

FAMILY-CENTERED CARE, PATIENT-CENTERED CARE, AND CULTURALLY
COMPETENT CARE: COMMON THEMES AND BACKGROUND MEANINGS

By

M. Catherine Pollock-Robinson

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The members of the Committee appointed to examine the thesis of M. Catherine Pollock-Robinson find it satisfactory and recommend that it be accepted.

Dawn Liam Doutrich, Chair

Linda Eddy

Lida Dekker

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Abstract

By M. Catherine Pollock-Robinson, BSN
Washington State University
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Chair: Dawn Doutrich

In nursing education and practice, the terms family-centered care, patient-centered care, and culturally competent care are used to describe many ways of being a nurse. Nursing competence (or nursing care) incorporates all of these concepts to some extent. Institutional and organizational definitions of family-centered, patient-centered, and culturally competent care overlap. In order to provide nursing care that is appropriate, nurses may face the paradox of looking at patients as both part of a group and as individuals with personal beliefs and needs that are not necessarily those of their culture. In any nurse-patient relationship there are two cultures—that of the patient and that of the nurse, for nursing may be described as having a culture of its own within the larger healthcare culture. Nurses were interviewed about their ways of being family-centered, patient-centered, and culturally competent. A Heideggerian approach to analysis of the narrative data is used to explore the common themes and background meanings for the participants. Emerging literature from New Zealand, critical analyses, and the narrative analysis and recommendations are made for nursing. Self-reflection is discussed as an important technique for nurses to learn in order to support on-going development of nursing skills that will support safe and appropriate patient care for any patient who is different from the nurse.

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DEDICATION

This thesis is dedicated to my husband Kim. Not only does he love and support me in all of my endeavors, he bought me a bigger kitchen table. I love you.

CHAPTER ONE

Background

In nursing education and practice, the terms cultural competence and patient- or family-centered care (PFCC) are used to describe ways of being a nurse; however, there is little consensus on the definition or meaning of these terms or how they should be taught and learned. Dreher and MacNaughton (2002) suggest that cultural competence is actually nursing competence and that “all patients deserve family-centered care, greater allocation of time, and openness to biomedical alternatives” (p. 185). Healthcare education curricula use methods and approaches to culture that can lead to stereotyping and assumptions that make it difficult for us to assess and care for individuals who may or may not embrace the cultural attributes ascribed by a particular text or resource. Engebretson, Mahoney, and Carlson (2008) suggest that skills-based education might be of more use, such as including anthropological theories and ethnopharmacological studies, as well as a focus on “communication skills, such as eliciting patient’s explanatory models (EMs), decision-making preferences, family roles, and use of healing resources” (p. 173).

Family-centered care has most often been described in the context of caring for children in acute-care and outpatient settings (Shelton, Jeppson, & Johnson 1987, Hutchfield, 1999). Key components of family-centered care include partnership, participation, and care by parents.

Dreher and MacNaughton (2002) stated:

We contend that cultural competence is really nursing competence. It is the capacity to be equally therapeutic with patients from any social context or cultural background. Framing the issue as “cultural” diverts us from a

serious examination of the inadequacy of patient-provider communication in general (p. 185).

Accumulated cultural knowledge relies on cultural informants to provide an inventory of cultural information about specific groups. This information is utilized in nursing education as well as in healthcare settings where manuals and guides are provided as resources for culturally competent care. When practicing family-centered care, the nurse relies on the patient and family members to transmit information about the meanings of health or the explanatory model for the healthcare issue at hand. Nurses who respond to this information by incorporating this explanatory model into the plan of care are providing culturally appropriate care from the most immediate perspective—that of the patient and his or her family.

Statement of Purpose

Family-centered care involves the use of information obtained from patients and families in formulation plans of care that include the world-view of the family, including their perceptions of the health issue at hand. The objective of this study is to collect data, in the form of narratives, from nurses who care for families who they (the nurses) consider to be different from them. The hope is that this may help re-conceptualize the way that family-centered care and cultural competence are presented in nursing education. The purpose of this interpretive study is to use phenomenological inquiry to explore the common themes and background meaning(s) in the narratives of nurses who work with families with regard to family-centered and culturally competent care.

Conceptual Framework

Phenomenology

The Heideggerian phenomenological approach to this research was used to address the general question, “What does it mean to be a person?” Heideggerian phenomenology, as both philosophy and method, represents a “shift away from epistemologic concern...toward the more fundamental concern with ontology” (Leonard, 1989, p. 42).

Heideggerian phenomenology describes the person’s relationship with the world through several concepts:

1. The person as having a world. “World” in this sense does not represent our everyday meaning of the word. For Heidegger, according to Leonard (1989), the world is a priori—and “it is given in our cultural and linguistic practices” (p. 43). World is more than the sum of its parts. “Phenomenologically, world is the meaningful set of relationships, practices, and language that we have by virtue of being born into a culture” (p. 44). Although we may each define and describe our world differently, an assumption is made that there are some shared conceptualizations of the world among those who have a common language and culture.
2. The person as a being for whom things have significance and value. Because we, as humans being in the world, attend to people or objects, we can say that things matter. We participate in activities because they matter and have significance for the present and future. According to Leonard (1989), “persons not only have a world in which things have significance and value but they have qualitatively different concerns based on their culture, language, and individual situations” (p. 46). In order to understand what is significant and valuable to the person, it is important to study the person in context and describe the personal in relation to a given phenomenon.

3. The person as self-interpreting. Leonard stressing the importance of viewing self-interpreting as “nontheoretical and noncognitive” (p. 47). “Each encounter entails an interpretation based on our background” (p. 47).
4. The person as embodied. To be embodied creates the condition for the possibility “for the concrete actions of self in the world. It is the body that first grasps the world and moves with intention in that meaningful world” (p. 48)

According to Benner and Wrubel (1989), people cannot be studied as objects if we are to understand them. Citing Heidegger’s phenomenological view, they note that being takes precedence over knowing, and a way of being in the world is an ongoing process that will be “defined in the course of living a life” (p. 41). Phenomenology explores the lived experience and seeks to answer questions that will describe what it means to “be” in the world. This study seeks to utilize concepts of phenomenology in order to explore what it means to participants to be family- and/or patient-centered and culturally competent.

Nurses approach each caring encounter with an ever-changing set of experiences and situations. This study seeks to explore the phenomena of providing family-centered care and culturally appropriate care, which involve human interactions, experiences, and concerns. According to Plager (1989), “Heideggerian hermeneutic phenomenology...is a nursing research methodology well suited to studying health and health promotion practices and activities in families” (p. 81).

