicability of this tool among the Mexican American

population. Validation of this tool among Mexican Americans as well as further use with the back translation would be a recommendation for further research.

A rather large limitation with the PSI is the lack of available scoring systems. There was no norm with which to compare the total range or the average of the PSI or the subscales. A patient satisfaction mean of 44 had no normative comparison, nor is there any way to qualify high and low scores. Comparisons could only be made within the group itself. Availability of comparable scores would enhance further research utilizing the PSI.

Leininger and Culture

Leininger's Theory of Cultural Care Diversity and Universality provided the framework for this research by suggesting that culturally sensitive care is good care and that satisfaction with care is dependent upon the provision of culturally sensitive care (Alexender et al., 1994). Leininger's theory purports that culturally sensitive care should be based on the specific characteristics of ones culture (Leininger, 1996). The results of the qualitative questions asked in this study did not support the idea that culturally sensitive care is dependent on understanding specific characteristics of a culture. A recurrent theme found suggested that the participants just wanted to be treated the same as everyone else. This recurrent theme could represent what is considered culturally sensitive care within this population and supports Williams (1997) which found that the greatest predictor of patient satisfaction is sensitive care. The other themes that emerged from the qualitative questions represented basic constructs of caring rather than concepts of culture.

This pilot study was conducted in a geographical area that could be referred to as a "border zone." The Mexican Americans in this border zone are influenced geographically and politically like no other group of Mexican Americans. Martinez (1994) describes the unique characteristics of the Texas-Mexico border region as "two contiguous geographical entities that are highly interdependent" (p. 304). In the Lower Rio Grande Valley, Mexican Americans are the majority, at 87.3% of the population (Texas Department of Health, 1997). The Mexican American culture in this location is very strong and unified. This is reflected in the qualitative results where subjects state they want to be treated the same as everyone else, or like the majority. These statements could stem from the fact the Mexican Americans in this geographical region are the majority and possibly do not see themselves as a minority. Further research among Mexican Americans in a different geographical region may elicit different results. Recommendation for further research should include the examination of political and social structures affecting the cultural group (Meleis, 1996). When studying culture within nursing, research may better focus on how health care marginalizes patients because they are a different culture (Meleis, 1996). Classifying patients by their ethnic background and treating all patients of that same culture uniformly may reduce the chance for providing holistic culturally sensitive nursing care. Treating patients as individuals and not stereotyping them into specific cultural categories would be the strongest recommendation of this research study.

Acculturation

The results of this study revealed that 92% of the population was a Level III or below on the ARSMA-II. This indicates a relatively low level of acculturation among

this population. No subjects were identified to be Level V on the ARSMA-II which is identified as very assimilated or anglicized (Cuéllar, Arnold , & González,1995). The level of acculturation had no significant influence on patient satisfaction. This could have been a result of the geographical location in which the study was conducted. The subjects in this study were the majority population and acculturation to a different majority population was not needed. The low level of acculturation among this population reflects the strong Mexican cultural influence of the region. Should this study be repeated in a population of Mexican Americans that equally represents all five levels on the ARSMA-II, the findings related to patient satisfaction may be different. The ARSMA-II is strongly recommended for further research examining acculturation among Mexican Americans.

Familism

Research using the PSI has not included family support as a variable; however studies with the ARSMA–II have included this variable. Familism is considered to be a central value of Hispanics. The importance an individual places on the family, and his or her attitudes toward the family, are essential in the concept of familism (Marin & Marin 1991). The Mexican American family is a support system for the individual and for the members (Keffe, Padilla & Carlos 1978; Ruiz, 1981). Family support may affect the rate at which an individual is acculturated (Cuéllar, Arnold & González, 1995). Padilla (1980) states that acculturation is not an interdependent process and that the extended family needs also be examined. The concept of families was included in this study. The researchers encouraged the participants to answer the questionnaires with their families and to have them assist with translation. Although familism was encouraged, no specific

opportunity was made to identify family members in the household or the support they provided. Inclusion of this variable could have provided more insight to the predictors of patient satisfaction. Further research in this area would benefit by the inclusion of this information.

