Providing Culturally Congruent Nursing Care to the Fox Valley Community

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Abstract

This paper articulates the best nursing practices which promote culturally congruent care to the medical facilities located in the Fox Valley Illinois area. Culturally congruent patient care will be achieved by professional nurses through better understanding of the Mexican culture and beliefs, respecting the difference between American and Mexican culture, and advocating for patients despite personal belief systems. The most valuable nursing interventions have been established after reviewing current literature on Mexican culture, traveling abroad to review the Mexican hospital system first-hand, and synthesizing all data. As the population of Mexican patients grows throughout the Fox Valley community, so does the importance of having a culturally competent professional nursing staff.
Providing Culturally Congruent Nursing Care to the Fox Valley Community

It is imperative that the care provided by nurses demonstrates cultural consideration for the increasing population of Mexican-Americans in the Fox Valley Illinois area. Acculturation of Mexican-Americans influences not only healthcare service utilization in Fox Valley, but also health-seeking behaviors and status. Nurses working in the Fox Valley region must work in professional environments dealing with diverse cultures and patients with many national traditions. Care which is provided by a caring, competent, and culturally sensitive nurse is known as culturally congruent care. Providing care that encompasses both Western medicine and traditional homeopathic practices allows nurses to re-invent the way that they approach Mexican-American patients in the care setting. There are many key elements that must be integrated together from Mexican and American nursing in order to provide the best possible patient care. Successful culturally congruent care will be demonstrated through two outcomes; disease prevention and health and wellness among the Hispanic population in the greater Fox Valley area of Illinois.

Fox Valley region of Illinois encompasses a large land area throughout Kane County and parts of Dupage County (appendix A). Aurora, the second largest city in the state of Illinois comprises most of the Fox Valley area on a map. Throughout this region, the population of Mexican-Americans is rapidly growing. In fact, Aurora’s 2000 census reported that the city was 33% Hispanic (United States Census Bureau (USSB), 2000). Moreover, an increase of 15,000 Mexican residents occurred between 1990 and 2000 in Aurora, Illinois alone (USSB, 2000). Thus, the importance of culturally congruent nursing care is increasing in the Fox Valley area. Conversely, the number of nurses readily available to speak Spanish in the Fox Valley area is declining greatly.
My (the writer’s) research is multi-faceted as it examines past and current data. This data identifies best nursing practices which may be implemented in today’s healthcare systems. I will examine which practices are best suited in caring for Mexican patients. Cultural congruent nursing care will be attained through better understanding of the Mexican culture and beliefs, respecting the difference between American and Mexican culture, and advocating for patients despite personal belief systems. As the population of Mexican patients grows throughout the Fox Valley community, so does the importance of having a culturally competent nursing staff. The most valuable nursing interventions have been established after reviewing current literature on Mexican culture, traveling abroad to experience the Mexican healthcare system first-hand, and synthesizing the two data.

There are several traditions and culturally unique aspects that affect the approach a nurse should take when caring for a client that is of Hispanic heritage. Mexicans incorporate many unique ideas into their health belief system. Health has traditionally been defined as a person’s well state resulting from good luck, behavior, of gifting from God and the Saints (Garcia, 2007). Such things include the tradition of the “Mal Ojo”, the hot and cold theory of sickness and health, the role of priests, curanderos, herabalists, homeopathic remedies and herbs, the language barrier for immigrants living in the United States, and the role of family during the rehabilitation phase. Further issues which may impede American healthcare provided to Hispanics in the Fox Valley area include lack of access to care, limited availability of insurance, and fear of immigration status being unacceptable for medical care.

As in any culture, Mexicans desire a certain standard of care be met while in the health system of the United States. One study performed by the University School of Public Health in Loma Linda, California concluded that Mexican-Americans hold many expectations of their
healthcare providers including nurses. Such expectations include the allowance of family-based decisions for care, personalized service for each individual, and respect (Manfred, Mcfadden & Belliard, 2006). Perhaps the largest difference between the Mexican and American view of health is the holistic approach which encompasses “balancing [of] the spiritual, natural, physical, emotional, moral, and communal factors within one’s life” (Manfred, Mcfadden & Belliard, 2006, p 225).

