Evolution of a grounded theory: Conflict resolution through culture brokering

This article describes the evolution of the middle-range substantive theory of culture brokering. The theory was generated by first conducting a concept analysis that yielded 12 attributes of the concept of culture brokering. The concept analysis was accomplished using the anthropology, health-related, and business literature. In addition, data from an interpretive ethnographic study were used to further develop the concept of culture brokering. The theory was then generated from four grounded theory studies. Each study was used to frame the grounded theory model and to strengthen and refine the categories and links between categories within the basic social process of culture brokering. The culture brokering theory can guide the practice of nurses in situations where conflict is present in the health care interaction. The theory is grounded in the experiences of nurses attempting conflict resolution in the context of health care interactions. Key words: *culture brokering, grounded theory, nursing theory, theory construction*

Mary Ann Jezewski, RN, PhD
Assistant Professor
School of Nursing
University at Buffalo, State University of New York
Buffalo, New York

THE IMPORTANCE OF building a knowledgebase, generating and testing theory, and developing a grand theory for nursing has been discussed in the nursing literature since the 1960s. Wald and Leonard[1] advised the empirical approach (explanation, description, and hypothesis generation) to build theory. They also encouraged the use of concepts and hypotheses from actual nursing experiences to build nursing practice theory. Wald and Leonard emphasized the importance of the bond between the development of nursing practice and theory development. Recent discussions of the history of theory in nursing have also emphasized the importance of this scholarship for nursing as a practice profession.[2–4] Meleis[5] proposed that the experiences of nurses and clients be considered and accounted for in nursing theories to enhance the descriptive and explanatory power and the scope and utility of the theories.

The types of theory best suited for nursing practice are the middle-range theories, that

Adv Nurs Sci 1995;17(3):14–30

is, theories that are more focused in application and more readily testable. For the purposes of this discussion, *theory* is defined as a creative and rigorous structuring of ideas that project a tentative, purposeful, and systematic view of phenomena.[3] One method of developing theory with an important history in nursing is the grounded theory method of Glaser and Strauss.[6] This qualitative method of inquiry has been refined and clarified by the originators of the method and by others.[6–10] Grounded theory is a constant comparative method of data collection and analysis generating middle-range, substantive, and formal theories that are grounded in the everyday experiences of people in the study situation.

As the title of this article implies, evolution is an important aspect in the generation of theory. The dictionary defines *evolution* as a gradual process in which something changes into a different and usually more complex or better form.[11] Theory development is a gradual process that takes time and cannot be forced for expediency. In this article, the author presents the development of a grounded theory of culture brokering and explains the basic assumptions that guide this research. Next, I discuss the evolution of the culture brokering theory, from the first intuitive glimmer that this concept might in some way explain what goes on when there is conflict in health care interactions. In addition, I describe the generation and refinement of culture brokering as a middle-range substantive theory. The generation and refinement process includes the development of the concept of culture brokering from literature sources and the empirical generation of the culture brokering theory based on four grounded theory studies. Both process and product are described.

PERSONAL AND PROFESSIONAL ASSUMPTIONS

Certain assumptions influence my research and theory generation. They evolve from my background in anthropology and nursing. First, I view culture in its broadest form, as a system of learned and shared standards for perceiving, interpreting, and behaving in interactions with others and with the environment. A second assumption is my view of the health care system as a cultural and social system. This view is influenced by Kleinman's[12] discussion of the health care system as a system of meanings and behavioral norms attached to particular social relationships and institutional settings. Kleinman's concept of a health care system consists of relating external factors (social, political, economic, historical, epidemiologic, and technological) to internal processes (psychophysiologic, behavioral, and communicative). This model grounds health care in sociopolitical structures, a symbolic system built out of meanings, values, and behaviors.

As I began to study the grounded theory method, I was influenced by symbolic interactionism and the writings of George Herbert Mead and Herbert Blumer, as well as those who were influenced by them.[13–15] Symbolic interactionism influences the way I view interactions between health care providers and clients in the context of expecting, giving, receiving, and evaluating health care. Other closely aligned assumptions that influence my thinking evolve from my practice experience, which has demonstrated that professional nurses are a valued component in clients' interactions within the health care system. The nurse and client interact on an ongoing basis, and

the interaction provides a basis for shared meaning.

During an interaction, individuals bring a set of values and beliefs to the interaction that influences the degree of shared meaning possessed by the participants. The nurse comes to know the client, and a trusting relationship is built over time. In turn, nurses are able to interpret the client's needs to others. Nurses are the bearers of information, support, guidance, and caring who interact with the client to effect appropriate health care. My use of the term "client" applies to the person who is seeking care as well as all those people who are "connected" to that client by kinship or friendship.

Another assumption is that people have a right to health care that, ideally, they are able to manage in cooperation with the health care provider. When this ideal is not possible, when people are politically, economically, or personally powerless to use care autonomously, someone needs to intervene. This intermediary must provide a bridge between the clients and the providers in the health care system.

CONCEPT DEVELOPMENT

Concept analysis is recommended as a way to begin to examine information in preparation for theory construction.[2] Concept development (creating conceptual meaning) allows one to examine attributes or characteristics of a concept.[2,3] Concept analysis is described by Walker and Avant[2] as a formal linguistic expertise used to determine the defining attributes of a concept. It is a rigorous and precise procedure that yields tentative meaning to a concept. The eight steps of concept analysis as described by Walker and Avant include

1. selecting a concept;
2. determining the aims or purposes of analysis;
3. identifying all the uses of the concept that can be discovered;
4. determining the defining attributes;
5. constructing model cases that reflect the critical attributes;
6. constructing borderline, related, contrary, invented, and illegitimate cases;
7. identifying antecedents and consequences; and
8. defining empirical referents (occurrences of the concept).