Religion

Mexican Americans are strongly influenced by a central element of religion. Many Mexican Americans believe their lives and health beliefs are controlled by divine will and fate, over which they have little control (Mickley & Soahen, 1993; Burk, Weiser & Keegan, 1995). Identification of religious affiliations of the subjects may have produced significant results. Religion may have influenced patient satisfaction. Recommendations for further research would include identification of the subjects religious affiliation.

Researcher-Subject Ethnicity

Researcher-subject ethnicity differences contributed to the interpretation of the results found from this research. One of the researchers was of the same ethnic background as the subjects, and the other two researchers were of a different ethnic background than the subjects. This was a positive aspect of this study since it provided a different and more well rounded ethnic interpretation of the results. The researchers studied the qualitative results together and decided upon categories as a multiethnic group. The implication is that the researchers perspective was neither solely insider nor outsider, which strengthens the research. Meleis (1996) supports that the processes inherent in matching researcher and subject in ethnicity hinders the cultural diversity in research.

Qualitative Versus Quantitative

The quantitative aspect of this study did not reveal any significant findings. This may have resulted from the reductionistic nature of quantitative methodology. It may have rendered satisfaction results devoid of much of the meaning that was intended (Williams, 1994). It has been noted that patients display a critical nature when given the opportunity through more open ended questions (Locker & Dunt, 1978). A qualitative approach was added for this reason. Qualitative information provides potentially valuable information about healthcare services and lends insight into clients' perceptions of patient satisfaction. Qualitative data of this study revealed five recurrent themes. When given the opportunity, subjects discussed factors that lead to satisfaction and dissatisfaction with care. This insight could not have been revealed using the PSI alone. Placing too much reliance on rigid satisfaction surveys may run the risk of channeling patients' concerns into avenues defined by the providers, rather than promoting greater consumer involvement (Avis, et al., 1997). Therefore, researchers need to incorporate multiple, and different data-gathering methodologies to measure and define patient satisfaction.

Conclusion

Patient satisfaction is an important issue in this age of consumerism. Although no conclusive predictors of patient satisfaction were found, this pilot study was an important one. It served to investigate the existence of cultural issues among Mexican Americans in the Lower Rio Grande Valley. Through their participation in the study, subjects have had an increased awareness of their own cultural identity, have been encouraged to examine their own belief systems, and have been provided an opportunity to have their

opinions heard. This research has been successful as it empowered the participants through an increased awareness of their cultural identity and their role as consumers within the health care system.

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APPENDIX A

PSI

Directions: The researcher is interested in your opinion of the care you have received. Please give your honest opinion for each statement on this list by circling one of the five answers to describe the nurse(s) caring for you:

1. The nurse should be more attentive than he/she is.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

2. Too often the nurse thinks you can't understand the medical explanation of your illness, so he/she just doesn't bother to explain.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

3. The nurse is pleasant to be around.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

4. A person feels free to ask the nurse questions.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

5. The nurse should be more friendly than he/she is.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

6. The nurse is a person who can understand how I feel.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

7. The nurse explains things in simple language.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

8. The nurse asks a lot of questions, but once he/she finds the answers, he/she doesn't seem to do anything.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

9. When I need to talk to someone, I can go to the nurse with my problems.

   STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

10. The nurse is too busy at the desk to spend time talking with me.

    STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

11. I wish the nurse would tell me about the results of my tests more than he/she does.

    STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

12. The nurse makes it a point to show me how to carry out the doctor's orders.

    STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

13. The nurse is often too disorganized to appear calm.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

14. The nurse is understanding in listening to a patient's problems

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

15. The nurse gives good advice.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

16. The nurse really knows what he/she is talking about.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

17. It is always easy to understand what the nurse is talking about.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

18. The nurse is too slow to do things for me.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

19. The nurse is just not patient enough.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

20. The nurse is not precise in doing his/her work.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

21. The nurse gives directions at just the right speed.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

22. I'm tired of the nurse talking down to me.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

23. Just talking to the nurse makes me feel better.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

24. The nurse always gives complete enough explanations of why tests are ordered.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

25. The nurse is skillful in assisting the doctor with procedures.

STRONGLY AGREE AGREE UNCERTAIN DISAGREE STRONGLY DISAGREE

PSI

Direcciones: Las investigadoras de éste estudio están interesadas en su opinión sobre los cuidados de la enfermera/el enfermero que ha recibido. Por favor de su opinión sincero para cada afirmación en ésta lista. Circule solamente una de las cinco respuestas que describe la enfermera/el enfermero que la/lo ha cuidando.

