HERMENEUTIC PHENOMENOLOGICAL STUDY TO EXPLORE THE EXPERIENCE OF NATIVE HAWAIIANS PATIENTS IN TERMS OF SATISFACTION/DISSATISFACTION WITH NURSING CARE

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Abstract

The survey as a traditional method for evaluating patient satisfaction/dissatisfaction may limit the ability of patients to express their opinions. The aims of this research study were to: 1) better understand the experience of the Native Hawaiian patient in terms of satisfaction or dissatisfaction with nursing care, and 2) identify barriers and facilitators that Native Hawaiian patients experience in terms of the Press Ganey Satisfaction Performance Suite which is used to measure patient satisfaction. The proposed methodology for this study was a hermeneutic phenomenology research approach that sought to elicit and capture the lived conscious experiences of people (phenomena) within their everyday lives (van Manen, 1997). Major themes that emerged and resonated participants included: 1) Expectations of Professional Behavior, 2) Patient-Centered Care, 3) The Caring Environment, and 4) The *Ohana*. Implications of this proposed study for nursing include: 1) giving a voice a to a marginalized and vulnerable population through its own unique and rich experiences, and perceptions of the phenomena of patient satisfaction/dissatisfaction, and 2) expanding the knowledge base for nurses who will be able to form more meaningful partnerships with Native Hawaiian patients in order to provide more appropriate advocacy, education, and nursing care, and 3) supporting the use of qualitative methods to explore patient satisfaction/dissatisfaction.

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Chapter One

Introduction

Patient satisfaction is increasingly being monitored as an indication of the effectiveness of quality nursing care. Patient satisfaction surveys are used as benchmarks to measure and compare performance in facilities locally and nationally as well as to compare units within facilities. However, concerns regarding common patient satisfaction surveys include the following: 1) the concept of patient satisfaction is not well defined (Bjertnaes, Sjetne, and Iversen, 2012; Uhlmann, Inui, and Carter, 1984; Kravitz, 2000; Esperidiao and Triad, 2006) ; 2) there is lack of evidence of reliability and validity in patient satisfaction studies (Sitza, 1999); 3) surveys do not capture the importance and meaning of the unique patient experience (Rozenblum et al, 2011; Kleinman, 1980); 4) surveys may not elicit valuable information that is also not included in the medical record (Cleary, 2003); and 5) there are inconsistencies in interpreting and utilizing data retrieved from patient satisfaction surveys (The Joint Commission, 2009).

In addition, little is known about patterns of responses to patient satisfaction surveys from diverse populations. The patient surveys may underrepresent many groups by failing to: 1) provide surveys in several languages, 2) consider literacy levels, 3) adequately explain the purpose of the surveys to potential participants, and 4) ensure that patients who are discharged from the facility receive the surveys.

Hermeneutic phenomenology provides a research approach which empowers vulnerable groups such as Native Hawaiians to share their own unique perceptions of phenomena such as satisfaction/dissatisfaction with nursing care. Hermeneutic phenomenology focuses on what individuals are going through in their day to day lives. This methodological approach will then provide a means for nurses to keep in close touch with the reality of a patient's experience in order to provide quality nursing care.

Background of this Study

This paper uses data derived from a previous paper that described results of patient satisfaction with nursing care based on the Press Ganey Satisfaction Performance Suite (Press Ganey, 2010). The sample consisted of acute care patients from several ethnicities in a small rural acute care hospital on the Big Island of Hawaii.

The setting is a rural and ethnically diverse hospital in Hilo town on the island of Hawaii. Hawaii County has one of the highest ethnic diversity Indexes in the United States (U.S. Census, 2000). Hilo Medical Center (HMC), established in 1897 as a 10-bed hospital, is currently the largest regional facility of Hawaii Health Systems Corporation (HHSC) which is a state-wide government entity. HMC is also the main medical facility on Hawaii Island. The HMC campus has 264 licensed beds, with 130 acute licensed beds and 22 skilled nursing beds and a home-health agency. A 20-bed psychiatric hospital and a 112 bed licensed long term facility are adjacent to the main hospital. HMC has recently initiated electronic medical records and has expanded data indicators to monitor and improve quality, safety management, patient satisfaction, and risk assessment and reduction.

As part of the quality initiative, HMC uses the Press Ganey Satisfaction Performance Suite (Press Ganey, 2010) for inpatients. The Press Ganey Satisfaction Performance Suite, developed by the Press Ganey Company, provides a standardized survey instrument used to assess patients' perceptions of their healthcare. At HMC, the instrument is known as the Press Ganey Patient Satisfaction Survey. The Press Ganey Patient Satisfaction Survey is mailed to patients after they are discharged from HMC. It is only offered by HMC in English and in written form.

Many measures on the Press Ganey Patient Satisfaction Survey fail to isolate nursing care from the whole health care experience. In addition, concepts of satisfaction on this survey are defined according to hospital personnel roles rather than to patient's perception of nursing care. It is important that research examines the multiple layers that influence patient satisfaction such as: 1) socio-demographics; 2) patient expectations; 3) physical environment; 4) communication and information. In addition, it is important to distinguish between expectations, desires and preferences are attributed to the role of the nurse within the context of the setting and culture (Bjertnaes, Sjetne, & Iversen, 2012). A patient's expectations, desires, and preferences can only be identified through direct collection of the information, and descriptive studies which can provide rich data from which to identify culturally appropriate interventions (Kleinman, 1980).

Analysis of HMC Press Ganey Patient Satisfaction Survey Results by Ethnicity. This author measured patient satisfaction scores related to nursing care over a six-month period using the HMC Press Ganey Patient Satisfaction Survey (Press Ganey, 2010). The sample (N=727) included aggregate data: 1) generated from patients discharged from HMC acute hospitals beds in the 12-month period from August 31, 2010 to September 1, 2011, and 2) sorted according to ethnicity. The intent of the analysis was to explore possible variations in various ethnic groups' satisfaction with nursing care. It was hoped that the resulting data could be used to improve organizational quality in the facility.

Preliminary results from the HMC Patient Satisfaction Survey sample (N=727) focused on the following groups which showed the largest percentage of respondents: 1) Native Hawaiian (n=14; 2%), 2) Part-Hawaiians (n=181; 25%), 3) Filipino (n=43; 6%), 4) Whites (n=220; 30%), and 5) Japanese (n=157; 22%). These responses are mostly consistent with percentages from HMC admissions data (HMC, 2013) - of 30,706 total patients admitted during

2013: 1) Native Hawaiian (1.96%), 2) Part-Hawaiians (30.1%), 3) Filipino (8.7%), 4) Whites (29.15%), and 5) Japanese (10.76%) (Figure1).

Figure 1: Respondents on Press Ganey Patient Satisfaction Survey (2010) and HMC Admissions Data (2013) According to Select Ethnic Groups

Select Ethnic Groups Per Self-Report	Total N = 727 n per Select Ethnic group	Percent per Select Ethnic Group	Total N= 30706 Percent of Select Ethnic Group Admitted to HMC Acute Care Units
White	220	30	29.1
Part-Hawaiian	181	25	30.1
Japanese	157	22	10.76
Filipino	43	6	8.7
Native Hawaiians	14	2	1.96

Further analysis of the Press Ganey Patient satisfaction Survey sample showed some variation in patient satisfaction between ethnic groups (Figure 2). Analysis of patient demographic data according to age, insurance, patient's perception of health status, and sex, though showing some variation between groups, failed to show any useful patterns. Part-Hawaiians showed mixed results with "Friendliness/courtesy of the nurses", "Nurses' attitude towards requests", and "Skill of the nurses" falling below the mean. White respondents reported overall the highest scores and all items were above the mean. Filipino respondents also showed

mixed results with “Friendliness/courtesy of the nurses”, “Attention to special/personal needs”, and “Skill of the nurses” slightly below the mean. White respondents reported overall the highest scores and all items were above the mean. In contrast, Japanese respondents reported overall the lowest scores and all items as below the mean.

Figure 2: Responses to Press Ganey Patient Satisfaction Survey by Ethnicity

Question	Native Hawaiian mean n= 14	Total mean N= 727	Variance	
Std Nurses	86.6	83.8	3.92	
Friendliness/courtesy of the nurses	90.3	87.6	3.645	
Promptness response to call	86.1	81.7	9.68	
Nurses' attitude toward requests	88.9	84.6	9.245	
Attention to special/personal needs	84.7	83	1.445	
Nurses kept you informed	81.9	81.4	0.125	
Skill of the nurses	87.5	85.8	1.445	

Question	Total mean N= 727	White mean n = 220	Japanese mean n= 157
Std Nurses	83.8	86.5	80.7
Friendliness/courtesy of the nurses	87.6	90.5	84.9
Promptness response to call	81.7	84.5	77.6
Nurses' attitude toward requests	84.6	87.2	82.1
Attention to special/personal needs	83	85.8	79
Nurses kept you informed	81.4	83.7	77.6
Skill of the nurses	85.8	88.0	84.1

Question	Total mean N=727	Part-Hawaiian Mean n=181	Filipino mean n=43
Std Nurses	83.8	84.2	83.7
Friendliness/courtesy of the nurses	87.6	86.8	86.3
Promptness response to call	81.7	82.6	82.5
Nurses' attitude toward requests	84.6	84	84.9
Attention to special/personal needs	83	84.3	82.7
Nurses kept you informed	81.4	84.2	81.6
Skill of the nurses	85.8	85.7	85.0

Survey analysis of Native Hawaiian patient responses patients did show overall higher means of satisfaction for each response item (Figure 2). Responses to "Nurses kept you informed" scored the lowest and responses to "Friendliness/courtesy of the nurses' scored highest. However, all scores in this group are above the mean for all items. The preliminary data showing surprisingly overall higher patient satisfaction scores of Native Hawaiian respondents in combination with lower admissions numbers (HMC) led to a proposal for a study to further explore the experience of the Native Hawaiian patient from the perspective of the patient. The scope of concern of this paper will continue to be satisfaction or otherwise with nursing care.

Research Question of Proposed Study

The proposed qualitative research study will use a hermeneutic phenomenological methodology to explore the questions:

1) "What is the experience of Native Hawaiian patients in terms of satisfaction/dissatisfaction with nursing care?"

2) "What are the barriers and facilitators that Native Hawaiian patients experience related to completing the Press Ganey Patient Satisfaction Survey?"

Aims of Proposed Research Study

The aims of this study are: 1) to better understand the meaning of the experience of the Native Hawaiian patient at HMC with nursing care, and 2) to identify barriers and facilitators that a patient of self-identified Native Hawaiian ethnicity experiences related to completing the Press Ganey Patient Satisfaction Survey.

Significance of the Research Study

According to van Manen (1997), one major research activity of the phenomenological research process is to focus on the nature of the lived experience that is important to us as human beings. Increasing understanding of the experience and perceptions of Native Hawaiians living in Hawaii will help to illuminate the lived experience of a unique, vulnerable population. The hermeneutic research approach (van Manen, 1997) can give a voice to a people who are from diverse in their identity, share unique historical events, maintain their community cultures, and have often endured neglect, discrimination and exclusion. The Press Ganey Satisfaction Patient Survey is not designed to elicit the meaning that each patient satisfaction item holds for patients from different ethnic groups. Understanding the perspectives of Native Hawaiians within a socio-cultural context can enable health care providers to improve health outcomes for this population (Campbell, 2001).

Definition of Terms

Patient Satisfaction: is the degree to which the patient's desired expectations, goals and or preferences are met by the health care provider and/ or service. The dimensions of patient satisfaction include: 1) art of care (caring attitude), 2) technical quality of care, 3) accessibility and convenience, 4) finances (ability to pay for services), 5) physical environment, 6) availability, 7) continuity of care, and 8) efficacy and outcome of care (Ware, Davies-Avery and Stewart, 1978).

Native Hawaiian: "Native Hawaiian" is "any individual who is a descendant of the Aboriginal people who, prior to 1778, occupied and exercised sovereignty in the area that now constitutes the State of Hawai'i." (U.S. Congress, 1993); and/or any individual self-identifying as

having strong social, historical, and geographic relationships to the Hawaiian cultural and ancestral lands (Kanaʻiaupuni and Liebler, 2005).

Phenomenology can be considered as both a philosophy and a research approach. Phenomenology is an inductive type of qualitative research seeks to explore, capture, and understand the lived conscious experiences of people (phenomena) within their everyday life-world (van Manen, 1997).

Hermeneutics is the art of interpretation in context within the "life world" (Moran, 2000). Hermeneutics is one branch of phenomenological inquiry which 1) explores the dynamic relationship between the part and the whole, at a whole series of levels and 2) describes the relationship between different aspects of the phenomena being explored and the interpreter (Smith, 2007).

Native Hawaiians

Native Hawaiians according to U.S. census data: According to the revised Office of Management and Business census data is required to be categorized according to six ethnic groups: 1) White, 2) Black or African American, 3) American Indian or Alaska Native, 4) Asian, 5) Native Hawaiian or Other Pacific, Islander and 6) Some Other Race (United States Census Bureau, 2010)

The 2010 Census also for the first time allowed respondents to check one category checkbox for particular ethnic groups for the people of the Pacific (United States Census Bureau, 2010). For example, "Native Hawaiian alone" consists of individuals who chose only that one race (e.g. Native Hawaiian). However, the organization of the data can be problematic, because for census purposes, the "Native Hawaiian alone" is combined into the category of "Native

Hawaiian or Other Pacific Islander" or "NHPI". The NHPI category refers to a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. The NHPI population includes people who marked the "Native Hawaiian" checkbox, the "Guamanian or Chamorro" checkbox, the "Samoan" checkbox, or the "Other Pacific Islander" checkbox. The NHPI population also includes people who reported any of the following Pacific Islander categories: 1) Polynesian, such as Tahitian, Tongan, and Tokelauan, 2) Native Hawaiian, such as Marshallese, Palauan, and Chuukese, 3) and Melanesian, such as Fijian, Guinean, and Solomon Islander (Hixon, Hepler, and Kim, 2012).

A second major combined response category is "Native Hawaiian and Other Pacific Islander in combination with one or more other races". For instance, a respondent may check both "Chamorro" and "Asian" checkboxes.

The organization of self-identified ethnicities can be problematic when attempting to uncover data about only one particular ethnicity such as Native Hawaiians alone or to compare data combined into various categories (Hixon, Hepler, and Kim, 2012). In addition, a multitude of categories may risk that the population sample becomes overwhelming, less meaningful, and less applicable to research studies (Kaneshiro, Geling, Gellert, and Millar, 2011).

Where Native Hawaiians live: According to 2010 U.S. Census, over 52% of those who responded to the category "Native Hawaiian Pacific Islander alone-or-in-combination with one or more races" live in only two states: 1) Hawaii, with Native Hawaiian population of 356,000, and 2) California, with a Native Hawaiian population of 286,000. Between years 2000 to 2010, Native Hawaiians in categories of "NHPI alone-or-in-combination with one or more races"

increased their population numbers in all states in the United States. The fastest areas of growth have been in the Western and Southern states (U.S. Census Bureau, 2010).

Of all counties in the State of Hawaii, Honolulu County has the highest number of "Native Hawaiians Alone or in Any Combination" (Figure 3). However, Hawaii County shows the highest percentage of this population of all Hawaiian counties based on 2010 U.S. Census data (U.S. Census, 2011).

Figure 3: Number of Native Hawaiians Living in Hawaii by State and County (2010 U.S. Census Data)

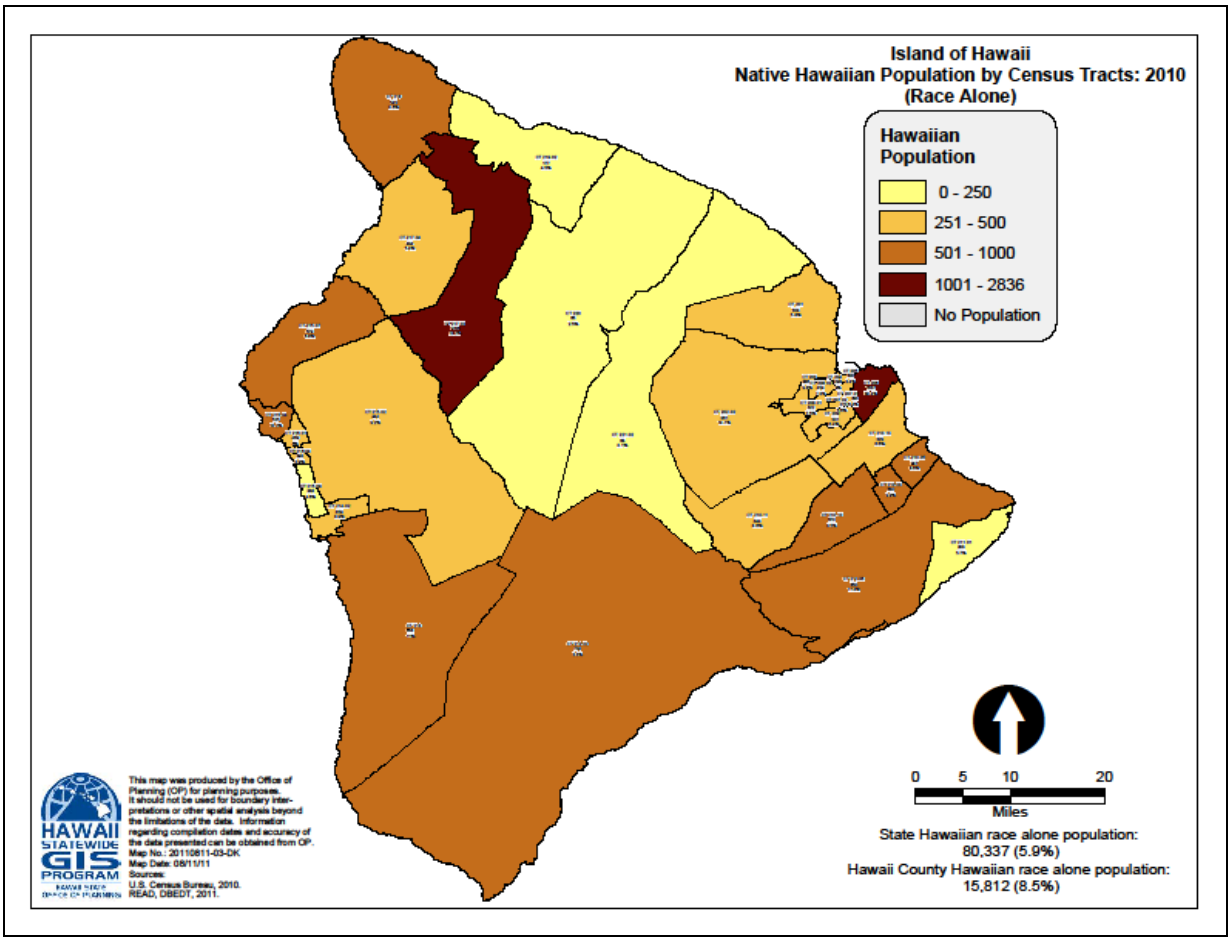
Population Group	**State of Hawaii**	**Honolulu County**	**Hawaii County**	**Maui County**	**Kauai County**
Total Population	**1,360,301**	**953,207**	**185,079**	**154,924**	**67,091**
Native Hawaiian Alone or in Any Combination	**289,970**	**182,120**	**54,919**	**36,804**	**16,127**
Percent Native Hawaiian (alone or in any combination)	**21.3 %**	**19.1%**	**29.7 %**	**23.7%**	**24.0%**

U.S. Census Bureau (2011)

The census tracks with the highest numbers of Native Hawaiians living on the island of Hawaii are : 1) Census Tract 217.02 Waimea-Puÿu Anahulu with total population of 9,540, Native Hawaiian population alone or in any combination population number at 3,655, and percentage of population at 38.3%, and 2) Census Tract 206 Hilo: Keaukaha-Panaÿewa with total population of 5,391, Native Hawaiian alone or in any combination population number is

reported at 3,485, and percentage of population at 64.6%. (Figure 4 shows these two concentrated areas in red).

Figure 4: Map of Hawaii Island Native Hawaiian Population by Census Tracks: 2010 (Race Alone)



Hawaii Statewide GIS Program, 2010

Identification of Native Hawaiians: United States Public Law 103-150: 1) acknowledged the 100th anniversary of January 17, 1893 overthrow of the Kingdom of Hawaii, and 2) offered an apology to Native Hawaiians on behalf of the United States for the overthrow of the Kingdom of Hawaii. This law also defined at the Federal level "Native Hawaiian" as

"any individual who is a descendant of the aboriginal people who, prior to 1778, occupied and exercised sovereignty in the area that now constitutes the State of Hawai'i." (U.S. Congress, 1993). According to the U.S. Code 7517 (U.S. Congress, 2008), Native Hawaiian ancestry is acknowledged by: 1) genealogical records 2) Kupuna (elders) or Kamaaina (long-term community residents) verification, and 3) certified birth records.

The above definition is only one of many definitions of Native Hawaiians and Hawaiians. The Office of Hawaiian Affairs Data Book (OHA, 2013) uses the following terminology: 1) "Native Hawaiian": Native Hawaiian with a upper case "N" which refers to all persons of Hawaiian ancestry regardless of blood quantum, and 2) "native Hawaiian" with a lower case "n" which refers to those with 50% and more Hawaiian blood. The OHA (2013), with the inclusion of itself and the National Census, has identified nineteen organizations (N =19) using various criteria such as: 1) single category Hawaiian/Part Hawaiian (n= 3), single category Hawaiian (n=4), two categories Hawaiian and Part Hawaiian (n=5), 4) category related to parents or birth certificate (n=3), 5) sovereignty, residence, or blood quanta (n=4). Law enforcement officers write in their own determination of racial/ethnic background (OHA, 2013).

Usefulness of Native Hawaiian identification by racial or ethnic categories is challenging. Race is generally considered to be a construct based on biological markers, observation of physical characteristics such as color of skin (Cooper, 1994). Members of particular ethnic groups may share similar lifestyle habits, language, diet, spiritual food practices, and health behaviors which may result in similar health outcomes (Erikson, 2001).

It is often difficult to collect meaningful racial and ethnic data in a richly multiethnic and diverse state such as Hawaii, which is one of the most ethnically diverse states. Other than in

instances where race is a primary variable, as in genetic disease, caution should be considered when using race as predominant variable to the exclusion of associated socioeconomic and environmental factors (Kaneshiro, Geling, Gellert, and Millar, 2011). Kana'iaupuni and Liebler (2005) found Native Hawaiian self-identity to be tied to memories of place or collective memory of social and geographic relationships to the cultural and ancestral lands. Memories of place also include a historical connection through times of colonial and cultural oppression, dispersion and times of upheaval and change.

When studying such a small yet diverse population of Native Hawaiians, many respondents have been shown, when given a choice, to identify themselves as Native Hawaiians: 1) in combination nation with another ethnicity, and 2) more strongly connected to either racial and blood ties or to ethnicity and culture. Therefore, allowing for multiracial and multiethnic samples may be more representative of the population and provide higher and more meaningful participation (Kaneshiro et al., 2011).

Health of Native Hawaiians in Hawaii: In the state of Hawaii, 82% of adults over the age of 18 have at least one of the following health conditions: heart disease, heart attack, stroke, diabetes, asthma, physical or mental disability, cancer, chronic obstructive pulmonary disease, and high cholesterol. Compared with the State of Hawaii and Honolulu County, the island of Hawaii shows higher rates of adult mortality for stroke, coronary artery disease, and cancer as well as higher rates for adults who are obese and those who smoke (Hawaii Department of Health, 2010) (Figure 5).