Folk illness

Many folk-illness beliefs exist among Mexican patients. Health and illness is greatly influenced by one’s belief in God and the Holy Saints and not just their physical health habits (Baca, 1969). Often times sickness and disease which is caused by bacteria or other agents according to American nurses, is known in a different way to Mexican patients. For example, coughs, fevers and rashes are thought to be caused by wet and bare feet in cold weather (Flores, 2000). Conjunctivitis (commonly called pink eye) is thought to be a result of wind drafts more often than disease agents (Flores, 2000). Treatments for these illnesses would likely shock any American nurse not familiar with them. Practices such as salt enemas, lemon juice or cigarette smoke on the eyes, urine on the face, or placing bleach in wounds are all detrimental to a patient’s health. However, all of these treatments may be promoted in Mexican folk illness and treatment. Nurses practicing in the United States should understand the patient’s rationale for using these treatments to better understand their Mexican patients’ medical care decisions. It is suggested that a nurse treating a patient who practices folk medicine remains culturally sensitive while explaining the harm of such remedies. Perhaps the most important part of enabling trust between the nurse and patient is maintaining respect and not being judgmental. Most of the folk illness traditions are passed on through several generations and become part of the normal
disease thought processes. Contraindications in the patient’s normal health seeking behaviors should therefore be addressed with care and treated with culturally sensitive responses.

*Traditional Folk Medicine*

Folk medicine is widely used today throughout the world to cure, help, and heal common people using special indigenous practices (Leininger, 1988). Many Mexican-Americans believe that each individual ailment needs individualized and unique attention by specialists. However, in traditional Mexican folk medicine these specialists are community-based members appointed to help cure disease. Such folk-healers include body workers (sobadores), herbalists (herbistas), priests (curanderos) and general practitioners (parcheros) (Manfred, Mcfadden & Belliard, 2006). Unlike American medicine which requires an educated degree and licensure, folk healers work independently in the Mexican communities which they serve and hold high credibility amongst their patient base.

Although a nurse may not believe in this traditional medicine him or herself, it is only appropriate to respect the beliefs of patients and remain sensitive to their cultural needs. Most of the treatments provided in folk medicine are items found around a Mexican household. It is common for community nurses that make home visits to Mexican households to find herbs and spices being utilized as therapy in the home (Baca, 1969). Remedies such as herbal teas, oils, and certain foods may be used as treatment or cures for many ailments. By judging a patient who uses such remedies, a blockade is put up against the chances of that patient returning for further and often necessary care. Gaining the knowledge of Mexican folk illness and medicine is a primary step in becoming culturally competent in practice.
Mal Ojo Theory

In a patient interview performed by the *Journal of Pediatrics* in 2000, over 70% of Mexican patients reported having symptoms of the “Mal Ojo” (Flores, 2000). This percentage accounted for the highest number of incidences of a certain disease or disorders (Flores, 2000). The “Mal Ojo” literally translated from Spanish to English means “the evil eye”. A majority of Mexicans believe that when a person stares at a child with forceful and coveting eyes, the child is ill-affected physically (Flores, 2000). The belief is that someone stares at the child intentionally or un-intentionally, the child’s blood heats up causing symptoms such as fever, diarrhea, crying, and gas (Flores, 2000). A competent nurse should recognize that the symptoms of Mal Ojo emulate conditions such as gastroenteritis, dehydration, electrolyte and chemical imbalances, sepsis, and infection. Cultural care of this type of patient may be demonstrated by providing standard practice treatments such as antibiotics and fluid restoration, while allowing the family to carry on their preferred herbal remedies if approved by the physician. The traditional cure for Mal Ojo is rubbing eggs, chili peppers, lemons, or rue over a child’s body (Flores, 2000). It is important for the nurse who cares for pediatric patients to be aware of their eye movements and body language because of this may be misrepresented by the patient’s family due to this belief. Therefore, a truly culturally sensitive nurses care for Mexican patients in a manner which decreases the risk of instilling the condition of the Mal Ojo to their patients.