The theoretical definition that emerges from concept analysis summarizes insights that form while creating conceptual meaning and describes the essential meaning of the concept.[3] The method of concept analysis used for culture brokering was guided by Wilson[16] and Chinn and Jacobs,[17] and it is similar to the approach Walker and Avant[2] described in their writings. Development of the concept of culture brokering eventually led to the generation of the culture brokering theory using the grounded theory method of inquiry.

PROCESS OF CONCEPT DEVELOPMENT

Early in my doctoral studies in anthropology (1983–1986), I was a research assistant on a project that focused on describing intercultural communication patterns in a pediatric clinic serving a multiethnic, inner-city community.[18] The method of inquiry was interpretive ethnography. Data collection included 8 months of participant observation in the clinic and informal and formal interviews with staff and families of clients who used the clinic. During analysis of data,

barriers and breakdowns in communication between clients and providers were identified. Subsequently, the ways that staff ameliorated these breakdown situations were analyzed.

At the conclusion of the study, I serendipitously read an article in the anthropology literature on culture brokering.[19] The role of the broker described in this article was similar to the role of the nurses in the pediatric clinic as they attempted to resolve conflict situations and breakdowns in communication between the clients and providers.

This first introduction to culture brokering initiated a concept analysis similar to what Chinn and Kramer[3] described as creating conceptual meaning. The goal was to produce a description of the concept of culture brokering that could then be used to explain conflict resolution in health care interactions in the pediatric clinic. In reality, the concept of culture brokering was not developed sufficiently in the literature to be useful as a model to explain what was occurring in these health care interactions. The meaning created from the literature, however, provided the direction in which to further investigate and describe the concept of culture brokering in health care situations.

A variety of literature sources were used to create conceptual meaning for culture brokering. First, there was a search of the anthropology literature, which yielded about 20 published articles, several books, and two unpublished papers. A review of the health-related literature that discussed culture brokering in relation to health care delivery yielded nine articles and a chapter in a nursing textbook on nursing interventions. Because the term "broker" is most familiar in the context of business (real estate broker, stockbroker, foodbroker), the business literature was also reviewed. Throughout this process, newspapers or magazines that featured phrases or discussions of brokering or bridging gaps were saved, and the clippings were analyzed to further develop the attributes of culture brokering. After the literature was reviewed and attributes developed to explain the concept of culture brokering, the data from the interpretive ethnographic study were analyzed again. The attributes of culture brokering between the health care providers and families of pediatric clients were identified and explained.

MEANING OF CULTURE BROKERING

Initially, dictionary definitions of "culture" and "brokering" were reviewed. *Webster's Third New International Dictionary*[20] defines culture in several ways. The primary definitions refer to cultivating the land. It is not until the fifth definition that a definition corresponding to the anthropologic use of the term is presented. *Culture* is defined as "the total pattern of human behavior and its products embodied in thought, speech, activities and artifacts and dependent upon man's capacity for learning and transmitting knowledge to succeeding generations through the use of tools, language and systems of abstract thought."[20(p552)]

The term *broker* is defined by the same dictionary[19] as "Negotiator. Intermediator. A go between in affairs of love or sex. An agent professionally engaged in arrangement of marriage. An agent or middleman who for a fee or commission negotiates contracts of purchase or sale between buyers and sellers without himself taking possession of that which is the subject of negotia-

The culture broker role carries with it a set of expected behavior patterns, obligations, and privileges, but there is considerable variation within the defining attributes.

tion."[20(p282)] This view is a rather narrow one of the broker compared to the literature.

In the anthropology literature a variety of situations are described where culture brokering occurs. Although there is no consensus on the exact role of the culture broker, certain attributes are described. The culture broker role carries with it a set of expected behavior patterns, obligations, and privileges, but there is considerable variation within the defining attributes that influences how this role is carried out by the broker. In most of the anthropology-based discussions of culture brokering, the broker is placed within a context of peasant societies dominated by colonial rule, where tensions and conflict are high between the tradition of the Western powers that control and the local peasant societies that are ruled by these colonial powers. The possibility of an analogy exists between this context and the context of Western health care, with the asymmetry of power between the traditions of the Western medical system and the traditions of clients.

The health-related literature yielded many of the same attributes of the culture broker that were found in the anthropology literature. Many of the authors of articles in the health-related literature were medical anthropologists, and many were also health care practitioners. The following 12 attributes of culture brokering were identified in the anthropology and health-related literature:

1. intervening in conflict situations when tensions exist in interactions,[19,21–29]
2. standing guard over critical junctures in the context of interactions,[21,25,30]
3. possessing role ambiguity in the context of brokering and functioning in asymmetric relationships,[19,24,25,28,31–33]
4. functioning marginally in one or more systems while brokering between systems,[25,29,32,34]
5. encouraging potential for changing systems,[19,25,33,35]
6. dealing with others positively and cultivating varied social relationships,[19,21,24,28,29,32,33,36]
7. mediating between traditions,[19,24,28,33,37]
8. innovating when traditions are inflexible,[19,25]
9. facilitating communication by translating interests and messages between groups,[19,21–23,25,27,28,30]
10. bridging value systems,[28,29,36,38]
11. functioning as a go-between,[19,21–23,27,32] and
12. bringing people together through networking.[38]

Some attributional overlap in concepts was apparent, and certain attributes are described differently in the health-related literature than in the anthropology literature. One attribute not found in the health-related literature was role ambiguity, most probably because health care professionals as culture brokers function in a specific contextual capacity in the health care system, and brokering is an intervention used by the provider for specific situations in the health care encounter.