Figure 5: Table of Chronic Disease Health Risk Indicators and Morbidity for Select Conditions in Hawaii 2005-2010

	Estimated Annual Percent of Adults with Diabetes	Estimated Annual Percent of Adults who are Obese	Estimated Annual Percent of Adults who smoke	Stroke Mortality Rate (per 100,000 age adjusted)	CHD Mortality Rate (per 100,000 age adjusted)	CANCER Mortality Rate (per 100,000 age adjusted)
State	8.8	21.9	16.1	38.2	135.2	134.7
Honolulu	9.0	21.3	15.3	37.7	131.5	137.7
Hawaii	8.8	23.6	19.6	45.6	154.8	143.6

Hawaii' Dept. of Health, 2010

Socio-economic disparities and risks also exist for the Big Island (Figure 5). Hawaii County shows higher percentages for Households receiving SNAP or public assistance, population living below the Federal Poverty level, adults without health insurance, and civilian unemployment. Hawaii County is second to Honolulu County in percentage of Population $\geq$ 65 years of age, and adults without a high school diploma (Figure 6).

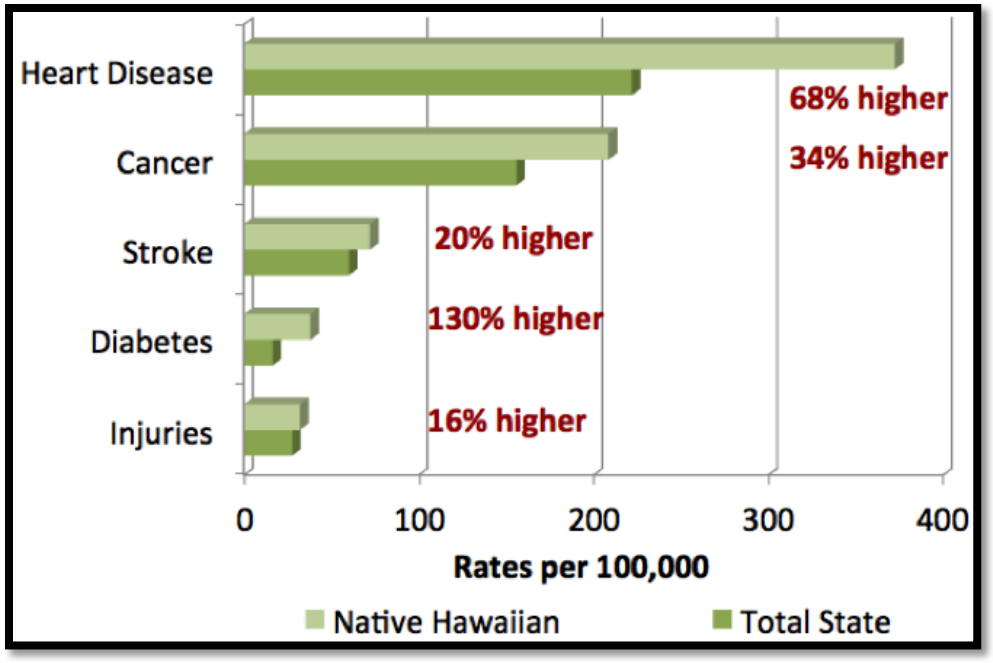
Figure 6: Socio-Economic Risk Indicators for Hawaii

	Population <100% of Poverty (2006-2010)	Population Age 65 and Over (2006-2010)	Civilian Unemployment Rate (2006-2010)	Adults Without HS Diploma (2006-2010)	Households Receiving SNAP or Public Assistance (2006-2010)	Health Uninsured Adults (2005-2010)
State	9.6%	14.0%	4.6%	10.2%	8.4%	7.1%
Honolulu	8.8%	14.2%	4.0%	10.1%	7.6%	6.1%
Hawaii	14.4%	14.05	6.3%	9.5%	12.6%	10.1%

Hawaii' Dept. of Health, 2010

Compared with the state of Hawaii Native Hawaiians over the age of 18 show higher rates of heart disease (68% higher), cancer (34% higher), stroke (20% higher), diabetes (130% higher), and injuries (16% higher). These disparities are shown in Figure 7.

Figure 7: Disparities in Native Hawaiian Health Conditions Compared with the State of Hawaii



Department of Native Hawaiian Health Center for Native and Pacific Health Disparities Research. JABSOM. University of Hawaii. Source: (Johnson, Oyama, and Marchand, 2004)

Cultural aspects of health of Native Hawaiians: Health of a culture must be understood within the context of day to day life and values of culture and not merely as a marker of disease state. Emphasizing disease conditions according to the mainstream meaning of health and non-health may identify and stigmatize the "unhealthy" and reinforce social inequities (Crawford, 1994). Understanding the health and non-health status of a culture requires understanding the worldview and prominent values within that culture.

The world view of Native Hawaiians reflects values of relationship. The Native Hawaiian value of *aloha* is identified with multiple meanings including compassion, love, mercy or a greeting (Pukui and Ebert, 1986). Aloha is developed through teachings of the family in the *pohai ke aloha* or circle of aloha which include: 1) Native Hawaiian cultural roots, and 2) the right way of living or *pono* (McCullough, Wilson, Rhymes, and Teasdale, 2002). Other Native

Hawaiians values that reflect relationship are: 1) the *'ohana* or link to the family and the community, 2) the *aina* or link to environment and nature, and 3) the link to the gods or the spiritual realm. Values of the ʻohana is identified with the family unit, extended family, and the community itself though l¯ok¯ahi (balance, unity), kuleana (right, responsibility) and k¯okua (helpfulness, cooperation) (Mokuau, 2011). The value of *aloha ʻ ¯aina* or *m¯alama ʻ ¯aina* (caring for the land) connotes respect, stewardship, healing, and sustainability. The Hawaiian sovereignty movement, dedicated to reclaiming traditional native Hawaiian lands from State and Federal hands, reflects the strong bond of Native Hawaiians to the ocean and lands. In addition, the value of *aina* extends to taking care and protection of the health of self, family, and the greater community (Goodyear-Kaʻopua, Kauai, Maioho, & Winchester, 2008). Indeed, care for the health of lands, oceans, and fresh water is essential to the health of Native Hawaiians (Casken, 2001). *Kalo* represents the relationship of the person to the god or spiritual realm (*'akua*). The energy of life or *mana* is found in animate and inanimate entities and also is found as spiritual power. *Mana* provides to the strength and power to calm and heal (McCubbin and Marsella, 2009.). Through *mana* the person exists in dynamic and harmonious balance (*lokahi)* with the triad of *ohana* and *aina* and *'akua*. This mutual state of connection is termed as *pono.* A state of disharmony between the *pono* triad results in *(ma'i)* or sickness.

Revitalization of Native Hawaiian Health: Concepts of health for Native Hawaiians are constructed and embedded within the context of the social-cultural, political and economic, and social aspects of the Native Hawaiian experience. The traditional lifestyle and holistic health maintenance and curing practices of indigenous Native Hawaiians were destroyed by socio-cultural and economic colonization (Bushnell, 1993). Western contact resulted in introduction of many infectious diseases, banning of indigenous healers and midwives, harsh working conditions

on plantations, and displacement from access to lands and oceans. The biomedical and socio-political view of Native Hawaiians as a diseased and unhealthy population may continue to mask the socio-political inequities of Native Hawaiians to have access to land and oceans, beaches and valleys, capture their own food, and have traditional Hawaiian foods readily available at food stores (Blaisdel, 1989).

The movement towards the revitalization of the native Hawaiian view of health encompasses ancestral, historical, and social relationships (McMullin, 2005). Firstly, Native Hawaiians increasingly identify with the "Healthy Ancestor" who lived in a more "natural" state in diet and exercise. Secondly, the meaning of food becomes a pivot for native Hawaiian social relationships. Proper diet is tied to caring for family and the community. Thirdly, health and health is linked to the strong Native Hawaiian re-establishment of relationship to the land and ocean. The movement for access to the lands and ocean underscores the desire of native Hawaiians to have control over growing and capturing food and own their own health practices. Being a person who is has health means to be a Healthy Hawaiian in body, mind, and spirit within the everyday realities of life.

Review of the Literature on Patient Satisfaction

Introduction. Health care providers from all disciplines must be able to provide care for an increasing diverse population. Regulatory and accrediting agencies such as The Joint Commission (2009, 2010), which was formally termed the Joint Commission on Accreditation of Healthcare, along with the National Committee for Quality Assurance, (2006, 2010), the Institutes of Medicine (2001, 2003, 2009), emergent models of the medical home model accountable care organizations, and insurance plans have recognized the need for culturally

competent care as part of their planning for accreditation and practice guidelines to ensure safe, high quality, and patient-centered care. In order to improve health outcomes, the Healthy People 2020 initiative pressed for equitable outcomes as one of the national health priorities in order to reduce health disparities that adversely affect people who have systemically experienced greater obstacles to health based on racial or ethnic group (U.S. Department of Health and Human Services, 2012). As new technology is introduced to monitor practice patterns according to quality outcomes and enhance communication between health services, "symmetrical approaches" that "balance" patient's views along with those of providers and health institutions must be developed (Carruthers and Jeacocle, 2000).

Patient Satisfaction as an Outcome of Quality. Health care systems and providers use self-reported patient satisfaction as consumer-oriented and evidence-based indicators considered to reflect health care. Patient satisfaction or dissatisfaction indicates patient behaviors such as: 1) choosing providers, 2) using health services and exiting from services, and 3) filing wage complaints and malpractice litigation (Ware et al, 1987). Higher satisfaction has also been shown to correlate with increased adherence to treatment regimens (Weisman and Koch, 1989, p. 167). Peterson (1998) elicited the following client satisfaction components as: 1) being comfortable, 2) being treated as a mature individual, 3) getting information about what will happen, 4) leaning how to participate in care, 5) feeling safe, 6) needing reassurance, 7) feeling more in control, 8) decreasing stress, and 9) having staff available to listen. From his review of the literature, Spitzer (1988) summarized patients' dissatisfaction with health care staff who: 1) showed little involvement when the patient experienced a dehumanizing situation, 2) distanced themselves from patients, 3) did not involve patients in decision making, 4) focused more on procedure than on the patient, 5) showed a lack of empathy or openness to patient's feelings, and

6) discussed a patient in the presence of another health professional. By measuring patient satisfaction, healthcare providers can identify areas of improvement for program planning and evaluation in areas such as quality of care issues, hospital procedures, and patient education and follow up (Weisman and Koch, 1989).

Various methods can be used to measure patient satisfaction. Petersen (1998) noted that while a self-administered questionnaire is the most common and systematic method, it is usually administered long after care has been given. Other methods to measure patient satisfaction after care has been given include focus groups, client suggestion boxes, and client hotlines (Petersen, 1998). Concurrent methods during a patient's hospital stay such as informal visits by staff or healthcare providers not directly involved in care, can help determine that both patient and clinical goals are congruent in order to maximize patient cooperation and satisfaction with care during hospitalization.

Another important quality care measurement is a patient's perception of satisfaction or dissatisfaction with healthcare received. This measure is multidimensional and includes "settings and amenities of care, to aspects of technical management, to features of interpersonal care, and to the physiological, physical, psychological or social consequences of care. A subjective summing up and balancing of these detailed judgments would represent overall satisfaction" (Donabedian, 2002, p. 25). The structure-process-outcome framework developed by Donabedian (1980, 2002) has been used to measure patient satisfaction in various healthcare settings such as: 1) patient satisfaction with diabetes management (Paddock, Veloski, Gevirtz, and Nash, 2000; and 2) patient satisfaction with nurses' coordination of care following discharge from the hospital (Yen and Lo, 2004).

Concerns Regarding Patient Satisfaction Surveys. One major concern regarding patient satisfaction surveys is that the concept of patient satisfaction has not been well defined. Although concepts such as "patient expectations", "patient preferences", "patient desires", "patient requests", and "patient experiences", are related, they are distinct phenomena (Bjertnaes, Sjetne, and Iversen, 2012; Uhlmann, Inui, and Carter, 1984). There is disagreement regarding approaches for measuring these phenomena both separately and under the broader concept of "patient satisfaction" (Kravitz, 2000). Esperidiao and Triad (2006) identified in a review of the literature that the primary concepts of patient satisfaction such as attitude, fulfillment of needs and expectations, and equity, are derived from the literature of marketing and psychology. Therefore, the authors anticipate difficulties with the transfer of the concept of "satisfaction' into healthcare.

A second major concern with patient satisfaction surveys is that analyses have shown a lack of evidence as to reliability and validity in patient satisfaction studies (Sitza, 1999). Low survey response rates and inconsistencies on target response rates within and across facilities bring into question the usefulness of surveys, even those showing high reliability (Barkley and Furse, 1996). Timing and method of tool administration can influence patient satisfaction scores, as surveys which were given just before facility discharge and administered in person were shown to yield higher patient satisfaction scores than retrospective phone or mail delivered surveys (Barr and Vergun, 2000).

It is also important to carefully consider the sampling time frame and adjust for patient characteristics (Jackson, Chamberlin, and Kroenke, 2001). Daily patient satisfaction surveys and patient complaints handled with electronic records can yield real-time response to patient concerns better than retrospective patient surveys (ED Management, 2005). Documentation of

adverse life-threatening and preventable events not elicited in a timely manner can result in poor recall of these events (Weissman et al, 2010).

A third major concern is that the patient satisfaction surveys cannot elicit the meaning that each patient satisfaction item holds for each patient. Clinicians' lack of ability to recognize the importance and meaning of patient experience creates a clinical "blind spot" regarding patient satisfaction (Rozenblum et al, 2011). According to Haviland, Morales, Reise, & Hays (2003), Hawaiian and Pacific Islanders are considerably less satisfied with health care than other groups in the United States. The authors attribute this finding to Native Hawaiians' lack of comfort while in the health care arena and because of healthcare providers' lack of sensitivity to Hawaiian communication patterns or healing traditions.

A patient's expectations, desires, and preferences can only be justly identified through direct eliciting of the information, and descriptive studies which, though time consuming, can provide rich data from which to identify cultural appropriate interventions (Kleinman, 1980). Rather than health professionals speaking on behalf of patients, patient-centered quality improvement requires auditing health outcomes and quality improvement from patients' perspectives (Brown and Bell, 2005).

A fourth concern is that patient satisfaction surveys may not elicit valuable information that is also not included in the medical record. Routinely asking patients about their experiences and suggestions for improvement has been shown to provide invaluable information about a healthcare system's communication, team work and organization, pain management, education and treatment as to dignity and respect (Cleary, 2003). In addition, the process of describing patient experiences in either positive or negative terms is shown to hide a variety of reported

negative experiences and not capture the complexity of service provision and patient experiences (Williams, Coyle, and Healy,1998; Alemi and Hurd, 2009). While a patient satisfaction survey can serve as a high-level screening tool, secondary tools such as focus groups and interviews, which allow for direct dialogue with patients, can delve more deeply into discovering the root cause analyses of problems uncovered by the survey tool (Burroughs, Cira, Chatock, Davies, and Dunagan, 2000).

A fifth concern is the inconsistency in interpreting and utilizing data retrieved from patient satisfaction surveys. Careful assessment of raw data can yield information regarding current performance, priorities and areas for improvement, and root causes of problems in order to improve and design new processes. Most importantly, feedback should be obtained directly from patients to assess whether changes in processes are indeed meeting patient needs and expectations (Cleary, 2003).

Using Patient Satisfaction Data. Fratalli (1991) proposed suggestions for effective ways of using patient satisfaction feedback effectively in a systems healthcare design: 1) review and follow- up on patient satisfaction data, 2) include multivariate analysis of patient satisfaction data according to ethnic groups in order to examine patterns of negative or positive cross-cultural outcome, and 3) address social determinants of health as major components of cultural considerations in the multivariate analysis.

According to Williams, Coyle, and Healy (1998), a process must be developed to identify how service users evaluate patient satisfaction results and interpretation of satisfaction as the outcome. While a patient satisfaction survey can serve as a high-level screening tool, secondary

tools such as focus groups and questionnaires can best be utilized to gather more context specific and useful data.

Fratalli (1981) proposed that staff should identify program weaknesses and strengths in order to anticipate or minimize structure and process concerns to clients. The areas identified should direct culturally appropriate changes through staff education or behavior or environmental changes. Fratelli suggests using pattern analysis of both qualitative and quantitative data as a means to demonstrate the effectiveness of cultural competency and other patient centered initiatives on patient satisfaction. As weaknesses and strengths are identified, focus groups and face-to-face interviews can provide information as to cultural appropriateness of measurement tools and measurement delivery as well an in-depth look at more specific data as to ethnic variations and commonalities in responses. Qualitative data can be analyzed according to content analysis, thematic interpretative phenomenology, and other qualitative techniques. Suggestions for improvement can be elicited from respondents that are culturally specific and grounded in day-to-day living that occurs within the diverse communities.

Patient Satisfaction as Focus of Research. Quantitative, qualitative, and mixed-methods approaches to research have been found in research studies of patient satisfaction**.**

***Qualitative analysis of patient satisfaction/dissatisfaction*.** Questions regarding the validity of measuring patient satisfaction with survey tools have led researchers to qualitative or mixed-qualitative and quantitative research methods grounded in the voices, values and experiences of patient. These qualitative approaches add the patients' voices and provide greater patient participation in planning and evaluation of healthcare (Avis, 1997). In order to elicit a deeper understanding of patient satisfaction from the patient's perspective, a body of qualitative

research has emerged. The following themes were found to mediate patient satisfaction: 1) relationships and the development of trust (De la Cuesta, 1997) and 2) eliciting and meeting patient expectations (Rosenblum et al, 2011). Caregivers' attributes identified in both quality and nonquality reported experiences include: 1) attitudes, 2) communication, 3) individualized care, and 4) response to special needs (DePalma, 2000).

***Quantitative Approach with Ethnic Focus**:* Many researchers have utilized a quantitative approach to studying aspects of ethnicity and race as related to patient satisfaction. Phillips, Chiriboga, and Jang (2012) used a regression model to find that patient/provider racial/ethnic concordance on patient satisfaction may not be universal for older persons. However, the researchers noted that the perceived interpersonal sensitivity of the provider was shown to have a strong influence on patient satisfaction of older adult regardless of race or ethnicity. In a study involving participants in the National Breast and Cervical Cancer Early Detection Program, Schutt, Cruz, and Woodford (2008) demonstrated that multidimensional factors such as ethnicity, economic resources, health status, and primary language are related to dimensions of patient satisfaction. Mokuau, Braun, and Danigellis (2012) studied interventions that are both effective and acceptable for female breast cancer patients in later stage of recovery care. Because Native Hawaiian women experience illness, including cancer, within the context of their families, the authors found that more health skills, efficacy, and support by building family capacity enhanced coping for Native Hawaiian women with breast cancer.

Thomas, Groff, Tsang, and Carlson (2009) examined relationship between ethnicity and patient satisfaction in patients with varying types of diagnosed cancer. The primary predictor variable of cancer care satisfaction that emerged from this study was being non-White, over other predictors such as patient age, cancer site, duration of illness, and presence or absence of

metastases. The authors noted indicated the need for health care providers and facilities to become more responsive to persons from all ethnic backgrounds. Hunt, Gaba, and Lavizzo-Mourey (2005) used multivariate analyses used regression methods of national telephone interview data to detect independent effects of respondent race and ethnicity on satisfaction and trust with physician. Racial and ethnic minorities are more likely than Whites to have lower levels of trust and satisfaction with their primary providers. Latino and Native American/Asian American/Pacific Islander/Other ("Other") populations show the most differences in trust and satisfaction, even while controlling for health plans.

***Qualitative Approach with Ethnic Focus*:** A few authors have examined ethnicity and race as related to patient satisfaction using a qualitative approach. To better understand what patient satisfaction means to Australians in everyday use, Henderson, Caplan, and Daniel (2004) interviewed patients following discharge from an Australian hospital. Thematic analysis revealed that "medical outcomes", "clinical outcomes", and "professionalism and competency of staff" were the most consistently discussed themes across interviewees. A descriptive study using focus groups and interviews showed that at-risk Latino patients with diabetes reported confidence in taking their medications, though demonstrating a lack of understanding of medication instructions. Participants also described numerous barriers related to language and communication with health care providers, lack of cultural congruence between patients and providers, and a preference for illustrated patient teaching tools (Mohanm, Riley, Boyington, and Kripalani, 2013).

Mixed Method Approach with an Ethnic Focus: Using a mixed quantitative and qualitative method research methodology, Anderson, Barbara, and Feldman (2007) identified seven domains of healthcare based on content clusters related to patient perceptions of high

quality of care. These domains included: 1) access, 2) communication, 3) personality and demeanor of provider, 4) quality of medical care processes, 5) continuity of care, 6) office staff, and 7) quality of facilities. Domains related to negative patient satisfaction scores included: 1) communication, 2) care coordination, 3) interpersonal skills, and 4) barriers to access. Using an open-ended question supplement to a patient satisfaction questionnaire, Bialor, Musial, Rojas, and Fegan (1999) identified two previously unidentified domains of cultural sensitivity and physician honesty of care. Eriksson and Svedlund (2007) used narrative interviews and content analysis to reveal dissatisfied patient experiences as related to lack of attention to and confirmation of their situation and what they have had to endure as a result of the lack of treatment received.

Edwards, Staninszweska and Crichton (2004) investigated the patients' process of reflection on patient care and social pressures that construct the ways that patients report satisfaction with care. These pressures were identified as: 1) dependency of the patient within the healthcare system, 2) general preference for keeping a positive outlook on situations, and 3) need for keeping a constructive relationship with care providers.

Mixed method studies of Native Hawaiians focused on breast screening utilization among Hawaiian women attending church. The church played a central role in encouraging women to participate in the studies. Ka`opua (2004) utilized "talk story" discussions which focused on health beliefs, attitudes, and experiences related to breast cancer screening along with views of spirituality and religion relevant to health practices of Native Hawaiian attending church services. Ka'opua, Mitschke, and Kloezeman (2008) further extended this research using phenomenological approaches to explore religion and ethnocultural traditions in Native Hawaiian women who underutilize traditional breast screening services. Results identified the

theme of *kakou* (we or us) or orientation to the family collective as a means for coping as well as a lack of trust and unfamiliarity with the structure of the health system. Ka'opua, Park, Ward, and Braun (2011) continued this research to test the feasibility of other breast screening interventions.

Predictors of patient satisfaction. Several areas have been identified to be predictors of patient satisfaction. Inattention to unmet needs has been found to be a powerful predictor of patient satisfaction at all points of the inpatient and outpatient experience (Jackson, Chamberlin, and Kroenke, 2001). Shared governance and empowerment of frontline staff have boosted positive attitudes of hospital staff and resulted in a better focus on patients (ED Management, 2007). Salient determinates of overall patient satisfaction in relation to access to care include: 1) type of insurance and cost of premiums and co-payment, 2) difficulty obtaining referrals, 3) cost of taking time off from work to see a provider, 4) marital status, 5) perceived self-health rating, and 6) being over 80 years of age (Akinci and Sinay, (2003). Patient satisfaction was found to be only weakly correlated to patients' personality dimensions of: 1) agreeableness, 2) conscientiousness, 3) emotional stability, 4) autonomy, and 5) extraversion (Hendriks, Smets, Vrielink, Van Es, and De Haes, 2006). Heuer (2004) found no association between hospital accreditation scores and independent measures of patient satisfaction scores. Jaipaul and Rosenthal (2003) found higher patient satisfaction scores associated with dimensions of communication, care coordination, and nursing care and only weak satisfaction scores associated with physician care.

In a review of the literature of patient satisfaction and nursing care within the context of healthcare, Johansson, Oleni, and Fridlund (2002) identified nursing factors influence patient satisfaction according to the following domains: 1) patient socio-economic background, 2)

patients' expectations regarding nursing care, 3) the physical environment, 4) communication and information, 5) participation and involvement, 6) interpersonal relations between the nurse and the patient, 7) the nurse's medical and technical competence, and 8) influence of the healthcare organization on both nurse and patient.