Nursing care

This research used “care” in relationship to nursing as discussed by Benner and Wrubel (1989) who wrote:

Caring sets up the condition that something or someone outside the person matters and creates personal concerns. Without care, the person would be without projects and concerns. Care sets up a world and creates meaningful distinctions, and it is these concerns that provide motivation and direction for people (p. 1).

Family-centered care

Family-centered care, as a concept, has most often been described in the context of the nursing care of children, and views family as the constant in the child's life (Shelton, Jeppson, & Johnson, 1987). This view situates the family as context rather than client. Nurses who care for adults in the acute care and other settings may also provide what they define as family-centered care. This concept was explored further as the interviews evolved and data were analyzed.

Patient-Centered Care

The Institute for Family-Centered Care combines the terms patient- and family-centered care. Their definition of patient- and family-centered care is that it "is an innovative approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among healthcare patients, families, and providers...[it] applies to patients of all ages, and it may be practiced in any health care setting." Core concepts include dignity and respect, information sharing, participation, and collaboration (Institute for Family-Centered Care, n.d.).

Culturally competent care

Cultural competence, cultural sensitivity, and culturally appropriate care have been defined by nurse theorists as individual concepts as well as part of grand theories and philosophies of nursing. Both the American Nurses Association (ANA, 1985) and the International Council for Nurses (ICN, 2006) discuss the importance for providing care that is

respectful of the patient's culture. The National League for Nursing (NLN, 2008) and the American Association of Colleges of Nursing (AACN, 1997) require cultural content in healthcare curricula.

The National Transcultural Nursing Society was founded by Madeleine Leininger in 1974, and its *Journal of Transcultural Nursing* was first published in 1989. Dr. Leininger developed her Culture Care Theory of Diversity and Universality by combining features of anthropology and nursing. Culturally competent nursing, according to Leininger (in Tomey & Alligood, 2006), "refers to the elicited use of culturally based care and health knowledge in sensitive, creative, and meaningful ways to fit the general lifeways and needs of individual or groups..." (p. 479).

Review of the Literature

There is a paucity of studies that address the meaning of family-centered, patient-centered, and culturally competent care to nurses in practice. Several critical analyses, though not specifically research oriented, were reviewed in preparing for this study, as well as concept analyses and organizational definitions of the phenomena of interest.

The impetus for this study emerged from a reading of a critical analysis of culture and nursing from Gray and Thomas (2005). The authors explored predominant assumptions about culture found in nursing literature. "Our common views of culture seem to reflect an essentialist view in that culture is portrayed as a distinct and given feature of the social world in much the same way that DNA is assumed to be a clear and distinct feature of living organisms" (p. 253). This view, according to Gray and Thomas leads to what they call "packaging" of culture that can be used to describe cultural groups. "The 'packaging' of culture... contributes to an artificial

sense of comfort and confidence with respect to the adequacy of our knowledge about culture and our ability to care for members of various cultural groups” (p. 254).

Thomas and Gray suggest that nurses ask themselves questions about their own cultural heritage and the culture of nursing and explore how they (nurses) may be perpetuating or challenging “features of power imbalanced relationships” (2005, p. 257).

Research Question

The overall research question for this study was: What are the common themes and background meanings for nurses who provide family-centered and/or culturally competent care to patients who are different from them? Interview questions included open-ended questions with follow-up questions to be based on responses. Questions included such concepts as:

1. What is your definition of family-centered care? How is this different from nursing care, in general?
2. How do you know that you are providing family-centered care?
3. How did you learn to be family-centered (or culturally competent)?
4. How do you define cultural competence?
5. Can you give me an example of a time when you knew the care you were giving was culturally competent? Family-centered?
6. Tell me about a time when you felt the care you were providing was not family-centered or culturally competent?

Definition of Terms

The terms cultural competence, cultural sensitivity, cultural awareness, and culturally appropriate care all appear in the nursing literature. Some are considered steps to cultural competence. Additionally, family-centered and patient-centered care may have various meanings

for the participants. For the purposes of this study, the terms cultural competence, family-centered care, and patient-centered care were defined by the participants according to their own worldview. Their emerging narratives and subsequent analysis of the words and phrases used guided the researcher in order to explore what these terms mean to practicing nurses.

Significance to Nursing

Given the changing demographics in the United States, it is highly unlikely that any text might contain a package of information for individuals of every particular culture. According to the Pew Research Center (2008), the racial and ethnic mix in the United States will increase significantly and the non-Hispanic white population will comprise less than 50 percent of the population. Four out of ten blacks do not consider “black” to be a single race. In the 2002 U.S. Census, 2.4 percent of the respondents self-identified with two or more racial categories.

As the population of the United States changes, it becomes increasingly difficult to utilize packaged information about culture. Caution must be taken to use cultural information about groups only for generalizations as opposed to stereotypes.

Participant responses and analysis of common themes and background meanings provided insight into the way that nurses who work with people who are different from them provide care that they consider to be family- or patient-centered and/or culturally competent.

CHAPTER TWO

Overview of the Design

Martin Heidegger, according to Dreyfus (in Benner, 1994), believed that human beings “are defined by their self-understanding and the stand they take upon themselves, which in turn sets up the range of possibilities open to them” (p. ix). We are each continuously participating in our own lives—not looking from afar and analyzing our actions. In every day interactions we find experiences and encounters that matter to us. Phenomenology assumes that “human being does not have fixed properties, like an object or animal, but...the basic human way of being is care.”

Heideggerian phenomenology is an approach to inquiry that may be utilized to search for an interpretation of meaning, using information from narratives/text as data. Munhall (2001) describes phenomenology as both method and philosophy (p. 95). Phenomenology has been utilized in nursing to explore the meaning of various phenomena to nurses, families, and individuals.

Setting and Population

Following approval by the Washington State University Institutional Review Board Interviews were to be conducted on the campus of Washington State University, Vancouver (WSU-V). Specific interview space was determined by availability and level of privacy required. Participants will be students enrolled in the Registered Nurse to Bachelor’s of Science in Nursing (RNB) program at WSU-V. To be included as a participant, candidates must have practiced nursing for at least one year. Excluded from the interviews were nurses who have matriculated directly from the Associate’s Degree in Nursing (ADN) program to the RNB program without working as registered nurses. Demographic information was collected from participants, including age, cultural background, gender, work setting, and years of experience.