The business literature review yielded similar attributes to those listed previously.

A database consisting of 800 academic, management, and business journals (1981–1986) was reviewed for discussions of brokering. The review yielded 66 brokering articles and revealed multiple ways that the concept of brokering is used in business. The most common use was that of insurance brokering, but many other types of brokering were also represented in this literature (mortgage, discount, retail, organ, money, real estate, precious metal, commodities, transportation, and energy brokering). It was also about this time (1986) that articles began to appear about information brokering (disseminating information) as a new growth industry.

Attributes of brokering described in the business literature include

- complementing the existing way of doing business,
- possessing public confidence and reputation,
- establishing links,
- being the right person for the role,
- increasing competition in the business world, and
- ensuring that the client knows the benefits of a broker.

Although not found in the anthropology or health-related literature, an important aspect of brokering found repeatedly in this review of the business literature was the importance of education in terms of teaching a person how to broker and continuously enhancing brokering skills through seminars and workshops.[39–42] The attribute of educating or training others to be brokers resulted in the formulation of focused interview questions in each of the four empirical studies used to generate the grounded theory of culture brokering. The participants in the studies were asked, "What would you tell an inexperienced nurse about facilitation of health care for migrant farmworkers? effectively caring for persons who are homeless? the process of obtaining consents for do-not-resuscitate (DNR) status?" These questions enabled the investigator to understand the types of information, support, and clinical experiences that experienced nurses felt were necessary in brokering situations.

A comparison of brokering situations in the literature and observations in the pediatric clinic demonstrated the antecedents, consequences, and attributes of culture brokering. Conflict in interactions in health care encounters between the person seeking care and the person providing care is the most important antecedent to culture brokering. In the anthropology literature, it was asymmetry of power between peasant societies and colonial governments. In the pediatric clinic, it was asymmetry of power between the health care system and the clients (poor, urban, ethnic minority) who used the system. In each situation, conflict in the presence of this asymmetry of power is resolved only when someone steps in to mediate.

A reanalysis of the data from the study in the pediatric clinic yielded situations where nurses and sometimes physicians functioned as mediators in health care encounters involving conflict. The nurse usually acted as a broker of information between the physician and the family member. In one of the early model cases, which serve as "real life example of the use of the concept that includes all the critical attributes . . . a pure case of the concept, a paradigmatic example,"[2(p40)] the physician instructed a mother to give her infant a particular medication when the infant had a fever. The mother sat quietly while the physician explained why and how to give the medication. As the

mother was getting ready to leave the clinic, the nurse coordinator of the clinic reviewed the instructions with the mother and pointedly asked her three questions: Did she have a thermometer at home? Did she know how to take a temperature? Did she have money to buy the over-the-counter medication the physician had instructed her to give the infant? The answer to all three questions was no. The nurse at this point intervened to mediate a solution to this conflict.

The conflict was created because the physician assumed that this mother had the knowledgebase and economic means to carry out the treatment instructions. The nurse went back to the physician to discuss the problem with the treatment plan and arranged for another agency to provide funds for the medication. In other situations the health care providers negotiated referrals to specialty clinics when parents had a difficult time obtaining appointments. Many families who attend this clinic spoke only Spanish and found it difficult to communicate their needs when Spanish-speaking staff were not available.

Resolution of conflict is the primary consequence of culture brokering. The more experienced broker can prevent conflict situations through culture brokering. The consequence of brokering in health care interactions where potential or real conflict issues arise is facilitation of access and use of health care for people seeking care.

The theoretical definition of* culture brokering *resulting from this initial concept analysis is the act of bridging, linking, or mediating between groups or persons of differing cultural systems for the purpose of reducing conflict or producing change.

The theoretical definition of culture brokering is consistent with the attributes of culture brokering previously listed. The theoretical definition of *culture brokering* resulting from this initial concept analysis is the act of bridging, linking, or mediating between groups or persons of differing cultural systems for the purpose of reducing conflict or producing change. The literature yielded attributes of culture brokering; next, empirical data from health care situations were needed for concept and statement synthesis[3] and, ultimately, the generation of the culture brokering theory.

GENERATION OF THE CULTURE BROKERING THEORY

Process—Grounded theory method

The research process for generating theory is designed to discover and describe a phenomenon as free from the influence of preconceived notions as possible.[3,6] After initial concept analysis, four studies were completed to further develop culture brokering as a grounded theory. *Grounded theory* is a qualitative method of inquiry that espouses continual and simultaneous collection and analysis of data for the purpose of generating theory that is grounded in empirical data. The focus of this method is to look for a core variable or process that accounts for most of the behavior in the situation under study.[7] The use of comparison groups through multiple studies provides theoretical relevance for further development of emerging categories.[6] The scope of a substantive theory can be carefully in-

creased and controlled by a conscious choice of groups.[6] The grounded theory of culture brokering was generated primarily in the emergent fit mode with the goal of theoretically constructing the concept of culture brokering.[7,9]

In the four studies conducted by the author, field notes from participant observation or transcripts from in-depth interviews (or both) were the primary sources of data. The process of analysis involved open coding to identify substantive codes, continuously comparing codes, and grouping like codes into categories. *Open coding* is the process of breaking down, examining, comparing, conceptualizing, and categorizing data.[10] Open coding is similar to what Walker and Avant[2] referred to as concept synthesis. Categories that emerged from the analysis were also compared and reduced in number by subsuming similar categories under more abstract categories. Glaser and Strauss[6] referred to this process as "reduction."