Phenomenological studies of Native Hawaiians related to patient satisfaction. Phenomenological studies of Native Hawaiians related to patient satisfaction are few. Lassetter, Caister, and Miyamoto (2012) noted the value of improved competencies for health providers in understanding cultural health beliefs and behavioral norms of Native Hawaiians children and their families who must seek treatment on the mainland. The participants (N=27) were interviewed in Las Vegas using a semi-structured interview tool. Integration of traditional Hawaiian therapies and care-giving were shown to enhance patient satisfaction and prevent cultural conflicts.

Qualitative analysis of a survey and qualitative analysis of the comment section of this survey were performed to access satisfaction of patients with diabetes with a community deliver diabetes self-management website project. Participants were Native Hawaiian (N=25) and met criteria for Diabetes Type 2. The retention rate for two interviews was high and this was attributed to many follow up calls to participants. Results showed participants as highly satisfied with the enhanced communication with providers, self-management encouragement, sense of empowerment and accountability in self-tracking. Many participants expressed dissatisfaction with technology limitations (Palakiko, 2008).

Kaholokula, Saito, Mau, Latimer, and Seto (2008) explored perceptions of patient satisfaction of Samoan and Native Hawaiians with heart failure (N= 36). Thematic analysis

identified the following domains: 1) health beliefs and attitudes, 2) preferred health practices, 3) social support systems, and 4) barriers to heart failure care. Native Hawaiians preferred and believed in the efficacy of traditional methods of healing such as *lomilomi* (Hawaiian therapeutic massage) and *la au lapa au* (use of Hawaiian herbs) over Western treatment methods.

Strengths of these phenomenological studies include 1) enhanced understanding of deep structures of social, environmental, historical, and psychological forces that impact health in Native Hawaiians, and 2) identification of perceptions specific to Native Hawaiians with specific health conditions or circumstances. One limitation of these studies is the difficulty generalizing findings to the larger population of Native Hawaiians because of the specific circumstances and settings for these studies. A second limitation is a lack of follow-up studies indicating changes in health care delivery or patient outcomes based on findings. No phenomenological studies of Native Hawaiians related to patient satisfaction were found. This gap of phenomenological research in this area suggests further efforts for research concentration.

Summary

Patient satisfaction, despite its strengths and weakness as an indicator of quality, is a desired outcome of healthcare and its assessment must be included in the design of heathcare systems (Donabedian, 1988, p. 1743). Performance measurement systems should play a central role for giving voice to the patient through reports and ratings from patients and family caregivers (IOM, 2005). The social policy background of patient satisfaction surveys is a desire for increased patient representation and participation. Within this context, it is assumed that satisfaction surveys embody patients' evaluations of services, though this is not always evident in

data collection design or interpretation (Williams, Coyle, and Healy, 1998). Therefore, caregivers' perceptions of the quality of care provided should also be incorporated into the measurement system. In addition, all instruments used and application strategies should take into account the importance of cultural and linguistic differences among the populations (van de Vijer and Lueng, 1997).

Many studies have focused on patient satisfaction, some with a focus on patient satisfaction and ethnicity and a few giving voice to Native Hawaiians related to patient satisfaction. These studies have used quantitative, qualitative, and mixed-method approaches. However, in the literature so far, no study that have used a hermeneutic phenomenological approach to explore perceptions of patient satisfaction through the lived experience of Native Hawaiians. Therefore, this study will add to the body of nursing and healthcare knowledge.

Chapter Two

Conceptual Orientation- Phenomenology

Introduction

Chapter two presents a review of the philosophical orientation of phenomenology which serves as a framework for the study of the lived experience of patient satisfaction. The increasing use of hermeneutic phenomenology as both a philosophical perspective and as a qualitative research methodology supports its consideration and appropriateness for guiding nursing theory and research.

Background

Phenomenology can be considered as both a philosophy and a research approach. Phenomenology is an inductive type of qualitative research seeks to explore, capture, and

understand the lived conscious experiences of people (phenomena) within their everyday life-world (van Manen, 1997). This form of study seeks to uncover rich and hidden meanings of human experience in day to day experience (Polkinghorne, 2005).

When using the phenomenological approach, reality is subjective and the participant is integral with environment. Truth can be considered an interpretation of some phenomenon and may be shared with others. Multiple realities and truths can exist at the same time. In phenomenology, the researcher acts as the primary instrument for implementing the research process (Fleming, Gaidys, and Robb, 2003). The researcher's reality is also considered to be subjective and experiences are unique to him or her.

Phenomenology as Philosophy

Phenomenology as a philosophy stems from early 20th century works of Husserl, Sartre Heidegger and Merleau-Ponty (Moran, 2000). This philosophy of phenomenology seeks to describe phenomena as the study of conscious experience. Conscious experience includes intentional forms and meanings, dynamics and enabling conditions of perception, imagination, emotion, thought, volition and action. Rather than reductionism of human experiences though the natural sciences, phenomenology introduces a means of study of the life world. Two major approaches to phenomenology study are: 1) classical phenomenology or "pure description of lived experience", and 2) hermeneutics, or "an interpretation of experiences via some text or symbolic form" (van Manen, 1997, p 25).

Phenomenological tradition of Husserl. Classical phenomenologists such as Husserl focused on the pure description of beings or phenomena (Moran, 2000). Husserl, who is credited with founding the study of phenomenology, emphasized the science of pure

consciousness as "the things themselves" or "let's get down to what matters!" (Husserl, 1970; Moran, 2000). A central concept of classical phenomenology is intentionality, or awareness of phenomena as well as contextual features of those phenomena through research and questioning (van Manen, 1997). In order to uncover the essential essence of a phenomenon, the researcher must use extensive description of the phenomenon. The phenomenon should be described before interpretation is imposed upon it and freed as much as possible from its cultural context. A technique termed *eidetic reduction* is used in order capture the essence or basic components of phenomena, while the researcher attempts to "bracket" or remove" his or her "natural attitude" or prejudices (Moran, 2000).

Phenomenological tradition of Heidegger; Both classical and hermeneutic phenomenology traditions: 1) focus on the human experience as it is lived in world, and 2) seek to examine experiences, which though seemingly trivial and mundane, create meaning and understanding (Wilson & Hutchinson, 1991). Husserl viewed human beings as "knowers" who engage in acts of attending perceiving, recalling, and thinking (Annells, 1996). In contrast, Heidegger viewed human beings as concerned beings who exist in a world that often feels alien, but who seeks understanding and meaningfulness in existence (Annells, 1996). A central tenant for Heidegger's philosophy is the "Dasein", which in the German language means life or existence. Heidegger, breaks down the word 'Dasein" into its components: "Da" or site, and "Sein" or the disclosure of being. Heidegger developed the concept of Dasein as the situated "meaning of being in the lived world," or how the person exists, acts, or is involved in the day-to-day world (van Manen, 1997). A primary characteristic of Dasein is that it is a being that is concerned and "cares" about its own existence. Dasein is ontico-ontological, existing on two levels. The *ontic* level is concerned with the specific, local, and concrete entity of Dasein. The

ontological level is concerned with the deep structures underlying existence, and is the level where Dasein discloses its own being. Dasein as human is the only entity that can ask the question of being and anticipate the possibilities of existence. Dasein experiences and names many other beings, yet in what Heidegger terms the ontological difference, the Dasein also names and thinks the *being* of other beings (das Sein des Seienden) and understands the *being* that belongs to all beings (Gadamer, 2007).

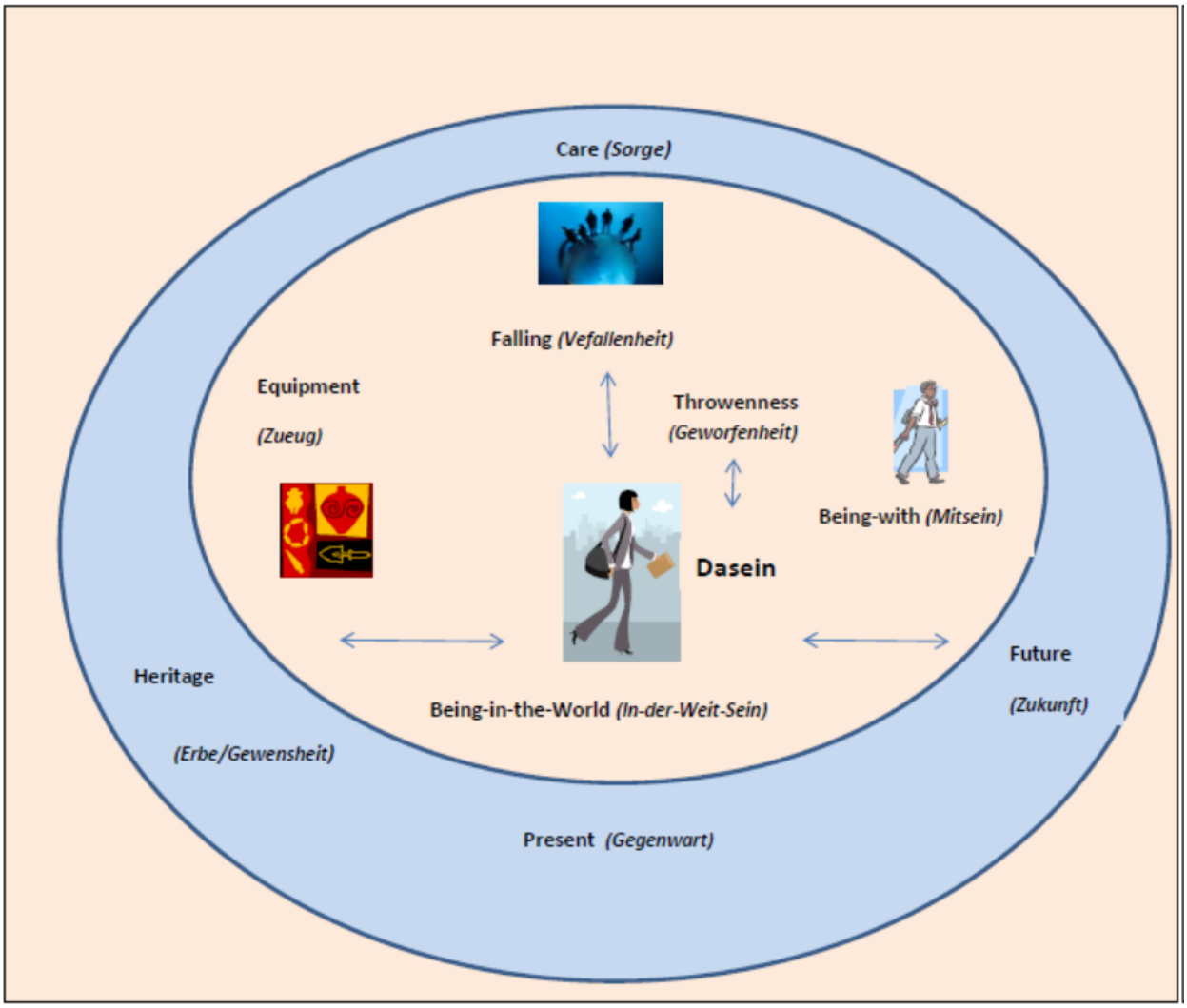
Components of Hermeneutic Phenomenology

Heidegger, Gadamer, and Merleau-Ponty modified classical phenomenology as a means to interpret experience by relating it to relevant features of context through hermeneutics, or the art of interpretation in context within the "life world" (Moran, 2000). Components of this life world include: 1) *temporality*, 2) *spatiality*, 3) *corporeality* or lived body, and 4) *relationality* or lived human relation (Merleau-Ponty, 1962). These components provide a vehicle for phenomenological inquiry, reflecting, and writing (Dowling, 2005). Components of "Being in the World" are shown in Figure 8.

Temporality, or lived time, is more of a connectedness than a linear process. It is through an authentic relation of lived time that a person becomes sensitive to Being and where Dasein is revealed. As a cultural- historical being, the person is "rooted" in the past tradition that is share with others. The person moves back and forth to the past or to "heritage' which is always with the person. The past stretches into present where Dasein experiences "throwness" a term Heidegger uses to signify that the person is "thrown into existence". At this point, Dasein has the opportunity to pick up the past and take hold of the present and choose possibilities to orient and project itself into its future. Throwness is then an "exilic" experience or a determination of

being wherein the Dasein loses origins and heritage and at the same time opens up to future potentials and conceptions (Vallega, 2003). Dasein moves towards its future projection into an engagement with both a personal world and a world "along with" other entities. The choice to pursue future possibilities defines the person as unique.

Figure 8: Depiction of Heidegger's "Being in the World"



C Beck, 920140 based on diagram by Johann Loh

A second component of hermeneutic phenomenology is the concept of spatiality. This concept does not just refer to the spatial relationship of a being to objects and other beings in the world or special-geometric points but relates to "being in the world" or "situation". Heidegger often explains "being in the world" as akin to "dwelling" or to having a familiar "place" in the world. Being in the world requires "involvement" engagement or Bewwandtnis with one's environment. The environment is inhabited by "equipment" which is objects and tools utilized by the person and shared with others. Equipment is always considered as interrelated and within context (e.g. a book is related to a student or to a library). The environment as situation also finds Dasein as intimately bound up with "Others" in the spatiality of a cultural and social world. This cultural and social world is always rooted in the cultural-historical heritage of the past. The situation then allows for possibilities for shared ways of engaging with Others in the world.

A third component of hermeneutic phenomenology is corporality or lived-body. This concept does not reflect separate body parts or the mind-body dualism of the Cartesian model. Rather, the body is unified and integrated within the lived context of its environment in time and place. The Heideggerian Dasein dwells in his lived-body as a multifaceted being: 1) embodied in a vulnerable physical body, 2) as a psychological being, 3) as a being with a spiritual nature, and 4) as a being which is part of the cosmos. While health may be considered as harmony between the physical body and the lived-body, illness may be considered as embodiment in an unhomelike and unfamiliar body (Thoibisana, 1998). Anxiety or "angst" is created through the inability to control the body and realizing that the corporal body is finite and limited. However, illness does not take place only in the physical body, but within the lived-body within the context of its environment. Therefore, healing can take place, by affirming and utilizing the larger psychological, socio-cultural, and political aspects of live-body (Bialystok, 1997).

A fourth component of hermeneutic phenomenology is *relationality* or lived human relation. During 'Falleness" the Dasein drops into involvement in a world of other entities, both animate and inanimate. Equipment as inanimate objects is shared and used in context with other equipment and people. Dasein also "falls into" a world of other animate entities and travels "alongside" other animate entities in the world. One of the fundamental ways a person as Dasein comports itself towards other entities is through understanding. Understanding has a referential structure. In order to understand another particular entity, the person must understand it with reference to something else. This wider context or frame of reference is what Heidegger calls "meaningfulness". Heidegger contends that the conscious acts of attending, perceiving, recalling, and thinking, as proposed by Husserl, are understood and meaningful only if oriented as part of and within interlocking and interrelated systems. Indeed, Heidegger finds that *understanding* that is oriented towards *meaningfulness* is the fundamental and defining structure of phenomenology. Therefore, Dasein's understanding of being is the understanding of the being and relatedness of entities. The person and the world are "co-constituted" as a connected unit and not detached (Koch, 1996). As "Dasein" each human being is a unique entity actively immersed within the wholeness of world and every part of being is in itself a reflection of that wholeness.

Phenomenology as a Philosophical Perspective for Nursing and Nursing Research

Carper (1978) identified four patterns of nursing knowledge: 1) empirical, 2) aesthetics, 3) personal, and 4) moral knowledge. Van Der Zalm and Bergum (2000) claimed that Hermeneutic Phenomenology meets criteria for all four ways of nursing knowing.

According to Carper (1978 p.15), *empirica*l nursing knowledge is "systematically organized into general laws and theories for the purpose of describing, explaining, predicting

phenomena of special concern for the discipline of nursing." According to this definition, hermeneutic phenomenology would not be considered as empirical. Hermaneutic phenomenology does not have an objective, context-free single view of reality, is not replicable, and is not used to predict phenomena (Van Der Zalm and Bergum, 2000). However, Jacobs-Kramer and Chinn (1988) re-conceptualized Carper's notion of empirical knowledge in that describing, explaining, and predicting can also be expressed as facts, theories, models, and descriptions that impart understanding.

Meleis (1997) expanded the definition of nursing theory "a symbolic depiction of events of reality that are discovered or invented for describing, explaining, predicting, or prescribing responses, events, situations, conditions, or relationships " (Meelis,1997 p.12) . The author noted that description and prescription have the most usefulness for nursing. Hermeneutic phenomenology meets the criteria for nursing theory in that it: 1) describes and explains phenomena, events, situations, or relationships, and 2) demonstrates predictive usefulness, though it does not act to produce a situation as with prescriptive theories (Meleis,1997). Hence, the choice and usefulness of a thick description inherent in hermeneutic phenomenology should be congruent with goals of understanding and explaining human processes.

According to Caper (1978) a second pattern of knowing is *aesthetic* knowledge or artfulness within the art of caring (Carper 1978; 1992). In aesthetic knowledge, the nurse shows expression, creativity, and empathy in perception and is able to transform the experience into relationships and holistic contexts (Van Der Zalm & Bergum, 2000). Perception of contexts is essential in the art of caring (Carper 1978; 1992). Aesthetic knowledge combines artful nursing practice in a particular situation with a synthesis of man forms of knowledge (Jacobs-Kramer &

Chinn, 1988). Hermeneutic phenomenology reflects aesthetic knowledge as: 1) addressing ontological questions of meaning, being, and reality (Sorrel, 1994), and 2) discovering and reflecting on the connectedness, relationship, and meaning of actions, perceptions, and language ((Van Der Zalm & Bergum, 2000).

A third pattern of nursing knowing identified by Carper is *personal* knowledge or "knowing, encountering, actualizing of the concrete, individual self" (Carper, 1978 p.18). Personal knowledge as history, beliefs, and culture is enriched through storytelling, poetry, art, and literature (White, 1995). Though reflection and awareness of the self, the nurse is able to engage with another person as a personal being in the nurse-patient relationship (Jacobs-Kramer & Chinn, 1988). Personal knowing includes awareness of the self as an historical, cultural, and social being. Hermeneutic phenomenology facilitates knowledge of personal contexts and meanings as being in the world.

A fourth pattern of nursing knowledge is *moral* knowing based on "the primary principle of obligation embodied in the concepts of service to people with respect for human life (Carper, 1978 p.20). This moral or ethical knowledge is formed through the nurse understanding the person as not only an object, but as multifaceted person living in the world (Burgum, 1994). The nurse encounters the person who is experiencing health and illness in the wholeness of the lived experience and meaning that health and illness has to the person (Gadow, 1992; Kleinnan, 1976). Understanding aids the nurse in uncovering rich meanings of health an illness of patients and families. With moral knowledge, the nurse attends to, makes decisions, and takes action based on the lived wholeness of the situation. In hermeneutic phenomenology, the person becomes aware of and makes choices for action based on understanding of the self and others as multifaceted

beings interacting and relating to each other in context of the environment. Understanding aids the nurse in uncovering rich meanings of health an illness of patients and families.

Further evolving the work of Carper (1978) and Jacobs-Kramer & Chinn, 1988), White 1995) proposed *socio-political* knowledge as a fifth pattern of nursing knowledge within "the broader context in which nursing and healthcare take place" (White, 1995, p. 83). This pattern has two components: 1) sociopolitical context of the persons (nurse and patient), and 2) the sociopolitical context of nursing as a practice profession (White, 1995). Hermeneutic phenomenology inquiry encourages both nurse and patient to discover and understand social, cultural, and political structures that affect the health of people and communities (Campbell, 2001).

Hermeneutic Phenomenology as an Approach to Inquiry

When using the hermeneutic phenomenological approach to inquiry, reality is subjective and the participant is integral with environment. Truth can be considered an interpretation of some phenomenon and may be shared with others. Multiple realities and truths can exist at the same time. The researcher acts as the primary instrument for implementing the research process (Fleming, Gaidys, and Robb, 2003). The researcher's reality is also considered to be subjective and experiences are unique to him or her. In the hermeneutic phenomenology tradition, language is essential to understanding "being in the world" or how human beings act, exist, or are involved in the day-to-day world (van Manen, 1997). According to Gadamer, because language is biased as to the values of the culture, communication through language can never be unbiased (Fleming et al, 2003).

Hermeneutic phenomenology offers the "hermeneutic circle" in which the interpreter of phenomenon begins by exploring preunderstandings, or what Heidegger (1962) termed "forestructures" of understanding "the things themselves". These preunderstandings of the interpreter include: 1) "fore-having" or practical background familiarity of the phenomenon, 2) "fore-sight", or sociocultural background that provides a point of view, and 3) "fore-conception" or the sociocultural background which allows the interpreter to anticipate what may be found in examining a phenomenon. The researcher then moves from examining the whole of the phenomenon to the parts of the phenomenon, then back to the whole in a reciprocal manner (Moran, 2000). Hermeneutic phenomenology, in contrast to a positivist approach, believes that the researcher cannot be detached from his/her own presuppositions and must be aware of her own explicit beliefs (Gadamer, 1975). Therefore, bracketing of the researcher's pre-understandings and prejudices is not necessary.

Summary

In summary, hermeneutic phenomenology is useful to nursing by addressing: 1) the embodiment of the person in the context of the lived world, 2) temporal connects to past, present, and future, 3) the organization and meaning of lived experience, 4) and relationships to self, others, and the environment.

The hermeneutic process of inquiry facilitates engagement of both nurse and patient and gives voice to the integrated and wholeness of experience. This approach to inquiry adds language and dialogue to the meaning of day-to-day existence. As both a philosophy and methodology for inquiry, hermeneutic phenomenology makes a useful contribution to the body of nursing knowledge through rich description of nurses, patients, and human processes.

Chapter Three

Research Design and Method

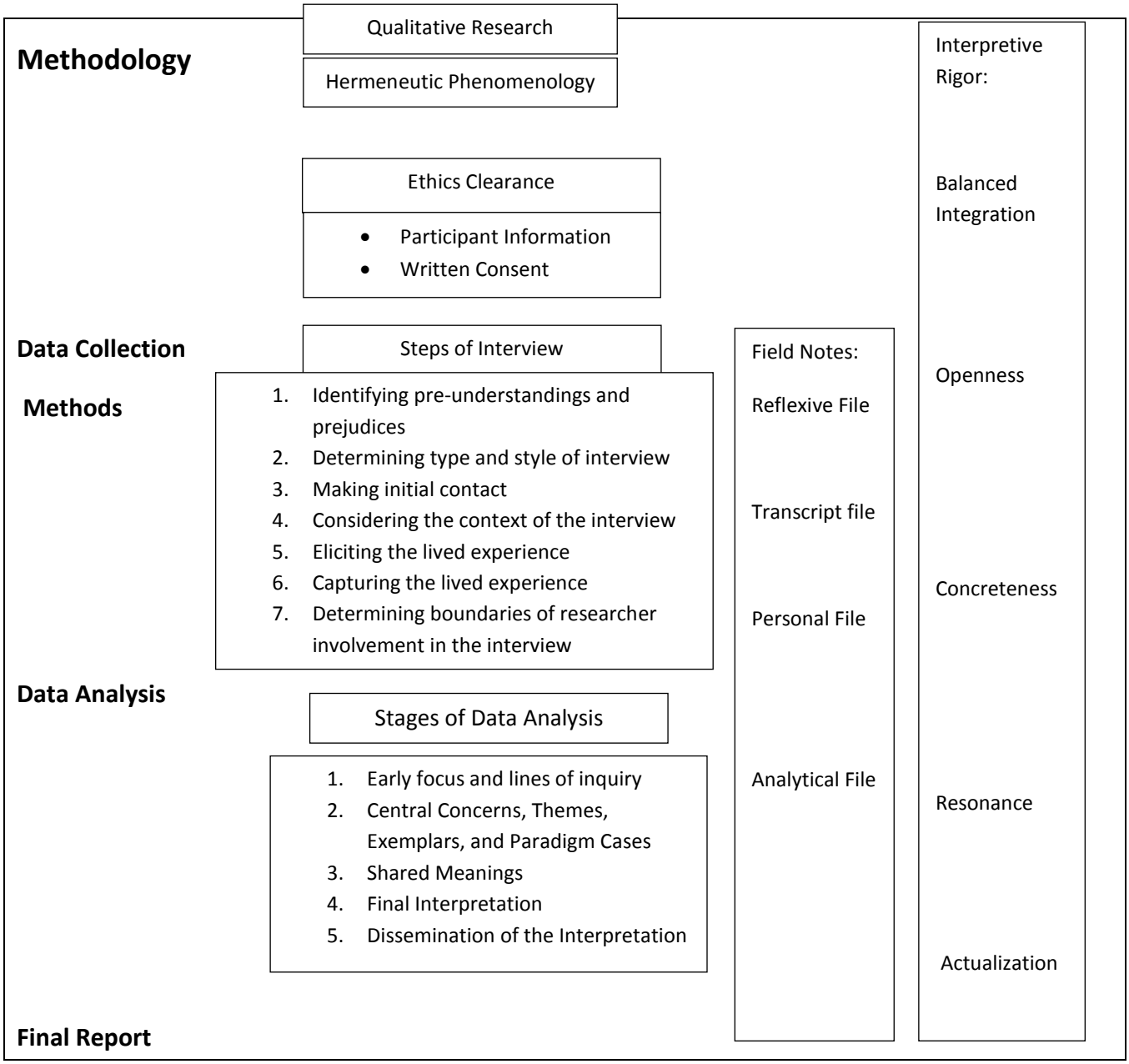
Research Design

This study sought to answer the question of how discharged patients of Native Hawaiian ethnicity perceive patient satisfaction or otherwise of nursing care during their stay in an acute care facility. To answer this question, the main objective was to explore and describe these perceptions within the context of the lived experience.