Participants

Entre' was obtained by requesting permission from RNB instructors to invite participants from current RNB courses. A letter of introduction was sent via electronic mail to RNB students enrolled in courses during Fall Semester 2008 with contact information for the researcher. Interestingly, not a single participant emerged from this approach. The electronic mail was resent and after discussion with the primary instructor, it was determined that the cohort of RNB students was at a point in their studies where they had little or no time in which to volunteer.

At this point, the researcher turned to a group of nurses at the local hospital system where she worked. After receiving approval from the Institutional Review Board and the department manager, a letter was posted in several nursing lounges and participants contacted the researcher. The first three nurses to respond were selected for the interview process and were interviewed in a private office during non-work time.

According to Benner, (1994), “[s]ample size is limited by the text that will be generated and the number of researchers that will be available to analyze the text” (p.107). A specific number of participants cannot be predicted a priori, as this will be dependent on the quality of the text. However, the initial number envisioned at the outset of this study is three.

Data Collection

Data was collected through audio taped interviews conducted with the individuals who volunteered to participate in the study. Open-ended questions were asked with follow-up questions in order to expand on themes, clarify participant's statements, or request specific practice examples. Interviews were conducted in an office that afford privacy. The interviewer made entries in a journal immediately following each interview in order to stimulate reflection, critical analysis of assumptions and biases on the part of the researcher, and any other

observations made about the participant, the interviewer, or the environment. “Phenomenology is not only the language of words but also the language of semiotics—the symbols and the signs in our environment that ‘speak’ to us and tell us what is going on in this environment” (Munhall, 2001, p. 123).

Scientific Merit

Guba and Lincoln (1989) propose trustworthiness as another term for scientific merit that may be used for the evaluation of constructivist inquiry, as opposed to internal and external validity, reliability, and objectivity, which are used in conventional or positivistic research studies. Embedded in trustworthiness are the criteria of credibility, transferability, dependability, and confirmability.

Credibility

Credibility was addressed through precise description of methods used, including information from field notes. Establishing the trust of the participants was paramount, along with maintaining a focus on the research question, debriefing with peers, and monitoring the researcher’s own involvement and understanding of the phenomena. The researcher came to the process with her own experiences and ideas. Continuous “checking-in” with one’s self was important in order to maintain the condition for the possibility of the participant’s thoughts and ideas to take precedence. Checking-in with participants as interviews progressed supported the researcher’s understanding of the narratives. (Guba & Lincoln, 1989).

Transferability

Results of the study are presented utilizing information from the coding and analysis of the data as well as selected text from the interviews themselves. It is up to the reader to determine the level of meaning this study may hold for them and what application the meanings

may have to their setting(s). “The major technique for establishing the degree of transferability is thick description...” (Guba & Lincoln, p. 241). Thick description includes detailed, specific information about the processes utilized in this study.

Dependability

It is important for the researcher to track any changes or shifts in the original intent of the inquiry. A journal was kept to record surprising or confounding events that may or may not have affected the outcome of the study. Decisions made by the researcher can be tracked through a journal and/or personal correspondence. Documentation of deviations from the proposed process have been documented thoroughly and can be made available to the public or participants upon request. Such decisions involve the method of participant selection and the setting for the interviews.

Confirmability

According to Guba & Lincoln (1989), “confirmability is concerned with assuring the data, interpretations, and outcomes of inquiries are rooted in contexts and persons apart from the evaluator and are not simply figments of the evaluator’s imagination” (p. 243). Participants were asked for permission to be contacted following the interviews, in order to review emerging constructs and get further feedback as needed. Additionally, the researcher invited input from scholars who were not involved in the collection of the data.

Family-Centered Care, Patient-Centered Care, and Culturally Competent Care:
Common Themes and Background Meanings

Catherine Pollock-Robinson

Washington State University

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Abstract

In nursing education and practice, the terms family-centered care, patient-centered care, and culturally competent care are used to describe many ways of being a nurse. Nursing competence (or nursing care) incorporates all of these concepts to some extent. Institutional and organizational definitions of family-centered, patient-centered, and culturally competent care overlap. In order to provide nursing care that is appropriate, nurses may face the paradox of looking at patients as both part of a group and as individuals with personal beliefs and needs that are not necessarily those of their culture. In any nurse-patient relationship there are two cultures—that of the patient and that of the nurse, for nursing may be described as having a culture of its own within the larger healthcare culture. Nurses were interviewed about their ways of being family-centered, patient-centered, and culturally competent. A Heideggerian approach to analysis of the narrative data is used to explore the common themes and background meanings for the participants. Emerging literature from New Zealand, critical analyses, and the narrative analysis and recommendations are made for nursing. Self-reflection is discussed as an important technique for nurses to learn in order to support on-going development of nursing skills that will support safe and appropriate patient care for any patient who is different from the nurse.

Introduction

In nursing education and practice, the terms cultural competence and patient- or family-centered care are used to describe ways of being a nurse; however, there is little consensus on the definition or meaning of these terms or how they should be taught and learned. Dreher and MacNaughton (2002) suggest that cultural competence is actually nursing competence and that “all patients deserve family-centered care, greater allocation of time, and openness to biomedical alternatives” (p. 185). Healthcare education curricula may use methods and approaches to culture that may lead to stereotyping and assumptions. Consequently, it may be difficult for students and nurses to assess and care for individuals who may or may not embrace the cultural attributes ascribed by a particular text or resource. Engebretson, Mahoney, and Carlson (2008) suggest that skills-based education may be of more use, such as including anthropological theories and ethnopharmacological studies, as well as a focus on “communication skills, such as eliciting patient’s explanatory models (EMs), decision-making preferences, family roles, and use of healing resources” (p. 173).

Family-centered care has most often been described in the context of caring for children in acute-care and outpatient settings (Shelton, Jeppson, & Johnson 1987, Hutchfield, 1999). Key components of family-centered care include partnership, participation, and care by parents.

Dreher and MacNaughton (2002) stated:

We contend that cultural competence is really nursing competence. It is the capacity to be equally therapeutic with patients from any social context or cultural background. Framing the issue as “cultural” diverts us from a serious examination of the inadequacy of patient-provider communication in general (p. 185).

Accumulated cultural knowledge relies on cultural informants to provide an inventory of cultural information about specific groups. This information is utilized in nursing education as well as in healthcare settings where manuals and guides are provided as resources for culturally competent care. When practicing family-centered care, the nurse relies on the patient and family members to transmit information about the meanings of health or the explanatory model for the healthcare issue at hand. Nurses who respond to this information by incorporating this explanatory model into the plan of care are providing culturally appropriate care from the most immediate perspective—that of the patient and his or her family.

