CULTURAL CONFLICTS BETWEEN ORGANIZATIONAL, NURSING, AND MEXICAN AMERICAN CULTURES IN AN AMBULATORY CARE SETTING

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A mini ethnographic study was conducted, in which the interactions between organizational, nursing, and Mexican American cultures were observed in an ambulatory care setting in a medium size South Texas city. The purpose was to improve nursing care through examining the impact of cultural conflict on care.

Leininger[1] stated that culturological assessments are important in helping nurses understand, consider, and respect the cultural values, beliefs, and practices of their patients. She defined culturological nursing assessment as "a systematic appraisal or examination of individuals, groups, and communities as to their cultural beliefs, values, and practices to determine explicit nursing needs and intervention practices within the cultural context of the people being evaluated."[1]

This report summarizes the literature regarding the Mexican American culture and presents findings from the ethnographic field study. Finally, the implications for nursing and recommendations to improve care are presented.

Review of Literature

This literature review focuses on the Mexican-American culture: the target population served by the ambulatory care setting.

The norm of Spanish as the primary language among traditional Mexican Americans must be considered when caring for Mexican American

patients. Spanish is not seen as just a language but also as a symbol of cultural tradition and existence as a social group. Therefore, language barriers are only part of the problem when the health care staff is primarily English speaking. It is very important that health care providers never criticize their patient's use of Spanish in the health care setting.[2]

The extended family, consisting of nuclear family members, relatives, and close friends, plays a significant role in the delivery of health care to Mexican Americans. In major crises, as well as in daily problems, the extended family provides protection, advice, assistance, care, and support.[3] When a Mexican American person is ill, it can be expected that many of these family members will be involved in decisions regarding the person's illness and treatment.[4] The Mexican American patient must consult with extended family members before illness is accepted and treatment can be decided.[2]

A dictating manner by the health care worker will only turn the patient and family away, since final authority when making decisions always remains with the family.[4] This loyalty to the extended family can be manipulated by health care providers in a positive manner to initiate life style changes or obtain compliance to medical regimens if the providers are aware of the role of the family in decision making.

Unlike whites who tend not to distinguish between bonds of friendship and familism in the search for emotional support, Mexican Americans regard familial support for emotional problems as superior to that of all others.[6] Grebler, Moore, & Guzman described the existence of "family communism," a value according to which it is considered shameful to seek help outside the family circle, especially when the welfare of aging parents is at stake.[7]

Mexican Americans who lack a local kin network are unlikely to have alternative sources of help in times of stress. Also, Mexican Americans who do not have a well integrated family may experience additional stress, because this situation does not correspond to their ideal extended family system.[6] The support and presence of family was seen as being most important in maintaining morale and self-esteem in elderly Hispanics.[8]

Mirande viewed the strong emphasis on familism among Mexican Americans to be the most significant characteristic of their family.[9] Grebler, Moore & Guzman defined familism as the needs of the family as a whole outweighing the needs of an individual family member.[7] This sometimes leads to the family benefitting at the expense of the individual.

While acculturation to the dominant American culture may have decreased the number of extended families, Mexican American family systems with extended family characteristics still exist. Thus, the values of the extended family need to be considered when providing care to Mexican Americans.[8]

Other cultural norms that need to be considered are the Mexican American family structure and roles given to its members. The traditional Mexican American patriarchy, where power and prestige are absolute prerogatives of the male head of household, is more of an ideal than a norm.[7] The father is indeed the recognized head of household. But Mexican American family relations are much less rigid and authoritarian than commonly portrayed. The assumed male dominance or machismo is largely a fabrication of social scientists, according to Mirande.[10] Machismo is the demonstration of a man's masculinity not only by his sexuality, particularly extramarital sexual affairs, but also by domination over the affairs of his family, especially his wife.

