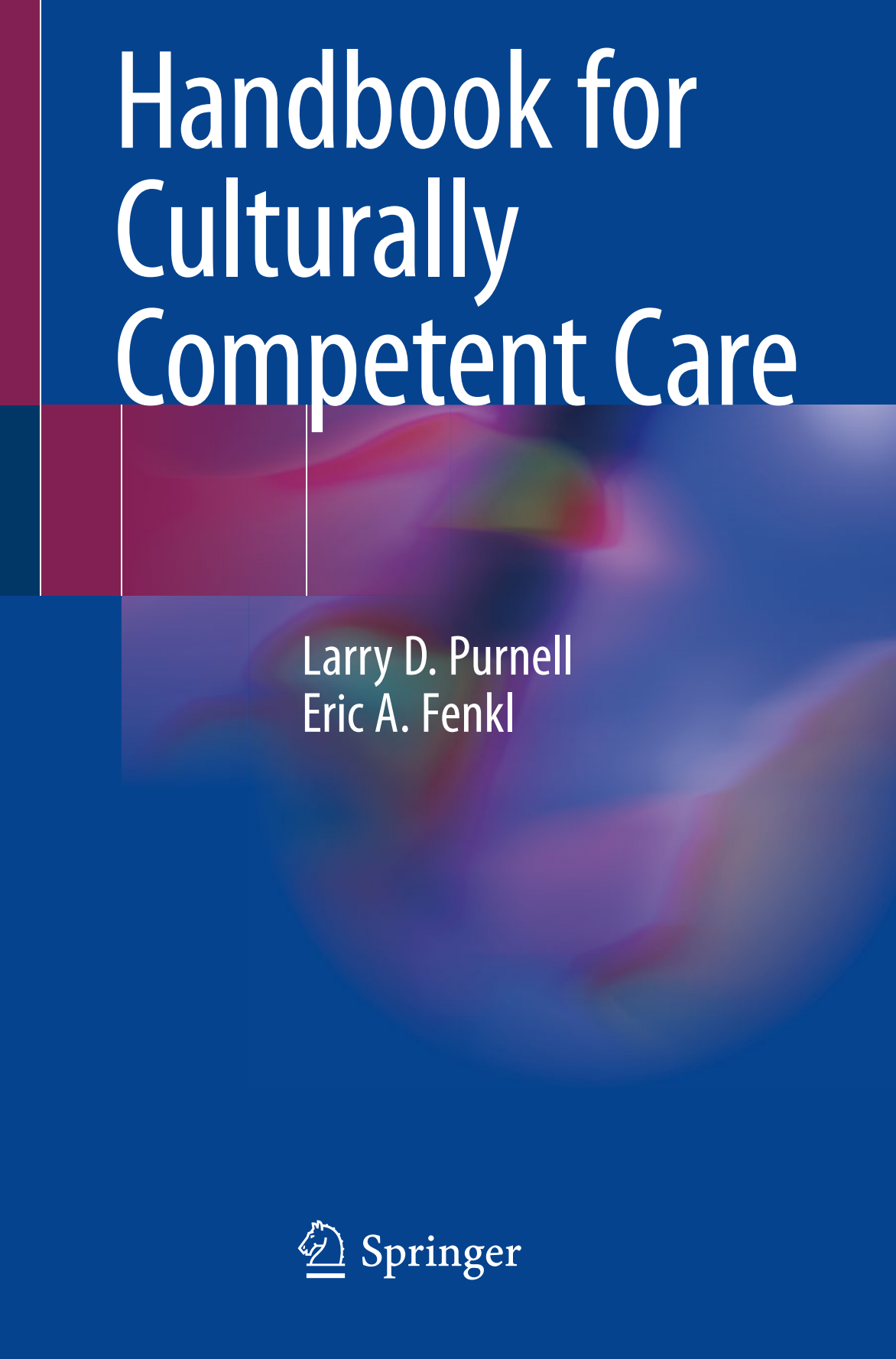
# Handbook for Culturally Competent Care

Larry D. Purnell
Eric A. Fenkl



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# Preface

The usefulness of the Purnell Model for Cultural Competence, its organizing framework, and comprehensive assessment guide has been established globally. They are being used worldwide for individual and family health-care assessment and planning and intervention in health promotion and wellness; illness, disease, and injury prevention; and health maintenance and restoration.