Given the changing demographics in the United States, it is highly unlikely that any text might contain a package of information for every particular culture. According to the Pew Research Center (2007), the racial and ethnic mix in the United States will increase significantly and the non-Hispanic white population will comprise less than 50 percent of the population. Four out of ten blacks do not consider “black” to be a single race. In the 2002 U.S. Census, 2.4 percent of the respondents self-identified with two or more racial categories.

Nurses in the clinical setting encounter people from diverse backgrounds who have entered the healthcare arena for treatment, diagnosis, and care. Regardless of one’s background, the healthcare arena can be an exotic environment that has its own culture. Patients and their families learn to navigate the healthcare system with help from nurses and other members of the healthcare team who have varied backgrounds, beliefs, and experiences. Each patient/family also enters the hospital setting with a different set of experiences and expectations—all of which affect their ability to participate in their care. In this respect, each healthcare encounter may be bicultural.

Purpose

Family-centered care involves the use of information obtained from patients and families in formulation plans of care that include the world-view of the family, including their perceptions of the health issue at hand. The objective of this study was to collect data, in the form of narratives, from nurses who care for families who they (the nurses) consider to be different from them. The purpose of this interpretive study was to use phenomenological inquiry to explore the common themes and background meaning(s) in the narratives of nurses who work with families with regard to family- or patient-centered and culturally competent care.

Methodology

Heideggerian phenomenology was selected as it is an approach to inquiry that may be utilized to search for an interpretation of meaning, using information from narratives/text as data. Munhall (2001) describes phenomenology as both method and philosophy (p. 95). Phenomenology has been utilized in nursing to explore the meaning of various phenomena to populations, nurses, families, and individuals.

The Heideggerian phenomenological approach to research can be used to address the general question, “What does it mean to be a person?” Heideggerian phenomenology, as both philosophy and method, represents a “shift away from epistemologic concern...toward the more fundamental concern with ontology” (Leonard, 1989, p. 42). This approach explores the way that we participate in our world as a dynamic process in which each experience and encounter informs the next, but often without conscious awareness of why we are being this way.

According to Benner and Wrubel (1989), people cannot be studied as objects if we are to understand them. Citing Heidegger’s phenomenological view, they note that *being* takes precedence over *knowing*, and a way of being in the world is an ongoing process that will be “defined in the course of living a life” (p. 41).

Methods

Participants

As originally proposed, participants were to be recruited from among the students in Registered Nurse to Bachelor's of Science in Nursing (RNB) program on the local campus of a state university. Institutional review board (IRB) certification of exemption was obtained from the author's university and permission was granted by the lead instructor to contact the students via e-mail through the department administrative assistant. This assured that the students did not feel compelled to participate as a condition of their coursework or grading. After three e-mails, no participants had contacted the researcher. At this point, the researcher turned to the nursing staff of one local hospital system where she is employed. With the consent of the institution's IRB, a notice was placed in an area frequented by nursing staff and the first three nurses to contact the researcher were scheduled for interviews.

Ethical Considerations

Written consent was obtained from the three participants. Assurance was given that they would not be identified. Audio tapes were coded and kept separate from consent forms. Once the audio tapes were transcribed, they were erased. Participants were informed that they could withdraw from the study at any time. None of the participants worked directly with the researcher and all worked in different departments of the institution and were not in a position to be evaluated by the researcher as part of their job. Interviews were conducted before or after work or on lunch hours with the approval of the researcher's manager.

Data Collection and Analysis

Data was collected through audio taped interviews conducted with individuals who volunteered to participate in the study. Open-ended questions were asked along with follow-up

questions in order to expand on themes, clarify participant's statements, or request specific practice examples. Interviews were conducted in rooms that afforded privacy.

Trustworthiness

In this qualitative study, trustworthiness represents processes that were followed in order to assure the merit, or validity, of the study. Trustworthiness, as described by Guba and Lincoln (1989) includes aspects of credibility, transferability, dependability, and confirmability.

The interviewer made entries in a journal immediately following each interview in order to stimulate reflection, critical analysis of assumptions and biases on the part of the researcher, and any other observations made about the participant, the interviewer, or the environment. "Phenomenology is not only the language of words but also the language of semiotics—the symbols and the signs in our environment that 'speak' to us and tell us what is going on in this environment" (Munhall, 2001, p. 123).

The interviewing process involved use of probing questions with participants when the researcher desired further explanation of comments. The foundational questions remained the same for all interviews. Participants were encouraged to provide examples that illustrated their definitions and statements. During the process of transcription, the researcher kept notes that described what she was noticing about the interviews.

Transcripts were reviewed and discussed with a group of scholars who were either members of the researcher's thesis committee or had experience in phenomenology. A naïve reading was done and members met to discuss their findings. There was a high level of agreement on the themes and meanings that the researcher identified during the interview and transcription process with those that emerged through the group reading of the transcripts. Further discussion was held to explore specific exemplars in the transcripts.

Findings and Discussion

Analysis of the interview transcripts uncovered several common themes, including power and control, compromise, self-reflection and self-knowledge, and perceptions. These themes are presented and background meanings are discussed in this section. All three nurses spoke of eliciting, in some way, an understanding of the individual patient or family needs in order to best provide nursing care. Interview participants are identified by pseudo-initials SM, CG, and KM to protect their identities.

When SM, a pediatric nurse for 10 years, described the cultural/spiritual question in the admission history she acknowledges that a question like this implies that the needs of the patient or family should not be considered as something “special,” but something that they tell us that helps us to understand the meaning of the hospitalization to them. She commented that nurses are the veterans and families are the neophytes. This speaks to the fact that not only is there a difference in perception between families and nurse who are participating in the same event, but that nursing itself is a culture. Each nursing encounter brings together two cultures—that of the patient/family and that of the nurse. Engebretson, Mahoney, and Carlson (2008) describe this as the point where “the ‘culture of the sick’ comes into contact with the ‘culture of healthcare’” (p. 174). CG, a 30-year NICU nurse, reflected that nurses have power because they know the language further illustrates this point and acknowledges the vulnerability of those in her care.

