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Comparison of Four Cultural Competence Models in Transcultural Nursing: A Discussion Paper

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Abstract

Globalization has brought about tremendous changes to societies around the world. Increased immigration has led to increasing diversity among patients, making culturally congruent healthcare an absolute necessity. Like all healthcare fields, nursing is expected to adopt a global practice of culturally congruent care. Thus, nurses must acquire an in-depth understanding of cultural beliefs, practices, and differences, thus developing a practice of avoiding premature generalizations. Cultural competence models have and will continue to play a crucial role in making nursing practice more efficient and effective. The aim of this paper is to describe and discuss four well-known cultural competence models in the nursing literature. These models have enhanced nursing care delivery to diverse populations by providing a means to overcome difficulties and challenges when dealing with culturally diverse patients. Ultimately, cultural care models encourage culturally competent care for patients belonging to different cultures by helping nurses become more understanding and adaptive to various circumstances, and better able to apply culturally-focused interventions. This paper reflects on the impact of cultural competence nursing education on patient care.

Keywords

Diversity, Culturally competent care, Cultural competence, Models

Introduction

Transcultural nursing has been integrated into modern nursing education due to the increased heterogeneity of patient populations. As more people from a variety of cultures and with a variety of ethnicities now utilize healthcare facilities, nurses need to be aware of their varying perceptions and levels of tolerance for healthcare. This situation can lead to departures from the practice norms that would otherwise direct patient care, thus opening up a wide array of options regarding treatments and follow-ups. Decision making in patient care involves many important considerations, including patients' attitudes and how they will react to treatment advice [1-3]. For these reasons, the adaptability of nursing professionals is crucial, particularly when it comes to cultural diversity, because this issue can affect the quality of service provided to patients.

Nurses should have sufficient information about different cultural backgrounds and customs to be able to conduct holistic patient assessments. For optimal care, the completion of a thorough assessment is particularly important when a patient comes from a different culture [4]. The provision of high-quality care builds patients' comfort and confidence in the healthcare system while promoting patient satisfaction [5]. Therefore, the assessment process should be designed to be accurate, comprehensive, and systematic; in essence, it should assist nurses in reaching concrete conclusions regarding suitable patient interventions [6,7]. To this end, researchers have developed models to help nurses overcome challenges when caring for culturally diverse patients. These models were designed to encourage culturally appropriate and culturally competent care, and the developers of the models emphasize how nurses can use this skill to work effectively with any population [8]. Following an introduction to transcultural nursing, this paper includes the comparison of four prominent models of cultural competence: Leininger, Giger and Davidhizar, Purnell and Campinha-Bacote [9-12]. It also discusses the application of these models with respect to the present literature and outlines the recommended standards for achieving best practices.

Concepts and Definitions

Transcultural nursing refers to various culture-related aspects of healthcare delivery that can affect disease management and the status of individuals' health and well-being [13]. The main objective of transcultural nursing is to promote the delivery of culturally congruent, meaningful, high-quality, and safe healthcare to patients belonging to similar or diverse cultures [13]. Accordingly, when different cultures are studied, healthcare professional scan understand their similarities and differences. Culture affects an individual's concepts and approaches to health and illness. Because nurses need to care for patients belonging to different cultures, cultural competence is essential for nursing [14].

Culture care emphasizes consideration of a patient's beliefs and heritage when developing a healthcare plan. Moreover, it requires nurses to acknowledge that individuals belong to different cultures and races and, therefore, necessitating treatment that respects the uniqueness of each individual [15]. Transcultural nursing employs the concepts of ethnicity, race, and culture in order to understand individuals' perceptions and behaviors. Nurses must consider these concepts in order to deliver culturally congruent healthcare. The nursing literature has developed a variety of applicable concepts, including acculturation, cultural awareness, and cultural competence.

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In addition, certain culture-related concepts are particularly relevant to healthcare and nursing [15]. These include culture, race, ethnicity, and cultural competence. Culture refers to a set of beliefs, assumptions, values, and norms that a group of individuals largely observe and transfer across generations [16]. Ingram defined culture as a learned worldview demonstrated by a group of individuals that is transferred socially [17]. Culture affects the beliefs, values, norms, and behaviors of individuals, and it is reflected in language, food, dress, and social institutions. Culture can significantly affect various aspects of human life, including health and preferences for managing health conditions. Multicultural trends are emerging in numerous countries due to globalization and mass immigration [17].