The aggregate data, a research principle, in culturally specific chapters is meant as a guide. The content may not apply to every individual in that culture depending on individual preferences, acculturation, and assimilation into the dominant culture. The variant cultural characteristics on the model help prevent stereotyping, assuring patients are individuals within their culture.

Each chapter is organized by the model's 12 domains of culturally competent care and provides key approaches and interventions highlighted in bold type, providing a quick reference for working with each individual. Thus, recommended approaches and interventions may need to be adapted based on patient's and family's personal perspectives and circumstances. The health-care provider must make a concerted effort to set aside any ingrained personal biases and prejudices.

With increased migration around the world, health-care providers are caring for patients whose cultures are foreign to them, making care more complex. Given the worldwide diversity, and the diversity within cultural groups, it is impossible to include the beliefs and practices of all cultures and subcultures.

Specific criteria were used for identifying the groups represented in the guide and were selected based on a variety of the following criteria:

- The group has a large population in North America, such as people of African American, Appalachian, Cuban, Jewish, and Mexican heritages.
- The group is relatively new in its migration status, such as people of Arab, Bosnian, Hmong, Somali, and Vietnamese heritages.
- The group is widely dispersed throughout the world, such as people of Chinese, Cuban, Greek, Filipino, Hindu, Iranian, and Puerto Rican heritages.

- The group has little written about it in the health-care literature, such as people of Brazilian, Haitian, Japanese, Korean, Russian, and Turkish heritages.
- The group was of particular interest to the readers, such as people from Amish, Hmong, and Somali heritages.

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# Contents

# Introduction

Caring for culturally diverse patients and families has become commonplace throughout most of North America and worldwide. Geographical areas that previously were largely homogenous, with the exception of possibly one or two culturally diverse groups, no longer exist. This multicultural mosaic being created is adding richness to our communities and societies at large.

Many cultural groups fall into the category of vulnerable populations with increased health and health-care disparities. Even when disparities are not a concern, patient satisfaction may be of concern. If we are to decrease health and health-care disparities and increase patient satisfaction, more attention must be paid to cultural values, beliefs, and practices, which include spirituality and complementary and alternative therapies. If health-care providers and health-care delivery systems do not adapt and include diverse practices, patient and family care are compromised, resulting in not only poorer health outcomes but also an increase in cost.

Recent efforts to promote global recognition of multiculturalism have encouraged health-care providers to become more aware of their own cultures and to the cultural differences among their patients in order to provide effective, acceptable, and safe health care. Each provider and organization must make a strong commitment to providing culturally competent care, regardless of the setting in which the care is provided and the backgrounds of the participants in care. As a result of this commitment, health-care organizations and educational programs have begun to recognize the need to prepare health-care professionals with the knowledge, skills, and resources essential to the provision of culturally competent care.

Culturally competent providers value diversity and respect individual differences regardless of one's race, religious beliefs, or ethnocultural background. The goal of this Guide is to provide a framework to promote transculturally competent care that respects each person's right to be understood and treated as a unique individual.

Educational programs and access to resources necessary for cultural competence are not always readily available in a format that is concise and easy to use. This Guide has been developed to be used in a manner that can be easily accessed and understood. This approach to gaining essential knowledge using aggregate data is

designed to help health-care professionals provide the highest quality care for patients and families of all backgrounds. Respect is essential to the development of dynamic interpersonal relationships that promote a positive influence on each person's interpretation of, and responses to, health care in a multicultural environment.

The real challenge for health-care providers is gaining timely access to concise information that facilitates an accurate understanding of cultural beliefs from the perspective of both the patient and the provider. This concise Guide uses the Purnell Model as a framework to simplify health assessments and interventions quickly and accurately, while enabling culturally relevant care. Although the primary focus of the handbook is on the needs of health-care providers in the United States, the organizing framework and major concepts presented in each chapter are relevant to multicultural health care throughout the world. The small size of this Guide and the outline format of its presentation, with recommended highlighted culturally relevant interventions, make it an essential resource for all health-care providers who are committed to providing culturally competent care, regardless of their practice setting.