Husband-wife decision making and action taking is basically egalitarian. A woman may defer to her husband in public or be reluctant to engage strangers before consulting him, but this does not mean that she is weak or without power in the family.[9] Mothers have always made day-to-day decisions affecting children, running the household, and so forth.[7]

The role of caretaker is predominantly a woman's role, and she continues to provide the principal source of health information to the family.[5] Lee found that the pattern of paternalism is weak in the process of making medical decisions

in the home.[11] The wife or mother made the decisions on the patient's medical care most of the time.

It is also important for health care providers to understand the Mexican American's perception of illness and expectations of the health professional as care giver. Mexican Americans perceive illness as a state of discomfort. They see good health as a strong body, the ability to perform normal activities and the absence of pain and discomfort. Persons with disease that have no outward symptoms, such as tuberculosis and heart disease, are perceived to be healthy. This makes prevention a hard concept for Mexican Americans to accept.[4]

According to Clark, Mexican Americans try to be strong and frequently deny illness until acutely ill. But once the illness is accepted, they rarely blame themselves. They reason that what could be done to withstand the illness has been done; therefore, they are not responsible for getting sick. It is an accepted belief that illness just happens to people.[2]

When Mexican Americans evaluate care received, they value a good "bedside manner" as especially important in their treatment. They expect a curer to be reassuring, understanding, sympathetic and to care what happens to them. They believe that if the curer has no interest in the patient, the curer may not really be trying to help them.[2]

In Lee's study, 50 Mexican American families were asked if they preferred medical staff of their own ethnic background.[11] Ninety percent of both American-born and Mexican-born groups answered that ethnic background did not matter as long as the medical staff were sincere in taking care of patients and that their services were good.

Curanderismo, the Mexican American practice of folk medicine, is another strong cultural norm. It is a mixture of American Indian, medieval Spanish medicine, and the Christian belief system.[12] *Curanderos* or folk healers are not formally trained. They are members of the community that have learned more of its medical lore and, therefore, are regarded as specialists.[2]

Hentges, Shields & Cantu described a folk system as having a "cultural fit."[12] It meets the important needs of the sick person, often by involving the family in the healing process. The healer uses the same language and is usually from the same cultural background as the patient. Both share the same set of assumptions about causes of illness and treatments.

Mexican American patients may consult a folk healer at any time during their illness, irrespective of contacts with orthodox medical practitioners.[13] Farge concluded from a survey of 150 Mexican American heads of household that folk medical beliefs did not inhibit simultaneous belief in modern medicine or in appropriately seeking scientific medical care.[14]

Traditional Mexican Americans believe folk illnesses exist and will defend their existence. The doctor or nurse who denies folk illnesses will, therefore, be seen as either a fool or a liar.[2] Instead of denying the existence of folk illnesses and usefulness of folk remedies, health care professionals should try to use the folk system in the plan of care of Mexican American patients who believe in folk medicine.[4] Health care providers may be delivering less than quality health care if they ignore the cultural belief system of Mexican American patients, whether deliberately or through ignorance.[12]

In conclusion, values, norms, and expressions regarding language, family, health-illness and care, play a part in affecting the relationships between the health care organization, the nursing staff, and Mexican American patients. All of these cultural patterns are potential sources of cultural conflict.

Methods

In order to examine the impact of cultural conflict on care, a mini ethnographic study was conducted. This qualitative research approach involved systematic observation, recording, and analysis of events. The small-scale study was narrowly focused on the interaction among organizational, nursing, and Mexican American cultures. It was carried out in an ambulatory care setting located in a medium size South Texas city during

its normal 40 hours of operation over a 3-month period. Permission to conduct the research was granted by the chief medical officer of the facility.

The large majority of clients served by the ambulatory care facility were observed to be middle- and low-income Mexican American men and their families. Health care providers were from white, Mexican American, and other Hispanic ethnic groups.

Leininger's second culturological assessment domain (cultural values, norms, and expressions) and the del Bueno and Vincent organizational culture framework were used to guide data collection. Data was obtained using participant observation strategies: observation, interview and participation. In-depth, focused interviews were conducted with six key informants, selected for their knowledge of the cultures by reason of their roles and experience. The principal investigator, posing as a staff nurse in the ambulatory care setting, collected data from sixteen general informants through informal interviews and systematic observations. See Table 1 for characteristics of the informants. Key informants gave verbal consent to participate after the research and its purpose were explained.

