

A Review of the Theoretical Framework of Culture and Value Applied to Nursing

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ABSTRACT

Background: Culture is a unique component of each patient, and nurses are charged with caring for the whole patient while in their care. Cultural competence is an important tool that guides the practice of the nurse while providing care to the patient. Understanding the theory behind culture and the nurses' cultural competence. The Purnell Model of Cultural Competence (PMCC) is a valid framework to apply to the application of culture and values. As health care in the US is changing, it is important to note the impact that culture plays in health outcomes. This article explores the use of the PMCC to culture and values as it applies to health care. The intent is to provide an overview of the theory, relate the theory to the concepts, discuss the existing research, recommendations from the existing research, and application to future research recommendations.

Keywords: *Purnell Model of Cultural Competence, nursing, health, culture, values.*

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Background:

The Purnell Model of Cultural Competence (PMCC) is used as a mid-range theory for research examining culture, and within the context of culture, values are also discussed. The PMCC is a mid-range theory created by Larry Purnell, and it is based upon his observations of undergraduate nursing students interacting with patients from different cultural backgrounds (Purnell, 2002). Culturally competency is a key agenda item for healthcare in the U.S. (Fortier, 2004), and healthcare professional programs, such as nursing, are experimenting with charge of teaching culturally competent healthcare.

Relationship of Framework to Concepts

Culture and value are two key concepts related to the study of cultural competence in undergraduate nursing students, and the PMCC explains the relationship of an individual's journey from cultural incompetency to competency within the context of values. Culture is defined as the manner in which individuals behave and make decisions in a social organization, and it is dependent upon factors such as the individual's ethnicity, minority status, customs, religion, world views, and upbringing. Value is defined as a certain sense of worth, a benefit, and subjective, and the subjective nature of value means the individual has a perception of value dependent upon his or her culture, experiences, and personality. The two concepts of culture and value are related to the PMCC as they are essential components of the framework.

Use of Theory in Existing Research

The PMCC is cited frequently in research as the mid-range theory examining the impact of cultural competence and interactions between two or more cultural groups. Cultural competency is relevant in healthcare education as minorities will constitute 54% of the total U.S. population by 2050 (U.S. Census Bureau, 2008). Research in cultural competence using the PMCC also evaluates the impact of interventions such as service learning and the change on cultural competence following the intervention (Callen & Lee, 2009; Chen, McAdams-Jones, Tay, & Packer, 2012; Hayward & Charrette, 2012; Lipson & DeSantis, 2007). Studies examining the impact of service learning show a statistically significant increase in cultural competence for experimental subjects. Research uses the PMCC as a means to guide and evaluate the teaching of cultural competence in health services related curriculum (Crandall, George, Marion, & Davis, 2003; Watts, Cuellar, & O'Sullivan, 2008). Some healthcare providers have conducted research regarding the PMCC and developed a framework for cultural safety to serve the unique needs of its population (Woods, 2010). Research involving the PMCC is used as the theoretical framework for determining the healthcare providers role and responsibilities in caring for particularly vulnerable populations, such as patients seeking asylum and healthcare in the host country (Suurmond, Seeleman, Rupp, Goosen, & Stronks, 2010) and minority cancer patients (Yeo, Phillips, Delengowski, Griffiths, & Purnell, 2011). Additional research using the PMCC examines cultural assessment tools, such as the Blueprint for Integration of Cultural Competence in the Curriculum Questionnaire (BICCCQ) (Tulman & Watts, 2008). It is important to note that the PMCC is often used in conjunction with other mid-range theories related to culture or cultural competence, and much of the previously described research is based on a combination of the PMCC and other cultural competence frameworks.

Recommendations from Existing Research

Current research offers many recommendations related to the PMCC. Literature regarding service learning recommends that service-learning projects constitute a longer time span, such as an immersion experience, for the maximum effect (Chen et al., 2012). Some schools have found the PMCC to be effective in teaching cultural competency, and some schools recommend researching other cultural competency frameworks to determine the best fit for a particular educational program and an evaluation of the curriculum (Crandall et al., 2003; Watts et al., 2008; Tulman et al., 2008). Research recommends that despite the provider's level of cultural competence, the provider show be aware that some culturally diverse groups may challenge the cultural competencies of even the most skilled culturally competent caregiver (Suurmond et al., 2010; Yeo et al., 2011). The strongest recommendations from the literature include a prolonged period of exposure to cultural competence learning, and the finding supports the proposed research included in this paper.

Application to Future Research

The concepts of culture and value are explored within the PMCC model. The PMCC frames the journey along the continuum of cultural competence in a manner that the interaction between culture and values are well integrated.