Categories were developed according to their properties and dimensions, and eventually they were linked to an identified core category. A core category accounts for much of the variation in the data and serves to conceptually link the major categories, their properties, and their dimensions to form a descriptive whole.[7] Theoretical codes were used to link the major categories and their properties to the basic social process of culture brokering. Theoretical codes conceptualize how the substantive categories relate to each other as they are integrated into a theory.[7] Theoretical coding forms the basis of statement synthesis. In the four studies, the nurses' exemplars of their interactions with clients provided the cases (model, borderline, partial, and contradictory) that developed the basic social process of culture brokering. A *basic social process* (BSP) is a core category that is processual, having two or more clear emergent stages.[7] BSPs describe process, change, and movement over time.

Theoretical sampling is an integral component of the grounded theory method. It was accomplished by asking analytic questions of the data and the participants that expanded the breadth and depth of the major categories. In theoretical sampling, the investigator decides what data to collect next based on analysis of previously collected data. The goal is to more fully develop and link emerging categories in the theory. For instance, when the category "conflict" emerged from the data, all previous and subsequent data were analyzed to look for incidents of conflict. This process helped to more fully develop the properties and dimensions of the category conflict in the brokering theory.

Another of the basic questions in theoretical sampling (in either substantive or formal theory) is, "What groups or subgroups does one turn to next in data collection?"[6(p47)] Groups are chosen for theoretical purpose and relevance. The criteria for sampling are designed to be applied based on theoretical relevance for development of emerging categories. The scope of "a substantive theory can be carefully increased and controlled by such conscious choice of groups."[6(p52)] Memos were written throughout the analysis. Memos are notes that preserve the thoughts of the investigator about the emerging categories and the theoretical links between categories. Memos provide an audit trail and eventually form the basis for writing the theory.

Process—Empirical generation

The culture brokering theory is a descriptive theory that describes a phenomenon, including the properties and the circumstances under which it occurs.[7] But culture brokering is also moving toward a prescriptive theory that addresses nursing actions, including the conditions (person–environment interactions) and the consequences (effect on the client life processes) of interventions.[7] The culture brokering theory, based on conflict resolution in interactions, was empirically generated in the context of caring for groups of clients who were politically and economically powerless (migrant farmworkers and homeless persons) or persons who because of extreme circumstances (life-threatening illness) needed to make informed decisions (consenting to DNR status) under the most stressful conditions. The clients in these contexts displayed a vulnerability that hindered their autonomous use of the health care system. The theory (Fig 1) consists of intervening conditions that affect the brokering process and three stages that are used to ameliorate conflict in health care situations. The intervening conditions in the

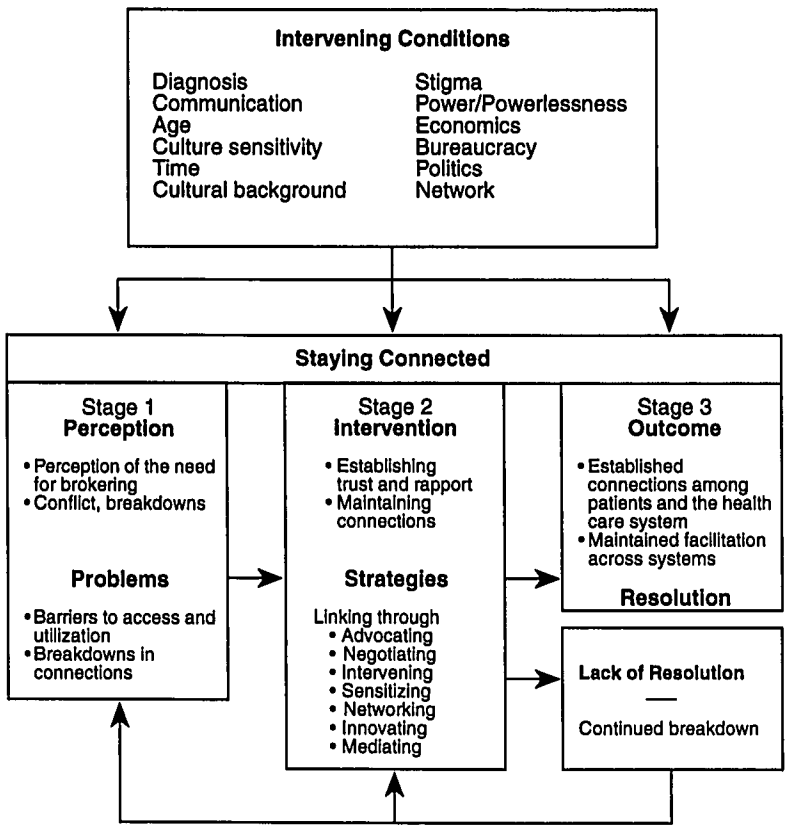

Fig 1. The culture brokering theory.

model are elements that either assist or impede facilitation of health care through culture brokering. The three stages of the model illustrate the process of facilitating care that maintains a client's connectedness to the health care system during conflict situations.