Each culture has distinct characteristics and therefore, individuals belonging to different cultures can differ considerably. These differences must be respected and each individual treated as a unique human being. Indeed, even people belonging to the same race may differ culturally. Race is a social classification based on physical characteristics like skin color [16]. It can also serve as an identifying trait of a culture. Similarly, ethnicity indicates cultural membership based on people having similar cultural characteristics that have led to a common history. Ethnicity tends to remain with people throughout their lives [16].

Cultural competence refers to a set of culturally congruent practices, behaviors, and policies that allow nursing professionals to deliver high-quality services in a variety of cross-cultural scenarios [16]. Cultural competence is an essential requirement in nursing. Culturally congruent healthcare does not aim to facilitate patient care for ethnic or racial minority groups only; rather, the objective is to improve healthcare delivery by considering differences in age, gender, religion, and socioeconomic status [18].

Healthcare professionals, especially nurses, should make an effort to understand and learn about different cultures. Understanding a patient's religious and cultural background can be highly beneficial in delivering healthcare. This understanding may cause healthcare professionals to evaluate their own cultural and religious beliefs, which may in turn influence their practices [19]. Such cultural awareness denotes an individual's self-awareness of his or her own cultural background, differences, and biases. Acculturation, on the other hand, signifies the process of learning about a new culture. Nurses should adapt to different cultures by making modifications to their nursing practices [20].

Evolution of Transcultural Nursing

Leininger uncovered a core concept of care during her early education; this concept later became her motivation to specialize in transcultural nursing specifically [9]. She explained this concept as a fundamental nursing component based on her experience and positive feedback from patients. During her work at a child-guidance home, she experienced a cultural shock, leading her to realize that a lack of understanding regarding cultural diversity could explain recurrent behavioral patterns in some children. She recognized a major deficit in understanding differential patient demands in the context of care and wellness. She maintained that the quality of nursing education suffered due to the absence of training in cultural diversity, the result being a disconnect between patient and nurse.

The theorist's identification of this problem shaped a new paradigm in nursing care, leading to the advent of transcultural nursing [9]. Leininger defined transcultural nursing as an area of study that focuses on comparative cultural care based on the beliefs, practices, and values of care-seeking patients. Its main purpose is to provide both universal and culture-based nursing practices that promote well-being and health. Additionally, it aims to help patients overcome illness in a culturally intelligent and responsive manner [16].

Models of Transcultural Nursing

Transcultural nursing models provide nurses with the foundation required for gaining knowledge about different cultures during healthcare delivery. The models are under continual development and they guide nursing practice all over the world. Hence, this paper focuses on the four particularly significant models.

Leininger Sunrise Model

The Leininger Sunrise Model represents the structure of culture care theory by describing the relationship between anthropological and nursing beliefs and principles [9]. Nurses use this model when making cultural evaluations of patients. The model connects the concepts of the theory with actual clinical practices, while offering a systemic approach to identifying values, beliefs, behaviors, and community customs. The model encompasses numerous aspects of culture: religious, financial, social, technological, educational, legal, political, and philosophical dimensions. These factors, along with language and social environment, significantly affect the services delivered by systems, whether traditional or professional. Traditional healthcare systems are based on conventional beliefs related to health, whereas professional systems rely on learned knowledge, evidence-based practice, and research [13]. The nursing profession considers patients' physical, spiritual, and cultural needs. A thorough understanding of these needs facilitates the achievement of desired clinical outcomes. Moreover, Leininger's model helps healthcare professionals to avoid the stereotyping of patients [13]. To accomplish such goals, the model utilizes three concepts: culture care maintenance/preservation, culture care negotiation/accommodation, and culture care restructuring/repatterning. Cultural preservation refers to nurses' provision of support for cultural practices, such as employing acupressure or acupuncture for anxiety and pain relief prior to medical interventions. Similarly, cultural negotiation refers to the support provided to the patients and their family members in carrying out cultural activities that do not pose threats to the health of the patients or any other individual in the healthcare setting. Finally, cultural restructuring refers to nurses' efforts to deliver patient-centered care by helping patients modify or change their cultural activities. Cultural restructuring is suggested only when certain cultural practices may cause harm to the patient or those in the surrounding environment. These concepts can inform nurses in achieving their ultimate goals [16].