Table 1
Characteristics of Key and General Informants

Position	Number	Sex	Ethnicity
Key informants			
Clerk	1	female	Mex. American
Client	1	male	Mex. American
Lab Technician	1	female	Mex. American
Licensed voc. nurse	1	female	Mex. American
Nursing superv., BSN	1	female	Afr. American
Social worker	1	male	Mex. American
General informants			
Admn. supervisor	1	female	white
Asst. director of nursing	1	male	Mex. American
Clerk	2	female	Mex. American
Client	4	male	Mex. American
Daughter of client	1	female	Mex. American
Daughter-in-law of client	1	female	Mex. American
Friend of client	1	male	Mex. American
Physician	1	female	Mex. American
Physician	1	female	white
Staff nurse	1	female	white
Wife of client	1	female	Mex. American

Brief notes of observations were discretely made following events. Each evening the notes, which were anonymous and confidential, were expanded and recorded in a loose leaf notebook. All entries were categorized as observational, theoretical, methodological, or personal notes.[16]

Data was analyzed using the analytical induction method.[16] Categories for coding were developed based on the observations, Leininger's second culturological assessment domain, and the del Bueno and Vincent organizational culture indicators. See Table 2 for a listing of the categories, codes, and definitions.

Results

Inductive analysis of the observational notes describing the interactions between the organizational, nursing, and Mexican American cultures in the ambulatory care setting identified communication problems between nursing and clerical staff and conflicting values regarding care between providers and Mexican American patients. The propositions listed below describe the findings of the study.

1. *Bureaucratic organizational lines of communication and highly centralized decision making patterns within administrative departments of the ambulatory care setting inhibit interdepartmental cooperation.* Observation of organizational communication patterns revealed that the administrative and clincal personnel have internalized the formal lines of authority as drawn on the organizational chart. Within each of the two departments, adminstration and medicine, there are lines of communication between divisions. While there is frequent interaction among divisions within each department, it was observed that there is little association between personnel from different departments.

The wall separating the administrative and clinical offices symbolizes the interdepartmental segregation. An "us and them" attitude between

Table 2
Categories and Codes Used to Analyze Cultural Data

Category	Code	Definition
1. Acculturation	A	Adapting to environment by taking on value system of larger Anglo society
2. Extended family	EFS	Involvement of family members, relatives, and compadres in patient's medical decisions and care
3. Folk practices	FP	Curanderismo, folk remedies, and beliefs
4. Familism	F	Needs of family collectively supersede needs of individual member
5. Traditionalism	T	Elements of culture passed down from generation to generation including religious practices
6. Machismo	M	Masculinity as defined by man's sexuality and also his domination over family and wife
7. Maternal influences on family	MIF	Role women play in running of family in decision making in health matter
8. Personal caring behavior	PCB	Personal caring favored over technological aspects of care
9. Perception of illness	PI	Illness seen as not feeling well, not being able to function
10. Language	L	Use of Spanish, Enlgish as second language
11. Family communism	FC	Family cares for itself, does not look to outsiders for aid
12. Image	I	How organization sees itself, how others see organization
13. Envirnoment	E	Work space, noise level, privacy, break areas
14. Communication	C	Lines of communication, formal and informal
15. Meetings	M	Who attends, importance, how they are run
16. Division of labor	DL	How tasks are assigned, how work is carried out
17. Work values	WV	Being on time, reliable, not missing work

the nursing and clerical divisions has resulted in each group blaming the other for problems.