Hot and Cold Theory

One of the oldest Mexican health traditions is the hot and cold theory of medicine and health. This approach revolves around environmental factors that must be balanced within one’s life in order to achieve maximum health and wellness. Hippocrates first produced the idea of hot and cold theory as a belief that disease resulted from insomnias (Manfred, Mcfadden & Belliard,
In Hippocrates’ theory of hot and cold, four body fluids including black bile, yellow bile, phlegm, and blood all function together creating a balance or imbalance in the state of well-being (Manfred, Mcfadden & Belliard, 2006). Furthermore, disease was explained in the eighteenth century using the hot and cold theory to be a disruption of human homeostasis as a result of a threat such as disease, illness (acute and chronic), or injury (Manfred, Mcfadden & Belliard, 2006).

Language Barriers

Language proficiency between Mexican patients and non-Spanish-speaking nurses is one of the largest barriers to culturally congruent care. Thirty-one million people living in the United States do not speak the same language as their primary health care provider which demonstrates the great need for bilingual nurses and doctors (Flores, 2000). It may be difficult for the nurse to effectively communicate as he or she would like to with patients that speak primarily Spanish. As a consequence, the bond between patient-caregiver and patient mutual trust may be compromised.

To gain a better perspective of the language barriers that Mexicans face in the Fox Valley area, I traveled to five hospitals across Mexico in May and June of 2008. I visited Cancun, Playa del Carmen, Merida, and Queretaro. After touring cross-country I realized how different I felt being an American in a Mexican healthcare setting. Most of the workers I spoke with on the telephone or in person-to-person interviews did not know any English. While traveling through the hospitals in Cancun, I noted that there were a few Caucasian patients in their census. On the other hand, I did not see a single Caucasian person in the hospitals located in the center of the country. In cities such as Queretaro and Merida the prevalence of Americans was much less than the tourist-targeted cities. I hypothesize that the difference in patient census was primarily due to
the locations of the cities. Cancun is a key tourist area that draws people from all over the world due to its charisma and beachside location. However, not many tourists travel towards the center of the country for a leisurely vacation.

In both the American and Mexican cultures respectively, trust is a powerful part of the nurse-patient relationship. For example, although a Mexican patient may not agree or intend to comply with treatment recommendations by an American nurse, he or she will still listen and be courteous due to the cultural practice of “respectful appearance” (Manfred, Mcfadden & Belliard, 2006). One manner to improve trust and patient care is to make Spanish-speaking bilingual nurses readily available on all hospital staffs. An article titled “Culture and the Patient-Physician Relationship: Achieving Cultural Competency in Healthcare” from the Journal of Pediatrics states that Mexican-American children are 12 times more likely to have a regular primary care provider if their parent(s) speaks English (Flores, 2000). Additionally, a Journal of Pediatrics’ case study evidenced that the single most important factor in making Mexican-Americans comfortable with their healthcare nursing team is knowing the Spanish language (Flores, 2000). This minimizes the language obstacles between patients and nurses as evidenced by the higher rates of quality care which may be provided to Mexican-Americans. By promoting cultural diversity among the nurses in a healthcare system, barriers to care such as miscommunication, mistrust, and misunderstanding are easily avoided.