Power and control

The nurses interviewed each described an evolution of their practice over time that involved recognizing and adapting the use of the power that they had as those who could impact the patient/family experience:

I don't know if it's bossy people that are attracted to nursing or if we evolve as sort of bossy control-freaks, but I think it seems as a new nurse that things are so dynamic you want everything to be routine so that you feel like you are able to meet all the needs. I used to walk into rooms and say 'Okay we're going to do this first and then we're going to do b, c, and d,' and that was kind of something I needed to do...I think the evolution of my control was as I became a more experienced nurse, then I could schedule out what needed to be done but because of my experience and my feeling that I had more confidence in how I could deliver care, I could incorporate the families...instead of feeling like I had to control how we did it...I was still delivering what I needed to deliver to the patient, but incorporating their culture, in a sense. It made it much smoother for the child and the family, because families get to fix things. (SM, pediatric acute care).

KM, an obstetrics nurse, who also works as an educator, discussed the physical manifestation of the power of healthcare providers. While speaking of always trying to be face-to-face with patients in order to avoid standing over them she said:

It's very hierarchical...it's about power. Yeah. It takes away that piece of respect, you know, because when you respect somebody, you don't try to have control over them and you don't try to do the things that make them think that you're better than they...

CG brings up the decision-making power that nurses have as she told the story of a mom who wanted to breastfeed her infant on a ventilator:

...it's a really fine line between letting them call the shots and having it buck up against standard medical intervention. I had a patient on a ventilator and the mom would say every single day to the doctor, 'If I could just breast feed...[the baby] would be fine.' Back then, we never would have considered putting anything in their mouth, but things have evolved and little things like putting breast milk on a cotton swab and putting it on the tongue have shown to be beneficial to the emotional welfare of everybody...

The same nurse discussed the power that nurses have as a result of the information they hold. "...you have a lot more information than they do. You know the language and they don't...you have a lot more information about the whole event than they do. I have power, but I take it very seriously that I'm the patient advocate."

As a sub-theme of power and control, compromise emerged as an activity when discussing both family-centered and culturally competent care, but also included issues of patient safety. In describing both family-centered and culturally competent care, nurses discussed ways in which they had learned to create the conditions for the possibility of giving patients and families control over their own experience.

Compromise

SM reflected on being asked to put rosary beads on a toddler's bed. "As long as it's not going to affect any sanitary issue...most things it's been like so easy to incorporate." She talked about allowing the family to provide care:

I can't just bombard and take over to ensure that they have a good experience...You know, we have to maintain those roles...letting mom and dad

or grandma and grandpa do what they need to do to help care for this person in this crisis.

CG discussed a family's request to have their dying baby baptized using water from the source where all baptisms occurred in their religious community:

...the family wanted to baptize the baby the way they baptized everybody and they needed to bring water in from a muddy creek somewhere, and at that point it wasn't going to hurt the baby to be anointed with muddy water...you do have to think about it...just compromise, negotiate.

KM talked about partnering with patients and letting them know that the information they had to share was important to their care. She told the story of a patient who was scheduled for discharge but had a low hematocrit and was very pale. KM asked her if she was feeling well and the patient said she was fine. KM was concerned and asked if the patient had been light-headed or faint. The patient responded with, "Do you want the truth?" KM assured her that she wanted the truth. The patient related that she was afraid that her discharge would be cancelled. KM told her that she just wanted to give her some things to watch for and report to the physician. KM summarized in this way: "If our patients don't feel safe in partnering with us, then we can't give them really good care. It's about being open to what they have to tell us." Not only are we to be open to what our patients have to tell us, we should be open about our own beliefs, prejudices, and biases. The nurses described their own processes for exploring their experiences and the way that can contribute to their effectiveness and professional growth.

Self-reflection and self-knowledge

Reflecting on current and past experiences provided background for the care provided by the nurses who were interviewed. "I'm always very aware of trying to not judge people," stated

KM. She also described the interview itself as a time to debrief and reflected that nurses need to do more of it. The inability to connect with some patients had an impact on KM and when asked to describe a time when she felt that the care she was providing was not family-centered or culturally competent, she described caring for a young couple with a birth plan. The episode has happened years ago, yet she said it had stayed with her:

It's rare that you don't bond with the couple that you're doing their labor with, but every once in a while you'll get a family that for whatever reason...for some reason, something that was done or said right from the get-go, you felt the tension...it's been ten years since that happened.

In describing barriers to family-centered or culturally competent care, she said,

...a big piece of it is our attitude. We've got to always remember that they're not here for me, I'm here for them, you know? This is the job I took on and yes, I'm having a bad day today, but put it aside when you walk in the door and go in and do your best. Everybody deserves it...

She also spoke of a change over time:

I can remember a time in my life when I didn't want to be open to certain things... 'Doggone it, I'm the nurse and this is how it should be'...as I've made some changes and taken some journeys, I started listening and you have to open yourself up first of all. You have to be willing to be vulnerable to admit, 'OK, maybe I was wrong'...

CG described herself as a positive person. She has come to this self-knowledge through self-reflection:

Self-reflection is a big part of my life in general. I may have judgments, but I don't have to act on them...I think part of who I am is a positive person, so when you think of things in a positive sense you see the benefits and not the negative side...when somebody asks me if they can do this, why not? As opposed to 'let me think about how that is going to wreck everything or cause trouble...I go to the benefit side first...hopefully I know when things shouldn't be done...

MS mentioned being aware of projecting her values onto others: "It's just being aware of how I am assuming...I feel like I'm so invasive as a nurse...and almost want to give them extra space and just being aware of projecting...my own perceptions on them..."

Benner (2000) wrote that ethical comportment in nursing is about "a commitment to meeting and helping the other in ways that liberate and strength and not way that impose the will of the caregiver on the patient" (p. 15). In order to avoid such impositions, nurses must identify and reflect on their own beliefs and biases. The nurses in this study had many years of experience and it is evident, through their stories, that self-reflection has played a role in their professional development.

Perceptions

All three nurses spoke of perceptions, either their own or those of the patient/family in their care. SM described part of the admission assessment that included questions about spiritual practices,

...generally for every family there's something...I think there's probably a better way for us to address their perceptions of their experience...because actually what we're doing is saying, 'Do you have any cultural or spiritual things,' but we're not really asking how they perceive their healthcare experience...we could try to do

that better...because we're the veterans in the situation, they're neophytes...just coming into the hospital is frightening [and] you don't know the background of how they perceive the hospital...I come to the hospital every day...it's just part of my daily life, whereas anybody else, I imagine it has to be a crisis.

Additionally, SM noted that her perception of how she is giving care is based on an awareness that may not initially be evident. She related the way that she thought she was becoming automatic in the way she approached the admission of a patient:

Wait a minute, this isn't just an intake process...you're caring for a little person; you're caring for their family. And sometimes it's that quick. Other times you might not be aware...[I] might think it's going okay because I'm perceiving it by what I value or how my day's going...but you know, you might learn later that you forgot to get the water for a particular family and for them that was a priority...we have those days where we think everything is going well until little things that we could have addressed...and all of a sudden it gets kind of explosive because there were things I was insensitive to...