The following incident illustrates lack of cooperation in solving problems due to bureaucratic lines of communication: The medical administrative officer, in the head office, notified the chief medical officer, in the same location, of a problem concerning the ambulatory care setting, located 150 miles away. The nursing supervisor at the ambulatory care clinic was contacted by the chief medical officer regarding the problem. The administrative supervisor in the ambulatory care setting had complained to the medical administrative officer in the head office that the ambulatory patients were not being interviewed by the nurses prior to the arrival of the physicians. When the nursing supervisor sought to clarify the situation with the administrative supervisor, the administrative supervisor informed the nursing supervisor that there were no lines of communication between them, thus, there was no reason to discuss the problem with the nursing supervisor before reporting it to the head office. Since this meeting, the nursing supervisor has decided any future problems with the administrative division will be reported directly to the head office rather than dealing with them through the administrative supervisor on site.

2. *Health care providers in the ambulatory care setting sometimes deliver care with an individualistic perspective of responsibility for care while their Mexican American patients exhibit a familistic perspective of responsibility for care.* Family members commonly accompany Mexican American patients seeking care and speak for the patient. For example, while it was evident that a

stroke patient could talk well, his wife insisted in answering questions directed to him about his health by the nurse.

Another confused, elderly man, who had recently moved in with his son and daughter-in-law because he could not care for himself, was brought in for medical evaluation. The young daughter-in-law expressed concern, but not devastation, over the tremendous responsibility for care. The nurse wondered why she was not interested in nursing home placement for her father-in-law.

A confused, Spanish speaking elderly man who had been burned was brought in for care by a bilingual friend who interpreted for the patient during the nursing interview and a brief interview in Spanish by a Mexican American physician. When the interpreter attempted to accompany the patient into the physician's office, the physician abruptly told the friend to stay in the waiting room.

3. The norm for nursing assessment of patient problems is nurse-centered, efficient interviews while Mexican American patients expect client-centered, holistic interviews demonstrating personal concern. Following a lengthy interview of a patient with several health needs by a recently employed baccalaureate nurse, another nurse informed her that the nurses limit patients to brief interviews; when patients continue describing problems, they should be interrupted and firmly told that the physician only treats walk-in patients for one complaint.

4. *Physician concepts of care frequently dismiss folk medicine while Mexican American patients' concepts of care include folk medicine along with scientific treatment.* An elderly Mexican American man with stomach discomfort and vomiting explained in broken English that he had been sick since eating food at a party. The food was served to him by a woman, friendly at the time but who had been angry at him because she thought he owed her $15. He figured out the woman had poisoned him. A Mexican American vocational nurse who had heard the interview stated, "Witches, he sometimes goes to witches, and he probably has one of them mad at him now." When it was suggested that the patient might have *susto*, the physician rolled her eyes, laughed, and said that he always had some crazy story. The doctor suggested he probably had a touch of gastroenteritis, and she would do a blood test to be sure.

Implications and Recommendations

The findings and conclusions imply that at times there is lack of understanding and acceptance of the Mexican American culture by physicians and nurses in the ambulatory care setting. Furthermore, the bureaucratic nature of the communication pattern of the organizational culture is not always in the best interests of effective decision making.

Based on the findings, and implications, these recommendations are made for providers working in this ambulatory care setting:

1. Nurses should actively seek to improve communication with the administrative department.

2. Nurses should include and involve family members or support persons in assessing, planning, and implementing care of the Mexican American patients.

3. Registered nurses and physicians should become knowledgeable about and work to accept the Mexican American folk health-illness system.

4. Active listening, empathy for patient problems, demonstration of concern and respect and to facilitate client decision making should characterize provider-patient relationships.

Hypotheses

The following deductions were reached from the results of the qualitative analysis of the data. Stated as hypotheses, they are tentative conclusions which need further research.

1. Interdepartmental communication increases organizational effectiveness.

2. Provider ignorance of Mexican American family involvement in health care decision making decreases patient compliance.

3. Provider communication patterns characterized by respectfulness and personal concern at a leisurely pace increases Mexican American satis-

faction with care.

4. Provider acceptance of safe folk practices performed by patients increases patient-provider trust.

5. Culture-specific health care increases patient compliance.

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