Another part of being culturally competent as a nurse is ensuring that the maximum patient outcome is obtained through nursing interventions. Bilingual staff should be hired at all Fox Valley area hospitals. As mentioned earlier, the number of Mexicans in each hospital census is increasing while the number of nurses who speak Spanish is decreasing. If a nurse is unable to communicate effectively with a Mexican patient, it is crucial that an interpreter be
provided to make the best use of resources possible throughout hospitalization. A nurse must always utilize hospital resources to provide appropriate and medically accurate translation, and not a family member of the patient. Family members may use incorrect language and lack the knowledge of medical terminology. Furthermore, medically sensitive information may be shared that the patient would not want the family to hear. Spanish translators are certified to speak using medical terminology. By providing a Spanish translator in the room, all information is accurately portrayed to the patient. Lastly, all care information and paper resources handed to the patient must be in Spanish. Besides the importance of speaking Spanish to the patient, it is vital that learning materials be easy and clear to read. Culturally competent nursing interventions aimed at optimum healthcare to Mexican patients improve not only the quality of care but also the patient-nurse rapport.

*Family Role*

The largest difference I have noticed between the American and Mexican patient is the role of family. Mexicans are more apt to include the family members in their healthcare decision-making. In Mexican-American culture a strong sense of family is of utmost importance for support especially during illness (Padilla & Villalobos, 2007). Mexican culture may also impact a patient’s decision to inform their family of medical diagnosis and healthcare decisions. An article published by the Family and Community Health journal provides the example of Attention Deficit Disorder. Due to the emphasis on respect, good manners, and well-mannered children, many Mexican parents with ADD-diagnosed children disguise the condition from the rest of the family (Padilla & Villalobos, 2007). Some illnesses and diseases are thought of as disgraceful and inappropriate in the Mexican culture. An important culturally sensitive nursing intervention is asking the patient who he/she would like incorporated into their care decision
making. It is imperative for the culturally competent nurse to remember that family is whatever or whoever the patient says it is regardless of blood lines or genetics.

While studying abroad in Mexico, the largest difference between Mexican and American hospital settings were the rooms and family role. In the Merida Community Hospital in Merida, Mexico, almost all of the patient rooms had two additional beds for the family to spend the night. As I passed through the halls of this hospital I noticed several families accompanying the patients at their bedside. Anisa, one of the nurses that I interviewed at the Merida hospital, told me that there are no specific visiting hours at this hospital. She informed me that in Mexico there are never any limits as to how many or how much time family and friends may come in the room. I previously held the belief that so much family time would take away from the patients’ rest and relaxation, which is an important aspect to healing. However, as I looked at the patients smiling faces, laughing with their families and not thinking of their illnesses, I realized that maybe it was beneficial to the patients to have family with them whenever needed. Providing culturally congruent care encompasses the family as a whole, ensuring that advocacy, trust, and integrity are maintained.

For the onset of a Mexican patient’s illness, the head of the household may also attempt to take on care duties themself (Baca, 1969). It is essential to respect the family’s desire to administer early care or treatment themselves. Moreover, it is important that the nurse abides by the family’s wishes and protects patient privacy. Nurses must examine the patient’s belief system about illness and wellness before implementing any interventions (Donnelly, 2000). A patient should always be asked who they desire to be included in their care. Respecting their wishes takes precedence over generalizing the importance of family role to the Mexican culture.
Protecting privacy ensures that a patient’s information will not be discussed against their wishes. As a result, this potentiates a caring and trustworthy patient to nurse relationship.

**A Cultural Experience: Differential Nursing Care between Mexico and the United State**

During my literature review, I concluded that the best way to experience Mexican healthcare culture and beliefs would be to travel to Mexico myself. I studied abroad throughout May and June of 2008. Throughout my two months spent abroad I traveled to Cancun, Playa del Carmen, Merida, and Queretaro (appendix B). Each of these cities differed greatly in their healthcare systems. My objective while traveling abroad was to interview multiple members of each hospital staff. I created a standardized interview of 40 questions to ask each healthcare team member (appendix G). These questions provided a wide range of information on everything from hospital environment and staffing, to patient’s insurance coverage and available treatments. Additionally, I compiled a list of helpful Spanish to English medical vocabulary to utilize while traveling and conducting the interviews (appendix H).