KM talked about exploring the patient perspective in order for her to understand the patient she was caring for as "getting her (the patient's) understanding of what was going to take place."

CG told the story of a grandfather who came to visit at change of shift and found nurses sitting down in various places throughout the unit. His comment to CG was that the "slacker crew" must be working that particular shift. When CG asked him what he meant by that, he explained that he was a foreman for a construction crew and that when people were sitting down they weren't working. At that point, CG explained to the grandfather that it was the end of the

shift and that charting was one of the tasks required of the nurses prior to their departure for the day. He apologized to her and she responded by relating to him that she herself had noted road workers sitting around construction sites and wondered if they were “slacking off.” This is the story that CG told when asked to discuss how she knew things were not going well with a patient or family who was different from herself.

The preceding narrative emerged when the interviewer asked to describe how she knew when things were not going well in terms of “culturally appropriate” care. While CG struggled with finding a general response, the narrative she provided, which was not about racial or ethnic difference nevertheless reflected the difference in culture between nursing and construction.

Nursing is a culture that has developed its own set of rituals and practices. Dreher and MacNaughton (2002) wrote that “[n]ursing itself is a cultural phenomenon in the sense that most expressions of care and comfort, universal to all communities, are learned responses, derived in social context and subject to variation across ethnic and national groups” (p. 184).

Spence (2005) describes the paradox faced by nurses who see patients as different from themselves but at the same time similar to one another in terms of their need for nursing care, thereby “simultaneously engaging with similarity and difference” (p. 410). The nurses interviewed each expressed a desire to be kind and compassionate in their nursing care. They also described times when they felt as though they were “butting heads” or noted that a patient was “bristling,” or that they felt uncomfortable with the way an encounter was going. This was not simply a function of race or ethnicity, but the fact that patients may not understand the culture of healthcare in general, or the culture of nursing specifically.

In order to explore the way that others have dealt with the phenomenon of nursing as a culture, a review and recent observation of nursing education in New Zealand became part of this study. Over the last 20 years, the concept of cultural safety has been taught and practiced in Aotearoa/New Zealand, growing out of a resurgent interest in the Treaty of Waitangi and the suggestion by a student nurse that beyond sensitivity there should be safety for Maori clients. Cultural safety education in Aotearoa/New Zealand has evolved to include other vulnerable populations and along with physical, emotional, and ethical safety is one criterion for the delivery of safe nursing care in New Zealand (Spence, 2003). The Nursing Council of New Zealand (2005, p. 4) defines cultural safety as:

The effective nursing or midwifery practice of a person or family from another culture, and is determined by that person or family...The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her culture has on his or her professional practice. Unsafe cultural practice comprises any action that diminishes, demeans or disempowers the cultural identity and well-being of an individual.

If nursing itself can be described as having a culture of its own, then any nurse-patient encounter may be described as bi-cultural. Through self-reflection, the nurse is able to explore the culture of nursing as a dynamic process that changes with each encounter. The nurses interviewed for this study told stories not only about families who spoke languages other than English, but who came from socio-economic, generational, and career backgrounds other than their own. The grandfather who worked in construction had a very different worldview about people sitting down on the job than the nurse caring for his grandchild.

The relationships we build and the way we build them with each patient/family encounter are the building blocks of all future relationships. According to Doane and Varcoe (2007) we are continually being molded by our actions and encounters, “and by the contexts within which we work...” As we develop a relational practice, we need to be constantly aware of “not only what it is we are doing, but also what it is that is shaping and influencing what we are doing” (p. 202). Nurses in this study all mentioned learning and changing over time. None of the nurses remembered specifically what they learned about culturally competent care in nursing school, although they were able to describe the essence of what they learned, and acknowledged its importance.

The preamble to the International Code of Ethics for Nurses (ICN, 2006) states, “Nursing care is respectful of and unrestricted by considerations of age, color, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status.” This is a departure from what may be described as caring for people regardless of such considerations. If nurses are without regard for these considerations, they run the risk of providing care that the patient may regard as inappropriate or culturally unsafe. Ramsden (2002) emphasized the need to provide nursing care that is “respective rather than irrespective of all of those factors which maintain our integrity as members of the human race” (p. 98). There is a subtle, yet significant difference between treating people regardless of their culture versus treating them with regard to their culture. This difference provides a key to providing nursing care that is considered culturally safe by the patient.

Limitations

As a matter of coincidence, the first three nurses to respond to the call for participants, as well as the researcher, had the majority of their experience in the maternal-child arena. As

previously noted, the concept of family-centered care originated in the field of maternal-child nursing; therefore, experienced nurses from that discipline have more experience with not only the practice, but the concept of family-centered care. Maternal-child nursing almost always requires family involvement and participation of some kind and therefore the meaning of family-centered care may be unique to these nurses. Future interviews with nurses from other disciplines may reveal different themes.

Another limitation is the small number of interviews. Although only three nurses from the same regional healthcare system were interviewed, there was a degree of saturation reached in the narratives.

The nurses interviewed were seasoned veterans. Although an attempt was made to access nurses with less experience, no candidates emerged.

Implications and Recommendations

As the racial and ethnic makeup of our nation and our workforce continue to evolve, nursing practice and education have an obligation to reflect critically on the way that issues of difference are addressed. Self-reflection is a process that may be used throughout the span of a nursing career as a way to improve practice and consequently patient experience and response to our care. Reflecting on our practice and specific experiences can help to identify personal bias and judgments and the ways in which we may set those aside or avoid imposing them on those in our care. Although it is important to consider the culture of all of our patients and be sensitive to their needs and health beliefs, we must also respect them as individuals and avoid making assumptions or using generalizations and stereotypes (Doane & Varcoe, 2005).

Recommendations for future studies include interviewing a larger number of nurses from various nursing specialties and levels of experience. Additionally, the family and patient

perspective may yield different definitions of the meaning of family-centered or culturally competent care.

While the nurses in this study have described their desire to partner, cooperate, and negotiate with patients and families, the meaning of this to families may be very different. Darbyshire (in Benner, 1994) suggests that partnership may not mean the same thing to families as it does to nurses, and that elements of mutuality were missing. If relational care is the goal of nursing, the perspective of each patient and/or family must be explored. It is not enough to use reference information alone to guide culturally appropriate or competent care. Self-reflection is one way to explore the meaning of culture as it pertains to individuals. The nurse and/or student who practices self-reflection may have insights and understanding about their own way of being with patients that contributes to competent nursing care, which includes family centered care, patient centered care, and culturally competent care.