The four studies, summarized in Table 1, served to refine the conceptual synthesis of culture brokering and generate the culture brokering theory. Table 1 outlines the purpose, sample, data collection methods, and primary ways the four studies contributed to culture brokering theory development. The first study focused on the acquisition and utilization of health care by migrant farmworkers. It served to generate a draft of the model of culture brokering that was used in the theory development and refinement phases. This study was important in identifying, defining, and linking the major categories of the culture brokering theory.[43,44] The core categories of "conflict" and "breakdowns" emerged from the data, as did the stages of brokering; most important, the identification of intervening conditions that influence brokering emerged as well.

The second study was similar to the first in its purpose and data collection methods but included a different at-risk population.[45] Persons who were homeless and health care facilities that focused on the care of homeless people were chosen as a theoretical sample group because of their social, political, and economic similarity to migrant farmworkers. The focus of this study was to look at how health care is accessed and used by homeless persons and facilitated by the staff in nurse-managed shelter clinics. Theoretical sampling was attained by both sampling homeless persons as a group and sampling incidents of brokering in the interactions between health care providers and homeless persons attempting to access the health care system. The emergence of the core category "staying connected" was integrated into the culture brokering theory, and the intervening conditions were refined and saturated.

Staying connected is the glue that joins the stages of brokering. It encompasses linking clients with the health care system and helping them remain connected to the health care system in ways that meet their needs. The properties and dimensions of staying connected reveal three primary aspects of connectedness:

1. The nurse attempts to establish and maintain a connectedness to clients.
2. The nurse as broker establishes and cultivates networks with other health care providers in the community to maintain connections with health care facilities that can serve as sources for client referrals.
3. The nurse assists clients in establishing and maintaining connections with providers in the health care system.[45]

One nurse's explanation of her goal in caring for homeless clients describes the core of staying connected: "Our goal in the project is to link people with the traditional health care system . . . trying to make it as easy for the homeless person as possible so that they will then stay connected."

The context of the third and fourth studies was very different from the first two but like them presented situations with potential for conflicts and breakdowns in interactions between health care providers and clients and their families. The third study investigated the ways critical care nurses interacted with clients and families during the process of consenting to a DNR status.[46,47] Conflict

Table 1. Studies used to generate the grounded theory of culture brokering

Study purpose	Sample	Data collection	Contribution to theory development
Study 1 (Migrant Farmworker Study): To investigate the ways migrant farmworkers gain access to and use health care and the ways staff facilitate care at primary health care centers for migrants[43,44]	Thirteen primary clinic staff—nurses, physicians, outreach workers, drivers (8 white, 3 black, 2 Hispanic; 12 female, 1 male) and 31 migrant farmworkers interviewed (19 black, 6 white, 6 Hispanic; 24 male, 7 female)	Participant observation (field notes). Informal and formal semistructured interviews, transcribed from notes (1986–1988)	The initial culture brokering theoretical model was developed consisting of intervening conditions and three stages with a feedback loop.
Study 2 (Homeless Health Care Study): To investigate the ways homeless people gain access to and use health care and the ways staff at nurse-managed shelter clinics facilitate care[45]	Interviews with 11 staff members at nurse-managed shelter clinics (9 white, 2 black; all female). Interviews with 21 homeless persons (10 black, 7 white, 2 Native American, 2 Hispanic; 18 males, 3 females)	Participant observation in shelter clinics (field notes). Informal and formal semistructured interviews audiotaped and transcribed (1991)	A core category emerged: staying connected. The culture brokering theory was refined, particularly the theoretical definitions of the intervening conditions and the links between concepts.
Study 3 (Critical Care Nurse Do-Not-Resuscitate [DNR] Status Study): To describe critical care nurses' interactions with patients and families who are making decisions about DNR status[46,47]	Interviews with 22 critical care nurses (all white; 21 female, 1 male)	Semistructured formal interviews audiotaped and transcribed (1991–1992)	The core categories of conflict and consenting to DNR emerged. The concepts of conflict and breakdown in brokering situations were further developed, and the theoretical definitions of the intervention strategies were refined.
Study 4 (Oncology Nurse/DNR Status Study): To describe oncology nurses' interactions with patients and families who are making decisions about DNR status[48]	Interviews with 21 nurses practicing in oncology settings (all white; 19 female, 2 male)	Semistructured formal interviews audiotaped and transcribed (1992–1993)	Concepts and links between the intervening conditions and the stages of brokering were refined.

was a major category in this study, and the critical care nurses' descriptions provided rich data on the ways these professionals ameliorated or prevented conflict situations during the consent process. The results of this study helped to further refine conflict and breakdowns in the brokering process and expanded the description of the intervention strategies in stage 2. This refinement was an important juncture in describing what goes on in conflict situations in health care interactions.

The fourth study was similar to the third but used a sample of nurses practicing in oncology settings.[48] This study helped to further define the links between the intervening conditions of diagnosis, timing, and communication and the stages of the brokering theory.