Cancun, the first city I visited, is an ocean-front city that stretches for hundreds of kilometers. It is largely populated with tourists and out of town guests from the United States and Europe. Most of the population speaks at least a small amount of English, which made it very easy to communicate. The city mostly had clinics which did not accept insurance and were pay-as-you-go. The first clinic I visited was operated entirely by one physician, Dr. Jesus Kamate Rodriguez (appendix c). At this clinic there were always long lines waiting to get into the emergency department. Once inside the clinic I noticed that the cleanliness was not as god as the hospitals and clinics in the United States. Patient privacy was also an issue because beds were lined up in one room without any dividers between them. For example, while interviewing for an hour at the clinic, a patient in a hospital gown was on a stretcher lying outside the room in
the main hallway. Most of the supplies being utilized by staff were not sterilized, and many were considered reusable. During my interview with Dr. Rodriguez, I learned that they accept whatever form of payment the patients bring with them. If someone cannot afford medical care with money, they accept produce, meat, arts, and other crafts. This greatly contrasted with the United States’ system of payment plans, insurance coverage, and copays.

Playa Del Carmen was the second city I visited during my studies. Playa Del Carmen is one hour south of Cancun’s International airport, also situated on beach-front property. Although many tourists travel to Playa, it is not as inhabited with Americans and Europeans as Cancun. During my time spent in this city, I noticed that few people were fluent in English. This city did not have hospitals, but rather a clinic and a Red Cross (appendix D). I chose to visit the Mexican Red Cross facility located in the center of the town. I interviewed a paramedic and a physician at this location. Here I learned that payment is cash only, no insurance is accepted. The Mexican Red Cross is funded by the state government and other donations. Patients are able to walk into the Mexican Red Cross and see pricing listed clearly on the wall before they begin their visit. For example, an insulin injection is three US dollars equivalent, 20 stitches is $2.50, and a school physical is $4. What amazed me most about this location was that there was no guessing how much anything was going to cost. All prices were clearly displayed and the patients did not receive any bills. I found this to be a very efficient way to manage the clinic because most of the clients were in great need of care with little means to pay for services received.

Merida, the capital city of the Yucatan, was the third city I visited. Merida is a land-locked city located four hours west of Cancun’s coast. The inhabitants I encountered spoke only in Spanish. Very few tourists visit this area unless they are interested in the city’s “Avenue of
Art” or great shopping opportunities in downtown. During my week in Merida I conducted interviews at two hospitals and a cardiology clinic (appendix E). Each facility I visited was owned by the state government and accepted insurance. In an article produced by *Health Affairs* journal, Mexican patients that see a regular primary care provider in a private healthcare setting had better quality care and health (Barber, 2007).

The first hospital I visited was very clean and well-secured. Attached to the hospital was a cardiology clinic which I also toured. They were located in the center of Merida’s downtown area near the business district. As I entered the hospital through the emergency department I noticed that the waiting area and vestibule were very similar to the United States’ hospital system. Chairs were lined up side by side, and a receptionist took history information prior to the patients’ consults. A nurse named Anisa guided me around the hospital and cardiology clinic. She explained to me how there were three different levels of in-patient rooms at the insurance-accepting hospitals. The first type of room had two patient beds side by side with very simple amenities such as a call button and linens. An upgraded version was also available with a private bed and a bathroom. The highest quality room required patients to pay an extra fee outside of what insurance normally covers. Anisa explained to me that this room was called a “suite” because it had a living room and twice as much space. Family was encouraged to stay by the patients’ side throughout the hospital stay. In the family room portion of the suite there were pull-out sofa beds and small refrigerators to use. Consistent with my research findings, the families were usually accompanying the patient’s side throughout the entire hospitalization.