Giger and Davidhizar Transcultural Assessment Model

This model emphasizes the importance of considering every person as unique in his or her culture [10]. According to Giger and Davidhizar, there are six dimensions common to every culture: communication, space, social organization, time, environmental control, and biological variation [10]. The first dimension is communication, which is the holistic process of human interaction and conduct. The use and preservation of communication takes several forms - verbal, nonverbal, and written - and differs in terms of expression, language and dialect, voice tone and volume, context, emotional implication, facial expression, gestures, and body language. Language can become a barrier to quality healthcare due to simple misunderstandings and failure to communicate as intended. The second dimension is space, which is the distance maintained between interacting individuals; this "personal space" differs according to individuals' cultural backgrounds. The concept of space involves three other behavioral patterns: attachment with objects in the environment, body posture, and movement in the setting [10]. It is important to observe tact and to avoid overstepping boundaries with respect to these aspects of interaction, because doing so can cause patients unnecessary anxiety. The third dimension is social organization, which is how certain cultures group themselves in accordance with family, beliefs, and duties. This dimension requires nurses to remain aware that patient conduct can be influenced by factors like sexual orientation, acknowledgement and utilization of titles, and decision-making regulations. An awareness of this dimension can help nurses avoid being perceived as being derogatory or disrespectful. The fourth dimension is time, which is similar to social organization in terms of influence. Time is subdivided into whether the group is clock-oriented,

like most Westerners, or socially oriented. The clock-oriented group is fixated on time itself, and individuals with this orientation seek to keep appointments so as not to be seen as ill-mannered or offensive. The behavior of socially oriented groups emphasizes the here and now. Such individuals understand time as a flexible spectrum defined by the duration of activities; an activity does not begin until the preceding event has ended. The fifth dimension is environmental control, which implicates how the person perceives society and its internal and external factors, such as beliefs and understandings regarding how illness occurs, how it should be treated, and how health is uplifted and maintained. The sixth and last dimension is biological orientation. Races vary biologically due to differences in DNA, and some races are more prone to certain diseases than others. Other notable elements of this model are a deeper understanding of pain tolerance and deficiencies and predilections in nutrition [21,22].

Purnell Model for Cultural Competence

The Purnell model focuses on providing a foundation for understanding the various attributes of a different culture, allowing nurses to adequately view patient attributes, such as incitement, experiences, and notions about healthcare and illness [11]. This model is presented in a diagram with parallel circles that represent aspects of global society as well as the community, family, and person. The Purnell model includes twelve domains: overview or heritage, communication, family roles and organization, workforce issues, bio-cultural ecology, high-risk behaviors, nutrition, pregnancy, death rituals, spirituality, healthcare practices, and healthcare professionals [11]. Purnell considered these domains to be important in evaluating the traits and characteristics of various ethnic groups. The model can be depicted with a frame representing global society and an outer circle signifying community. The second circle signifies family, and the innermost circle depicts the individual [23].

The first domain is culture and heritage, which includes the country of derivation, the geographical influence of the original and present home, political affairs, economics, educational status, and profession. The second domain comprises important notions relevant to communication, such as primary language and dialects, circumstantial effectiveness and convenience of the language, paralinguistic differences, and nonverbal communication. The third domain, family roles and organization, involves who heads the household in terms of gender and age. The organization of the family is affected by goals and priorities, developmental tasks, social status, and alternative lifestyles. The fourth domain is workforce issues, including acculturation, autonomy, and the presence of language barriers. The fifth domain includes factors of bio-cultural ecology, which encompass observable differences with respect to ethnic and racial origins, like skin color and other physical variations. The sixth domain is high-risk behaviors, such as using tobacco, alcohol, or recreational drugs. This domain also includes physical activity and levels of safety or precautions taken. The seventh domain is nutrition. Depending on their place of origin, individuals or groups are accustomed to certain foods and draw meaning from the foods they eat. Food consumption associated with certain rituals may affect health. Some ethnic groups suffer from certain nutritional limitations and deficiencies. The eighth domain is pregnancy. Pregnancy is viewed differently, because there are a myriad of beliefs accompanying this life phase. The act of birthing and the postpartum period involve certain practices that need to be taken into consideration when dealing with a particular ethno-cultural group. The ninth domain is death rituals. Perceptions of death differ from culture to culture in terms of how death is accepted, what rituals are performed, and how one should behave following a death. The tenth domain is spirituality, which includes religious practice, use of prayer, individual strength, the meaning of life, and how spirituality relates to health. The eleventh domain reflects healthcare practices. This domain includes the responsibility for health and the barriers that must be overcome to achieve successful health outcomes. Healthcare practices include traditional practices, magical religious practices, chronic-disease treatment and rehabilitation, mental-health practices, and the roles of the sick. The twelfth and final domain, healthcare professionals, involves the perceptions and roles of traditional and folk healthcare practices [24].