The research design guides the research through the planning and implementation of the study in order to achieve the intended goal of the study (Burns and Grove, 2003). This proposed study was exploratory, descriptive, and contextual, which are three attributes of a qualitative research study (Leedy and Ormrod, 2013). The research design used a qualitative research design which will include the dimensions of exploration, context, and description within an interpretive phenomenological approach. Figure 9 provides an overview of the methodological approach adopted for this research study.

Qualitative Research: Qualitative research is a form of inquiry focusing "on the way people interpret and make sense of their experiences and the world in which they live" ((Holloway, 1997, p.2). Qualitative research design is directed on uncovering new insights, understandings, and meanings (Wood and Ross-Kerr, 2006). Qualitative research can provide an in depth analysis of the problem in order to understand the "why" and "what" of human behavior. The aim of such research is to "investigate the meaning of social phenomena as experienced by the people themselves." (Malterud, 2001, p. 398). Qualitative research utilizes

Figure 9: Overview of the Methodology Approach Adopted for this Research Study



methods that explore how people make meaning of their lived experiences and their views of the world (Cresswell, 1998). Therefore, qualitative research takes place in natural settings and employs a variety of empirical methods such as interview case study, life story, and personal

experience "that describe routine and problematic moments and meanings in individuals' lives." (Denzin and Lincoln, 2004, p. 2).

***Exploratory research*:** According to Wood and Ross-Kerr (1998), exploratory research explores new and relatively unknown areas in order to gain new insight into the phenomenon under study. This research study utilized an exploratory research approach order to gain insight into patient satisfaction or otherwise of nursing care as perceived by people who self-identify as from Native Hawaiian ethnicity, an area which is area in need of study and understanding.

***Contextual research*:** Qualitative research adopts a holistic approach by focusing on participants' perceptions, values, language, interactions, lifestyles as an integrated whole. Knowledge of a particular phenomenon is organized into a gestalt or clusters of linked ideas. Analysis concentrates on the relationships between elements and concepts, and considers that the whole is always more than the sum (Burns and Grove, 2003).

Qualitative research employs a patient-centered approach, considering the original context of the lived experience as unique. Qualitative researchers work to glean an in-depth insight of the phenomenon while creating a temporal-spatial picture of the participant's values, reality, social and cultural context in which the phenomenon under study occurs (Holloway, 2005). This research study attempted to understand how participants think and feel about patient satisfaction or otherwise within the contextual framework of their lived experience as members of a population with a unique history and culture. The data made sense only in context, and this context-bound information could only be acquired with a qualitative approach.

***Descriptive research*.** When a phenomenon has been rarely studied, description is necessary. Qualitative research focuses on exploring the "emic" perspectives and ideas of participants. Emic constructs arise from group-specific common knowledge, interpretations, and

meanings that exist within a culture. Conversely, "etic" constructs originate from generalized observations, categories, and explanations of persons outside of a culture. The researcher comes from the "etic" perspective and therefore must be open-minded and prepared to encounter complexity in the situation and interaction with participants. In order to accurately describe and interpret the emic view as accurately as possible, qualitative research requires systematic collection, organization, and analysis of subjective narrative data. Categories then emerge from the data leading to larger patterns to explain the phenomenon under study (Holloway, 2005).

Little is known about the perceptions of patient satisfaction or otherwise as perceived by Native Hawaiians. The study utilized an open and flexible semi-structured interview format in order to allow participants to describe their experience of patient satisfaction of nursing care and their experience with the Press Ganey Patient Satisfaction Survey (Appendix D). The interviews were captured as verbatim reports and/or observation of non-verbal language. This study employed descriptive data collection and analysis processes in order to accurately describe the perceptions of participants, interpret the emic view, and expand awareness of this phenomenon (Wood and Ross-Kerr, 2006).

Foundations for Phenomenological Research

The philosophers who laid down the foundations of phenomenology as philosophy did not develop guidelines for the discipline of phenomenology. Van Manen (1997) offered a set of guidelines for human science research which has served as the template for research in nursing, law, and the social sciences. Building on the work of van Manen, researchers such as Colaizzi (1978); Giorgi; (1985); Fleming et al (2003); Koch (1996); Morse and Field (1995); and Crist and Tanner (2003) have developed guidelines for research for both phenomenological and hermeneutic traditions.

Hermeneutic Approach for this Study

Annells (1997) noted the importance of researchers to declare to whether using a classical phenomenological or a hermeneutic research approach, in order for the inquiry to remain true to that tradition. A hermeneutic or interpretive methodology was identified as the best means for this study.

Firstly, this study focused on the perceptions of the experience of nursing care within a particular setting and culture. The hermeneutic approach is a suitable for research on experiences of patients and nurses within healthcare environments (van Manen, 1999). Secondly, this study viewed nurses and patients as unique beings who create personal meanings of day to day lived experience, which is a consideration in hermeneutic research. Thirdly, it was important to give voice to Native Hawaiians who have rarely been given the opportunity to share their unique experiences regarding patient satisfaction. Through the context of language and active listening, the hermeneutic approach allows persons to be understood and for the researcher as interpreter to understand (Munhall, 2001). Fourthly, this study strived to broaden the understanding of nursing care as experienced by Native Hawaiians who are living in Hawaii (Annells, 1997). Lastly, the study of perceptions of patient satisfaction or otherwise explored the relationship of the event of receiving nursing care and the patient, and how meaning was formed in that relationship. In the hermeneutic approach, perceptions are considered intertwined within a relational engagement with the world (Merleau-Ponty, 1962).

Though the methodology in this paper drew on the work of many researchers of phenomenology, the approach held to the basic activities of hermeneutic research as proposed by van Manen (1997). These activities included: 1) turning to the nature of the lived experience,

2) investigating experience as it is lived, 3) identifying and reflecting on essential themes, 4) phenomenological writing and rewriting, 5) maintaining a strong and oriented relation to the lived experience, and 6) balancing the research by considering parts and the whole.

Ontological position. The ontological position regarding this study was as follows. Firstly, language was one way of knowing reality. Secondly, data was contained within the unique perspectives of the participants as expressed in their own language. Thirdly, the researcher employed an open-ended interview to investigate the perceptions of patient satisfaction of nursing care as expressed in the participants' own words and body language. Fourthly, the researcher was engaged with participants in collecting and analyzing the data in order to reflect and enrich the lived experience of participants and glean out its meaning (Holloway, 2005). Lastly, the researcher attempted to remain detached from his/her own presuppositions and stayed alert to her own explicit beliefs. The researcher's own beliefs were addressed through identification of pre-understandings and prejudices in the preparation phase as outlined in the data collection phase of this paper.

Participants

Sample. Inclusion criteria was identified in order to increase the likelihood that a homogeneous sample was obtained. A more homogenous sample helps reveal how an experience is perceived and what that experience means to a particular group (Patton, 2002). The criteria for this study included participants who: 1) were formally discharged as patients on an acute care unit or emergency room from Hilo Medical Center from November 1, 2014 –April 30, 2015, 2) were adults over 18, 3) self-identified themselves as being Native Hawaiian per the definition used in this study, 4) were able to speak English, 5) were willing to be interviewed

once or twice for 1-2 hour session through the computer application of Skype or in person, 6) were willing to have the Skype or face-to-face interviews audio and video recorded, 7) were willing to speak on the topics under study, and 8) were willing to have the services of an assistant if needed to complete the demographic information (Appendix C) and human subject participation consent form (Appendix B). The terminally ill and persons with dementia were excluded from the study. Suggestions for an adequate number of phenomenology research interview participants range from 6 (Morse, 1994) to 5-25 (Creswell, 1998). This researcher set 10-12 participants as the target goal and interviewed 10 (N=10) participants. Adequacy of sample was determined when: 1) analysis revealed clear interpretations, 2) new participants added no new findings, and 3) the narratives become redundant (Benner, 1994).

Human subject protection. The study conducted the informed consent procedure according to the University of Hawaii Manoa guidelines for protection of human subjects and federal requirements that protect the rights and dignity of informants. Four elements which comprise consent were addressed: 1) disclosure of adequate information, 2) ability of the participant to comprehend the information 3) competence of the participant to make decisions about participation and 4) participation that is voluntary and without coercion or duress.

Before data collection began, the study received approval from the University of Hawaii Manoa Institutional Review Board and the Hilo Medical Center Institutional Ethical Review Board. All participants were volunteers. The purpose of the research, the interview procedures, and ongoing voluntary participation were discussed in detail before proceeding with the interviews. Participants were informed that there are were no direct benefits and no identified risks as a result of their participation. A written consent form was reviewed and signed by each participant (Appendix B) at the beginning of each interview. The majority of Native Hawaiians

speak and write English, learned and spoken in school or home, or both. Therefore, though an interpreter was made available an interpreter was not needed for the interview phase. Strict confidentiality was maintained throughout the research process. Names or other identifying information was attached to audiotapes, transcripts, field notes, computer databases. All access to all data was restricted only to the researcher and appropriate research team members.

Ethical considerations. The research methodology proposed in this paper involved research that is complex and that asks participants to express their thoughts, feelings, and have their behaviors observed during the interview. In addition, the population who self-identified as Native Hawaiians can be considered vulnerable in light of their colonial history and socioeconomic and cultural challenges in Hawaii. Therefore, approval from the necessary ethnics committee(s) was obtained. All participants had the opportunity to ask questions. All participants had the following explained to them: 1) the purpose and process of the study, 2) that they were under is no obligation to participate, 3) that informed consent ensured participant autonomy to withhold information and withdraw from the study at any time without negative consequences, 4) all data was anonymous, was kept in a secure place, and was shared with any person, agency, community group, or provider not connected with the study.

Recruitment. Study participants were recruited through two strategies: 1) distribution of a recruitment handout by the Patient Satisfaction Representatives (PSR) of Hilo Medical Center, and 2) recruitment fliers disseminated throughout the Big Island community. Information on the recruitment handout included: 1) name of study, 2) purpose of study, 3) criteria for participation, and 4) contact information. Patient Satisfaction Representatives are trained staff of Hilo Medical Center who check in on patients and try to address any patient needs or concerns. The role of the

Patient Satisfaction Representatives is to inquire of patients if they are having their needs met, and then contact appropriate hospital personnel who can then address those specific needs. Patient Satisfaction Representatives assisted only with recruitment and assisted those who are unable to read the recruitment flyer. The Primary Investigator met with the Patient Satisfaction Representative supervisor to explain the purpose of the study, criteria for participation and contact information. In order to decrease sample selection bias, the Patient Satisfaction Representatives were asked to distribute recruitment fliers to all adults on the acute care settings who are not cognitively impaired (Appendix D). The Patient Satisfaction Representatives placed and posted in HMC outpatient clinics. The PI disseminated recruitment in outpatient specialty and primary and physical therapy clinics within the East Hawaii Region and to Native Hawaiian community organizations throughout the Big Island. Recruitment was on ongoing activity for over six months.

Data Collection

A second major research activity is to investigate experience as it is lived (Von Manen, 1997). This study systematically gathered data in order to expand the knowledge and discourse of the phenomenon.

Preparation. Preparation for the interview require that the researcher reflect on the interviewing process (Richards, 2005). According to Gadamer (Flemimg et al, 2003), within the hermeneutic tradition, researchers must reflect upon and identify their pre-understandings or prejudices of the topic under study. This allows the researcher to move beyond or transcend their own preconceived horizon in order to more clearly view the phenomenon. Pre-understandings can be initiated or uncovered by means of confrontation with colleagues, researchers, or through texts (Fleming et al, 2003). In this study, the identification of pre-

understandings was initiated through conversations with colleagues. The pre-understandings identified within the conversations have been described and analyzed within the research report. The researcher kept a research diary to note the change to these pre-understandings throughout the course of the study and periodically reviewed the diary in order to maintain focus on the phenomenon (Fleming et al, 2003).

The interviewing process. After obtaining informed consent, the interviews began. The interviewing process with participants who were recruited and ongoing recruiting of new participants occured simultaneously (Benner, 1996). This study applied steps in interviewing process as outlined by Walker (2011). These steps were: 1) determine the type and style of the interview, 2) make initial contact with participants, 3) consider the context of the interview, 4) elicit the lived experience of satisfaction or otherwise with nursing care, 5) capture the lived experience of satisfaction or otherwise with nursing care, 6) determine the boundaries of the researcher, and 7) conclude the interview.

***Determining the type and style of the interview*.** The type and style of the interview was determined based on the purpose of the interview in relation to the study (van Manen, 2007). The purpose of the interview was to explore the experience of being a Native Hawaiian in relation to satisfaction or dissatisfaction with nursing care. In hermeneutic phenomenology, the interview serves purposes of : 1) gathering and exploring narratives of experiences a lived by participants as told in their own words, and 2) developing a discourse between the researcher and participant about the meaning of the experience of the phenomenon (van Manen, 1997). This conversation is crucial to the researcher's immersion into understanding the phenomenon and should not be delegated to a research assistant (Gadamer, 1975). A semi-structured interview technique was utilized (Appendix E) in order to elicit themes of participant's own lived experience while

ensuring that the researcher stays focused in order to gather the information needed (Morse and Field, 1996; van Manen, 1997). The main body of the interview and focus group used a semi-structured interview technique with open-ended questions and probes. This interviewing technique allowed participants to freely share their experiences in response to inquiries while ensuring that the researcher stayed focused on the phenomenon. Making participants comfortable in sharing their thoughts and feelings is often challenging. Therefore, interviews and the focus group began with broad opening inquiries. New research questions and probes evolved during the interview and observation process, as meanings, concerns, and practices from varied perspectives emerged. Subsequent open-ended questions and inquiries asked the participant to expand on their narrative and allowed flexibility for the interview to flow in the direction of responses

Making initial contact. Each participant was contacted by telephone in order to discuss: 1) the inclusion criteria for the study, 2) discuss participant protection and confidentiality, and 3) review the risks and benefits of participation. The participant was given a choice of participating by two means: 1) via Skype.com, a computer application that offers a free download that allows individuals to videoconference via webcams from computer to computer, and 2) a face-to-face interview on the Big Island at a convenient and comfortable location determined by the participant and the researcher. All participants requested a face-to face interview for the initial interview and a face-to-face or a telephone interview for the follow-up confirmation of themes. After the potential participant expresses interest in participating in the study, The PI and participant mutually arranged convenient interview times as well as identified any special needs such as physical disability (Appendix C). From the initial contact an approach of trust and

equality was initiated to set the foundation of the researcher-participant relationship (Walker, 2011).

Considering the context of the interview. In scheduling the interview, it was important to consider its context. People in remote and rural areas of the Big Island Hawaii might not have access to ready transportation, might live in a remote rural area of the Big Island, or have family, work, or community responsibilities to attend to. Therefore, it was initially anticipated that Skype would be used to conduct and record the interviews. Participants, however, preferred the face-to-face interviews because : 1) they felt more comfortable face-to-face, 2) they did not own a computer, or 3) they were unfamiliar with or felt intimidated by the Skype application. Respondents stated they were comfortable with being audiotaped (n=1) or videotaped (n=9) during the face-to-face interview. An I-pad with capabilities of videotaping and audiotaping was used for the face-to-face interview. This system captured the body language of the participant, was flexible for setting-up for each interview, and was unobtrusive in size. In addition, all interview records were easily and securely transported on the I-Pad until they were uploaded onto a secure computer file before being permanently removed from the I-Pad. An I-pad was used for the face-to-face confirmation of themes interview. A telephone on speaker call recorded by an I-pad was used for the telephone confirmation of themes.

Eliciting the lived experience of satisfaction or dissatisfaction with nursing care. According to Gadamer (1975), the interview is a means to gain understanding through dialogue with participants (Fleming, 2003). It was important that the interview was arranged so that dialogue was relaxed. Participants felt comfortable sharing their experiences, and distractions were at a minimum. Demographic information of the participant was obtained from a structured questionnaire (Appendix E). The main body of the interview used a semi- structured interview

technique with open-ended questions (Appendix D). This interviewing technique allowed participants to freely share their experiences in response to answers and probes while ensuring that the researcher stays focused on the phenomenon (Morse and Field, 1996; van Manen, 1997). The interview began with these grand open-ended questions : "Tell me about your experience at Hilo Medical Center" and "Have you ever participated in an interview before?'

This approach allows the possibility that new research questions will evolve during the interview and observation process, as meanings, concerns, and practices from varied perspectives emerge (Crist and Tanner, 2003). Thus, subsequent open-ended probing questions should ask the participant to expand on their narrative which allow flexibility in the interview to flow in the direction of responses.

Interpretation and meaning which central to this study as the text is the "vehicle" (van Nes, Tuneke, Jonsson, and Deeg, 2010). Language differences across cultural contexts create challenges when the translation results in loss of meaning. Therefore, this study used an integrated collaboration pattern of working with the interpreter (Shimpuku and Norr, 2011). A Native Hawaiian key informant experienced with Native Hawaiian and Pidgin Hawaiian was integrated into the research process, was called upon to review the interviews for accurate transcription and translation, and cultural insights into the analysis, and was called upon also to assist with recruitment. The choice of the Native Hawaiian key informant was based on her previous experiences, her previous training specific for this research, and how well she had developed trust of the Native Hawaiian population on the Big Island of Hawaii.

The face-to-face interviews were audio and video recorded. Telephone interviews were audio recorded. Field notes were taken by the PI from audio and visual recordings of the

participant and PI interaction before and after the interview. No notes were taken during the interview in order to focus on ad listen attentively to the participant The PI performed occasional checks during the interview which included paraphrasing, requesting further clarification, and summarizing in order to confirm the narrative is as faithful as possible to the participant's words and gestures.

Determining the boundaries of the researcher. In hermeneutic interpretative phenomenological research, it is accepted that the researcher is situated in his or her world (Merleau-Ponty, 1962). The knower and the known are interactive and inseparable (Lincoln and Guba, 2000).

The researcher reflected upon and identify their pre-understandings and prejudices of the topic under study, which Heidegger (Moran, 2000) termed "forestructures". During the interview process the researcher was aware of and acknowledge these forestructures as much as possible, which makes bracketing unnecessary (Moran, 2000).

In the health professional and academic role, this researcher attempted to minimize power imbalances by: 1) active and attentive listening to the participant, 2) valuing the participant's contribution to the study, and 3) following up or referral on any need for support that the participants may have expressed before, during, or after the interview (Walker, 2011).

Concluding the interview. At the conclusion of the interview, the researcher thanked the participant for his or her valuable participation and asked for any addition to the narrative of the phenomenon or any other issues they may wish to discuss. The researcher addressed any follow-up interviews to confirm thematic analysis as needed. Transcription of the face-to-face and telephone interviews were completed by the PI by playing the audio and video recording while

typing the interview into Microsoft Word. The PI transcribed the interview verbatim and then checked the transcription for accuracy. The key informant assisted with interpreting Hawaiian phrases or nuances to ensure faithfulness to the participant's words in context.

Field notes. This study utilized four types of field notes: 1) the transcript file, 2) participant personal file, and 3) the researcher's diary, and 4) the analytical file.

The transcript file contained the transcribed and, if needed, translated raw data from the interviews. The participant personal file recorded details of: 1) demographic information and contact information. 2) gestures and facial expressions of participants during the interview, 3) the setting, and 4) other people present. The researcher's diary included: 1) the identification of the researcher's identified pre-understandings, 2) works of art, literature, journalism, etc… that may resonate with the researcher regarding the phenomenon, and 3) any changes in the researcher's thinking or perception of the phenomenon, that occurred throughout the course of the research. The analytical file contained: 1) ongoing reflections, insights, and question of how the research progressed in relation to the phenomena under study, 2) insights offered by the native Hawaiian key informant , and 3) a critique of ideas that emerged in relation to the research question and aim.

Data Analysis

The data analysis may be considered the researcher's dialogue with the text (Fleming, 2003). The analysis in interpretive hermeneutic inquiry requires: 1) reflecting on essentials themes, 2) the art of writing and re-writing, 3), maintaining a strong relationship with the experience as it is lived, and 4) sticking a balance between the parts and the whole of the research context (van Manan, 1997). In the data analysis for this study, the interpretative process

followed a circular, not linear, process. The narrative texts were examined simultaneously as the interpretation emerges. At the same time, the participant's own unique story and context was always considered.

This research study used QSR NVivo 10 qualitative research software to assist in organizing, classifying, and managing data. This type of software for qualitative research facilitated a systemic exploration and analysis of complex, contextual ideas and material (Richardson, 2005).

The researcher applied Crist and Tanner's five phases in interpretative data analysis: 1) early focus and lines of inquiry, 2) central concerns, general themes, exemplars and paradigm cases, 3) shared meanings, 4) final interpretations, and 5) dissemination of the interpretation (Crist and Tanner, 2003).

Early focus and lines of inquiry. Firstly, the researcher became immersed in and familiar with the data and sought to obtain a sense of the meaning of the text. This immersion helped facilitate the organization and coding of the data (van Manen, 1997). Following the interview and when the observation transcriptions have been transcribed verbatim, the tapes were compared for integrity. The Native Hawaiian key informant was asked to assist with understanding of cultural and language nuances. Missing or unclear passages were tagged and discussed and further explored with the researcher's advising team (Crist and Tanner, 2003). No subsequent interviews with participants were needed for clarification or elaboration of lines of inquiry. The post-analysis review of themes provided further validation and understanding of meanings.

Central concerns, important themes, exemplars, and paradigm cases. In this phase, the participants' central concerns, important themes and salient meanings are uncovered for each participant as they are situated (Benner, 1991). The researcher sought for understanding of the participant's narrative by identifying first order constructs which capture the participant's ideas as expressed in their own words. Next, second order constructs were identified and grouped into themes and sub-themes. This abstraction helped to build a picture of each participant's narrative as a whole. The reading and re-reading of the data, and moving from parts to the whole and back again allowed for synthesis of broad themes.