My final visit in Merida was to the Star Medica Hospital, which has a partnership with hospitals in the United States (appendix E). This hospital only accepted medical insurance as payment for treatment. Star Medica was the largest and cleanest hospital I visited during my
travel. All rooms contained single beds and separated bathrooms with private showers. The supply room held all individually sterilized packages much like those standard in the United States. This hospital prided itself on the latest technology in Mexico. In fact, this hospital had up-to-date equipment such as cardiac scanners and three dimensional ultrasound machines. As I toured Star Medica I felt like I was in a hospital much like the ones in the United States.

Queretaro, Mexico was the last stop during my travel abroad research. The majority of the scenery in Queretaro is colonial. Queretaro is full of churches, statues, and historic architecture (appendix F). It is located four hours west of Mexico City in the center of the country. No one that I encountered spoke any English during my visit to Queretaro. While in Queretaro I visited another Mexican Red Cross. Prices for all available treatments were clearly listed on the wall much like the location in Playa Del Carmen. I also went to a large Queretaro state hospital which accepted insurance payments. Security was very tight at this hospital and I was escorted around the hospital by a secretary. Identification badges were worn by every visitor that entered the hospital.

Another large difference between the Mexican and American healthcare system is the prescription drug regulation. During the last portion of my studying abroad I visited pharmacies in Playa Del Carmen (appendix D). A citizen of Mexico can enter any pharmaceutical store and purchase “prescription” medications. Antibiotics, anti-nausea medications, and anti-depressants are a few examples of drugs which are regulated by doctors in the United States. However, Mexicans may go to any pharmacy and purchase these medications at their own discretion. No prescription or physician order is needed unless it is a narcotic. While interviewing a pharmacist I learned that there are very few drug sales on the streets because everything is readily available in the local stores. This makes it difficult for Mexican immigrants to understand why a doctor
visit is necessary to obtain each medication they desire. Mexican patients may be accustomed to self-treating their family’s ailments without consulting a physician. It is important for culturally competent nurses to understand and empathize with their patients’ frustrations rather than criticize them.

*Madeleine Leininger’s Multicultural Theory of Nursing*

The history of culturally congruent nursing care dates back to the 1950’s. Madeleine Leininger is a nursing theorist who epitomizes a culturally accepting and knowledgeable professional nurse. The central purpose of her theory is to explain transcultural nursing care using a holistic and multi-faceted approach (Leininger, 1997). Patients benefit with better health and well-being through their situations of disability, sickness, and death by using the theories Leininger proposed (1997). Premises of her theory include eight basic concepts of transcultural nursing. The eight premises include; Technological factors, religious and philosophical factors, kinship and social factors, cultural values and lifeways, political and legal factors, economic factors, educational factors, and holistic well-being health (Leininger, 1997). Premise eight defines nursing as, “A transcultural phenomenon requiring knowledge of different cultures to provide care that is congruent with the clients’ lifeways, social structure, and environmental context” (pg 156).

Use of this theory has been widely accepted into all forms of nursing care since it was first proposed. In fact, Leininger’s theory was one of the first to be utilized in pediatric patients with different cultural backgrounds than their nurses (Leininger, 1988). Currently in the United States, nurses are still making use of the multicultural nursing approach which she presented decades ago. Leininger predicted that in the year 2010 nurses would be mandated to be knowledgeable to work in a hospital setting with people of many diverse cultures (1997).
Purnell Model for Cultural Competence

Larry Purnell, a doctor at the University of Delaware has developed a model for providing culturally competent care to acculturated patients. In his model there are twelve domains which contribute to behaviors a culturally competent nurse should hold. Purnell defines this nurse as someone who, “Develops an awareness of his or her existence, sensations, thoughts, and environment without letting these factors have an undue effect on those for whom care is provided” (Purnell, 2002, pg 193). Furthermore, the trust and bonding between healthcare worker and patient comes by respect of the patient’s cultural heritage and their own uniqueness (Purnell, 2002). Additionally, Purnell discusses the nutrition assessment for multicultural patients. It is important to ask Mexican patients if they have any necessary modifications with their diet. Purnell’s Model for Cultural Competence can be utilized for many different types of clients. Levels of cultural competence are seen for the global society, community, family, and individual by looking at the model (appendix I).