# Chapter 1
# Transcultural Diversity and Health Care


## 1.1 The Need for Culturally Competent Health Care

The need for cultural competence is increasingly recognized by health-care providers and health-related organizations in the United States and globally. The social ideology of a melting pot has been replaced by recognizing that people deserve respect within their cultural framework and as individuals. The literature on health and health-care disparities across ethnic, social, and economic groups continues to demonstrate compelling evidence for health-care providers and health-care organizations to be attentive to cultural diversity and inclusion as well as cultural competency. Major goals of Healthy People 2020 that impact on health disparities, with culture being one force to help eliminate them, are to (a) attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; (b) achieve health equity, eliminate disparities, and improve the health of all groups; (c) create social and physical environments that promote good health for all; and (d) promote quality of life, healthy development, and healthy behaviors across all life stages.

Culture is defined as the totality of socially transmitted behavioral patterns, beliefs, values, customs, lifeways, arts, and all other products of human work and thought characteristics of a population of people that guide their worldview and decision making. These patterns may be explicit or implicit, are primarily learned and transmitted within the family, are shared by most members of the culture, and are emergent phenomena that change in response to global phenomena and technological advancements. Culture is learned first in the family, then in school, and then in the community and other social organizations. Culture is largely unconscious and has powerful influences on health and illness beliefs and treatment. Health-care providers must recognize, respect, and integrate patients' cultural beliefs and practices into health prescriptions to help eliminate or mitigate health disparities and provide patient satisfaction.

This handbook describes aggregate data on the dominant cultural characteristics of selected ethnocultural groups and provides a guide for assessing cultural



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values, beliefs, and practices. Based on individuality and the **variant cultural characteristics of culture** listed below, aggregate data will **not fit every individual in a cultural group.** Health-care providers who understand their own cultures and their patients' cultural values, beliefs, and practices are in a better position to interact with their patients and provide culturally acceptable care that increases opportunities for health promotion and wellness; illness, disease, and injury prevention; and health maintenance and restoration. To this end, health-care providers need both cultural general and specific cultural knowledge. The more one knows about a cultural group, the more targeted will be the assessment and interventions. Without specific knowledge of cultural groups for whom they provide care, health-care providers might not know what questions to ask to provide culturally competent care. However, any generalization made from aggregate data about the behaviors of a cultural group or individual is almost certain to be an oversimplification; within all cultures are subcultures, ethnic groups, and individuals who do not adhere to all the values of their dominant culture and vary according to variant cultural characteristics as identified later in this chapter. Subcultures, ethnic groups, and ethnocultural populations are groups of people who have experiences different from those of the dominant culture with which they identify. For this Guide, subcultures are defined as a group of people from several cultures who join together for an array of reasons. For example, a support group for substance abusers, bikers, or veterans may have members from European American, Korean, and Panamanian cultures; they create their own subculture within their dominant culture.

Culture has a powerful unconscious impact on health professionals. Each health-care provider adds a unique dimension to the complexity of providing culturally competent care. The way health-care providers perceive themselves as competent providers is often reflected in the way they communicate with patients. Thus, it is essential for health providers to think about themselves, their behaviors, and their communication styles in relation to their perceptions of different cultures. Before addressing the multicultural backgrounds and unique individual perspectives of each patient, health-care professionals must first address their own personal and professional knowledge, values, beliefs, ethics, and life experiences in a manner that optimizes assessment of and interactions with patients who come from a culture different from that of the health-care provider. Self-awareness in cultural competence is a deliberate and conscious cognitive and emotional process of getting to know oneself: one's own personality, values, beliefs, professional knowledge, standards, ethics, and the impact of these factors on the various roles one plays when interacting with individuals who are different from oneself. The ability to understand oneself sets the stage for integrating new knowledge related to cultural differences into the professional's knowledge base and perceptions of health interventions.