Summaries of central concerns with salient excerpts, and important themes were written and rewritten. This phenomenological writing and rewriting is an essential activity in the research process (van Manen, 1997). These summaries were reviewed for emerging interpretation and emerging exemplars and paradigm case (Crist and Tanner, 2003). Exemplars were identified from parts of stories or narratives that have similar meanings within the participant's narratives. Paradigm cases are usually more vibrant narratives which the researcher tends to return to in order to examine them with new perspectives (Crist and Tanner, 2003). The naming or conceptualization and coding of these central concerns, important themes, exemplars and paradigms, was a continuous process which shifted as more interviews and analyses were done. At all times, the researcher strived to maintain a strong and oriented relation to the lived experience (van Manen, 1997).

Shared meanings. After each of the participant's central concerns are identified, the researcher explored meanings that were connected and shared across narratives of the participants. The researcher wrote and rewrote summary interpretations of these connections or "constitutive patterns" (Diekelmann, 1993). This process of constitutive phenomenology allowed

the phenomenon to take shape as in the researcher's consciousness from the first impressions or parts to the full picture of the whole phenomenon. The linkage of patterns across data sets helped to illuminate the phenomenon and highlight key findings. Three (n=3) participants agreed to meet face-to-face or discuss via phone regarding whether or not the emerging overall themes were important to them or resonated with them.

Final interpretation. In this stage, the researcher used concomitant writing which flows from and integrates the examination of exemplars and paradigms, central concern summaries, interpretation of shared meanings, and final interviews. The researcher worked towards an interpretation that balances the parts and the whole of the phenomenon (van Manen, 1997). The final interpretations that emerged aimed for final in-depth interpretations, clarification and refinement of themes, and increased understanding of the phenomenon under study.

Dissemination of the interpretation. Final manuscripts of the interpretations will be refined and disseminated to participants for validation and then to research peers for review. Journals and field notes were reviewed and provided for auditing and considered for inclusion in the final report. The approved final report of findings will be presented to participants and to the Hilo Medical Center. This study will provide information on Native Hawaiians' perceptions of satisfactory/unsatisfactory nursing care, which may be used to improve patient outcomes. The hermeneutic interpretive process is non-ending, readers of the report will add to the final evaluations. As nursing is praxis, feedback from health professionals, researchers, and academics may test the relevance of this study and the meaningfulness of its findings. In addition, the researcher will suggest ways that the study results may be used to improve clinical practice. As to evaluation, questions for the researcher to consider are whether the concern or research question has been answered and the aim achieved (Packer and Addison 1989).

Quality

In order to ensure systematic and accountable methodology, criteria of rigor must be applied. This study applied the criteria of rigor framework of de Witt and Ploeg (2006) which is methodologically and philosophically consistent with interpretative phenomenological research. These criteria include: 1) balanced integration, 2) openness, 3) concreteness, 4) resonance, and 5) actualization. These five criteria are aligned with hermeneutic research as based on a philosophy proposing the existence of multiple realities and auditability focused on process rather than outcome (de Witt and Ploeg, 2006).

Integration. The criterion of balanced integration requires that the researcher account for the philosophical tenets within the study findings (de Witt and Ploeg, 2006). To meet the criteria, this study strived to: 1) articulate how well the philosophical theme fits with the research topic, and 2) interweave philosophical concepts within the selected method of the study and with the interpretation of the findings.

Openness. To meet the expression of the criterion of openness, the researcher must show a systematic process for decision- making throughout the research process (de Witt and Ploeg, 2006). To meet this criterion, the transcript file, participant's personal file, and the analytic file were reviewed weekly to maintain the focus of the study. The PI's reflexive journal included a daily account of decisions made throughout the research process.

Concreteness. The third expression of rigor is concreteness. Concreteness is demonstrated through highlighting examples from the research data which: 1) place the reader within the context of the phenomenon, and 2) link the reader with the participant's lifeworld experience (van Manen, 1997). To meet the criterion of concreteness, this study integrated

historical, cultural, and day- to- day experiences as lived by participants and quoted salient passages from the participant's narratives.

Resonance. Resonance, the fourth expression of rigor, refers to moments when the reader recognizes an understanding of the meaning of study. To meet this criterion, the researcher carefully selected language and exemplars from the research data which conveyed a depth of expression and richness of the phenomenon.

Actualization. The fifth expression of rigor is actualization which refers to the realization of the resonance of the study findings in the future. Interpretive phenomenology is not complete when a research study ends, but proposes that readers in the future will continue their interpretation (Madison, 1988). A mechanism for formalizing actualization does not exist at this time.

Conclusion

This paper has described and utilized a research design method to best explore the experience of the Native Hawaiian patient in relation to patient satisfaction. The conceptual philosophy and research methodology used the hermeneutic interpretive phenomenology process of: 1) gathering together the data of the life experience, 2) analyzing data and gleaning essential themes form the text, and 3) suggesting ways to improve praxis (van Manen, 1997).

Chapter Four

Presentation of Findings

Introduction

The results of the study entitled Hermaneutic Phenomenological Study to Explore the Experience of Native Hawaiians in Terms of Patient Satisfaction/Dissatisfaction with Nursing Care is presented in Chapter Four. This section includes the description of the sample, thematic analysis with supporting data in the participants' words, synthesis of the findings, and a summary. An exemplar is provided and viewed within the framework of Hermeneutic phenomenological philosophy which was used as the guiding conceptual orientation.

Sample for Participant Interviews

A total of ten participants (N=10) from the Island of Hawaii participated in this study. The sample consisted of six women (n=6) and four men (n=4) ranging in age from twenty-two to sixty-eight. Eight (n=8) of the participants lived in within the urban area of Hilo. The remaining two participants (n=2) lived in rural communities of Pahoa and Kurtistown both within the district of Puna, Hawaii.

Three participants (n=3) identified themselves as Full Native Hawaiian by family, cultural traditions, and blood. Seven participants (n=7) identified themselves as Part-Hawaiian by family, cultural traditions, and blood.

The participants were admitted to Hilo Medical Center for a variety of health reasons. Two (n=2) of the participants were admitted to the emergency department (ED) only. One (n=1) participant was admitted to the Labor and Delivery unit only. Seven (n=7) of the participants were admitted first to the ED and later transferred to one or more other unit(s) within Hilo Medical Center. These other units included intensive Care Unit (ICU), Cardiovascular Unit (CVU), Surgical Unit, and Medical Unit. Participant diagnoses made during their hospitalizations per participant statements included: abdominal pain and sprained arm (n=1),

orthopedic surgery (n=2) panic attack (n=1), septicemia (n=1), urinary tract infection following prostate surgery (n=1), kidney infection followed by myocardial infarction (n=1), newborn meconium aspiration (n=1), thromboembolism followed by cardiac arrest (n=1), and myocardial infarction (n=1). All interview participants were covered under some form of health insurance plan. Four interview participants were under private insurance plans (n=4), two interview participants were under Medicare Associated insurance plans (n=2), two interview participants were under Medicaid-associated insurance (n=2), and two interview participants were under Veterans Administration insurance plan (n=2). Four See Figure 10.

Sample for Follow-up Confirmation of Themes

Follow-up interviews to confirm thematic findings were done face-to-face at the Hilo Public Library or via phone. A total 3 (N=3) participated in this confirmation. Two (n=2) identified themselves as full native Hawaiian, while one (n=1) participant identified herself as part-native Hawaiian. Two (2) follow-up participants had been admitted to the emergency department and transferred to other hospital units. One (n=1) participant was admitted to the emergency department only. One (n=1) participant was male, and two (n=2) were female. Two (n=2) participants lived within a two mile radius of Hilo, and 1 (n=1) participant lived more than ten miles out of Hilo. One (n=1) follow-up participant was under a Medicare-associated insurance plan (n=1) , one follow-up participant was under a Medicaid-associated insurance plan (n=1), and one follow-up participant was under a private insurance plan (n=1). See Figure 10.

Figure 10: Demographic Summary for Participant Interviews and Follow -Up

Finding	Interview Participants (N=10)	N	Follow Up With Participants (N= 3)	n
Age	20-30 years of age:	1	20-30 years of age:	
	30-40 years of age:	2	30-40 years of age:	
	40-50 years of age:	3	40-50 years of age:	2
	50-60 years of age:	2	50-60 years of age:	
	60-70 years of age:	2	60-70 years of age:	1
How Self-Identifies as Native Hawaiian	Full Native Hawaiian by family, cultural traditions and blood:	3	Full Native Hawaiian by family, cultural traditions and blood:	2
	Part-Native Hawaiian by family, cultural traditions and blood:	7	Part-Native Hawaiian by family, cultural traditions and blood:	1
Acute Care Area Hospitalized	Admitted to emergency department and transferred to other units (ICU, medical, surgical, cardiovascular)	7	Admitted to emergency department and transferred to other units (ICU, medical, surgical, cardiovascular)	2
	Labor and delivery	1	Labor and delivery	
	Emergency department only	2	Emergency department only	1
Sex	Male	4	Male	1
	Female	6	Female	2
Current Residence	Within 5 miles of Hilo	8	Within 5 miles of Hilo	2
	Over 10 miles of Hilo:	2	Over 10 miles of Hilo:	1
Insurance	Private	4	Private	1
	Medicare Associated	2	Medicare Associated	1
	Medicaid Associated	2	Medicaid Associated	1
	Veterans	2	Veterans	0

Findings for Participant Interviews

The participants shared their stories of care at Hilo Medical Center which generated a large amount of rich, descriptive data. Through data analysis using a phenomenological interpretive process, the experience of being a patient was illuminated. The participants spoke freely of their impressions and feelings about the care they received. Fictional names have been assigned to the participants. Throughout this chapter, the participants' words are in italics. The participants' stories of their hospital experience had many common threads. They all expressed that they appreciated the opportunity to talk story about their experiences as Native

The participants' stories of their hospital experience had many common threads. They all expressed that they appreciated the opportunity to talk story about their experiences as native Hawaiian patients. In telling their stories they voiced understanding of what they considered satisfactory or unsatisfactory care within the context of their individual experiences.

Thematic Analysis

Thematic analysis of the data revealed six primary themes. Themes were chosen, defined, and named based on the number of participant responses that support that aspect of the acute care experience. The themes that emerged from the interviews are taken from the first order constructs as expressed by participants in their own words. Sub-themes were identified for each participant who were then arranged according to larger themes. Patterns of themes were then analyzed to uncover shared meanings of participants. Interpretation of those shared meanings and their impact on patient satisfaction /dissatisfaction were explored.

Identifying subthemes and themes is helpful in understanding the complexity of the participants' experiences. The primary themes that emerged from the data are Expectations of

Figure 11: Diagram of Thematic Analysis

Themes	SUBTHEMES	IMPACT
Expectations of Professional Behavior	Attentiveness	Patient Satisfaction/ Dissatisfaction
	Commitment to Role	
	Response	
	Skill	
The Caring Environment	Active Listening	
	Showing Empathy	
	Providing Comfort	
Patient-Centered Care	Explaining Things Respect of Person Encouraging Self-Care	
The Ohana	Hospital as Community	
	Approach to Family	
	Being Hawaiian	

Professional Behavior, Patient Centered Care, Creating a Caring Environment, and the Ohana.

The theme of Expectations of Professional Behavior is further categorized in the sub-themes of

Attentiveness, Response, Commitment to Role, and Skill. The theme of Patient-Centered Care is further divided into sub-themes of Explaining Things, Respect of Person, and Encouraging Self-Care. The theme of Creating a Caring Environment was further sub-divided into sub-themes of Active Listening, Showing Empathy, and Providing Comfort. The theme of The Ohana includes sub-themes of the Hospital as Community, Approach to Family, and Being Hawaiian. See Figure 11. Final interpretation and impact on patient satisfaction/dissatisfaction is discussed in Chapter 5. Each theme and sub-theme is discussed within this chapter.

Expectations of professional behavior: The participants often conceptualized their experiences of important events and thoughts during their hospitalization related to their expectations of what they perceived to be professional behavior of staff. Although importance of professional behavior showed to be a universal consideration of all participants, more distinct considerations of this theme became apparent through the analytic process. Expectations of Professional Behavior as a theme and the subthemes of Attentiveness, Response, Commitment to Role, and Skill are discussed.

Attentiveness: All ten of the participants spoke about the behavior of all staff to attend to, check in on, and focus on their needs as a patient. Attentiveness was the most frequently cited subtheme found during the analysis.

Attentiveness was considered a point of patient satisfaction as evidenced by Anani's expression that "*The nurses were really really awesome, very attentive."* Some participants related attentiveness to response to the nurses call buzzer. Jael, hospitalized for septicemia, noted that the staff often anticipated needs and smiled as he stated: "*I had this nurse that always came to check up on me, I never even need to press the buzzer. Me and him became close and became*

friends. Like I said he was disciplined and we got along. I only had him a few times. He was real nice."

Tadashi, who was recovering from prostate surgery, remarked *that "The nurses were really polite. They always ask me what we can do for you, do you need anything."*

Lana, admitted to the emergency department for pain and fever noted that*: "The nurses came in to check with me whenever you know every so many minutes like every ten minutes of so they'd pop by look in see if I needed water if I needed the bed pan just check on me "are you ok" and I'd say yes and they'd leave. So they were very, very attentive very professional."*

Palia discussed how nurses inquired about her status and needs *"They are always checking up and always making sure about things… they are always there to make sure you are all right, that you're getting what you need, if you are comfortable. They want to make sure you're not in pain you know… They always ask me what we can do for you, do you need anything…. Yeah, nurses' aides are real nice too they check in on you a lot."* Palia noted improvement in response from her last hospitalization. "*There is more care, they are more attentive. They are on it, not like before where you would lay there and ring the bell, ring the bell and nobody comes. But now you don't have to ring the bell and they are always there. They are always checking up and always making sure things….This time I don't know they were always there. Like I wanted to get up, somebody was there. I never had to keep on ringing the bell. Somebody was always checking, to make sure if I needed water, or if I needed to go to the bathroom, or am I in pain, they were always checking….I hardly even used the bell."*

Only two participants reported a lack of attentiveness while on the acute units at Hilo Medical Center, Anani reported the wait for pain relief in the emergency department after she endured a fractured hip and crushed femur from a fall. She was animated when she stated:

"When I first got hurt I and was in the emergency room, they were pretty attentive, but I was in too much pain and it took a while, to me it took a while before they gave me something to take away the pain. Because every time they would touch me I would scream. And my husband told them you have to give her something. And I had to tell them I was in a lot of pain, please hurry. My husband would say honey be quiet, but I said no, I couldn't even let them touch me. I'd scream there would be a shock to my body. The minute they try to take my pressure I told them please I'm sorry, can you please get something to give me. To me it took a while when I first got in emergency to get medication. That's what I think, that's what I remember. It took me a while, a couple of hours before the pain subsided, at least three to four hours to me, that's what I remember. I remember screaming three or four hours before something settled me down."

Another participant, Lana, reported lack of attentiveness to the dressing on her IV line site. This was attended to after her transfer to a second unit *"My IV … when I got there from the other room in the medical ward my bandages were filthy dirty. They hadn't been changed for two days. They were bloody and stinky and this other woman who I know who's the nurse there, she said, don't worry I take care of you and she took everything off, all the dirty bandages and cleaned them all up, all nice, put nice bandages on me and then she repoked me again."* Both Anani and Lana were transferred to an extended care facility and reported much longer waiting times buzzing until the nurses would respond compared the high level to attentiveness while on the acute care units at Hilo Medical Center .

Response: Some participants reported how the hospital staff responded to signs and symptoms the participant presented with or to changes in status during hospitalization. Mele was admitted through the emergency department for kidney infection. She related what remains a frightening memory of her illness when she stated shaking uncontrollably and felt that no one

was acknowledging what was occurring. Through body language she acted out her chills and breathing as she stated:

"I was shaking my teeth were chattering and my husband could actually hear it and he was like what is going on, but I wasn't bouncing on the bed yet until I got out of the bathroom and I was really cold and I had six blankets on me……. I was breathing so fast that it was affecting my heart. And nobody told me to take it easy, breathe slower, nobody told me that…… my husband was holding me down, you know he is a surfer so he's holding my legs, my feet and my whole body with this hand And my husband is holding me down , nobody's there so he's yelling, yelling for help, yelling for someone… So she CNA comes back holding the blankets, she's at the edge of the bed, she doesn't come close to me, she doesn't put the blanket on me, she just stands there. Then my husband looks at her and says can you go and call the doctor….She just stood there at the edge of the bed, of my foot." The nurse was finally called. "But there was nothing, no communication whatsoever. Until she said we have to take you to ICU."

Tadashi relays another, though more positive event, related to response to a patient's status. A nurse in the emergency department persevered in her assessment that the patient required an ECG. Tadashi stated*: "She was kind of saying like only you know your body. If you think something is wrong with you, something must be wrong … She wheels into a one of the curtain rooms without a door and hooks up an EKG machine to me, and takes the paper to the doctor and I hear the doctor yelling at her "you didn't do this right, you did something wrong". So he sends another nurse, an R.N. is that what you call her, an R.N. She takes an EKG, another one, comes out the same…. . I was having a heart attack. "*

Commitment to role: Many participants spoke of their perceptions of how the staff approached their professional role. Lana discussed the determination and dedication of the

medical staff to find the correct pathogen causing her severe infection. She smiled as she said: *"I don't know, they just seemed very, they knew their job very well… And the folks up at Hilo Medical Center found it."* Lana also stated that the nursing staff as being dedicated to helping her health improve, and related: *" As soon as I got better they sent me home. So, I don't know, anyone going into the nursing profession has to be very dedicated."*

Conversely, Tadashi relayed his experience with a nurse who did not show commitment to addressing his pain. Tadashi emphatically stated: *"I felt like he wasn't going to help me at all, like he didn't care. Like I said he was there just for the paycheck. That kind of nurse shouldn't be a nurse at all".* Tadashi referred to the amount of work nurses do, the dependency of the patient and that bad experiences can negatively influence the patient's experience. *"You need to know how to express yourself to people and you need to learn the job and how to do it well. That's what you get paid for right and people depend on you. Especially the nurses. Yes, there's doctors, but actually it's the nurses that does everything. Like I said there were a lot of good nurses that I met, but just a couple that turn things around."*

Mele survived a severe infection as well as a myocardial infarction while she was hospitalized. Despite delay in diagnosing her myocardial infarction she states *"I think they did the best job that they could. I think they went beyond….. You know, for me, nurses, doctors, CNA's they're very important for the patients yeah and when they take that oath of being in one of those fields I feel they should take it very seriously only because if that's not what they want, they shouldn't be there."*

Skill: Participants discussed proficiency skills as important part of professional expectations. Participant scenarios regarding skills included invasive procedures such as

insertion of IV, PICC line, and Foley catheter. Most participants referred to the pain or frequency of the procedure.

Anani relayed the removal of a Foley catheter as painful and reported it to the physician. "*She (nurse) just said ok just hold your breath. She was rough to me and she just yanked it out. I have had catheters in me before because I have had bladder infections where they put a tube and it wasn't big enough so they had to put a bigger tube and I was bleeding and wasn't getting urine out. I had a couple of occasions before, but this one was like uh… all I know I screamed bloody murder. It was awful. So when the doctor came I said doc the nurse who took out my catheter hurt me so so bad. She said she'll have a talk with her, but I don't know if they did or not."*

Tadashi was recovering from prostate surgery and was unable to urinate. He relayed an experience of not being medicated while the nurse inserted a Foley catheter in a rough manner. *"So he came back, put the catheter in, gets his ointment that's it and shoves it in…. That was painful, very painful. I don't want anybody to go through something like that."*

Jael stated that his negative perception of nurses inserting IVs. During this event the nurses joked about not being initially successful with the procedure. Jael stated *" When they put the IV in. Them nurses, some of them don't know how to do it. At least when the paramedics do it it's like nothing. You don't feel nothing. I had a problem with this one nurse who couldn't get it and they were laughing, the two of them were laughing. I think they thought it was funny. She had to call another one to do it and she did it fine."*

Kalei stated several experiences of what he considered poor demonstration of skills while she was on the OB unit. *"I came here to give birth and the epidural, the worsest period, everybody was doing their job sitting down. I didn't like it. They sat down and did my*

blood test. They sat down and did my epidural. Like there was no comfort. Like yeah, I didn't like that. I just didn't like the whole procedure you know. It got done, but not in a comfort way of doing it." During labor she received conflicting *coaching "One nurse was saying "push" the other nurse is saying nurse is saying "hold". Who do I listen to, knock it off. Yeah. "Don't listen to her push", "Don't listen to her just breathe."*

Kalei also perceived nurses as not proficient in starting IVs. *"I know all the nurses are not great in taking blood or making IV and all that but the guy that took care of me literally poked every single part of me. I know if they can't do it over here they have to go over there, and once they hit this vein over here I get weak, I don't like it over here, I can take it over here better. No but over here better because got bigger veins. Oh yeah okay go ahead, but do it correctly."*

Patient – centered care. All participants relayed their perceptions of their hoptialization as a patient at the center of care. Their experiences conveyed their experiences of patient-centeredness in terms of Explaining things, Respect of Person, and Self-care.

***Explaining things*:** Several participants conveyed the importance of nurses and other health professionals explaining their symptomology, progress, and procedures. Mele, who was experiencing a myocardial infarction, experienced two very opposite experiences of receiving information about her health status. On the medical unit stated that the nurse neglected to inform her what was happening to her body as well as why she was being transferred to the intensive care unit (UCI) . She cried when she remarked*: "She (the nurse) was just standing there and I don't know how long she was standing there, the nurse, until she said we need to take you to ICU."* Conversely, Mele relayed that after she was transferred onto the cardiac unit, she encountered a nurse who "*addressed everything"*. Mele noted the uniqueness of this nurse as

"out of all the other ones I was with, he was the one who actually took the time, sat down, asked me if I had any questions and actually told me what I had gone through, but not so much where I understood him saying I had a mild heart attack." When Mele stated that she had not known she had a heart attack, the nurses continued to give her more information about the heart attack and various monitoring procedures regarding her condition. Mele stated that in the ICU, the nurses *"were on it. I mean seriously they were on it. They answered questions. … They just didn't just give me medication. They would say okay Mele you have to take this and this and this. Then I would say okay. They would say this is for your heart, this is to thin your blood. It was step by step that they would say this medication was for this to help this in your body."*

Lana stated that nurses were very informative when they were inserting a PICC line or an intravenous access placed in a major vein. She stated that they explained what was occurring through the entire process and stated: *"They explained instead of just poking and poking."* Nurses showed Lana pictures of the structures of her heart and the main vein where the PICC line was going into her body. Lana was smiling and exited as she stated: *"She (the nurse) showed me the chambers. This is what this one looks like and that one looks like, which is totally fascinating. She goes, "And I'm gonna show you your vena cava right now." And I was like, "Whoa!" you know. I was like, "Gee." She let me look and she was like, "Isn't that fascinating?" It's like, "Yeah."*

Tadashi referred positively to the white board in his room where tests and major teaching points were displayed for him every day *, "And then any remarks that were important, like "nothing by mouth" cause I'm gonna have a test or something the next day."* Tasahi stated that this board helped him following the hospital day and his progress.

Palia also had positive experiences with receiving information regarding her medication while she was a patient undergoing orthopedic surgery. She stated:

"I'm always full of questions. If you going to give me a shot I have to know why. What is it. You know. They explain it to you. It's different now. It's really good. I like it."…" Yeah I want to know what I'm getting. What is it. What is it going to do with me. That's what I want to know. But they answer, they don't give me any problems answered every question and if somebody didn't know something they would get somebody that did."