Amending Nursing Care for Cultural Congruency

Although culturally congruent patient care has improved there is still much more to be accomplished. While amendments to nursing care such as bilingual staff, interpreters, and materials written in Spanish have been made in the acute care setting, much more can still be done to improve care. The population in the United States continues to grow in number and cultural diversity. Nurses must perform interventions taking into account patient culture and beliefs now more than ever. Before any nurse is able to effectively practice culturally congruent care examination of his or her own belief system must occur. A culturally competent nurse holds, “The capability to provide nursing care effectively in cross-cultural situations regardless of personal values and beliefs that differ from those of the patient” (Villarruel, 1995, pg 18).
Being able to provide culturally competent care is a lifelong skill that improves a human life (Leininger, 1988).

In conclusion, the largest goal in culturally congruent nursing is to incorporate the client’s customs into the care plan. Patient outcomes for Hispanic clients can be improved by providing unbiased and sensitive nursing care. Nurses should explore Mexican culture before encountering Hispanic patients in the healthcare setting. This may be done by reading about cultural customs and practices, conversing with Mexicans about health beliefs, or traveling abroad to study and observe first hand. Caring for a Mexican patient also offers nurses the opportunity to learn about Mexican culture and tradition.

It is imperative for nursing staff to learn about Mexican customs such as the “Mal Ojo”, hot and cold theories, herbal medicines, and folk healing. Additionally, incorporating family into the care plan is important to the Mexican patient. Passion for multicultural nursing and the desire to reform care must be present inside the nurse for change to happen. Nurses’ behaviors will only modify if the information is readily available to them. Having research presented in their places of employment will be the easiest place to reach nurses and positively affect their care to Mexican patients. The nursing care provided must portray trust, advocacy, and privacy. Promoting health, wellness, preventing sickness, and assisting in the healing and recovery is the end result for which every culturally sensitive nurse strives (Leininger, 2000). Focusing on the Mexicans’ personal care beliefs, morals, ethical values, and current practices within their culture is imperative to maintain patient wellness (Leininger, 1999). A nurse’s actions in the patient care setting speak louder than any words will- or as they say in Mexico, “El movimiento se demuestra andando”.
References


Appendix A

Greater Fox Valley area, Illinois 1
Appendix B

Cities visited abroad in Mexico 1
Cancun, Mexico; city overview 1

Cancun, Mexico; Clinic 1
Appendix D

Playa Del Carmen, Mexico; City Overview 1

Playa Del Carmen, Mexico; Red Cross 1
Playa Del Carmen, Mexico; Pharmacy 1
Appendix E

Merida, Mexico; City Overview 1

Merida, Mexico; Hospital Emergency Dept 1
Merida, Mexico; Cardiology Clinic 1

Merida, Mexico; Star Medica Hospital 1
Appendix F
Appendix G

Entrevista Medical
(medical interview)

1) La fecha (the date) ______________________

2) Como se llama el hospital? (What is the name of the hospital)

3) Como se llama la persona que esta completando la entrevista? (What is the name of the person that is helping to complete the interview)

4) Cuantas camas hay en este hospital? (How many beds are in this hospital)

5) Approximadamente, cuantos doctores/enfermeras trabajan aqui? (Approximately how many doctors and nurses work here)

6) En que se especialise este hospital? (What does this hospital specialize in)

7) Que tipos de departamentos hay? (What types of departments are there)

8) Las enfermeras necesitan un titulo para cuidar a los pacientes? (Do the nurses need a degree to take care of patients)

9) Cuantos anos de escuela necesitan las enfermeras antes de practicar? (How many years of school do the nurses need before practicing)

10) Cuantos anos de escuela necesitan los doctores antes de practicar? (How many years of schooling do the doctors need before practicing)