Culture and race are not synonymous. However, the controversial term *race* must be addressed when learning about culture. Race is genetic and includes physical characteristics that are similar among members of the same group, such as skin color, blood type, and hair and eye color. Although there is less than a 1% genetic

difference among the races, this difference is significant when conducting health assessments, determining genetic conditions, and prescribing medications and treatments, as outlined in culturally specific chapters that follow. People from a given racial group may, but do not necessarily, share a common culture. Perhaps the most significant aspect of race is social in origin; race can either decrease or increase opportunities, depending on the environmental context.

## 1.2 Variant Characteristics of Culture

Major attributes that shape peoples' worldview and the extent to which people identify with their cultural group of origin are called variant characteristics of culture. Some characteristics may change while others remain stable over life. Variant characteristics include:

- nationality,
- race,
- skin color,
- gender,
- age,
- religious affiliation,
- educational status,
- socioeconomic status,
- occupation,
- military experience,
- political beliefs,
- urban versus rural residence,
- enclave identity,
- marital status,
- parental status,
- physical characteristics,
- sexual orientation,
- gender issues,
- health literacy,
- length of time away from the country of origin, and
- reason for migration (sojourner, immigrant, or undocumented status).

Immigration status influences a person's worldview. For example, people who voluntarily immigrate generally acculturate and assimilate more easily. Sojourners who immigrate with the intention of remaining in their new homeland for only a short time or refugees who think they may return to their home country may not have the need or desire to acculturate or assimilate. Additionally, undocumented individuals (illegal immigrants) may have a different worldview from those who have arrived legally. Some variant characteristics of culture may be fluid and should not be seen as categorically imperative.

The literature reports many definitions for the terms *cultural awareness, cultural sensitivity*, and *cultural competence*. Sometimes these definitions are used interchangeably. However, cultural awareness has more to do with an appreciation of the external or material signs of diversity, such as the arts, music, dress, or physical characteristics. Cultural sensitivity has more to do with personal attitudes and not saying things that might be offensive to someone from a cultural or ethnic background different from that of the health-care provider. Increasing one's consciousness of cultural diversity improves the possibilities for health-care providers to provide culturally competent care. Cultural competence, as used in this book, means:

1. Developing an awareness of one's own existence, sensations, thoughts, and environment without letting them have an undue influence on those from other backgrounds.
2. Demonstrating knowledge and understanding of the patient's culture, health-related needs, and culturally specific meanings of health and illness.
3. Continuing to learn about cultures of patients to whom one provides care.
4. Recognizing that the variant cultural characteristics determine the degree to which patients adhere to the beliefs, values, and practices of their dominant culture.
5. Accepting and respecting cultural differences in a manner that facilitates the patient's and family's abilities to make decisions to meet their needs and beliefs.
6. Not assuming that the health-care provider's beliefs and values are the same as the patient's.
7. Resisting judgmental attitudes such as "different is not as good."
8. Being open to cultural encounters.
9. Being comfortable with cultural encounters.
10. Adapting care to be congruent with the patient's culture.
11. Engaging in cultural competence is a conscious process and not necessarily a linear one.
12. Accepting responsibility for one's own education in cultural competence by attending conferences, reading professional literature, and observing cultural practices.

As of July 2015, the U.S. population was more than 321 million (U.S. Department of Commerce: U.S. Census Bureau 2015). Immigration continues at approximately 11% per year. India was the leading country of origin for new immigrants, with 147,500 arriving in 2014, followed by China with 131,800, Mexico with 130,000, Canada with 41,200, and the Philippines with 40,500. Table 1.1 shows the diversity of the U.S. population.

The census collects data on two categories: race and ethnicity; therefore, these numbers total more than 100%. Race and Hispanic origin are two separate and distinct categories. Race categories as used in Census 2010 include the following:

1. *White* refers to people having origins in any of the original peoples of Europe, the Near East, the Middle East, and North Africa. This category includes Irish, German, Italian, Lebanese, Turkish, Arab, and Polish.