Bane was admitted to the emergency department thinking he was having a heart attack, but was diagnosed as having a severe panic attack. Bane stated that the staff notified him of everything that was going on to calm his panic attack. Bane stated:

"Yeah, they told me everything that was going on, what kind of procedure they were going to take and all it was a panic attack….they gave me instructions and they gave me some medicine…they did explain what it was for… why I was doing these things, why I must do these things. The doctor came in and said are you feeling okay. I said no, I cannot lift up my arm. He said well you according to the EKG and all the other things we went through you didn't have a heart attack or a stroke. So they said I had a panic attack. So I said that can happen like that. I didn't know all the things that happened to me was a panic attack. He said yeah, but don't feel like you came in for no reason. He told me that."

Tadashi had a negative experience when the nurse did not explain the procedure of inserting a Foley catheter. Tadashi stated *"He (the nurses) came back with a plastic bag that they put this stuff in, ripped it open and said okay I have to put this thing in you his guy didn't explain anything…I knew what it was for, but at least he could have said, this going hurt, or do you want something for your pain. But he didn't say anything*."

Respect for person*:* Participants stressed the importance of staff to respect them as a person in terms of mutual respect, acknowledging their presence, and considering their privacy.

Lana conveyed how important that being able to eat her meals and visit with her family as part of her recovery. Lana stated that she was interrupted while she was eating from her tray and her husband had just come in the room to visit. She appeared frustrated when she stated:

"I was just sitting here eating my lunch and some woman walks in saying she's from patient services asking these questions and not telling me why she wanted that information. She was rude. ... My food had just gotten there before she walked in, she sat, and she started proceeding with questions about if I have a will and what I would I like done if I should pass away. And I'm about to eat my meal, and my husband's sitting there with me and she's asking me questions about my ultimate demise. And I didn't take to that very kindly and I, I think I asked her to leave."

The patient representative proceeded to inform Lana that she would be transferred to extended care. Lana expressed that she had little time to ask questions or discuss options and relayed :

"She (patient representative) was very threatening, you know, and here I am vulnerable, the patient in the bed, and she's telling me what she's gonna do bam, bam, bam, bam, bam, bam, bam, bam. Cause I guess I, I was rude to her and I told her she would please leave and let me, you know, have my lunch."

Delena, who works in a customer service occupation, stated *that "I'm all about customer service so I know, you know, what customer service is. They (the staff overall) have*

none… like, you know, everything should be focused on the patient not like, "ok, let's get them out," you know, like, "ok we got to clear beds," or, you know, like actually care for who they are caring for." Delena stated that she perceived that many of the staff tended to talk down to her when she expected to be treated with mutual respect. *"They kinda take it to the head, you know. And I mean I respect everybody in any profession higher than I am, you know, nurses, doctors, I respect, I respect those people. I just, you know, want to receive that respect back. It's important, you know, you want to seem equal not, you know, unequal."* In addition, Delena stated that staff would often having conversations among themselves and speaking over her *"they were mostly talking amongst themselves, you know, the staff, about their, about what's going on or the shift or, you know, complaining about their shift and I thought that was really kinda rude, you know, because I'm right there."*

Kalei expressed the experience of having her newly delivered baby transferred via emergency airlift to Oahu because of meconium aspiration noted one day after delivery. Her husband was aboard the medivac. Kalei relays that at first the staff kept her up-to-date on her baby's progress and related: *"Before the baby and the dad went on top of the medivac they was telling me every hour about what was going to happen you know what I mean."* Following the transport, when Kalei asked the staff for updates, she was told that her husband would now be instructed on the progress of her baby in Oahu. Kalei conveyed the experience of being left in a room alone and feeling *"like a number"* and fearful for the health of her baby and status of her husband. Kalei stated that the golden rule should apply with mutual respect and staff should *"give the attitude that you would want back. You know what I mean. You going to give good, you going get good. Golden rule."* The next morning Kalei left the hospital before being discharged. She relayed her feelings of frustration when she related: *"But after baby left there*

was nothing to do with mom. You know what I mean. They didn't even worry about me. So I literally packed all my stuff. I was so frustrated."

Tadashi was readmitted for infection following prostate surgery and recalled a slight to his personhood. He was admitted to the emergency department was and unable to walk. As the nurse wheeled him into emergency department *"the doctor looks at me and says "oh no not this guy again". Just like that eh……. If I could have gotten out of the chair! …"*

Some participants mentioned their perception of the lack of privacy. Jael stated *"Sometimes when they're talking about another patient or talking to the patient you can hear everything…They should have a room divider where it rolls out to make it more silent. You can hear everything and I'm sure they can hear everything when the doctor is talking to me… It's very difficult when you're a patient, then they lack privacy"*

Anani stated she was physically exposed when a male nurse did not keep the curtain closed when she was being assessed. *"It was just frustrating. It was really frustrating because when he was doing me he was like pulling on my curtain, he was talking to other people*." Anani stated that she wanted to say to the nurse: *"Hey dude hurry up get out of here!"*

Lana stated much lack of privacy in the intensive care unit as compared to the emergency department. *"There were a lot of people in my room, first of all, all at once. In the emergency room it was very private, very quiet; one nurse came in at a time. Upstairs in the intensive care there would be the cleaning person, there would be a male nurse's aide that would be walking back and forth, there was strange people I didn't even know coming in to wash their hands in the basin."*

***Self-care**:* Several participants noted that one important aspect of hospitalization was the time for reflection on their health and self-care. Aspects of self-care discussed include staff mediating encouragement, information, or resources, and follow-up, in maintaining or improving health and self-care.

Palia stated that her home-going instruction and follow-up was very thorough. *"They'd monitor, and then, just develop all these routines and educate me so that when I go home I can better take care of myself. And then when I finally left they put me in contact with Health Ways and a nurse called me the next day. And we talked on the phone and she made some recommendations, she made two recommendations so when I went in to see my doctor."*

Anani was diagnosed as a borderline diabetic and was instructed on pre-diabetes and to avoid sugar soda. She stated *"I love my soda. Sometimes I wean myself off and go two days without it. So I'm not really a sodaholic. But I love soda. If I can I would go through my drawers looking for a spare can, like an alcoholic looking for a bottle."* Anani stated that staff encouragement to avoid soda was helpful and stated: *"But then I can go without it if I put my mind to it I can do it. I hear stories (about diabetes) so I say okay I'm not going to do it and I just don't go store and I just drink a lot of water. And I've deal t with it. I've gone two or three months without it."*

Lana stated that she had time to think about her health and to discuss stress reduction and life balance with nurses and other staff. She stated she became more mindful *"about bringing my body and mind and spirit in harmony to one another, you know, just being all on the same level and not letting any one of them get any more out of control than the other. And just finding that balance for me is an everyday, is an everyday endeavor, because it's not an easy thing to do. Especially when you get so many things around you that distract you, other people's problems*

out there that you're working on every day, concerns that come up and, you know, and then you have to balance."

Bane stated that he had some information on panic attacks and how to control them. He stated that his hospital experience reminded him to avoid bad habits and said: *"They talked to me about not being healthy. Just running amuck… Just eating and not taking care of things that I'm supposed to take of. That kind of stuff. And as a Hawaiian, I know there's a lot of other things I can be doing instead of just staying away from the haole food."*

Jael, who has been hospitalized several times, stated that he had some helpful advice from his physician on his last hospitalization *"Just do what the doctor tells you. As a Native Hawaiian do what helps my health. That's what the doctor told me. Keep your sense of humor because it helps a lot. Because I always joke with my doctor."*

Anani stated that she began having urethral pain after her urinary catheter was painfully discontinued before she left the hospital. She grimaced as she said:

"That one I can remember, pulling out the catheter. I guess she was used to doing it. But to me, I didn't have a bladder infection, but up to now I have urethra pain. It has gone away, but like last month I had it about a week or more. But I try to drink cranberry juice which I have a hard time to drink. I have a hard time to drink that, I even tried to drink it with grape or apple." Anani was being seen in a physical therapy center twice a week but was unsure whether to call her primary care provider about her urinary symptoms. Anani stated would inform for primary care physician of the matter on her visit which was scheduled the following week of her interview for this study,

Kalei stated that she received little follow-up instructions on discharge. She stated she had informed the staff that she was having a lot of vaginal bleeding which was not decreasing. She stated: *"Can you imagine being so sore. I mean I literally had to call my primary care provider telling them I need some kind of pills to stop the bleeding. I had so much stress I had to change myself all time of the day."*

Caring environment: All participants patient describes experiences of what can be classified as the creation of a caring environment. As Tadashi expressed *"When you don't have care for the patient something's wrong…. The way I think, if you want to be a nurse you need to have it in you."* These caring attributes were described as Active Listening, Showing Empathy, and Providing Comfort. Often caring attributes were linked to concepts of genuineness, kindness, and sincerity

Active listening. Several participants noted the importance of staff to take a moment and sincerely make the patient perceive that they have been heard.

Delena described the focus of staff as sincere when they were listening *"Like they really genuinely care for you, like how you feel, you know, they're listening, like actively listening not just listening and writing down that's it, you know, not just getting the signs and symptoms or where it hurts, you know, genuinely caring."*

Palia tells of her experience post-orthopedic surgery when the physical therapists wanted her to walk. *"They were really nice with me. They didn't force me to go all the way down there and walk. If I could only stand up and take two steps and they were happy with that… And they listen to us. I mean you know. They listen. Like If I said okay and if it's their thing to get you up and get you over there and back here. I couldn't and she understood that I couldn't and they*

didn't force me. You know little by little they would come back and ask "you want to try again"? You think you're ready? I'm ready. And they ask you and they work with you."

Lana, recovering from a cardiac arrest and pacemaker insertion, described nurses as *"Strong, they have to listen to so many people who say help me. They showed me care and listened to me. They were sincere when they listened to my pain."*

On a negative note, Kalei stated that some of the staff *"weren't listening at all…It was like demand, demand, demand. The other kind (of staff) ask are you okay? I just didn't like it. I just don't know how to explain it."*

Showing Empathy: Several participants related the presence or lack of empathy or ability to understand what the participant was feeling or experiencing.

Delena noted that nurses need to be sincere despite professional boundaries. She forcibly stated: *"I feel that in nursing you have to genuinely care about the people that you're caring for not like, well there's a professional boundary I mean, but you actually have to care about how they're feeling. They (the nurses) took into account how I felt and all that."*

Palia related experiences of nurses who had cared for him on other units, stopping by to ask how he was doing and if he was sleeping they would leave *"little notes of kindness and encouragement, like it's OK, it's getting better, you doing good, they would do that."*

Kelei expressed that she had little support when she was going through labor. She appeared angry when she stated:

"Why not (staff) come to the patient and say "you know Kelei kind of relax, don't breathe so hard", try to see what I'm going through, something just to give reassurance to the patient

and the patient's family. Sympathy, you know what I mean sympathy seriously. One of the few things, that would have to be sincerity like, you know, not just put on a face, you know."

***Providing comfort*:** Many participants related experiences where nurses and other health professionals would inquire as to comfort needs of participants or anticipate those need unsolicited. Some participants related experiences of pain for which they sought pain relief.

Jael stated that he can distinguish between genuine and ingenuous caring *"When I say nice and caring, I can feel if it's real and not fake." Jael stated that nurses would check in and ask "Do you have enough blankets?... Is it cold in here?" "No I like it that way."*

Lana noted that staff would anticipate needs regularly. She stated: "I think they just took the time to, to care, to come in and check and take your vitals. I mean they were taking my vitals almost every time they came into the room and asking do you need anything do you need anything. And I'd say yes and then they'd get it come right back. And if I said no they'd say ok do you need the light turned down do you want the door open or closed, do you want the curtain open or closed. And then they'd leave and then they'd come back a few minutes later, they make sure the button was there if I needed anything, you know, if I needed the bed pan"

Anani related her post-operative experience where she was medicated for pain and provided with small caring acts to improve her comfort. She was tearful when she stated:

"Umm, when I first came out of surgery at midnight, they made me comfortable and because I was in a lot of pain all night they had nurses coming in and out. That was the great part. They made me feel like they would change me even though I was in a lot of pain….They would shampoo my hair and they would comb it and they would be so sweet. I was like, that was really excellent care…. I know there was this one nice nurse who would pamper me out. She

wash my hair. And she said I would really want you to take a shower. I told her I just had surgery and I don't think I can work that thing. She said "I'm not talking about that. Can I bathe you in your bed." She was so sweet she would put powder on me and wash my hair and comb it. She would say you should put some lipstick. She was so cute…. I really loved her. I wish I could have taken her home with me. Other than that, the other girls they just come in and say are you okay and off they went. I guess they just short of nurses."

Kalei expressed her experience of discomfort when she asked to hug a pillow while she was having an epidural during labor. *"I'm like grabbing for a pillow, getting comfortable, getting the epidural but the man that was doing the epidural refused to pass me the pillow because he doesn't normally do that". Kalei stated that the provider offered no explanation why she could not have the pillow and "I wanted to hug the pillow to relax and that they're (staff) there to help that they're there to give comfort that they're there to do whatever it takes, not to just stay on the side."*

Tadashi also reported a negative experience related to comfort when the nurse not only ignoring his need for pain, but actually being untruthful that he (the nurse) would contact the doctor. Tadashi relayed how he had climbed out to bed to see if the nurse was contacting the doctor and had to assert himself to obtain pain relief:

"*He (the nurse) didn't even go talk to the doctor. He went down the hall and talked to another nurses. He comes back. And I told him I know where you went I saw where you went. He tells me the doctor said I cannot give you anything. It wasn't the doctor's fault. Because he never went to talk to the doctor. And when he came back I told him "you know what, you go back and ask him again." And he did the same thing again. Three times I sent him back."*

When the doctor made rounds, Tadashi stated that he told the doctor was in pain. Tadashi then relayed his surprise when *"He (the nurse) looks and says "oh do you want a morphine shot?" Then I looked at him I could have gotten out of the bed and choke that nurse by his neck because he never talked to the doctor."*

The *Ohana:* The fourth major theme relates to the '*ohana'*, a term from the Hawaiian name for family, the *"ohana"* extends beyond immediate family to include the community itself) (Mokuau, 2011). Al participants conveyed strong expectations of Hilo Medical Center as a part of their extended home and family. In relation to this, as participants told their stories, many streamed in and out of talking about past experiences in the hospital as well as the experiences of their loved ones. Hence, the experience of hospitalization is intertwined with past experiences and family experiences. Subthemes of *'ohana'* were found to be Hospital as Community, Approach to Family, and Being Hawaiian.

Hospital as community*:* Most participants told of their expectations of the hospital as a welcoming place. Participants spoke of comparisons to previous hospitalizations, and how they expected to feel welcomed at Hilo Medical Center as part of their community. Many participants had complex conditions which required previous hospitalizations, and most participants had many years of ties to the Hlio area. One newcomer to the area had high anticipations for her birthing experiences on her move to Hilo. Hilo Medical Center is the only full service hospital on the eastern part of the Big Island.

Delena was one participant who had recently moved to the Hilo area. She had felt welcome in Hilo and had hoped for a more welcoming facility. She stated *"Yeah, it's kind of disappointing, you know, cause I just moved here, to Hilo, a year ago and everybody else (in*

Hilo) has been super cool and this was the ER, was like, you know, it's like adding on to like how I feel, you know.´

Jael, who has had many hospitalizations, appreciated that HMC staff remembered and acknowledged him warmly*"Some of them remembered me from the last time. I think I'm a pretty good patient. I don't bother them for nothing. They like me…. But there's a couple of them who come by my room and they wave like this. They call me uncle. They yell "eh uncle!"*

Lana spoke of the how staff introduced themselves when they came on shift, and encouraged her to review the white board on the wall in her room. The board outlined physicians, registered nurses, and certified nursing assistants who were assigned to Lana every shift*"And there was a board, right straight ahead on the wall that had their first name and it would say "RN" and then the first name of the CNA. So, I would know…. So I knew, I knew their first names. Yeah. Everything was all by first name. Sometimes there were two RNs in there, and usually just one CNA, but once I had two RNs, I was like…wow "*

Lana also spoke about the friendly family atmosphere at HMC, *"Where they come and they ask about you, "Is that your family?" you know, "Is that your daughter? Your husband?" cause they're visiting. And then they go, "Hello," you know, "I'm gonna be her nurse today." And very friendly, just like, just like at home."*

Palia told of how HMC is connected to her outpatient care at the HMC residency clinic," *Even when I came in, I walked in the door they knew who I was already and they took me right into the back…Because I go to that Hilo what is that by the urgent care, it's part of Hilo Medical Center. That family health thing. That's my doctors over there."*

Mele, who had mixed positive and negative experiences at HMC, identidies one positive aspect as being the connection that some staff tried to forge with her. She had a wide smile when she stated*:*

"My experience is their care, I mean the doctors, the nurses the CNA's (certified nursing assistants) even the ones that come to clean, they're part of the hospital they welcome you, they say good morning, how are you, oh you lucky you have good lunch. They make a comment or start a conversation. They make you feel special or they make you feel welcome. Not just walk in and walk out you know. Anyone in the medical field, any department, you're intertwined with the medical center. To me you are part of them. It makes a difference in how you treat, how you react and how you talk to your patients."

Approach to Family*:* Many participants spoke of how staff treated and communicated with their family members during their hospitalization as well as during past hospitalizations of their family member.

Anani noted that her husband was reassured while she was in surgery. She related: *"Then I went to surgery… I probably went to sleep. I do remember a couple of nurses holding my hand and they told my husband they'll take care of me. They approached him (husband) the same way they approached me. They spoke to him as much as they spoke to me."*

Nelei found the approach to her family who was visiting as *"very frustrating. Everybody that came to my bed was sitting on that same chair. Can you move that chair someplace else I don't want anybody sitting there already? My family cannot sit there, why are you telling my husband to get on the side so you can sit there?"*

Mele relayed how her husband was treated in the emergency department, *"For me, from the ER nurses they took a while to even answer my husband's questions. They tried to make us as comfortable as they could because they didn't know what was going on. So that's understandable. And they asked my husband if he was okay, if he needed anything and stuff like that and me as well."*

However, on the medical unit, when she was shaking from a high fever and having a mild heart attack Mele remembered thinking *"She's (nurse) not acknowledging my husband at all. You know that really pissed him off." If she had just said Mr. -----we're trying to contact the doctor to see what we can do for your wife, the patient. If she had done that, and that's the only glitch that I had. If she had done that, addressed the patient's family member, to say I'm trying to contact the doctor, he's not responding, I cannot do nothing right now because we don't know what's going on, I don't want to take her out of here if he's on the floor. I mean whatever it is versus no response, because it was like there is a wall here and she's in her own little world and he's (her husband) still yelling at the wall!"*

Another change occurred when Mele was transferred to the intensive care unit (ICU) she spoke of how her husband was treated with respect, *" Because of the fact that only did they made myself comfortable, but they treated my husband just as good as me. He wasn't a patient, but they would ask if he was thirsty, if he needed something eat, if he needed to go to the bathroom just let me know and I will come and sit with her. They were really really good about just being a comfort to my husband and myself. They asked my husband if he needed a blanket, or if that chair would be good for him because he spent the night with me in ICU. So they asked is that chair going to be good for you, and he said yeah, but if not we have that one right there,*

and he said no. One of the nurses, and she is a woman, it was a big chair and she grabbed it and put it next to my bed for my husband."

Anani conveyed the experience of her nephew, who passed away a few years ago at Hilo Medical Center. Anani tearfully relayed: *"After an hour and a half that was enough we had to let him go. But they were really sad. I could see that it hurt them that they lost somebody. They really care. They really do care. Not like you're in a meat factory or they're just doing their job."*

Nalu, while speaking of his own pain, told of care and concern of the nurses who cared for his daughter who was hospitalized for severe asthma several years before, and said: *" And they (staff) break their backs to help when your child can't breathe. They do their best."*

Being Hawaiian*:* Some participants spoke of their hospital experience in relation to being Hawaiian. Many spoke about special communication between Hawaiians and the need for more local or Hawaiian staff.

Bane, who was experiencing a panic attack stated he had difficulty communicating. He stated he was concerned about what care he would receive due to his many previous hospitalizations and his native Hawaiian background. He related: *"I felt like being a Hawaiian and being into a lot of things, I thought it was good care."* He stated that staff *"Made me comfortable as a Hawaiian."*

Jael stated he was pleased when staff was Hawaiian. He smiled as he stated: *"When I went to the hospital I had a Hawaiian doctor and she introduced herself. She said her name was Dr. H-. I felt special because I had a Hawaiian doctor…. When I went down for CAT scan there was a Hawaiian girl there. There was another Hawaiian lady who came there. I looked at*

them there and I had to say something, you folks make me feel good because they were Hawaiians and we were joking around. I like to see Hawaiians working instead of seeing those traveling nurses." Jael also expressed his concern that more hospital staff were not Hawaiian or local. He emphatically stated: *"If you feel nurses are educated here and not travel nurses they would know better idea how to care for you as a patient….. Even if they're just local people, be local haoles, Japanese, whatever. Just a local person. You feel more comfortable with a local person."*

Anani states that the food menu has become more responsive of a Hawaiian diet. She laughed as she said , *" I always request poi. One thing I love in the hospital is I get poi. ..One night I had stew and poi. I said ah, stew and poi. The stew was pretty good. I was thrilled, ah stew and poi (laughing)."*

Response to Press Ganey Patient Satisfaction Survey

At the completion of their interview, participanst were shown a copy of the the Press Ganey Patient Satisfaction Survey as Administered at Hilo Medical form (appendix A). Initially, the PI had planned to facilitate a semi-structured interview style asused with the interviews on patient satisfaction/dissatisfaction. However, what may be called an iron wall appeared between the PI and all participants at this point, and the participants responded to the survey form in monosyllables. This was a distinct change from participants' responses to the more fluid open-ended interview format. Therefore, to keep participants engaged, a more structured, though somewhat limited, set of questions was used. This set of questions addressed: 1) if participants had seen the survey before and if so, had they completed the form , and 2) if participants thought such a questionaire was a good thing or no. Responses showed that five (n=5) participants stated

they had completed the form. Two (n=2) stated they did not complete the form . Three participants (n=3) stated they did not know or could not remember completing the form. All participants (N=10) thought that a patient satisfaction survey was a good thing. See Figure 12.

Figure 12: Results of Response to the Press Ganey Survey

Question	N=10 Yes	N=10 No	N=10 Do not know or cannot remember
Do you remember completing this survey?	n=5	n=2	n=3
Do you think a survey like this is a good thing or no?	Yes n=10	No N=0	Do not know n=0

Follow-up Confirmation of Themes

Participants were contacted after initial thematic analysis was completed. Three (n=3) participants agreed to meet as a focus group. However, because of family issues and severe weather conditions, only one participant (n=1) was able to attend the focus group. This one participant (n=1) was interviewed alone. The remaining two participants (n=2) agreed to be interviewed via phone. Participants were shown or described the themes and subthemes identified in the study's analysis, and asked if they were important or resonated with them. All participants (N=3) stated that all subthemes were important and resonated with their experience as a Native Hawaiian. Figure 13 shows the results of the follow-up confirmation of themes.

Paradigm Case in Relation to Conceptual Orientation

The conceptual orientation for this study draws from hermeneutic phenomenological philosophy as introduced by Husserl and further developed by Heidegger and Merleua-Ponty (Moran, 2000). This conceptual approach can help to describe the experiences of health and non-health within the world-view of the Native Hawaiian. Heidegger developed the concept of Dasein as the situated "meaning of being in the lived world," or how the person exists, acts, or is involved in the day-to-day world (van Manen, 1997). Nalu, one participant in this study, relayed

Figure 13: Results of Follow-up Confirmation of Themes

Themes	Sub-Themes	N=3 Important/ Resonates	N=3 Not Important/Does not Resonate	N=3 Do Not Know
Expectations of Professional Behavior	Attentiveness	n=3	n=0	n=0
	Commitment to Role	n=3	n=0	n=0
	Response	n=3	n=0	n=0
	Skill	n=3	n=0	n=0
The Caring Environment	Active Listening	n=3	n=0	n=0
	Showing Empathy	n=3	n=0	n=0
	Providing Comfort	n=3	n=0	n=0
Patient-Centered Care	Explaining Things	n=3	n=0	n=0
	Respect of Person	n=3	n=0	n=0
	Encouraging Self-Care	n=3	n=0	n=0
The Ohana	Hospital as Community	n=3	n=0	n=0
	Approach to Family	n=3	n=0	n=0
	Being Hawaiian	n=3	n=0	n=0

his hospital experience which will be an exemplar for the Dasein. Nalu was concerned and "cared" about his own existence. Nalu was also concerned with the specific local or concrete level day-to-day living and also concerned with deep structures underlying existence (Gadamer, 2007). While in the hospital he experienced cardiac arrest. Nalu is a being who experienced illness and was able to relate the story of his experience, which he stated was life changing for him.