1. La enfermera/el enfermero debe ser más atenta/o de lo que es.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

2. Muy de seguido la enfermera/el enfermero piensa que no puedo entender las explicaciónes médicas de mi enfermedad y no toma el tiempo para explicar.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

3. La enfermera/el enfermero es agradable.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

4. Una persona se siente libre hacer preguntas a la enfermera/al enfermero.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

5. La enfermera/el enfermero debe ser más amistosa/o de lo que es.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

6. La enfermera/el enfermero es una persona que puede entender como me siento.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

7. La enfermera/el enfermero da explicaciónes en una idioma simple.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

8. La enfermera/el enfermero hace muchas preguntas, pero cuando recibe las respuestas no hace nada más.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

9. Cuando necesito hablar con alguien yo puedo ir con la enfermera/el enfermero con mis preguntas.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

10. La enfermera/el enfermero está muy ocupada/o en el escritorio y no puede tomar tiempo para hablar conmigo.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

11. Deseo que la enfermera/el enfermero me cuente los resultados de mis examenes más de lo que hace.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

12. La enfermera/el enfermero se empeña en enseñarme como cumplir las ordenes del doctor.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

13. La enfermera/el enfermero esta desorganizada/o muy de seguido y no aparece con calma.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

14. La enfermera/el enfermero es comprensiva/o cuando escucha los problemas del paciente.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

15. La enfermera/el enfermero da buenos consejos.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

16. La enfermera/el enfermero en realidad sabe de lo que está hablando.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

17. Siempre es fácil entender de lo que la enfermera/el enfermero está hablando.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

18. La enfermera/el enfermero no tiene tiempo para atenderme porque es muy lenta/o.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

19. La enfermera/el enfermero no tiene suficiente paciencia.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

20. La enfermera/el enfermero no es precisa/o con su trabajo.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

21. La enfermera/el enfermero da direcciónes a buen velocidad.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

22. Estoy cansada/o de la enfermera/el enfermero faltandome el respeto.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

23. Solamente hablando con la enfermera/enfermero me hace sentir mejor.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

24. La enfermera/el enferemero siempre da explicaciónes completas sobre la razón que ordenan examenes.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

25. La enfermera/el enferemero es diestra/o en assitiendo al doctor con procedimientos.

DE ACUERDO FIRMEMENTE DE ACUERDO INCIERTO NO ESTOY DE ACUERDO NO ESTOY DE ACUERDO FIRMEMENTE

Acculturation Rating Scale - II
(ARSMA-II)

English Version	*Versión en Español*
Name: _____	Nombre: _____
Male: _____ Female: _____	Masculino: _____ Femenino: _____
Age: _____ DOB: ____/____/____	Edad: _____ Día de Nacimiento: _____
Marital Status: _____	Estado Civil: _____
What is your religious preference?: _____	Cual es su religión preferencia?: _____
(a) Last grade you completed in school: *(Circle your choice)* 1. Elementary - 6 2. 7 - 8 3. 9 - 12 4. 1 - 2 years of college 5. 3 - 4 years of college 6. College graduate and higher	(a) ¿Hasta que grado fué a la escuela? *(Indique con un círculo la respuesta.)* 1. Primaria - 6 2. Secundaria 7 - 8 3. Preparatoria 9 - 12 4. Universidad o Colegio 1 - 2 años 5. Universidad o Colegio 3 - 4 años 6. Graduado, o grado mas alto de Colegio o Universidad
(b) In what country? _____	(b) ¿En que país? _____
[Circle the generation that best applies to you. Circle only one.]	*[Indique con un círculo el numero de la generación que considere adecuada para usted. Dé solamente una respuesta.]*
1. 1st generation = You were born in Mexico or other country.	1. 1a. generación = Usted nació en Mexico u otro país [no en los Estados Unidos (USA)].
2. 2nd generation = You were born in USA: either parent born in Mexico or other country.	2. 2a. generación = Usted nació en los Estados Unidos Americanos (USA). sus padres nacieron en México o en otro país.
3. 3rd generation = You were born in USA, both parents born in USA and all grandparents born in Mexico or other country.	3. 3a. generación = Usted nació en los Estados Unidos Americanos (USA). sus padres tambien nacieron en los Estados Unidos (USA) y sus abuelos nacieron en México o en otro país.
4. 4th generation = You and your parents born in USA and at least one grandparent born in Mexico or other country with remainder born in the USA.	4. 4a. generacion = Usted nació en los en los Estados Unidos Americanos (USA), sus padres nacieron en los Estados Unidos Americanos (USA) y por lo menos uno de sus abuelos nació en México o algun otro país.
5. 5th generation = You and your parents born in the USA and all grandparents born in the USA.	5. 5a. generación = Usted y sus padres y todos sus abuelos nacieron en los Estados Unidos (USA).