**Table 1.1** Diversity of the U.S. population as of July, 2015

| | |
|---|---|
| White persons | 77.1% |
| Persons of Hispanic or Latino origin | 17.6% |
| Black and African American | 13.3% |
| Asian | 5.6% |
| American Indian/Alaskan Native | 1.2% |
| Native Hawaiian and other Pacific Islanders | 0.2% |
| Persons with two or more races | 2.6% |
| White persons—not Hispanic | 63.7% |

Data from U.S. Department of Commerce: U.S. Census Bureau (2018). Retrieved from http://quickfacts.census.gov/qfd/states/00000.html

2. *Black* and *African American* refer to people having origins in any of the black racial groups of Africa and include Nigerians and Haitians and any person who self-designated this category regardless of origin.
3. *American Indian* and *Alaskan Native* refer to people having origins in any of the original peoples of North, South, and Central America and who maintain tribal affiliation or community attachment.
4. *Asian* refers to people having origins in any of the original peoples of the Far East, Southeast Asia, and the Indian subcontinent. This category includes the terms *Asian Indian, Chinese, Filipino, Korean, Japanese, Vietnamese, Burmese, Hmong, Pakistani*, and *Thai*.
5. *Native Hawaiian* and other *Pacific Islander* refer to people having origins in any of the original peoples of Hawaii, Guam, Samoa, Tahiti, the Mariana Islands, and Chuuk.
6. *Some other race* was included for people who are unable to identify with the other categories. Additionally, the respondent could identify, as a write-in, with two races (U.S. Department of Commerce: U.S. Census Bureau 2015).

## 1.3 Reflective Exercises

1. What changes in ethnic and cultural diversity have you seen in your community over the last 5 years? Over the last 10 years? Have you had the opportunity to interact with newer groups?
2. What health disparities have you observed in your community? To what do you attribute these disparities? What can you do as a professional to help decrease these disparities?
3. Who in your family had the most influence in teaching you cultural values and practices? Mother, father, grandparent?
4. What activities have you done to increase your cultural competence?
5. Given that everyone is ethnocentric to some degree, what do you do to become less ethnocentric?
6. How do you distinguish a stereotype from a generalization?
7. How have your variant characteristics of culture changed over time?

8. Distinguish between a stereotype and a generalization.
9. What ethnic and racial groups do you encounter on a regular basis? Do you see any racism or discrimination among these groups?
10. What does your organization do to increase diversity and cultural competence?

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# Chapter 2
# The Purnell Model for Cultural Competence


The Purnell Model for Cultural Competence and its organizing framework can be used as a guide for assessing the culture of patients. The major explicit assumptions on which the Purnell Model is based include the following:

1. All health-care professions need similar information about cultural diversity.
2. All health-care professions share the metaparadigm concepts of global society, family, person, and health.
3. One culture is not better than another culture; they are just different.
4. Core similarities are shared by all cultures.
5. Differences exist within, between, and among cultures.
6. Cultures change slowly over time.
7. The variant cultural characteristics (see Chap. 1) determine the extent to which one varies from the dominant culture.
8. If patients are coparticipants in their care and have a choice in health-related goals, plans, and interventions, their health outcomes will be improved.
9. Culture has a powerful influence on one's interpretation of and responses to health care.
10. Individuals and families belong to several subcultures.
11. Each individual has the right to be respected for his or her uniqueness and cultural heritage.
12. Caregivers need both cultural-general and cultural-specific information in order to provide culturally congruent care.
13. Caregivers who can assess, plan, intervene, and evaluate in a culturally competent manner will improve the care of patients for whom they care.
14. Learning culture is an ongoing process that develops in a variety of ways, but primarily through cultural encounters (www.transculturalcare.net).
15. Prejudices and biases can be minimized with cultural understanding.
16. To be effective, health care must reflect the unique understanding of the values, beliefs, attitudes, lifeways, and worldview of diverse populations and individual acculturation and assimilation patterns.



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17. Differences in race and culture often require adaptations to standard interventions.
18. Cultural awareness improves the caregiver's self-awareness.
19. Professions, organizations, and associations have their own culture, which can be analyzed using a grand theory of culture.
20. Every patient encounter is a cultural encounter.
21. Providers who engage in critical self-reflection have a better understanding of their own biases and of patient's cultures.