The Native Hawaiian experiences aspects of existence as temporality, spatiality, and corporality. The Native Hawaiian experiences temporality or lived time is more than a linear process, but a connectedness. The Native Hawaiian is a cultural-historical being, "rooted" in the Hawaiian historical and ancestral pat that is shared others. Nalu was a VietNam combat veteran. He had worked as a mail courier until a motorcycle accident. He had been a caregiver to his wife for many years before she died from cancer.. He carried a lock of his wife's hair in a locket around his neck. He states his wife *"was a swimmer, she was a mermaid her ashes are in a bay here, but I will not tell you which one."*

The Native Hawaiian moves back and forth in time from present illness, to past illness experiences of as well as to those past illness experiences of his or her family members. Nalu spoke of the care the nurses at HMC had provided for his asthmatic daughter he stated with much emotion, "*You guys (nurses) get more pain than just the physical part. My daughter was an asthmatic and oh, try to breathe for you child and you can't… the nurse came, soothed my daughter, trying to take away her (daughter's pain) when I couldn't…she (the nurse) then put a hand on my shoulder and took away my pain."* Nalu also spoke of the care and concern he saw

form nurses caring for the wounded in the VietNam War who Nalu stated were *"under such stress, they do what they have to do, if they don't crack up, or jump out the window."* Nalu also spoke of his mother who worked as a scrub nurse for 20 years. He looked proud as he stated: "She *(his mother) brought home magazines of surgeries and stuff. I was pretty fascinated with her stories too. We (his family) all were."* Nalu was "thrown" into a present existence where he picked up the past and tales hold of the future with all its obstacles and possibilities. This journey required engagement as a unique individual with a unique personal world, yet was always entwined along with family and others in the community.

Nalu experienced spatiality which relates to his situation or "being in the world. This being in the world required his engagement with the environment and sharing objects such as food, clothing, music, living space. Nalu had several Hawaiian inspired tattoos on his body. Nalu identified himself as Part-Hawaiian and sang one Hawaiian song and one Portuguese song during his interview. Nalu's complex cultural and social world was always bound up in spatiality with other Native Hawaiian traditions of a unique cultural-historical past along with evolving Hawaiian language, traditions, and ethnic ties. Nalu stated that though he had traveled throughout the world as a sailor, he always came back to Hawaii and *stated "When you return, Hawaii will nurture you here and grow you anew."* At the same time, Nalu was submerged into a greater multiethnic cultural and social world. Here the blending of western medicine and Hawaiian tradition intersect. Nalu had to navigate through, blend with, and /or have conflict with a highly fluctuating and often unpredictable health care system. He stated that prior to this admission to HMC; he was rebellious and did not want to follow his Veterans Medical Clinic medical regimen. He stated vascular surgery was planned by surgeon at HMC, but he had put it off because of being *"sick of being stuck with tubes, so I said hey, wait a while."* He stated

however, that when he began to have symptoms of dizziness and pain *"I knew where to go; that they (the hospital) would take me and know what was happening to me"*

.A third component of hermeneutic phenomenology is corporality or lived-body. Rather than reflecting the Cartesian mind-body dualism, the corporal body of Dasein is integrated within the lived context of time and environment. For Nalu, being is not only embodied as a multidimensional vulnerable physical body, but as a psychological and spiritual being with ties to the cosmos. Nalu stated that in the intensive care unit he *"died*" for one minute during a cardiac arrest and that *"I saw the light, I saw the light…Then I work up, here I was the old man, laying here with all these tubes and all, and pain".* Nalo stated that he experienced a kind of rebirth which he conveyed to the nurses. Nalu stated*" they (nurses) thought it was wonderful, they listened, the nurses listened, as crazy as I might have sounded, they did hear me."* Healing and illness do not take place only in the physical body, but within the lived-body within the context of its environment. For the Native Hawaiian, health is found in the harmony of the *"lokahi*", or harmonious balance among the *"ohana"*, or family, 2) the *"aina"* or caring for the land and waters, and 3) the *"akua"* or spiritual realm.

A fourth component of hermeneutic phenomenology is relationality or lived human relation. During 'Falleness" the Dasein drops into involvement in a world of other entities, and travels alongside others. The Dasein seeks a wider context or frame of reference is what Heidegger calls "meaningfulness". Meaningfulness is established as an orientation for the perception, recall, thinking, about, and attending to of the self as part of and within interrelated systems. The Native Hawaiian as Dasein falls into illness and hospitalization and establishes an orientation through perception, recall, thinking about, or attending to the experience. Meaning is formed through relationship. Hence, the Native Hawaiian as patient frames the meaning of his

experience though the relationship with nurses, other healthcare professionals, hospital staff, and other patients. Nalu related his perception of these relationships: *"The doctor's job is to saw you up* (as with a surgeon's saw) *and stitch you up. When you are in pain or in a bad place, this is where the nurse picks you up, heals your heart."* The Native Hawaiian frames his relationship according to *aloha. Aloha* is identified through the expectation of professional behavior, patient-centered care, creation of a caring environment, and provision of welcoming community. The ability to actualize positive *ola pono* or good health depends on the Native Hawaiian's ability to participate in his own health care. Nalu relates story of an incident that occurred during his hospital discharge and had a strong impact on him. He relates: *" The nurse came in , she had been with me since I was admitted and had had been with me since…she leaned over the bed, put a hand on me and said" you take your medication, I like you, we all like you, but I don't want to see you again, not in this condition, OK? …If you feel tired: you breathe deep, you have a good heart, your veins are not so good, so you keep exercising, but eat better. She remembered me. She called me by my name."*

The hermeneutic philosophy was used as the philosophical foundation for this study. This philosophical approach shows the Native Hawaiian and his or her world as connected and not detached.The Native Hawaiian patient is actively immersed in the world of his hospital experience an each part of that experience, including patient satisfaction or dissatisfaction reflects the wholeness of the and experience as a Native Hawaiian appropriate for the Native Hawaiian experience of illness.

Therefore, the Native Hawaiian's understanding of being is the understanding of the being as related to other entities. The person and the world are "co-constituted" as a connected unit and not detached (Koch, 1996). As "Dasein" each native Hawaiian human being is a unique

entity actively immersed within the wholeness of world and every part of being is in itself a reflection of that wholeness. As Nalu expressed of his experience*: "Even in this small space (the hospital) they (the nurses) shut out all the world for a short time, and bring you to their care… and then you heal… and then you go."*

Summary

This study focused on capturing the hospital experiences of hospitalization as perceived by Native Hawaiians related to patient satisfaction/dissatisfaction. In accordance with the hermeneutic phenomenological process, the experiences of patient/dissatisfaction were explored from the perspective of Native Hawaiians in their own words. The phenomenological experience of hospitalized Native Hawaiians, as well as many cultural and ethnic groups has not been well researched. Moreover, the concept of patient satisfaction has not been well defined and is shown to be a contextually-dependent and multidimensional phenomenon. Therefore, this study has explored the relationship of each unique participant with the hospital experience within the context of their lived lives. This exploration then generates deeper understanding of the meaning of the experience. These experiences have been grouped into themes and sub-themes to provide a contextual and multidimensional picture of patient satisfaction/dissatisfaction through the voices of Native Hawaiians.

Analysis of the descriptive textual data provided by Native Hawaiian participants revealed four primary themes: Expectations of Professional Behavior, The Caring Environment, Patient-Centered Care, and the Ohana. These four themes represent the foundation of the hospital experience related to patient satisfaction/dissatisfaction. These themes emerged from the descriptive narratives of participants who identified them as important to their hospital

experience. Therefore, in the hermeneutic phenomenological tradition, this analysis provides both a holistic and unique view of the phenomenon of patient satisfaction/dissatisfaction.

Chapter Five

Discussion and Conclusion

Introduction

This study focused on the experience of Native Hawaiians in terms of satisfaction/dissatisfaction with nursing care. A comprehensive literature review was also completed. This chapter includes a discussion of the results of the study of patient satisfaction. The interpretive data analysis supports prior literature and broadens the understanding of patient satisfaction/dissatisfaction as perceived by Native Hawaiians. A brief discussion of the health care and the social-political environments which influenced this study is included. This chapter concludes with nursing implications, limitations of the study, implications for nursing, and suggestions for future research.

Results in Relation to Review of the Literature

The review of the literature for this study included research on: 1) patient satisfaction as an outcome of quality, 2) concern regarding patient satisfaction surveys, 3) using patient satisfaction data, and 4) patient satisfaction as a focus for research. The following is an interpretation of the study's results in relationship to the review of literature.

Patient satisfaction as an outcome of quality. In order to ensure high quality and safe patient care, prepare for accreditation, and adhere to evidence-based practice guidelines, facilities use self-reported patient satisfaction/dissatisfaction data as indicators to reflect patient the quality

of patient care. The literature linked satisfaction/dissatisfaction outcomes to: 1) choosing a provider, 2) using health care services, 3) initiating negligence and malpractice litigation (Ware, et al 1978), and 4) adherence to medical regimen (Weisman and Koch, 1989). Results in the study only partially supported these outcomes of satisfaction/dissatisfaction experience and study participants indicated no intention of not using the same facilities or providers or lack of adherence to treatment regime. Results showed that: 1) study participants preferred certain characteristics of a provider, including whether provider is local or Native Hawaiian, 2) health care providers and facilities on the Big Island are limited, and 3) most participants had limited resources which prevented them from seeking care off- island. One participant filed a complaint regarding an emotional ordeal experienced during hospitalization. It is interesting to note that the lack of providing explanation, lack of empathy, and lack of respect for the participant's family member were all reported as very important to participants. In one situation, the nurse's poor response to both participant and spouse led to the decision of the participant and spouse to submit a formal complaint to the hospital. This was the one formal complaint reported by any participant in the study.

Three of the four major themes that emerged from the study concurred with components of high patient satisfaction as described in the literature by Peterson (1998). These themes included: 1) expectation of professional behavior in their response and skill, 2) creating a caring environment, through active listening and providing comfort, and 3) providing patient-centered care through explaining things and encouraging self-care.

Major themes found in this study concurred with components of patient dissatisfaction in a review of the literature as identified by Spitzer (1988) regarding components of patient dissatisfaction. Concurrent themes include: 1) professional behavior that did not meet

expectations through lack of attentiveness to the patient, 2) lack of creating a caring environment through not showing empathy, and 3) lack of patient centered care through experiences that dehumanized the participant, showed lack of respect for the person, discounted patient participation of his or her care, and showed a lack of explanation of progress or procedures by the staff.

This study supported the literature regarding the subjective multidimensional nature of outcomes of patient/dissatisfaction as proposed by Donabedian (2002). Study participants expressed gratitude in being able to 'talk story" about their experiences in their own words. The open-ended interview format allowed participants to discuss what they perceived to be important as to the psychological, physiological, psychological and sociological consequences of their experiences, healthcare in various acute care settings, and in various aspects of their personal care.

This study supported the literature that various methods can be utilized to measuring patient satisfaction (Peterson, 1998). This study utilized an open interview format in this format wherein the participants spoke freely about their experiences, describing experiences of both patient satisfaction and dissatisfaction. At completion of the open-ended interview, participants were also asked to view the Press Ganey Satisfaction Survey form. At this point, the conversation between the participant and the interviewer became less open. In that all participants showed the ability to read, other considerations such as interruption in the flow of the interview were attributed to this change. The literature also suggests that visits by non-healthcare staff and utilization of focus groups provide a means for gather patient satisfaction/dissatisfaction data (Peterson, 1998). This study did not concur with these suggestions. Indeed, several participants described that patient care presentative at Hilo Medical

Center intruded on their personal space. For this survey, it was difficult to arrange for focus groups due to personal and family difficulties and some concern about speaking in front of and sharing information with another person.

This study included a short inquiry regarding patient response to the Press Ganey Patient Satisfaction Survey shown to participants at the conclusion of the main interview. Up to one month following discharge, participants had been mailed the survey tool to their home. This study showed data indicating that only five (n=5; N=10) respondents remembered completing the survey, while two (n=2; N=10) remembered the survey and that they did not complete the survey, and three (n=3; N=10) did not remember completing the survey form. This finding supports the literature describing that delay time from the time of discharge to the time of a discharged patient receiving patient satisfaction survey may result in a low participant response rate.

Concerns with patient satisfaction surveys: This study supports the literature regarding concerns with standard patient satisfaction surveys. These concerns include lack of definition of the phenomenon, lack of reliability and validity in patient satisfaction studies, difficulty eliciting the meaning of the phenomenon from participants, in ability to identify and utilize specific strengths, improvements, or problems for root cause analysis in a health system, and in the ability to capture the complexity of the patient satisfaction/dissatisfaction phenomenon.

Firstly, the literature suggests that the concept of patient satisfaction is not well defined. This study supported the literature that the concept of patient satisfaction contains distinct phenomenon (Bjertnaes, Sjetne, and Iversen, 2012; Uhlmann, Innui, and Carter, 1984). Themes emerging from this study included distinct phenomenon such as patient expectations, patient

preferences, and patient experiences. This study also reached beyond the marketing and psychology orientation of customer satisfaction which Espiridao and Trad (2006) found to limit understanding of the concept. The study instead attempted to encompass the unique healthcare phenomena of caring, showing empathy, providing comfort, and encouraging self-care.

Secondly, the literature has shown lack of evidence in reliability and validity in patient satisfaction studies (Sitzia, 1999) as well as lack of consideration of time frame in distributing the surveys (Weissman et al, 2010). In response to these concerns, this study utilized a phenomenological research method which applied criteria of rigor proposed by Witt and Ploeg (2006). The criteria included: 1) balanced integration of the philosophical themes of phenomenology, 2) openness of showing findings of the analytic file and other files, 3) concreteness of highlighting exemplar from data which reflect the historical and cultural lifeworld experience (van Manen, 1997), 4) resonance which conveys depth of expression and richness of phenomenon, and 5) actualization as proposals for continuation of the interpretation after this study ends. As to consideration of the time frame, participants were screened for hospitalization less than 6 months prior to the interview date. The study did not support the literature's suggestion that there is a lack of participant recall in retrospective studies (Barr and Vergun, 2000). Indeed, participants were able to describe their patient experiences vividly and put them into expressive language.

Thirdly, this study supports the literature that patient surveys alone cannot elicit the meaning of the patient experience. The hermeneutic phenomenology method of this study provided rich description through the patient's own words. This window into participants' experiences could not be procured from a simple survey.

Fourthly, this study supports the literature that unlike patient satisfaction surveys, phenomenological methods yield not merely patient satisfaction /dissatisfaction tendencies, but uncover the root cause of underlying strengths and problems within a healthcare system. In this study, many strengths and problems were uncovered from the dialogue of participants as to what appeared to be very unsafe and unethical situations.

Lastly, the literature shows inconsistent interpretation and utilization of data form surveys (Cleary, 2003). This study supports the literature in that the phenomenological method was able to capture the complexity of the service provision and patient experiences better than a simple survey would have gleaned (Williams, Coyle, and Healy, 1998). Direct dialogue with participants during the interviews uncovered very specific concerns important to each participant. These concerns include their perceptions of traveling nurses, issues with pain control, and violations of patient or family dignity. In addition, patient utilization and perceptions of new interventions of communication were identified, such as placement of the information white boards in each patient's room.

Using patient satisfaction data: A major goal of the process of obtaining data regarding patient satisfaction/dissatisfaction is to utilize the feedback effectively in a healthcare systems design. Results of the study will be shared with providers, nurses, and administrators at Hilo Medical Center. Most importantly, results and dissemination of the study will be shared with participants who will be informed that their voices have been heard. This study supports the literature regarding the importance of providing data which can be used to: 1) follow-up on existing patient satisfaction data, 2) examine patterns of negative or positive patient satisfaction outcomes, and 3) address cultural and social determinants of health (Fratalli, 1991).The open

narratives of the participants in this study provide rich context- specific data which can augment existing patient satisfaction tools and surveys (Williams, Coyle, and Healy , 1998).

Patient satisfaction as a focus of research. This study supported many themes that have emerged from quantitative, qualitative, and mixed-method research of patient satisfaction/dissatisfaction. The study also provides new knowledge from the thematic analysis.

Qualitative analysis. This study supported findings of patient satisfaction/dissatisfaction found in the literature and grounded in participant voices, values, and experiences. The participants' narratives provided information regarding importance of patient participation and in self-care (Avis, 1997). The study also identified themes that concur with the literature which include quality and non-quality participant experiences regarding the importance of: 1) eliciting and meeting participant's expectations of professional behavior such as response to special needs, (Rosenblum et al, 2011; DePalma, 2000), and 2) creating a caring environment for individualize care, and 3) providing patient centered care involving good communication in explaining things (De Palma, 2000).

Quantitative approach with ethnic focus: The results of the study were mixed as to supporting domains of high level healthcare proposed by Anderson et al (2007). Results of this study supported themes of positive patient satisfaction such as patient-centered care through explaining things and attentive listening, expectations of provider behavior such as skill behavior, and creating a caring environment though active listening and communication, However, participant conversations did not focus on quality measures and processes such as access and barriers to facilities or providers. Study results did support themes of cultural sensitivity as proposed by Bialor et al (1999) in participants who identified acknowledgment of

their Hawaiian heritage and culture as important. Only one participant discussed experiences regarding the honesty of the provider as identified as a theme by Eriksson and Svedlund (2007).

The study did support the literature regarding mixed-method approach of Ka'opua (2008) who utilized a "talk story" approach to ethnic-focused research. This study concurred with themes of *kakou* (we or us) or orientation to family as participants noted the importance of how the healthcare system approached and included their family members.

Predictors of patient satisfaction. This study supported the claim that attention to needs as the most powerful predictor of patient satisfaction as proposed by Jackson et al (2001). This study identified the theme of attentiveness of nurses and other staff as the most frequently reported theme. This study did not support themes of insurance and co-payments, loss of time from work, perceived health ratings, or age as reported areas of patient satisfaction or dissatisfaction as proposed by Akinci and Sinay (2003).

This study did not explore patient personality dimensions, (Hendriks et al, 2006), health care facility accreditation scores (Heuer, 2004), or higher satisfaction with nursing care versus physician care (Jaipaul and Rosenthal, 2003). The study did support predictors of patient satisfaction/dissatisfaction with such nursing factors as providing a comfortable physical environment, providing information, interpersonal relations between nurse and patient such as empathy, staff skill, and influence of the healthcare organization of both nurse and patient as regards staffing (Johansson et al, 2002).

Phenomenological studies of Native Hawaiian related to patient satisfaction. Phenomenological studies focusing on both Native Hawaiians and patient satisfaction are scarce

in the literature. However, because of the nature of qualitative research, most of the study results support the phenomenological literature.

It is interesting to note that some themes found in the qualitative literature were rarely identified by participants in this study. Study participants only lightly discussed topics such as waiting time in the emergency department, access the healthcare issues, health care insurance, concerns about billing, and concerns about follow up. Statements regarding waiting time was acknowledged as either understandable, due to understaffing, or perceived as sufficient time to wait in regards to the condition. Most participants were confident in feeling that Hilo Medical Center and staff were available All participants stated they had some type of medical insurance, which may account for themes regarding billing as appearing less frequently in this study's narratives. Another reason for lack of these topics in participants' interviews is that many qualitative studies utilize semi-structured interviews and therefore, the major themes for discussion have been predetermined by the primary investigator. Therefore, the themes chosen for inclusion may have been of concern to those designing the interview questions rather than what may have been of primary importance to participants.

Some phenomenological studies in the literature found that attention to cultural background, health beliefs, preferred health practices of participants improved patient satisfaction (Lassetter et al, 2012; Kaholokula et al, 2008).This study supports the literature through the identified theme of Being Hawaiian. This theme was reflected in some participants' preference for Native Hawaiian or local hospital staff. While only two participants in this study spoke of the political and economic aspects of being Hawaiian, several participants were pleased when staff acknowledged them as Hawaiian, and were pleased when Hawaiian staff would speak or joke with them in Hawaiian Pidgin or acknowledged them as Hawaiian. Some participants

expressed the need to finish meals and the joy of receiving Native Hawaiian food such as poi. This reflects the Native Hawaiian association of food with caring, nurturing, and health (Goodyear-Kaʻopua et al, 2008). As participant, Nalu stated *"See me as Hawaiian, a person who grows here* (Hawaii)."

One result which is new to the literature is the theme of the *ohana* as important to patient satisfaction/dissatisfaction. The *ohana* reflects the core value of family of the Native Hawaiian. Participants expressed great concern over the approach of staff at Hilo Medical Center to their family members. The same expectations of explaining things, respect of person attentiveness, providing comfort, and active listening were participant's expectations of how they and their family members should be treated by staff.

As a value in itself the *ohana* also extends into a larger community context implying commitment and emphasizing the collective (Mokuau, 2011). In this study were all were vested in telling their stories of their hospital experiences as vested members of the community in which the hospital resided. Furthermore, Hilo Medical Center was described by participants to be an integral extension of their extended community family and a part of participants' past, present, and future discourse regarding their lives on the Big Island. Participants shared their past experiences at the facility and shared stories of family members and friends who were cared for at Hilo Medical Center. Thus, participants' experiences were influenced by the holistic family context of their lives which extended into their relationships within the broader community (McCubbin and Marsella, 2009).

Results in Relation to the Socio-Political Context.

The values of Native Hawaiians are intertwined with relationships. Important relationships are the *ohana* (family), *aloha* (love, affection), and the ʻ*aina* (oceans and land). This study was influenced by a series of events that reflected the intense relationship that Native Hawaiians have with their *ʻaina* with the *ʻakua* (god or spiritual realm). In the spring of 2015 the Hawaiian sovereignty movement and numerous Native Hawaiian groups and other activists launched several protests to prevent the delivery an instillation of the Thirty Meter Telescope on the summit of Mauna Kea the largest mountain on the Hawaiian island chain. The University of Hawaii at Hilo Astronomy Center has been one of the major supporters and funders of the Thirty Meter telescope. The protests received local, state, and national media coverage addressing both sides of the controversy (Knapp, 2015). Mauna Kea, which is located near and can be seen from Hilo, is considered a sacred place in Hawaiian culture and is known as "Wao Akua" or the realm of the gods. This spot, an ancient burial site, is where it is said that, Wākea the Sky Father met the Earth Mother *Papahānaumoku* and created the Hawaiian island chain. The summit's volcanic crater thought to be *"piko",* the umbilical cord connecting the world to *Wākea.*

During the early stages of data collection, this PI received many referrals from the Hilo Medical Center's Patient Care Representatives (PCRs). However, coinciding with the media attention regarding the thirty meter telescope, the PCRs began to receive inquiries from potential participants regarding the intent of the PCRs in asking about their ethnicity to participate in this study. PCRs stated that many potential participants began to not accept the informational flyer about the study.