Conclusion

Nursing care that is respectful of each patient/family can be developed through a process of self-reflection. Each nursing encounter becomes part of the context that affects each future encounter. Some methods currently used to address cultural issues in healthcare may lead to stereotyping and culturally inappropriate care. This is not to say that cultural knowledge is passe' or inappropriate. In many circumstances, including the nursing care of communities, it is ethically responsible for nurses to know and share cultural information that is significant to that community. In the hospital setting, nurses care for individuals and families that have entered the culture of healthcare. It is we, the healthcare providers, who represent the exotic "other" in these relationships (Ramsden, 2002). Through a process of ongoing self-reflection, we may begin to understand the importance of assessing those in our care as individuals instead of members of a

particular group, and tailor nursing care to the needs and understandings of that individual, creating the condition for the possibility that people feel safe.

Self-reflection is a process that can enhance nursing education and practice as a means to explore the way that each encounter contributes to behaviors and understanding of the phenomenon of caring for people who are different from us. Looking within may provide tools and understandings that are more effective than the packaged cultural information that is available in references and texts.

Nurses interviewed provided narratives with common themes including power and control, compromise, perceptions, and self-reflection or self-knowledge. The nurses described the way they felt when things went well and when they did not. They consistently described their desire to approach all patients with kindness and compassion. Additionally, they did not make great distinctions between various “types” of nursing care—be it family-centered, patient-centered, or culturally competent. The nurses sought to give each patient the care that was appropriate in relation to the situation at hand, and noted that their ability to do that had evolved with experience and reflection on those experiences. In describing the way she felt about the interview process, KM said, “We need to have more conversations like this. It would really help nursing...I don’t think we sit down and talk about these things enough.”

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APPENDIX A

Informed Consent

WASHINGTON STATE UNIVERSITY
Intercollegiate College of Nursing

Research Study Consent Form

Study Title: Family-centered care, patient-centered care, and culturally competent care: Common themes and background meanings

Researchers:

Principle Investigator: Dawn Doutrich, PhD, RN, CNS, College of Nursing,
Vancouver Campus, CL-208R 360-546-9464

Co-Investigator: Catherine Pollock-Robinson, RN, BSN Graduate Student,
Vancouver Campus, 503-234-1820, 6423 SE 21st Ave, Portland, OR, 97202

You are being asked to take part in a research study carried out by Dawn Doutrich and Catherine Pollock-Robinson. This form explains the research study and your part in it if you decide to join the study. Please read the form carefully, taking as much time as you need. Ask the researcher to explain anything you don't understand. You can decide not to join the study. If you join the study, you can change your mind later or quit at any time. There will be no penalty or loss of services or benefits if you decide to not take part in the study or quit later.

What is this study about?

This research study is being done to gather information from practicing nurses about their way of being family-centered, patient-centered, and /or culturally competent. You are being asked to take part because you are a student in the RNB program at WSU-V **and/or** you have practiced nursing for at least one year and you have agreed to have your responses audio-taped as part of the research process. Taking part in the study will take about 90 minutes; however, if you give consent, the researchers may contact you with follow-up questions. You cannot take part in this study if you are under 18-years of age or if you have not practiced nursing for at least one year.

What will I be asked to do if I am in this study?

If you take part in the study, you will be asked to

- Spend about 10-15 minutes filling out a demographic form and reviewing the interview process with the co-investigator.
- Spend about an hour speaking with the co-investigator. You will answer questions about your thoughts on your nursing practice related to caring for patients and families. You may be asked to give examples of when things did or did not go well for you.

- The questions will be open-ended, which means they will generally require more than a “yes” or “no” response. You may be asked to recall patient care experiences that were uncomfortable and/or experiences that were rewarding.
- The interview will be audio taped using a tape recorder as well as a digital recorder. Depending on the background noise of the interview room, you may be asked to wear a clip-on microphone.
- You may ask that the interview be stopped at any time for any length of time. Any request to permanently terminate the interview will be honored without consequence. Any stipend you have been given for your part in the interview will be yours to keep.

Are there any benefits to me if I am in this study?

There is no direct benefit to you from being in this study. Your participation in this study may help others in the future.

Are there any risks to me if I am in this study?

The potential risks from taking part in this study are: Participants may experience stress due to time constraints, the physical environment of the interview venue (too hot, too cold), or the discomfort of re-living experiences that may have been uncomfortable. In the event that a participant experiences stress, they may terminate the interview at any time without consequence. Any stipend that has been extended (i.e. the \$10 gift card) will be retained by the participant.

Will my information be kept private?

The data for this study will be kept confidential to the extent allowed by federal and state law. No published results will identify you, and your name will not be associated with the findings. Under certain circumstances, information that identifies you may be released for internal and external reviews of this project.

Demographic data, consent forms, and any other identifying information will be kept separate from audio tapes. Tapes will be coded and kept in a locked filing cabinet in the co-investigator’s locked office. A master list of participant names and codes will be kept on a password-secure computer in the co-investigator’s locked office. Tapes will be transcribed by the co-investigator and destroyed following transcription. If data are coded and a key maintained separately, inform participant of the process.

Your privacy will be maintained at all times. Your instructors will not know of your participation in this study. You will not be required to interact with other participants.

Your information will be accessible to WSU's Institutional Review Board and the Primary and Co-investigators. Analysis of the data will be confidential. Transcripts will be entered into Ethnograph® software using a code instead of your name.

Your consent to be audio-taped is a condition of your participation.

The results of this study may be published or presented at professional meetings, but the identities of all research participants will remain anonymous

The data for this study will be kept for at least 3 years, as required by the WSU Institutional Review Board.

Are there any costs or payments for being in this study?

There will be no costs to you for taking part in this study.

You will receive \$10.00 in the form of a gift card of your choice to Starbuck's coffee shop, Legacy coffee bars, or the WSU-V Bookie for taking part in this study. If you decide to quit the study the gift card is yours to keep.

Who can I talk to if I have questions?

If you have questions about this study or the information in this form, please contact the researcher Catherine Pollock-Robinson, RN, BSN; 6423 SE 21st Ave. Portland, OR 97202; 503-234-1820; cprmaid@gmail.com; or, Dawn Doutrich, PhD: CL-208R, doutrich@vancouver.wsu.edu, 360-546-9464. If you have questions about your rights as a research participant, or would like to report a concern or complaint about this study, please contact the Washington State University Institutional Review Board at (509) 335-3668, or e-mail irb@wsu.edu, or regular mail at: Albrook 205, PO Box 643005, Pullman, WA 99164-3005.