Recently, data from the four studies have been reanalyzed to further saturate the categories and strengthen the links between categories. This reanalysis reflects the iterative nature of grounded theory. Although not specifically described by Glaser and Strauss,[6] the reanalysis of data is reflective of the constant comparative method of grounded theory analysis. For instance, staying connected was identified as a core category in the second study. Nurses caring for clients who were homeless described the importance of connectedness and links between clients and health care providers. After this core category (staying connected) emerged in the second study, the data in the first study were reviewed to look for incidents of this category. Data from the first study that were relevant in further refining this category were reanalyzed. A reanalysis of data from the migrant farmworker study yielded many incidents of staying connected. The ways nurses in the rural farmworker clinics intervened to help migrant farmworkers stay connected to the health care system were compared and contrasted with the ways of nurses in the urban shelter clinics.

For instance, when migrant farmworker children needed to be referred to a specialist, the farmworker family had to travel to the nearest city, which was 40 to 50 miles away. Consequently, transportation and the cost of transportation became economic issues that had an impact on the brokering process. The economic cost also meant that one or both parents would lose a day's pay in taking the child to the specialist. The nurse coordinator needed to find transportation to the city that was economical and minimized the amount of time the farmworkers were away from their work. Transportation was less of a problem in the urban shelter clinics serving homeless people. More transportation options were present in the city, and the shelters were relatively close to major health care institutions. By addressing these contingencies in each setting, the properties and dimensions of staying connected were refined. Ultimately, the categories in the culture brokering theory were developed to include variation within each category, making the theory applicable to a wider range of possibilities without being so broadly defined as to be ineffectual as a middle-range practice theory.

Product—Culture brokering theory

In the theory of culture brokering (Fig 1), the intervening conditions are inextricably linked to the stages of brokering. In some situations, an intervening condition facilitates brokering; at other times the same condition hampers the brokering process. In many situations the intervening conditions

influence each other. For instance, the medical diagnosis of the client can cause conflict in gaining access to health care, especially if the treatment for the diagnosis is costly and the client does not have health insurance. At other times, the diagnosis almost assures that the client will get appropriate health care and eventually assistance through a federal health insurance program. One such condition is pregnancy. The "diagnosis" of pregnancy influences and is positively influenced by the political arena. In the past several years, significant increases in federal funds have been available to agencies to provide prenatal care to women regardless of their ability to pay.

On the other hand, it can be extremely difficult for clients to access the mental health system or substance abuse programs, especially if they are homeless. Economic and political conditions prevent the development of adequate numbers of treatment facilities to provide care for substance abuse problems. In addition, because of stigma attached to the label "homeless" by some health care providers, homeless persons have often been put at the bottom of the list for admission to substance abuse programs.

Two very important intervening conditions in the culture brokering model are cultural background (which includes ethnicity) and culture sensitivity. Stigma was also linked to cultural background of the patient. For instance, migrant farmworkers and homeless persons whose ethnicity (black, Hispanic, Native American) was different from mainstream society often encountered the double stigma of the labels "homeless" or "migrant farmworker" plus the stigma associated with minority status. The nurse-as-broker needed to assess the degree of stigmatization to mediate or advocate for the patient, when necessary, to effect culturally relevant health care. Culture sensitivity enabled the nurse-as-broker to be aware of and sensitive to the needs of culturally diverse patients. When there was lack of culture sensitivity on the part of providers, there was an increased risk of conflict or breakdown in the health care encounter.

Two very important intervening conditions in the culture brokering model are cultural background and culture sensitivity.

In stage 1 of the culture brokering theory, nurses assess the impact of conflict and breakdowns in interactions in the health care encounter. Conflict or breakdown in a health care interaction is an antecedent to culture brokering, but assessment of the conflict is also a part of the brokering process. In addition to assessing conflict, in stage 1 the nurse also assesses the impact of the intervening conditions that may facilitate or impede the resolution of conflict.

Conflict emerges in many different forms in the four studies and becomes an important element that mandates the use of the intervention strategies in stage 2. In the migrant farmworker study, conflict occurred when farmworkers tried to access health care autonomously when they did not have health insurance, and hospital emergency departments were hesitant to provide care because the migrants were viewed as an economic liability. Conflict in the homeless setting also emerged in access to and use of health care, because many homeless persons also do not have health insurance. Conflict situations in both of these settings emerged as a result of the stigma attached by health

care providers to the label "migrant farmworker" or "homeless person." Conflict issues likewise arose in these settings when there were differences in values, beliefs, and behaviors between providers and clients concerning the appropriateness and feasibility of treatment plans. For instance, it is difficult for migrant farmworker clients to obey directives to rest for even short periods of time when they perceive that they are able to work in the field; losing a day's work means losing a day's pay and taking food from the family table.

Conflict situations that emerged in the critical care nurse and oncology nurse DNR status studies frequently involved differences in values and beliefs about the meaning of DNR status. The conflict is both intrapersonal and interpersonal. Intrapersonal conflict occurs when clients, families, or staff cannot come to terms with the appropriateness of a DNR status. It takes time for patients and families to come to terms with the patient's illness, and if they cannot, they very often refuse to consent to a DNR status. Interpersonal conflict takes place when patients, families, and staff come to different conclusions about the appropriateness of a DNR status for the patient. Usually staff believe that a DNR status is in the best interests of the patient and disagree with the patient or family members making the decision not to consent.

Breakdowns in the health care interaction are usually less serious than conflict. Nevertheless, breakdowns, if left unresolved, can lead to conflict and termination of health care for the patient. There were breakdowns in communication in each of the four studies, but the types of breakdowns were different across studies. In the migrant farmworker study, intercultural communication breakdowns were frequently identified. In the DNR studies, breakdowns in communication occurred as a result of the stress of clients and family members and the complexity of the meanings of DNR status consents.