The PMCC is depicted as four progressively smaller circles representing from largest to smallest, global society, community, family, and person. The inside of the circle is separated into 12 triangles depicting different values, referred to as cultural domains, and their accompanying concepts. The bottom of the visual depiction of the model is a jagged line representing the nonlinear concept of cultural consciousness. The 12 triangles, or domains, include overview and heritage, communication, family roles and organization, workforce issues, bio-cultural ecology, high-risk health behaviors, nutrition, pregnancy and childbearing practices, death rituals, spirituality, healthcare practices, and healthcare practitioners. The values are related to all facets of culture as they are represented within the innermost circle, and the model implies that external factors shape cultural competence. Amongst the external factors that influence cultural competence, although it is not enumerated, education is present in all four layers of the circles: global society, community, family, and the person. In an attempt to clarify the contribution of education related to cultural competence, education is depicted through the addition of an education box along non-linear functioning between unconsciously culturally incompetent to consciously culturally incompetent to consciously culturally competent to unconsciously culturally competent (see Appendix B). It is thought that education can serve as an interdependent variable to change the level of cultural competence and values as measured through different assessments and tools.

Previous research has indicated that cultural competence increases with exposure to a diverse range of cultural experiences (Campinha-Bacote, 1999), and the PMCC supports the addition of cultural education as a means to expose students to cultural competence. The purpose of the research is to determine the effect of teaching cultural competence to undergraduate nursing students outside of a service learning component. The PMCC suggests that along the continuum of cultural competence, education may play a role in the change of the student's level of cultural competence as measured with pre- and post- scores of undergraduate nursing students' level of cultural competence (Purnell, 2002).

The dependent variables measured in the research include the attitudes of healthcare providers towards the culture of others, the healthcare providers' attitude towards their values, and the correlation between culture and values, and the independent variable is education. The PMCC illustrates 12 values, and they all fit within the research study. The attitudes of the healthcare provider towards patients' culture and values may change with education. It is important to remember that cultural competence is not considered to be cultural expertise related to all cultural groups. Cultural competence implies that the healthcare provider knows enough to seek additional resources when working with groups that are unfamiliar to their skillset.

The value (domain) of overview and heritage suggests that each person is a unique individual with a past that shapes their cultural identity. When education is introduced, it may impact this domain by providing the healthcare provider with a better understanding of cultural background issues specific to one particular group. The value of communication coupled with education suggests that the healthcare provider may have a better understanding of communication with diverse groups if the provider receives information that not all cultural groups communicate in the same manner. The healthcare provider may be able to interpret different communication styles in a more culturally competent manner.

Family roles and organization are affected through education as the healthcare provider may now have a better understanding of the value of family role structure and change the way they provide care. Workforce issues and the value different cultures place on work are often unique to different cultural groups, and providing education on cultural competence may change the attitudes healthcare providers convey towards unique cultural groups. Bio-cultural ecology, such as skin color or genetics, should come as an educational component for the healthcare professional as it would be prudent to understand genetic risks related to a certain patient.

High-risk health behaviors, such as safety and physical activity concerns may require education for the healthcare provider to understand the implications related to certain cultural groups. Nutritional needs, such as limitations and common foods may require education or they patient may not receive adequate nutrition if they are not served culturally appropriate foods. Different cultures have different pregnancy and childbearing practices that they value, and the culturally competent healthcare provider should have a working knowledge of these. Death rituals are largely dependent upon the background of the client, and the culturally competent healthcare provider will recognize this. Spirituality is a concern for the healthcare provider as they care from culturally diverse patients, and it includes things like religion and the meaning of life. Healthcare practices, such as self-medication and mental health barriers are relevant for the healthcare practitioner, and if barriers exist, the culturally competent healthcare provider would address barriers with the patient. The last domain, or value, is healthcare practitioners, and this involves the perceptions of healthcare providers and use of folk provider. The culturally competent healthcare provider would be able to value the contribution of folk healers if the patient valued the practice of folk healers.

Education will change the pre- and post- assessment scores with relation to the attitudes of culture and value held by the provider. It is essential to understand the concepts of culture and values because of the impact of these things on healthcare to patients. Undergraduate nursing education appears to be an appropriate time to provide culturally competent education and measure the change in the level of cultural competence and change in values associated with such education. The true measure of change related to both concepts has not yet been explored, and is essential to understand the PMCC related to nursing education.

Conclusion

Cultural competence in healthcare is becoming more essential to the list of skills the healthcare provider must utilize when caring for patients. The PMCC is a model that guides the incorporation of culture and values and leaves room for the educational component necessary for changing the level of cultural competence the healthcare provider uses in interacting with the growing culturally diverse population within the U.S. Undergraduate nursing is a key opportunity to conduct culturally competent education

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