Campinha-Bacote Model of Cultural Competence in Healthcare Delivery

Campinha-Bacote first developed her model, known as "cultural competency in the delivery of healthcare services," in 1998, revising it in 2002 [12]. The model considers cultural competence not as a consequence brought about by certain factors, but as a process. The concept of cultural competence can be defined as a process in which the nurse attempts to achieve greater efficiency and the ability to work in a culturally diverse environment while caring for the patient, whether an individual, a family, or a group [12]. To achieve cultural competence, a nurse must undertake a process of developing the capacity to deliver efficient and high-quality care, a process that encompasses five components. The first involves cultural awareness, a process in which healthcare professionals consciously acknowledge their own cultural backgrounds, which helps them avoid biases toward other cultures. The second component is cultural skill, defined as the ability to obtain the necessary information from patients via culturally-appropriate conduct and physical assessment. The third component is cultural knowledge, a process in which healthcare professionals open their minds to understand variations in cultural and ethnic traits as they relate to patient attitudes toward illness and health. The fourth component is cultural encounter during which stereotyping is avoided through the interaction between healthcare professionals and members of different cultures. During this process, overreliance on conventional views is discouraged. The fifth and last component is cultural desire, which is the driving force for becoming educated, skilled, competent, and aware of culture; it also presumes a willingness to have transcultural interactions [25].

Discussion across Models

Transcultural nursing models have played a significant role in forming the basic foundations of nursing practice. Despite their positive contributions, the transcultural models have been criticized for their limitations and failure to acknowledge certain issues related to the educational and practical components of transcultural nursing [8]. For example, the Leininger model has been critiqued for failing to acknowledge political and structural processes. Critics have argued that it focuses exclusively on cultural diversity, biases, conventional views, and the inequity between nurses and patients. According to these critiques, the model also failsto acknowledge that cultural diversity needs to go beyond between group differences and be understood from the perspective of differences among individuals from the same culture, due to varying socioeconomic backgrounds, age groups, and types of communities. Conversely, the model has been praised for its clear and simple way of evaluating professional and societal cultures [3].

Integrating cultural competence models are a beneficial addition to nursing curricula and clinical training in undergraduate and graduate nursing programs [26-28]. Numerous studies have investigated how these models can be integrated effectively into nursing curricula. Kardong-Edgren and Campinha-Bacote assessed the effectiveness of four nursing programs' curricula in producing culturally competent graduates [29]. Two of these programs had adopted models advocated by transcultural-nursing theorists, such as Campinha-Bacote and Leininger. One of the other programs used an approach that integrated concepts from various models. The remaining program involves a free-standing course with no specific model used. According to the study's results, graduating nursing students scored in the culturally aware range, as measured by the Campinha-Bacote's Inventory for Assessing the Process of Cultural Competency among Healthcare Professionals-Revised (IAPCC-R) questionnaire, regardless of which program they attended [29].

This finding is consistent with Noble and Rom's study that employed the Campinha-Bacote model and an adaptation of the

IAPCC-R questionnaire to evaluate an educational intervention's effectiveness in strengthening the cultural competence of nursing students in Israel [30]. Nobel and Rom found that cultural knowledge among the students was low because they lacked an understanding of how cultural knowledge can be integrated with nursing interventions and applied in patient care. They also reported that employing a cultural competence program significantly enhances the level of cultural awareness among students, a realistic goal for undergraduate nursing students. Nobel and Rom also note that it may be more appropriate for faculty to expect a high level of cultural competence to occur after graduation [30]. Nobel and Rom also suggested that the usefulness of this approach was enhanced by allowing faculty who had experience with culturally competent care to share their expertise with faculty who were deficient in this respect [31,32].

The nursing program based on the Giger-Davidhizar transcultural assessment model was an appropriate guide for faculty to impart the skills necessary for culturally responsive and competent care with respect to six healthcare phenomena [10]. This simple and modern elaboration of the Leininger model is used to assess and strengthen nurses' acknowledgment of cultural diversity. Giger and Davidhizar take an approach that is different than Lininger's Sunrise Model, arguing that not every individual of the same culture or ethnicity behaves in the same manner. First developed in 2004, the model is used to help undergraduate nursing students provide and assess health care for individuals from varying cultural backgrounds. The current version of the model sets a framework that enables nurses to assess culture's role in health and illness. It can also serve as an academic and clinical framework for developing cultural competence [21].