In stage 2, the nurses establish rapport with clients that fosters connections between the health care professionals and the client. In this stage the nurses also network to establish links with personnel in their own or other health care facilities. Many strategies are used by the nurses during stage 2 to prevent or ameliorate conflict situations and to facilitate links and help their clients stay connected to the health care system. The nurses' descriptions repeatedly confirm their attempts to connect their clients to the health care system through the strategies of negotiating, intervening, advocating, and networking.

In stage 3, outcome, two properties emerge. Either conflicts and barriers are resolved, or there is continued conflict and breakdown. When the conflict is not resolved, the nurse attempts to come to a resolution by reverting to stage 1 (further assessment) or stage 2 (attempting different strategies) to assist the client.

The highest tensions and potential for disconnectedness at critical junctures in access and use of health care involve conflict situations and intervening conditions that impede health care. The brokering interventions used by the nurses who participated in the four studies to facilitate the clients' connectedness to the health care system encompassed a holistic approach. In the presence of conflict in an interaction between a health care provider and client, someone must ameliorate the conflict (facilitate the interaction) or effective health care will not take place. The culture brokering theory is a heu-

ristic theory that can guide nurses in assessing and resolving conflict in health care interactions. It is not possible within the limitations of this article to fully describe each category and all the links between categories. The article instead describes the evolution of the generation of the culture brokering theory.

• • •

Much remains to be accomplished in developing the culture brokering theory. Any middle-range theory grounded in everyday life situations is context dependent in application and dynamic and temporal in design. Although all of the major concepts in the theory have been described here based on data from the four empirical studies, many categories within the theory, including conflict across practice settings and networking in varied practice settings, would benefit from further concept synthesis. Additional concept and statement synthesis can be accomplished by continued analysis of data from the four completed studies, by conducting additional studies, and by continued review of the literature.

The intervening conditions and their links to the stages of brokering need to be looked at in relation to more varied client populations. It is anticipated that the number of intervening conditions will increase as additional studies are conducted. For instance, gender was not a strong influence on the facilitation of health care or the role of the nurse-as-culture broker in the four studies conducted so far. The lack of saturation of the gender category may be due to the focus of the data collection in the four studies. Future studies should look more closely at gender as an intervening condition in the brokering theory. A doctoral student is presently using the culture brokering framework to study lesbian help-seeking in relation to female health risks and primary care prevention. It is anticipated that this study will illustrate gender, life style, and marginalization as intervening conditions in the brokering theory.

In the context of discovery and justification,[2,49] the generation of theory occurs in the context of discovery, whereas the evaluation of theory takes place in the context of justification. Chinn and Kramer[3] referred to evaluation as critical reflection, or ascertaining how well the theory serves some purpose. They provide a detailed guide for critical reflection. The evaluation process for the culture brokering theory has only begun. Wider dissemination of the theory, through publications in a variety of nursing journals, will initiate discourse necessary to critically reflect on the utility of the culture brokering theory to nursing practice. This discourse has already begun through published accounts of the theory,[44,50,51] interpretation of the theory and comments by nurses,[52,53] and papers presented at national conferences. Further discussion of the meaning of culture brokering in relation to advocacy in nursing practice is necessary.[51]

If theory is to be useful for practice, theorists must be concerned about how theory relates to the practice arena. The use of grounded theory as a method of generating theory mandates that the investigator gather data in a phenomenologic context from the perspective of those who are experiencing the phenomenon under study. The tenets of the grounded theory method mandate that attempts to describe or predict aspects of nursing practice must be grounded in the experiences of nurses.