Cuellar, Arnold, and Maldonado (1995). Acculturation rating scale for Mexican-American –II: A revision of the original ARSMA scale. Hispanic Journal of Behavioral Sciences, 17(3), pp 275-304. © 1995 by Cuellar, Arnold, Glazier. Reprinted by permission of (Sage Publications), Inc.

SCALE 1

[Circle a number between 1-5 next to each item that best applies.]

1	2	3	4	5
Not at all	Very little or-not very often	Moder-ately	Rath or Very often	Extremely often or Almost Always

1. I speak Spanish	1	2	3	4	5
2. I speak English	1	2	3	4	5
3. I enjoy speaking Spanish	1	2	3	4	5
4. I associate with Anglos	1	2	3	4	5
5. I associate with Mexicans and/or Mexican Americans	1	2	3	4	5
6. I enjoy listening to Spanish language music	1	2	3	4	5
7. I enjoy listening to English language music	1	2	3	4	5
8. I enjoy Spanish language TV	1	2	3	4	5
9. I enjoy English language TV	1	2	3	4	5
10. I enjoy English language movies	1	2	3	4	5
11. I enjoy Spanish language movies	1	2	3	4	5
12. I enjoy reading e.g., books in Spanish	1	2	3	4	5
13. I enjoy reading e.g., books in English	1	2	3	4	5
14. I write e.g. letters in Spanish	1	2	3	4	5
15. I write e.g., letters in English	1	2	3	4	5

[Marque con un círculo el número entre 1 y 5 a la respuesta que sea más adecuada para usted.]

1	2	3	4	5
Nada	Un Poquito o A veces	Moderado	Bastante o Muy Frecuente	Bastante o Casi todo el tiempo

1. Yo hablo Español	1	2	3	4	5
2. Yo hablo Inglés	1	2	3	4	5
3. Me gusta hablar en Español	1	2	3	4	5
4. Me asocio con Anglos	1	2	3	4	5
5. Yo me asocio con Mexicanos o con Norte Americanos	1	2	3	4	5
6. Me gusta la musica Mexicana (musica en Idioma Español)	1	2	3	4	5
7. Me gusta la musica de Idioma Inglés	1	2	3	4	5
8. Me gusta ver programas en la televisión que sean en Español	1	2	3	4	5
9. Me gusta ver programas en la televisión que sean en Inglés	1	2	3	4	5
10. Me gusta ver películas en Español	1	2	3	4	5
11. Me gusta ver películas en Inglés	1	2	3	4	5
12. Me gusta leer e.g., libros en Español	1	2	3	4	5
13. Me gusta leer e.g., libros en Inglés	1	2	3	4	5
14. Escribo e.g., cartas en Español	1	2	3	4	5
15. Escribo e.g., cartas en Inglés	1	2	3	4	5

Acculturation Rating Scale (ARSMA-II) 3

1	2	3	4	5
Not at all	Very little or not very often	Moderately	Much or Very often	Extremely Often or Almost Always

16. My thinking is done in the English language	1 2 3 4 5
17. My thinking is done in the Spanish language	1 2 3 4 5
18. My contact with Mexico has been	1 2 3 4 5
19. My contact with the USA has been	1 2 3 4 5
20. My father identifies or identified himself as 'Mexicano'	1 2 3 4 5
21. My mother identifies or identified herself as 'Mexicana'	1 2 3 4 5
22. My friends, while I was growing up, were of Mexican origin	1 2 3 4 5
23. My friends, while I was growing up, were of Anglo origin	1 2 3 4 5
24. My family cooks Mexican foods	1 2 3 4 5
25. My friends now are of Anglo origin	1 2 3 4 5
26. My friends now are of Mexican origin	1 2 3 4 5
27. I like to identify myself as an Anglo American	1 2 3 4 5
28. I like to identify myself as a Mexican American	1 2 3 4 5