## 2.1 The Purnell Model

The Purnell Model for Cultural Competence and its organizing framework can be used in all practice settings and by all health-care providers. Moreover, it has been classified a holographic and complexity grand theory. In fact, even mediators with the American Bar Association have found the model valuable. The model is a circle, with an outlying rim representing global society, a second rim representing community, a third rim representing family, and an inner rim representing the person (Fig. 2.1). The interior of the circle is divided into 12 pie-shaped wedges depicting cultural domains (constructs) and their associated concepts. The dark center of the circle represents unknown phenomena. Along the bottom of the model is a jagged line representing the nonlinear concept of cultural consciousness. The 12 cultural domains and their concepts provide the organizing framework. Each domain includes concepts that need to be addressed when assessing patients in various settings. Moreover, health-care providers can use these same concepts to better understand their own cultural beliefs, attitudes, values, practices, and behaviors. An important concept to understand is that no single domain stands alone; they are all interconnected. The 12 domains are overview/heritage, communications, family roles and organization, workforce issues, biocultural ecology, high-risk health behaviors, nutrition, pregnancy and the childbearing family, death rituals, spirituality, health-care practices, and health-care practitioners. For a more complete description of the domains, the reader is referred to the textbook by Purnell, *Transcultural Health Care: A Culturally Competent Approach* (2013, Fourth Edition, F.A. Davis Company).

### *2.1.1 Assessment Guide*

Following each of the domains and concepts is a box that includes suggested questions to ask and observations to make when assessing patients from a cultural perspective. It is recognized that clinicians are not able to complete a thorough cultural assessment for every patient. The list of questions is extensive; thus, the clinician must determine which questions to ask according to the patient's presenting symptoms, teaching needs, and the potential impact of culture.

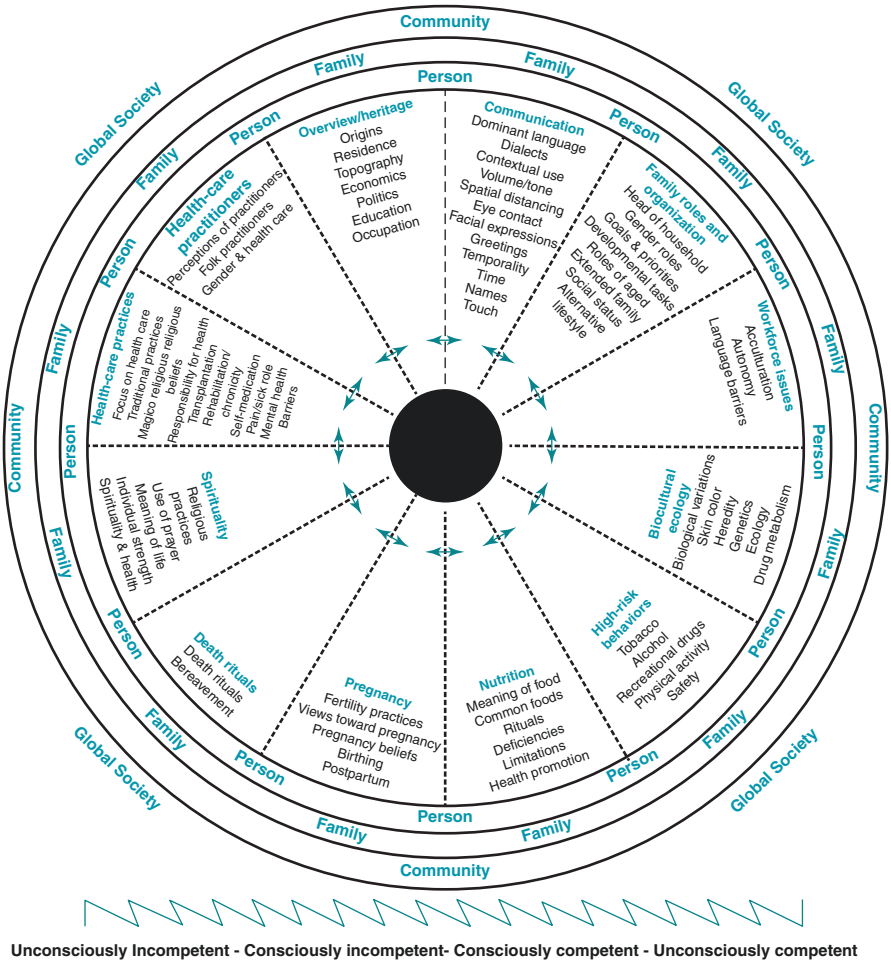


**Fig. 2.1** The Purnell model for cultural competence

## *2.1.2 Domains and Concepts*

### 2.1.2.1 Overview and Heritage

Includes concepts related to the country of origin and current residence; the effects of the topography of the country of origin and the current residence on health, economics, politics, reasons for migration, educational status, and occupations. See table below.