In addition, the Purnell model is a framework that can be employed to incorporate transcultural competence into nursing practice [11]. Lipson and Desantis noted that the Purnell model often is used in undergraduate communication and health assessment programs [22]. This model can be used by all healthcare professionals in both their practice and academic development. As a result, the model represents an organizing framework that utilizes precise questions and provides a helpful format for assessing culture in clinical settings. Flexibility is one of the strongest features of the Purnell model, enhancing its applicability in various healthcare contexts. Moreover, the model's healthcare framework allows nurses to learn the different characteristics and concepts of cultural diversity. The model interlinks historical elements and their influence on a person's international cultural perspective and elaborates on the chief relationships of culture, thus allowing culturally competent care [22]. The model's framework encourages nurses to consider and reflect on the unique characteristics of every patient, including their views of illness, motivation, and healthcare. Finally, the model's structure facilitates the analysis of cultural data, allowing nurses to cater to families, groups, and individuals in terms of their respective cultural uniqueness using various communication strategies [24].

Critical Appraisal of Transcultural Models

Brathwaite compared several transcultural nursing models using the following criteria: comprehensiveness, logical congruence, conceptual clarity, level of abstraction, clinical utility, and perspective [33]. Only the Campinha-Bacotecultural-competence process model met all of Brathwaite's criteria. Brathwaite's review indicated that the Campinha-Bacote model incorporates five components (cultural awareness, cultural skills, cultural knowledge, cultural encounters, and cultural desire) that build upon one another in a logical progression, providing concise outcomes for interventions, a clear description of processes, and an immediate clinical benefit in optimizing patient care planning. Furthermore, the nursing literature indicated that the Campinha-Bacote model is the one most often used as a framework for research and is frequently cited. In addition, several authors have indicated that Campinha-Bacote model is suitable as a framework for incorporating cultural competence into their practice [6,34,35].

Despite the criticisms of some transcultural nursing models, they remain a significant part of nursing education and practice. Nurses can benefit from the Leininger model by learning a simple method of exploring professional and societal culture [9]. Additionally, Giger and Davidhizar's six components can enhance their understanding of the processes of observation and reflection [10]. On the other hand, the major assumptions of the Purnell model for cultural competence and their associated framework involves drawing on a broader perspective, which makes them applicable to all healthcare environments and practice disciplines [11]. Finally, the Campinha-Bacote model holds more immediate appeal, because it helps in addressing cultural competence with respect to healthcare delivery [12].

Establishing Best Practice Standards in Cultural Competence Nursing Education. In order to establish quality nursing care, optimum standards for both local and global settings need to be developed in the nursing profession [36]. Nursing requires a distinct approach, one that involves reaching successful endpoints of traditional education and strategies necessary to achieve such goals. Salminen et al. point out the significance of acknowledging the demonstration of competency categories [37].

They offer recommendations for dealing with the future challenges pertaining to nursing education. For instance, they recommended requiring competency courses for nursing students and practicing nurses in their academic curricula and continuing education workshops, respectively. These courses and workshops may include subject-specific content, learning strategies, and assessments for acquired learning. In addition, successfully addressing the needs of culturally diverse populations ultimately requires the combination of theoretical research and clinical practice [38]. Ensuring the provision of high-quality nursing education is guided by local, national, and international guidelines that lead to universal standards of culturally sensitive healthcare practice to disseminate knowledge by means of cross-cultural activities and encourage the understanding of diverse populations [39].

Conclusion

This paper discussed the transcultural nursing models of Leininger, Giger and Davidhizar, Purnell, and Campinha-Bacote. No particular model was deemed superior to the others; all four have made and can make significant contributions to nursing education and practice. Leininger developed her model to bring about the practice of culturally congruent nursing. Her research gave rise to the concept of transcultural competence in nursing. Giger and Davidhizar focuses on the individual, not just the cultural group, seeing each individual as culturally unique from the perspective of the six dimensions. Purnell created a diagrammatic representation containing twelve cultural domains, which determine variations in values, beliefs, and practices of an individual's cultural heritage. Campinha-Bacote defines cultural competence as a process instead of merely an endpoint. Overall, the Campinha-Bacote model is sufficiently comprehensive to guide empirical research and the development of educational interventions. The model's five components can be used to strengthen the cultural competence of nurses practicing in countries all over the world.

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