1	2	3	4	5
Nada	Un poquito o Pocas	Moderado	Mucho o Muy frecuente	Mucho/Casi o Casi todo el tiempo

16. Mis pensamientos ocurren en el idioma Inglés	1 2 3 4 5
17. Mis pensamientos ocurren en el idioma Español	1 2 3 4 5
18. Mi contacto con México ha sido	1 2 3 4 5
19. Mi contacto con los Estados Unidos Americanos ha sido	1 2 3 4 5
20. Mi padre se identifica (o se identificaba) como Mexicano	1 2 3 4 5
21. Mi madre se identifica (o se identificaba) como Mexicana	1 2 3 4 5
22. Mis amigos(as) de mi niñez eran de origen Mexicano	1 2 3 4 5
23. Mis amigos(as) de mi niñez eran de origen Anglo Americano	1 2 3 4 5
24. Mi familia cocina comidas mexicanas	1 2 3 4 5
25. Mi familia cocina comidas Norte Americanas (Anglo Americanas)	1 2 3 4 5
26. Mis amigos recientes son Mexicanos	1 2 3 4 5
27. Me gusta identificarme como Anglo Americano	1 2 3 4 5
28. Me gusta identificarme como Norte Americano* (México-Americano)	1 2 3 4 5

*Norte Americanos de origen Mexicano

1	2	3	4	5
Not at all	Very little or not very often	Moderately	Much or Very often	Extremely often or Almost Always

1	2	3	4	5
Nada	Un poquito a A veces	Moderado	Mucho o Muy frecuentemente	Bastante o Casi todo el tiempo

29. I like to identify myself as a Mexican 1 2 3 4 5

30. I like to identify myself as an American 1 2 3 4 5

29. Me gusta identificarme como Mexicano 1 2 3 4 5

30. Me gusta identificarme como un(a) Americano(a) 1 2 3 4 5

end of Scale 1

DEMOGRAPHIC DATA SHEET

Please circle the answer that best describes you.

1. What is your ethnicity?

Mexican American non Mexican American

2. What is your age? ____

3. What is your gender?

Male Female

4. What is the highest level of school you have completed?

Elementary High School

College (undergraduate) Graduate

5. What is your marital status?

Single Married

Divorced/Separated

6. What is your socioeconomic status?

20,000 or below 20-30,000

30-40,000 40-50,000

50,000 or above

Please think of one particular nurse that has cared for you during your present stay.

Please apply the following question and the Patient Satisfaction Inventory to that particular nurse that stands out in your mind.

7. Is this particular nurse you are thinking of :

Mexican American non Mexican American

Datos

Por favor circule la respuesta que mejor la/lo describe a usted.

1. ¿Qué es su étnicidad?

   Mexicana/o Americana/o no Mexicana/o Americana/o

2. ¿Qué es su edad? _____

3. ¿Qué es su sexo?

   Hombre Mujer

4. ¿Qué es el nivel mas alto de educación que completo?

   Primaria Secundaria

   Colegio Licenciatura superior

5. ¿Qué es su estado civil?

   Soltera/o Casada/o

   Divorciada/o Separada/o

6. ¿Qué es su estado económico?

   $20,000 o menos $20-30,000

   $30-40,000 $40-50,000

   $50,000 o mas

*****Por favor piense en una enfermera/un enfermero que la/lo ha cuidado durante esta hospitalicación. Aplique la siguente pregunta y las preguntas en el questionario de satisfación (PSI) en la enfermera/enfermero en que usted esta pensando.*****

7. La enfermera/el enfermero en que usted esta pensando es:

   Mexicana/o Americana/o no es Mexicana/o Americana/o

APPENDIX B

McAllen Medical Center

301 W. Expressway 83
McAllen, Texas 78503
(956) 632-4000

University of Texas - Pan American
Department of Nursing
1201 West University Drive
Edinburg, TX 78539

To whom it may concern:

The purpose of this letter is to grant formal written permission to Shannon Dowdall, Alma Flores, and Karyn Taplay to utilize McAllen Medical Center for the purpose of their research study. The data collection for this research study, entitled *Culturally Congruent Care: Predictors of Patient Satisfaction Among Mexican Americans*, will take place in August and September of 1998. Data collection will take place on three or four adult care units volunteered by their unit directors. All subjects will be voluntary and give informed written consent prior to participating in the study.