REFERENCES

1. Wald F, Leonard R. Towards development of nursing practice theory. *Nurs Res.* 1964;13:309–313.
2. Walker L, Avant K. *Strategies for Theory Construction in Nursing.* 2nd ed. Norwalk, Conn: Appleton & Lange; 1988.
3. Chinn P, Kramer M. *Theory and Nursing.* 3rd ed. St. Louis, Mo: Mosby Yearbook; 1991.
4. Meleis A. *Theoretical Nursing: Development and Progress.* Philadelphia, Pa: Lippincott; 1994.
5. Meleis A. ReVisions in knowledge development: a passion for substance. *Schol Inq Nurs Pract.* 1987;1(1):5–19.
6. Glaser B, Strauss A. *The Discovery of Grounded Theory: Strategies for Qualitative Research.* Chicago, Ill: Aldine; 1967.
7. Glaser B. *Theoretical Sensitivity.* Mill Valley, Calif: Sociology Press; 1978.
8. Glaser B. *Basics of Grounded Theory Analysis.* Mill Valley, Calif: Sociology Press; 1992.
9. Chenitz W, Swanson J. *From Practice to Grounded Theory: Qualitative Research in Nursing.* Menlo Park, Calif: Addison-Wesley; 1986.
10. Strauss A, Corbin J. *Basics of Qualitative Research.* Newbury Park, Calif: Sage; 1990.
11. *American Heritage Dictionary.* Boston, Mass: Houghton Mifflin; 1982.
12. Kleinman A. Concepts and a model for the comparison of medical systems as cultural systems. *Soc Sci Med.* 1978;12:85–93.
13. Manis J, Meltzer B. *Symbolic Interactionism.* Boston, Mass: Allyn & Bacon; 1972.
14. Strauss A. *The Social Psychology of George H. Mead.* Chicago, Ill: University of Chicago Press; 1956.
15. Stryker S. *Symbolic Interactionism.* Menlo Park, Calif: Benjamin/Cummings; 1980.
16. Wilson J. *Thinking with Concepts.* New York, NY: Cambridge University Press; 1963.
17. Chinn P, Jacobs M. *Theory and Nursing.* St. Louis, Mo: Mosby; 1983.
18. McElroy A, Jezewski MA. Boundaries and breakdowns: applying Agar's concept of ethnography to observations in a pediatric clinic. *Hum Org.* 1986;45:202–211.
19. Geertz C. The Javanese Kijaji: the changing role of a cultural broker. *Comp Studies Sociol History.* 1960;2:228–249.
20. *Webster's Third New International Dictionary.* Springfield, Mass: Merriam-Webster; 1986.
21. Hopkins N, Ekpo M, Helleman J, et al. Brokers and symbols in American urban life. *Anthropol Q.* 1977;50:65–75.
22. LaFargue J. Mediating between two views of illness. *Top Clin Nurs.* 1985;7:70–77.
23. Lefley H. Approaches to community mental health: the Miami model. *Psychiatr Ann.* 1975;5:315–319.
24. Paine R. *Second Thoughts about Barth's Models.* London, England: Royal Anthropological Institute of Great Britain and Ireland; 1974.
25. Press I. Ambiguity and innovation: implications for the genesis of the culture broker. *Am Anthropol.* 1969;71:205–217.
26. Silver H. Beauty and the "I" of the beholder: identity, aesthetics, and social change among the Ashanti. *J Anthropol Res.* 1979;35:191–207.
27. Sussex J, Weidman H. Toward responsiveness in mental health care. *Psychiatr Ann.* 1975;5:306–311.
28. Tripp-Reimer T, Brink P. Culture brokerage. In: Bulechek G, McCloskey J, eds. *Nursing Interventions.* New York, NY: W.B. Saunders; 1985.
29. Wolf E. Aspects of group relations in a complex society: Mexico. *Am Anthropol.* 1956;58:1065–1078.
30. Barbee E. Tensions in the brokerage role: nurses in Botswana. *West J Nurs Res.* 1987;9:244–256.
31. Loffler R. The representative mediator and the new peasant. *Am Anthropol.* 1971;73:1074–1082.
32. Paine R. *Patrons and Brokers in East Arctic.* Toronto, Canada: University of Toronto Press; 1971. Newfoundland Social and Economic Papers No. 2.
33. Weidman H. Research strategies, structural alterations and clinically applied anthropology. In: Chrisman N, Maretzke T, eds. *Clinically Applied Anthropology.* Boston, Mass: D. Reidel; 1982.
34. Antonovsky A. Toward a refinement of the "marginal man" concept. *Soc Forces.* 1956;35:57–62.
35. Barnett H. *Innovation: The Basis of Cultural Change.* New York, NY: McGraw-Hill; 1953.
36. Adams R. Broker and career mobility systems in the structure of complex societies. *Southwest J Anthropol.* 1970;26:315–327.
37. Eisenhauer L. Health care brokering: a career option for changing times. *Nurs Health Care.* 1986;7:416–419.
38. Boissevain J. The place of non-groups in the social sciences. *Man* (New Series). 1969;4:542–556.
39. Benway S. By any other name: a stockbroker is still a stockbroker. *Barron's.* 1985;65(38):34,36.
40. Crawford D. Games show commodities broker strategies for amassing cash. *Wall St Comput Rev.* 1986;3:9–14.
41. Reynolds L. How to expand your markets. *Insurance Sales.* 1986;129(4):22–23.
42. Winters L, Dimino J. Power brokering in training. *Training.* 1984;21(5):49–55.

43. Jezewski M. *Using a Grounded Theory Method to Develop a Model of Culture Brokering in a Migrant Farmworker Health Care Setting.* Buffalo, NY: State University of New York at Buffalo; 1989. Dissertation. University Microfilms International 8913517.
44. Jezewski M. Culture brokering in migrant farmworker health care. *West J Nurs Res.* 1990;12:497–513.
45. Jezewski MA. Staying connected: the core of facilitating health care for homeless persons. *Public Health Nurs.* In press.
46. Jezewski MA, Scherer YK, Miller C, Battista E. Consenting to DNR: critical care nurses' interactions with patients and families. *Am J Crit Care.* 1993;2:302–309.
47. Jezewski MA: Do-not-resuscitate status: conflict and culture brokering in critical care units. *Heart Lung.* 1994;23:458–465.
48. Jezewski M. Oncology nurses' interactions with patients and families signing DNR consents: a preliminary analysis. *Oncol Nurs Soc West NY Chapter Newsletter.* 1993;11(3):1–2.
49. Rudner R. *Philosophy of Social Science.* Englewood Cliffs, NJ: Prentice Hall; 1966.
50. Jezewski M. Culture brokering as a model for advocacy. *Nurs Health Care.* 1993;14:78–85.
51. Jezewski MA. Nurse executives as culture brokers: a model for addressing diversity. *Aspen's Advisor Nurs Exec.* 1993;8(9):3–4.
52. Jezewski M. Acting as a culture broker for culturally diverse staff (208-94-4-48). *Capsules Comments Nurs Leadership Manage.* 1993;1(4):47.
53. Jezewski M. Nursing executives as culture brokers: a model for addressing diversity (208-94-4-47). *Capsules Comments Nurs Leadership Manage.* 1993;1(4):45.