11) Cuantos pacientes tiene cada enfermera que trabaja aqui? (How many patients does each nurse have that works here)

12) Tipicamente, cuantos horas trabaja cada enfermera cada semana? (Typically, how many hours does each nurse work each week)

13) Que responsibilidades tienen las enfermeras? (What responsibilities do the nurses have)

14) Que responsibilidades tienen los doctores? (What responsibilities do the doctors have)

15) Que tipos de medicinas necesitan recetas para tomar? (which types of medicines need prescriptions to take)

16) Como pagan los pacientes por el tratamiento en el hospital? (How do the patients pay for treatment in the hospital)
17) Hay seguro de enfermedad que puede ser usada aquí en este hospital? (Is there health insurance that can be used here in this hospital)

18) Cuánto porciento está cubierto por el seguro enfermedad? (How much percent is covered by medical insurance usually)

19) Cuánto tiempo puede pasar un paciente aquí, máximo? (How much time can a patient spend here maximum)

20) Describe un día típico en la vida de una enfermera aquí: (Describe a typical day in the life of a nurse here)

21) Cuánto gana cada horal as enfermeras? (How much do the nurses earn per hour)

22) Hay un sistema de codos en caso de emergencia? (Is there a system of codes in case of an emergency)

23) Que hacen Uds para protegerse de isolacion de contacto? (What do you do to protect yourselves in contact isolation)

24) Como pasan las medicinas a los pacientes? (How do you all pass medications to patients)

25) Quien tiene autoridad para recetar recetas de medicina? (Who has the authority to prescribe medications)

26) Que leyes de privacion hay para proteger a los pacientes? (What privacy laws are there to protect patient information)

27) Que porciento de pacientes son de los Estados Unidos en este hospital? (What percentage of patients in this hospital are from the United States)

28) Hay una guardaria infantil aquí? (Is there a nursery here)

29) Cuánto tiempo pasan las familias en el hospital con los pacientes? (How much time to the families of the patients spend here)

30) Hay limitas para visitants? (Are there limits for visitors)

31) Tienen Uds. un hospital psiquiatrico? (Do you all have a mental hospital section here?)

32) Que porciento de empleados pueden hablar idiomas ademas que espanol? (What percent of employees can speak languages other than Spanish)

33) Que papel tiene el cura aquí? (What role does the priest have here)
34) Cuantos cuartos son privados? Cuantos son compartidos? (How many rooms are private, how many rooms are shared)

35) Cuantas personas vienen al cuarto de emergencia diario? (How many people come to the emergency room daily)

36) Hay laboratorios dentro del hospital? Por ejemplo; sangre, radiografías…? (Are there laboratories inside the hospital? For example; blood and x-rays)

37) Durante la escuela/el colegio, cuanto tiempo pasa un estudiante en un hospital para seguir enfermeras/medicos? (During college, how much time does a student spend in the hospital following nurses and doctors)

38) Que equipaje hay en cada cuarto? (What equipment is there in each room)

39) Tienen un horario para tomar la presion arterial, temperatura, ritmo cardiaco, y respiraciones diario? (Do you all have a schedule to take blood pressure, temperature, heart rate and respirations daily)

40) Apuntes adicionales. (Additional notes)
Appendix H

Vocabulary list for Mexico Nursing trip

- Glucosa = glucose
- Creatinina = creatinine
- Urea = urine
- Acido Úrico = uric acid
- Lipidos = lipids
- colesterol = cholesterol
- citologia vaginal = pap smear
- ultrasonido = ultrasound
- antígeno prostático específico = PSA
- habitacion estander = standard room
- una noche de estancia en cuna = a night’s stay in nursery
- anestesia = anesthesia
- urgencia = urgencies/emergencies
- terapia = therapy
- el horario de visitas = visiting hours
- mascotas = pets
- ingerir = to ingest
- senalamientos = signs inside the hospital
- boletín = bulletin
- trasplante = transplant
- cunero virtual = virtual nursery (on-line)