It is our understanding that all results of this research study will be summarized and presented to McAllen Medical Center after its completion.

Sincerely,

Linda K. Daum

Linda K. Daum, CNE
McAllen Medical Center

NURSING DEPARTMENT
THE UNIVERSITY OF TEXAS - PAN AMERICAN
1201 West University Drive • Edinburg, Texas 78539-2999 • (956) 381-3491 / 316-7032 • Fax (956) 381-2384

MEMORANDUM

TO: George Avellano
Associate Vice President for Graduate Programs and Planning

FROM: Barbara Tucker, Coordinator MSN Program

returned to B. Tucker

DATE: July 14, 1998

RE: Human Subjects Review Committee

I was informed that Dr. Shelia Pozorski will chair the Human Subjects Review Committee in the Fall and Dr. Ernest Baca would continue during the summer. I have been unable to get in touch with Dr. Baca and my students are almost to the point to starting data collection.

The students are enrolled in NURS 7300 Thesis I (Proposal) this summer and will present the proposal to their committee ~~the first week~~ in August. They have appeared before the Institutional Review Board of McAllen Medical Center and have been granted permission to collect data at that institution.

Attached are copies of the abstract, the informed consent forms (English and Spanish), the approval from McAllen Medical Center, and signed confidentiality forms required by the hospital.

Please advise me as to how to proceed at this point.

Proposal is basic questionnaire format - no physical contact.

Approved.
7-20-98
Avellano

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Ms. Shannon Dowdall
Dept. of Nursing
University of Texas - Pan American
1201 W. University Dr.
Edinburg, TX 78539

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TRANSMITTAL

	Karyn Tapley
Fax:	956-381-2364
From:	Loree Sichelstiel
Date:	7/13/98
# of pages:	1

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July 13, 1998

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2009 Pelican Avenue
McAllen, TX 78504

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Material(s) requested: *JNCQ, 11:5, pp. 28-29*

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Loree Sichelstiel
Permissions Assistant
4209-5980

* **PLEASE NOTE:** As far as I am able to determine, the scale is not available in Spanish. Permission is granted to translate the scale into Spanish.

Consent and Release Form

Receiving high quality care while hospitalized is important to consumers. Discovering what consumers perceive quality care to be is important in shaping the delivery of that care. This research aims to investigate what factors contribute to patient satisfaction.

If you agree to participate in this study you will be asked to reveal basic information about yourself, complete two questionnaires, and answer a few questions on what you believe is quality care. No answer is right or wrong, only a reflection of your opinion. Your response will be kept confidential.

Your participation in this research is voluntary and you may choose not to give your consent. Your participation, or refusal to participate will in no way effect the care you receive while you are hospitalized. If at any time during the research study you wish to withdraw, you are free to do so.

I certify that I have read and fully understand the explanation of the study described.
I voluntarily give my consent to participate in this study.
I understand that I may withdraw my consent at any time.
I understand that my identity will not be revealed.
I have been given an opportunity to ask questions and they have been answered.

_____
Name (please print)

_____ _____
Your signature Date

Consetimiento

Recibir cuidados de alta cualidad cuando uno esta en el hospital es importante a los consumidores de estos servicios. Discubriendo lo que piensan de lo que es cuidado de alta cualidad es importante en formando esos cuidados.

Si usted participa en este estudio, le preguntaran que revele información básica, completar dos cuestionarios, y responder a varias preguntas sobre lo que usted piensa que es cuidado de alta cualidad. Ninguana respuesta es correcta o equivocada, solamente es una reflexión de su opinión. Sus respuestas seran confidencial.

Su participación en este estudio es voluntario y puede decidir no participar. Su participación, o falta de participar no afectara los cuidados que usted recibe mientras que este en el hospital. Si en algun momento de el estudio usted desea suspender su participación, es su derecho hacerlo.