What are my rights as a research study volunteer?

Your participation in this research study is completely voluntary. You may choose not to be a part of this study. There will be no penalty to you if you choose not to take part. You may choose not to answer specific questions or to stop participating at any time.

What does my signature on this consent form mean?

Your signature on this form means that:

- You understand the information given to you in this form
- You have been able to ask the researcher questions and state any concerns
- The researcher has responded to your questions and concerns
- You believe you understand the research study and the potential benefits and risks that are involved.

Statement of Consent

I give my voluntary consent to take part in this study. I will be given a copy of this consent document for my records.

Signature of Participant

Date

Printed Name of Participant

Statement of Person Obtaining Informed Consent

I have carefully explained to the person taking part in the study what he or she can expect.

I certify that when this person signs this form, to the best of my knowledge, he or she understands the purpose, procedures, potential benefits, and potential risks of participation.

I also certify that he or she:

- Speaks the language used to explain this research
- Reads well enough to understand this form or, if not, this person is able to hear and understand when the form is read to him or her
- Does not have any problems that could make it hard to understand what it means to take part in this research.

Signature of Person Obtaining Consent

Date

Printed Name of Person Obtaining Consent

Role in the Research Study

Note: For lower risk studies or studies with a large number of participants (mass administered questionnaires, etc.) it may be permissible for the PI to sign and date one copy and make copies of the informed consent document for participants.

APPENDIX B

Institutional Review Board Forms

MEMORANDUM

TO: DAWN DOUTRICH and M Catherine Pollock-Robinson,

FROM: Patrick Conner (for) Kris Miller, Chair, WSU Institutional Review Board (3005)

DATE: 9/18/2008

SUBJECT: Certification of Exemption, IRB Number 10550-001

Based on the Exemption Determination Application submitted for the study titled Family-Centered Care, Patient-Centered Care and Cultural Competence: Common Themes and Background Meanings, and assigned IRB # 10550, the WSU Institutional Review Board has determined that the study satisfies the criteria for Exempt Research contained in 45CFR 46.

Exempt certification does not relieve the investigator from the responsibility of providing continuing attention to protection of human subjects participating in the study and adherence to ethical standards for research involving human participants.

This certification is valid only for the study protocol as it was submitted to the IRB. Studies certified as Exempt are not subject to annual review. If any changes are made to the study protocol, you must submit the changes to the IRB for determination that the study remains Exempt before implementing the changes. Request for Amendment forms are available online at <http://www.irb.wsu.edu/forms.asp>.

In accordance with federal regulations, this Certification of Exemption and a copy of the study protocol identified by this certification must be kept by the principal investigator for THREE years following completion of the project.

It is important to note that certification of exemption is NOT approval by the IRB. The study materials should not include the statement that the WSU IRB has reviewed and approved the study for human subject participation. Please remove all statements of IRB Approval and contact information from study materials that will be disseminated to participants.

Washington State University is covered under Human Subjects Assurance Number FWA00002946 which is on file with the Office for Human Research Protections.

If you have questions, please contact the Institutional Review Board at (509) 335-3668. Any revised materials can be mailed to the Office of Research Assurances (Campus Zip 3005), faxed to (509) 335-6410, or in some cases by electronic mail, to irb@mail.wsu.edu.

Review Type: New Protocol

Review Category: Exempt
Date Received: 9/17/2008
Exemption Category: 45 CFR 46.101 (b)(2)
OGRD No.: N/A
Funding Agency: N/A

MEMORANDUM

TO: DAWN DOUTRICH and M Catherine Pollock-Robinson

FROM: Patrick Conner (for) Kris Miller, Chair, WSU Institutional Review Board (3005)

DATE: 10/6/2008

SUBJECT: Review of Protocol Amendment, IRB Number #10550-002

Your proposal to amend the protocol titled "Family-Centered Care, Patient-Centered Care and Cultural Competence: Common Themes and Background Meanings", IRB Number 10550-002 was reviewed for the protection of the subjects participating in the study. Based on the information received from you, the IRB has approved your amendment request on 10/6/2008.

This amendment includes Recruitment of additional participants at Legacy Health Systems, Portland, Oregon.

IRB approval indicates that the amendments described to the previously approved study protocol do not invalidate the exempt nature of the study. This approval does not relieve the investigator from the responsibility of providing continuing attention to ethical considerations involved in the utilization of subjects participating in the study.

If any more changes are made to the study protocol you must notify the IRB and receive approval before implementation.

If you have questions, please contact the Institutional Review Board at (509) 335-3668. Any revised materials can be mailed to Office of Research Assurances (Campus Zip 3005), faxed to (509) 335-6410, or in some cases by electronic mail, to irb@wsu.edu.

Review Type: Exempt
Review Category: 45 CFR 46.101 (b) (2)
Date Received: 10/3/2008
OGRD No.: N/A
Agency: N/A

Thank You,

Institutional Review Board
Patrick Conner
Office of Research Assurances
PO Box 643005
Pullman, WA 99164-3005
Phone:(509) 335-7195

Fax:(509) 335-6410

patrick_conner@wsu.edu



Alar Mirka, M.D.
Chair, Legacy IRB
Legacy Health System
1225 NE 2nd Ave.
P.O. Box 3950
Portland, OR 97208-3950

(503) 413-4873
(503) 413-4942 (FAX)
amirka@lhs.org

Legacy IRB: FWA00001280

October 8, 2008

M. Catherine Pollock-Robinson, RN, BSN
6423 SE 21st Ave.
Portland, OR 97202

RE: **“Family-centered care, patient-centered care and cultural competence:
Common themes and background meanings”**

Dear Ms. Catherine Pollock-Robinson:

As Chair of the Legacy Institutional Review Board I have reviewed the above cited proposal and determined that it is **“exempt”** from IRB review. That determination was made due to the fact that it is a “survey procedure” that does not collect information in a manner that human subjects can be identified per 45CFR46.101(b)(2).

The Legacy IRB is governed by an assurance granted by the Office of Human Research Protections (Federal Wide Assurance #00001280) as delineated in 45CFR46 and by FDA regulations (21CFR50) as well as Legacy institutional policy (LHS 100.18).

Sincerely,

Alar Mirka, M.D.
Chair, Legacy IRB