#### 2.1.2.2 Communications

Includes concepts related to the dominant language, dialects, and the contextual use of the language; paralanguage variations such as voice volume, tone, intonations, inflections, and willingness to share thoughts and feelings; nonverbal communications such as eye contact, gesturing and facial expressions, use of touch, body language, spatial distancing practices, and acceptable greetings; temporality in terms of past, present, and future orientation of worldview; clock versus social time; and the amount of formality in use of names. Differences between the language spoken by the health-care provider and the patient, educational level, and health literacy are additional communication add to the communication difficulties. Effective communication is the first and probably the most important aspect of obtaining an accurate assessment. See table below.

#### 2.1.2.3 Family Roles and Organization

Includes concepts related to the head of the household, gender roles (a product of biology and culture), family goals and priorities, developmental tasks of children and adolescents, roles of the aged and extended family, individual and family social status in the community, and acceptance of alternative lifestyles such as single parenting, same sex partnerships and marriage, childless marriages, and divorce. See table below.

#### 2.1.2.4 Workforce Issues

Includes concepts related to autonomy, acculturation, assimilation, gender roles, ethnic communication styles, and health-care practices of the country of origin. See table below.

#### 2.1.2.5 Biocultural Ecology

Includes physical, biological, and physiological variations among ethnic and racial groups such as skin color (the most evident) and physical differences in body habitus; genetic, hereditary, endemic, and topographical diseases; psychological makeup of individuals; and the physiological differences that affect the way drugs are metabolized by the body. In general, most diseases and illnesses can be divided into three categories: lifestyle, environment, and genetics.

*Lifestyle* causes include cultural practices and behaviors that can generally be controlled: for example, smoking, diet, and stress.

*Environment* causes refer to the external environment (e.g., air and water pollution) and situations over which the individual has little or no control (e.g., presence of malarial mosquitos, exposure to chemicals and pesticides, access to care, and associated diseases and illnesses). See table below.

*Genetic* conditions are caused by genes.

#### 2.1.2.6 High-Risk Health Behaviors

Includes substance use and misuse of tobacco, alcohol, and recreational drugs; lack of physical activity; increased calorie consumption; nonuse of safety measures such as seat belts, helmets, and safe driving practices; and not taking safety measures to prevent contracting HIV and sexually transmitted infections. See table below.

#### 2.1.2.7 Nutrition

Includes the meaning of food, common foods and rituals, nutritional deficiencies and food limitations, and the use of food for health promotion and wellness, and illness and disease prevention. Multiple diseases and illnesses are a consequence of this major cultural component. See table below.

#### 2.1.2.8 Pregnancy and Childbearing Practices

Includes culturally sanctioned and unsanctioned fertility practices; views on pregnancy; and prescriptive, restrictive, and taboo practices related to pregnancy, birthing, and the postpartum period. See table below.

#### 2.1.2.9 Death Rituals

Includes how the individual and the society view death and euthanasia, rituals to prepare for death, burial practices, and bereavement behaviors. Death rituals are slow to change. See table below.

#### 2.1.2.10 Spirituality

Includes formal religious beliefs related to faith and affiliation and the use of prayer; behavior practices that give meaning to life; and individual sources of strength. See table below.

#### 2.1.2.11 Health-Care Practices

Includes the focus of health care (acute versus preventive); traditional, magico-religious, and biomedical beliefs and practices; individual responsibility for health; self-medicating practices; views on mental illness, chronicity, and rehabilitation; acceptance of blood and blood products; and organ donation and transplantation. See table below.