This PI then reached out to local Hawaiian community groups to display and convey information about the study and that it was not connected with Uh Hilo or the telescope and was interested in hearing Native Hawaiian share their experiences to improve patient care. This

strategy was highly successful. On first contact, many potential participants stated they were Native Hawaiian and desired to be a part of study so that their stories could he heard. In this study only three participants agreed to meet at the U.H. Hilo library for their interviews, and only after the PI stated that the Hawaiian Studies room at the library would be used for the site of the interview. The remainder of participants agreed to meet at the Hilo Public Library, a place they were familiar with and felt comfortable in. Both libraries were within the city of Hilo and a short distance to one another.

It is unknown how many potential participants were influenced not to participate because of association of the study with the University of Hawaii, even though this study originated from the University of Hawaii at Manoa. All participants stated positive motivation about sharing their patient experiences as Native Hawaiians to improve nursing care at Hilo Medical Center

Native Hawaiians are firmly rooted in their past, which often shapes their perceptions of their present and future lives as Hawaiians living in a diverse and changing social and political environment. All participants had asked the PI if she had heard about the protests on Mauna Kea either at first contact or before or after the interview. Because of the sensitivity of the issue, This PI chose not to inquire if the protests had influenced participants' decisions to participate in the study. An opportunity may have been missed, but what became evident to the PI was the importance of the protest and its connection to themselves and their community as Native Hawaiians.

Limitations

Several limitations were identified:

- The study focused on Native Hawaiians who had experiences as patients at Hilo Medical Center and therefore, cannot be generalized to patients who had been hospitalized elsewhere.
- The study focused on adult patients who were admitted to the emergency room and /or acute care units, and does not provide information on experiences in skilled care, mental health, or long term care units.
- The study was not able to bring together a focus group to review thematic results and follow-up phone calls lacked the dynamic interaction of a focus group.
- The study was a qualitative study and therefore, had a small sample size (N=10).
- The study included participants who stated they had private insurance, U.S. Veterans insurance or Medicare-associated plans. Therefore, this study did not provide information about experiences with uninsured Native Hawaiians.
- The study focus was the participant's experience of patient satisfaction/dissatisfaction in their own words through a flowing narrative. Therefore, only limited information about perceptions of the Press Ganey Satisfaction Survey was gathered.
- Most participants had been hospitalized previously to the admission focused on during the interview. Most participants indicated they were able to recognize a registered nurse from a nursing assistant or other health care provider. However, some references to "nurses" may indicate personnel who were not registered nurses
- Participants knew that the study focused on patient satisfaction/dissatisfaction, which could have resulted in responder bias.
- On initial contact with participants, the PI requested that participants self-identify as part-Native Hawaiian and state they were hospitalized on an acute unit at Hilo Medical Center

within the last six months according to the study criteria. No other documentation of identity was requested and the PI relied on the narrative to determine adherence to the inclusion criteria.

Implications for Nursing and Healthcare

- The study identified four major themes as important to patient satisfaction/dissatisfaction: 1) expectations of professional behavior, 2) the caring environment, 3) patient-centered care, and 4) a theme identified in this study as the *ohana* of the hospital experience. These findings can be used to further define and refine the concept of patient satisfaction/dissatisfaction.

- The study described specific situations and contexts in which patient satisfaction/dissatisfaction was experienced. This study will be shared with staff, administrators, and board members of Hilo Medical Center to convey the very personal hospital experiences as lived by participants. Findings can support positive aspects of care as well as identify needed changes to patient improve care. In addition, findings from this study can augment less descriptive patient satisfaction surveys used by Hilo Medical Center.

- An essential component of patient-centered care is patient involvement in their health care planning. The study allowed Native Hawaiians to be part the process of improving their local hospital which they perceived to be a part of their extended community or *ohana.* All participants will receive a copy of the results, which acknowledges their contribution to healthcare improvement in their community.

- The study focused on the Native Hawaiian experience. The stories expressed by participants will be shared with nurses, nurse educators, and other health care professionals to enhance awareness of patient perceptions of aspects of satisfaction/dissatisfaction identified as important to Native Hawaiians. It is hoped that this knowledge will enhance culturally competent care.

- The study indicated the need for more Native Hawaiian and health professionals. Results of this study can support state and local initiatives striving to enhance the Native Hawaiian healthcare workforce (Levasseur & Qureshi, 2015)

- Results of the study showed the strong ties of Native Hawaiians with their community. Therefore, Hilo Medical Center may reach out to members of the Native Hawaiian community to plan volunteer opportunities involving Native Hawaiians and provide service activities focused on the health of Native Hawaiians.

Suggestions for Future Studies

• Results of the study provide preliminary work in eliciting from Native Hawaiians their perceptions of what they hold to be important in their care in acute care units at one particular facility of one healthcare system located on the Big Island of Hawaii. Further studies can be expanded to include other types of units in both acute and non-acute facilities, primary care settings, adult day care, and home care settings in other healthcare systems on the Big Island and on other Hawaiian islands.

- Results of the study identify specific contextual areas of care as perceived by each participant as satisfaction/dissatisfaction as perceived by native Hawaiians. Future studies can evaluate the use of data from such studies and the impact on improving cultural competency of healthcare staff and enhancing the patient healthcare experience

- Results of the study provide contextual data regarding a unique ethnic group of Native Hawaiians. Future studies can include Native Hawaiians in a community based participatory model of research (McMullin, Pang, K., Pang, V., and McEligot, 2010). Such participation will increase the capacity for Native Hawaiians to participate in their own healthcare design and research in order to enhance good health or *ola pono* (Mokuau, 2011).

Summary

This chapter presented a discussion of the study results in relation to: 1) the review of the literature, 2), the socio-political context, 3) limitations of the study, 4) implications for nursing, and 5) suggestions for further research.

The results of this study were identified as consistent with much in the review of literature on patient satisfaction/dissatisfaction and include three theme categories: 1) expectations of professional behavior, 2) the caring environment, and 3) patient-centered care. One subtheme of Being Hawaiian also supports the literature as to addressing the ethnic identify of patients. One result of this study which is new to the literature is the theme of the *ohana* of the hospital. The hospital as part of the ohana connects with the subthemes of: 1) the hospital as a part of their community, and 2) that the approach to family members is importance to their experience. In

addition, the richness of the narrative texts allows health care providers a deeper understanding of specific experiences of patient satisfaction/dissatisfaction as lived by participants.

The results of this study reflected the literature in relation to themes expectations of professional behavior, providing a caring environment, patient-centered care, and the sub-theme of Being Hawaiian. The conceptual orientation of Hermeneutic phenomenological philosophy reflects the Native Hawaiian's experience within the temporal, special, personal, and cultural realms of the world. An exemplar was utilized. The study also addressed the socio-cultural context of the study, specifically the controversy of the Thirty Meter Telescope on lands traditionally considered sacred to Native Hawaiians. Possible influence of the discourse surrounding this issue may have influenced recruitment of participants as well as securing a setting for interviews where participant may feel comfortable.

Because of sample size and participant characteristics, results of the study cannot be generalized to the general population or to other types of healthcare units or facilities. In addition, this study did not provide results from a focus group, uninsured participants' narrative regarding the Press Ganey Satisfaction Tool, focus group interaction and data, and participants' proof of hospitalization of Hawaiian ethnicity. There was no means to ensure that participants were able to distinguish registered nurses form other professional or non-professional healthcare providers. Responder bias was also a possibility.

Because the practice of nursing quality measures requires ways to elicit patient's perceptions of patient satisfaction/dissatisfaction, the results of this study may be applicable to nursing and healthcare. Native Hawaiian participants identified themes important to their care as: 1) expectations of professional behavior, 2) the caring environment, 3) patient-centered care,

and 4) a newly identified themes of the *ohana* of the hospital experience. Findings of the study can be used to further define and refine the concept of patient satisfaction/dissatisfaction, support cultural competency training, support growth in the native Hawaiian healthcare workforce. In addition, this study identified specific patient care practices which indicate a need for change, and identified positive aspects of patient care which can be further supported.

Results of the study can lead to future studies which can include: 1) extension of qualitative research to other types of patient care units and care settings, 2) design of evaluation studies to determine impact of patient satisfaction/dissatisfaction data on patient care, healthcare systems, and cultural competency, 3) inclusion of Native Hawaiian in the design of healthcare processes and research.

Conclusion

The study as interpretive phenomenology is not complete just because this study has ended. Actualization proposes that readers in the future will continue their interpretation (Madison, 1988). It is hoped that future readers will continue the interpretation proposed in the study in order to continue to capture the meaning of patient satisfaction/dissatisfaction as a living experience for Native Hawaiians.

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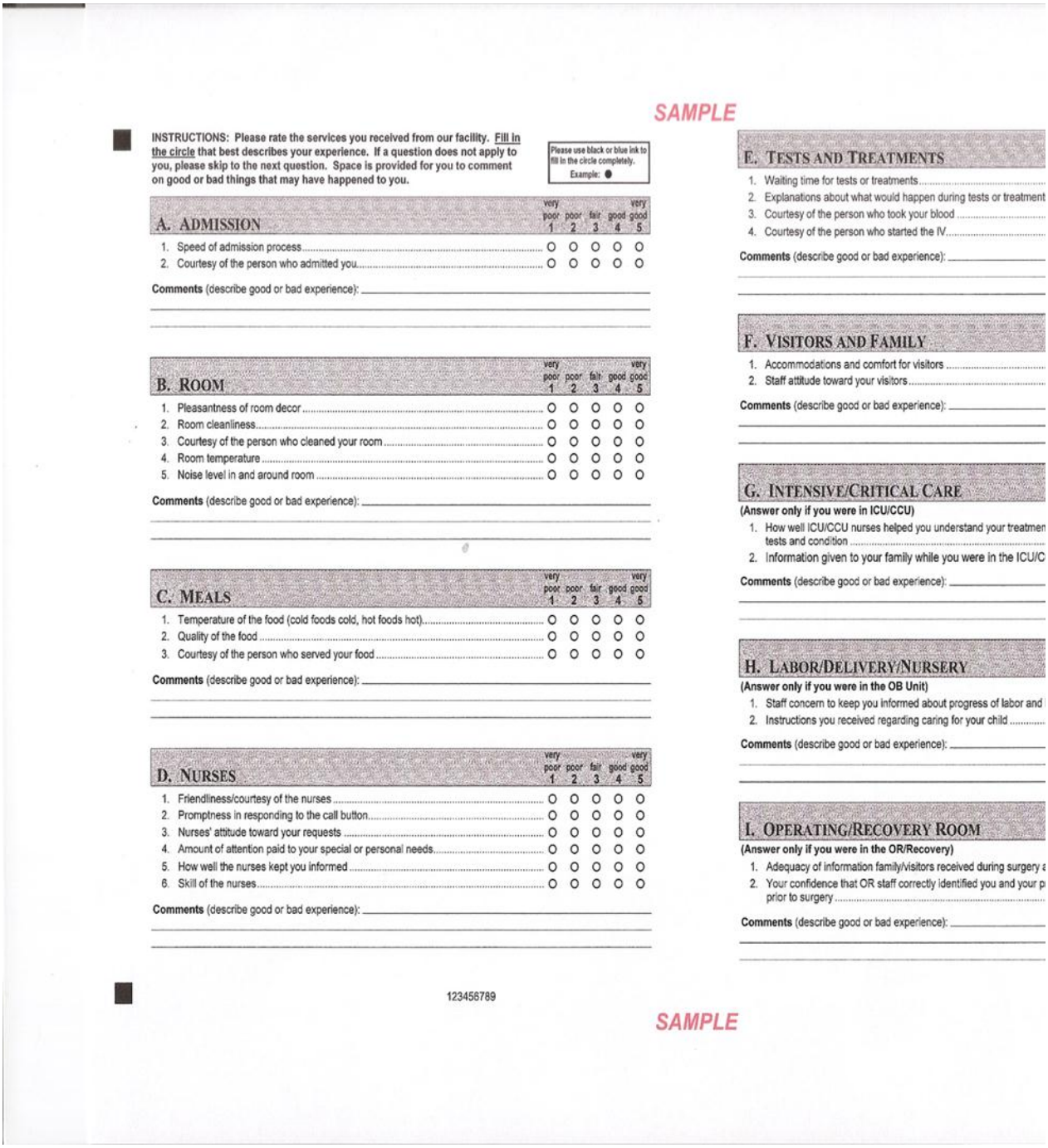
Appendix A

Page 1: Press Ganey Patient Satisfaction Survey as Administered at Hilo Medical Center



SAMPLE

INSTRUCTIONS: Please rate the services you received from our facility. Fill in the circle that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

Please use black or blue ink to fill in the circle completely. Example: ●

A. ADMISSION

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Speed of admission process	O	O	O	O	O
2. Courtesy of the person who admitted you	O	O	O	O	O

Comments (describe good or bad experience): _____

B. ROOM

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Pleasantness of room decor	O	O	O	O	O
2. Room cleanliness	O	O	O	O	O
3. Courtesy of the person who cleaned your room	O	O	O	O	O
4. Room temperature	O	O	O	O	O
5. Noise level in and around room	O	O	O	O	O

Comments (describe good or bad experience): _____

C. MEALS

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Temperature of the food (cold foods cold, hot foods hot)	O	O	O	O	O
2. Quality of the food	O	O	O	O	O
3. Courtesy of the person who served your food	O	O	O	O	O

Comments (describe good or bad experience): _____

D. NURSES

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Friendliness/courtesy of the nurses	O	O	O	O	O
2. Promptness in responding to the call button	O	O	O	O	O
3. Nurses' attitude toward your requests	O	O	O	O	O
4. Amount of attention paid to your special or personal needs	O	O	O	O	O
5. How well the nurses kept you informed	O	O	O	O	O
6. Skill of the nurses	O	O	O	O	O

Comments (describe good or bad experience): _____

E. TESTS AND TREATMENTS

1. Waiting time for tests or treatments
2. Explanations about what would happen during tests or treatment
3. Courtesy of the person who took your blood
4. Courtesy of the person who started the IV

Comments (describe good or bad experience): _____

F. VISITORS AND FAMILY

1. Accommodations and comfort for visitors
2. Staff attitude toward your visitors

Comments (describe good or bad experience): _____

G. INTENSIVE/CRITICAL CARE

(Answer only if you were in ICU/CCU)

1. How well ICU/CCU nurses helped you understand your treatmen tests and condition
2. Information given to your family while you were in the ICU/C

Comments (describe good or bad experience): _____

H. LABOR/DELIVERY/NURSERY

(Answer only if you were in the OB Unit)

1. Staff concern to keep you informed about progress of labor and
2. Instructions you received regarding caring for your child

Comments (describe good or bad experience): _____

I. OPERATING/RECOVERY ROOM

(Answer only if you were in the OR/Recovery)

1. Adequacy of information family/visitors received during surgery
2. Your confidence that OR staff correctly identified you and your p prior to surgery

Comments (describe good or bad experience): _____

123456789

SAMPLE

Page 2: Press Ganey Patient Satisfaction Survey as Administered at Hilo Medical Center

SAMPLE

J. PHYSICIAN

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Time physician spent with you	O	O	O	O	O
2. Physician's concern for your questions and worries	O	O	O	O	O
3. How well physician kept you informed	O	O	O	O	O
4. Friendliness/courtesy of physician	O	O	O	O	O
5. Skill of physician	O	O	O	O	O

Comments (describe good or bad experience): _____

K. DISCHARGE

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Extent to which you felt ready to be discharged	O	O	O	O	O
2. Speed of discharge process after you were told you could go home	O	O	O	O	O
3. Instructions given about how to care for yourself at home	O	O	O	O	O

Comments (describe good or bad experience): _____

L. PERSONAL ISSUES

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Staff concern for your privacy	O	O	O	O	O
2. How well your pain was controlled	O	O	O	O	O
3. Degree to which hospital staff addressed your emotional needs	O	O	O	O	O
4. Response to concerns/complaints made during your stay	O	O	O	O	O
5. Staff effort to include you in decisions about your treatment	O	O	O	O	O
6. Extent to which staff washed or sanitized their hands before examining you	O	O	O	O	O

Comments (describe good or bad experience): _____

M. OVERALL ASSESSMENT

	very poor 1	poor 2	fair 3	good 4	very good 5
1. How well staff worked together to care for you	O	O	O	O	O
2. Likelihood of your recommending this hospital to others	O	O	O	O	O
3. Overall rating of care given at hospital	O	O	O	O	O

Comments (describe good or bad experience): _____

Patient's Name: *(optional)* _____

Telephone Number: *(optional)* _____

123456789-1
Precode 1
Precode 2
Precode 3

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Hilo Medical Center
We Care for Our Community

INPATIENT SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

BACKGROUND QUESTIONS [write in answer or fill in circle (for example ●) as appropriate]

1. Patient's first stay here ..... O Yes O No
2. Admitted through the Emergency Department ..... O Yes O No
3. Was your admission unexpected? ..... O Yes O No
4. Did you have a roommate? ..... O Yes O No
5. Were you placed on a special or restricted diet during most of your stay? ..... O Yes O No
6. Did someone explain your extended life support (e.g., living will, advance directives, etc.) options? ..... O Yes O No
7. Did someone give you information about organ donation? ..... O Yes O No
8. Did someone give you information about the Patient's Bill of Rights? ..... O Yes O No
9. Do you have insurance that limits your choice of physician or provider (e.g., HMO or PPO)? ..... O Yes O No
10. Main source of payment for hospital stay: (fill in one circle only)
    - O Private Insurance
    - O Medicare
    - O Medicaid
    - O Worker's Compensation
    - O Self-Pay
11. Room number ..... [ ][ ][ ][ ]
12. Number of **days** in hospital ..... [ ][ ][ ] days
13. Date of discharge: [ ][ ] / [ ][ ] / [ ][ ][ ][ ] (month / day / year)
14. Patient's sex ..... O Male O Female
15. Patient's age ..... [ ][ ][ ] years
16. Compared to others your age, how would you typically describe your health? (fill in one circle only)

very poor	poor	fair	good	very good
O	O	O	O	O

continued...

16559349

SAMPLE

Appendix B: Consent Form

University of Hawai'i

Consent to Participate in Research Project:

Hermeneutic Phenomenology to Explore the Experience of Native Hawaiians in Terms of Satisfaction/Dissatisfaction with Nursing

Christine Deidre Beck
Primary Investigator
808-895-9901
cdbeck@hawaii.edu

My name is Christine Beck. I am a PhD student at the University of Hawaii at Manoa in the School of Nursing and Dental Hygiene. This research project is being conducted as a component of a dissertation for a doctoral degree. The purpose of my project is to learn more about the experience of Native Hawaiian patients in terms of their satisfaction or dissatisfaction with nursing care. The study asks participants to share their experiences in their own voice.

Activities and Time Commitment: If you participate in this project, I will: 1) meet with you for an interview at a location and time convenient for you for a face-to-face interview with me, or 2) I will ask you interview questions using the online Skype application. If you prefer the Skype method, and you do not have a webcam for your computer, a webcam will be provided free of charge to you.

The interview will consist of 8-10 open ended questions. It will take 45 minutes to an hour. Interview questions will include questions like ***"Tell me about your recent stay at Hilo Medical Center."*** Only you and I will be present during the interview. I will audio/video record the interview so that I can later transcribe the interview and analyze the responses. You will be one of about 10 people whom I will interview for this study.

At the end of the study, I may also ask you to participate in a small focus group to ask you and 4 or 5 other study participants to provide feedback to me about the study findings. This focus group will be held one time on the Big Island at a convenient time and place for all participants in the focus group. The focus group will consist of 8-10 questions like: "***Have you ever been in a focus group before?"***

Benefits and Risks: Participating in this research may be of no direct benefit to you. It is believed, however, the results from this study will increase knowledge and understanding of health care professionals providing care to Native Hawaiian patients.

During the interview or focus group, you may become stressed or uncomfortable answering any of the interview questions or discussing topics. If you do become stressed or uncomfortable, you can skip the question, take a break or withdraw from the study altogether.

During the focus group, other participants will be asked not to share outside of the group, but they may do it anyway.

I understand that if I am injured in the course of this research procedure, I may be responsible for the costs of treating my injuries.

Privacy and Confidentiality: I will keep all information in a safe place. Only my University of Hawaii at Manoa faculty advisor and I will have access to the information. Other agencies that have legal permission have the right to review research records. The University of Hawaii Human Studies Program has the right to review research records for this study. After I write a copy of the interviews, I will erase or destroy the audio/video recordings. When I report the results of my research project, I will not use your name. I will not use any other personal identifying information that can identify you. I will use pseudonyms (fake names) and report my findings in a way that protects your privacy and confidentiality to the extent allowed by law. All correspondence of messages or information will be encoded in such a way that only I can read it.

Voluntary Participation: Participation in this research project is completely voluntary. You are free to withdraw from participation at any time during the duration of the study with no penalty, or loss of benefit to which you would otherwise be entitled.

You will receive a $40 Visa gift certificate to thank for your time and effort in participating in this research study.

If you have any questions regarding this research study, please contact the primary researcher, Christine Deidre Beck at (808) 895-9901 or cdbeck@hawaii.edu

If you have any questions regarding your rights as a research participant, please contact the UH Committee on Human Studies at:

Phone: (808) 956-5007 Or Email: uhirb@hawaii.edu

Participant:

If you agree to the interview in the study being audio/video taped, please indicate "yes" or "no" below.

I have read and understand the above information, and agree to have the interview audio/video taped as part of my participation in this research project. Yes _____ No_____

If you agree to the focus group in the study being audio/video taped, please indicate "yes" or "no" below.

I have read and understand the above information, and agree to have the focus group audio/video tape if I choose to participate in the focus group part of the study: Yes _____ No_____

If you agree to participate in this study, please sign and date this signature page.

I have read and understand the above information, and agree to participate in this research

_____

Name (printed)

_____ _____

Signature Date

*You will be given a copy of this consent form for your records.

Appendix C: Demographic Information Form

Initials:
Where do you live?
Age:
Sex:
Do you identify yourself as Native Hawaiian?
Were you hospitalized at Hilo Medical Center within the past six months? If so, when?
Do you have medical insurance? If so, what type?
Do you need transportation?
Do you need special accommodations?
How is the best way I can contact you?
Would you prefer a face-to-face or computer –based (Skype) interview?
If yes to Skype: **Do you have access to a computer connected to the Internet?** **Does the computer have a camera?** **Do you know how to communicate using the Internet application called Skype?** **Do you need technical assistance with using the Internet?**

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231 **Appendix D: Recruitment Flyer**

The University of Hawai`i is conducting a survey

Are you a Native Hawaiian adult who will be or has been hospitalized at Hilo Medical Center within the last 6 months?

If the answer is *YES*.....I invite you to

Talk Story
Share Your Experience as a Patient

The purpose of this study to:

- ***Listen to Native Hawaiians share their experiences in their own voices***
- ***Learn more about the experiences of Native Hawaiian as hospital patients so that health care professionals can provide better care***

Interviews will take place online using Skype (webcam will be provided free of charge) or face-to-face at a convenient location for you.

- ***Study volunteers will receive a gift certificate***
- ***A summary of the results will be available to study participants***

To learn about this study please contact Christine at 808.895.9901 or cdbeck@hawaii.edu

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234 **Appendix E: Interview Guide**

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A-1: Interview: "Tell me about your recent stay at Hilo Medical Center."
B-1: Focus Group: "Have you ever been in a focus group before?"
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The main body of the interview and focus group will use a semi structured interview technique with open-ended questions and probes. This interviewing technique will allow participants to freely share their experiences in response to inquiries while ensuring that the researcher stays focused on the phenomenon. Making participants comfortable in sharing their thoughts and feelings can be challenging. Therefore, interviews and the focus group will begin with broad opening inquiries. New research questions and probes will evolve during the interview and observation process, as meanings, concerns, and practices from varied perspectives emerge. Subsequent open-ended questions and inquiries will ask the participant to expand on their narrative and allow flexibility for the interview to flow in the direction of responses
C-1: Focus group: "Tell me how you feel about this kind of survey." (Press Ganey Patient Satisfaction Survey?)

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