Yo certifico que he leido y entiendo la explicación del estudio.
Yo voluntariamente doy mi consentimiento para participar en este estudio.
Yo entiendo que puedo dehar de participar en cualqer momento.
Yo entiendo que mi identidad no sera revelada.
Me han dado la oportunidad de hacer preguntas y me las han respondido.

_____
Nombre (en molde porfavor)

_____ _____
Firma Fecha

VITA

121 E. Van Week
Edinburg, TX 78539
(956) 381-8530
aflores@stcc.cc.tx.us

Alma R. Flores

Experience

1997–1998 South Texas Community College McAllen, TX
Instructor

- Clinical instructor for the Patient Care Assistant Program
- Nursing skills instructor for the Licensed Vocational Nursing Program
- Pediatric guest lecturer for the Associate Degree Nursing Program

1995–1997 McAllen Medical Center McAllen, TX
Staff/Charge Nurse, Pediatric Medical Surgical Unit

- Perform charge and staff duties on 24 bed unit
- Floated into Pediatric Intensive Care Unit

Education

1996–199 University of Texas Pan American McAllen, TX

- Presently enrolled in MSN Program

1992-1995 Texas Tech University H.S.C. Lubbock, TX

- BSN

Certifications

Pediatric Advanced Life Support

VITA

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Circle #F
Edinburg, TX 78539
(956) 387-0265
shannon@hiline.net

Shannon M. Dowdall

Education

1996-Present University of Texas Pan American, Edinburg, TX

- Working toward completion of MSN with concentration in Education, Graduation May 1999. GPA 4.0

1991-1995 Laurentian University, Sudbury, ON, Canada

- Graduated cum laude with Bachelor of Science in Nursing (BScN).

1989-1991 University of Guelph, Guelph, ON, Canada

- Completed two years of BA Applied Science; Child and Family Studies. Credit hours transferred to Nursing Program.

Experience

Fall 1998 University of Texas Pan American, Edinburg, TX
Pediatric Consultant

- Acting as a clinical Pediatric consultant for a new faculty member. Offering clinical and theoretical expertise to both students and faculty member.

1996-Present McAllen Medical Center, McAllen, TX
Registered Nurse/ Pediatrics, Pediatric Intensive Care Unit

- Extensive experience with critical care of children, PALS certified.

1997-1998 University of Texas Pan American, Edinburg, TX
Graduate Assistant – Pediatric Clinicals

- ADN, and BSN levels. Responsible for grading careplans, evaluation of clinical participation, teaching several lectures, pre and post conference

Fall 1995-Spring 1996 Laurentian University/Sudbury Heart Health, Sudbury, ON, Canada
Nurse Consultant/Research Assistant

- Responsible for research proposal. Data collection, qualitative narrative analysis, and writing of initial draft.

Rulkholm, E. & Bailey, P. (1997). Shifting the health culture of a community: A qualitative narrative inquiry 1989-1996. Prepared for the Ontario Ministry of Health. Sudbury: Sudbury Heart Health.

VITA

2009 Pelican Ave
McAllen, TX 78405
(956) 631-9333
Taplayk@panam.edu

Karyn Taplay

Experience

1998-present University of Texas-Pan American Edinburg, TX
Lecturer
- Teach didactic and clinical components of the Associate and Baccalaureate Nursing programs.

1997-1998 University of Texas-Pan American Edinburg, TX
Teaching Assistant
- Assist with the clinical and didactic components of the Associate and Baccalaureate Nursing programs.

1995-present McAllen Medical Center McAllen TX
Childbirth Educator
- Provide expecting couples/mothers with the knowledge they will need to enhance their birthing experience.

1993-1998 McAllen Medical Center McAllen TX
Staff/Charge Nurse, Labor and Delivery
- Assist with unit personnel management and prepare staff asignments on a 31 bed unit.
- Originate and revise policies and procedures.
- Orient new staff members.

Education

University of Texas-Pan American Edinburg, TX
- Master of Science in Nursing presently enrolled

1988-1992 University of Toronto Toronto, Ontario
- Bachelor of Science in Nursing.

Certifications

- Inpatient Obstetrics, National Certification
- Neonatal resuscitation
- Basic EKG interpretation
- Childbirth Educator