The Purnell Model for Cultural Competence

LARRY PURNELL, PhD, RN, FAAN
University of Delaware

This article provides an overview of the Purnell Model for Cultural Competence and the assumptions on which the model is based. The 12 domains comprising the organizing framework are briefly described along with the primary and secondary characteristics of culture, which determine variations in values, beliefs, and practices of an individual's cultural heritage. All health care providers in any practice setting can use the model, which makes it especially desirable in today's team-oriented health care environment. The model has been used by nurses, physicians, and physical and occupational therapists in practice, education, administration, and research in Australia, Belgium, Canada, Central America, Great Britain, Korea, South America, and Sweden. The model has also been translated into Flemish, French, Korean, and Spanish. Although the model is only 4 years old, it shows promise for becoming a major contribution to transcultural nursing and health care.

The Purnell Model for Cultural Competence started as an organizing framework for student nurses to use as a clinical assessment tool. The following year, a schematic, the metaparadigm concepts, and the cultural competence scale were added. Because the model has a schematic combined with an organizing framework and because it is applicable to all health care disciplines in all practice settings, it has been classified by some nurse theorists as complexity and holographic theory. The intention of the textbook, *Transcultural Health Care: A Culturally Competent Approach* (1998), which contains chapters on 27 cultural groups, was to provide general and cultural specific knowledge. The model has now been translated into French, Spanish, Flemish, and Korean.

MAJOR ASSUMPTIONS

The assumptions are developed from a broad perspective, allowing their use across practice disciplines and environmental contexts. A culturally competent health care provider develops an awareness of his or her existence, sensations, thoughts, and environment without letting these factors have an undue effect on those for whom care is provided. Cultural competence is the adaptation of care in a manner that is consistent with the culture of the client and is therefore a conscious process and nonlinear. The major assumptions follow.

1. All health care professions need similar information about cultural diversity.
2. All health care professions share the metaparadigm concepts of global society, community, family, person, and health.
3. One culture is not better than another culture; they are just different.
4. All cultures share core similarities.
5. Differences exist among, between, and within cultures.
6. Cultures change slowly over time in a stable society.
7. The primary and secondary characteristics of culture determine the degree to which one varies from the dominant culture.
8. If clients are coparticipants in care and have a choice in health-related goals, plans, and interventions, health outcomes will be improved.
9. Culture has powerful influence on one's interpretation of and responses to health care.
10. Individuals and families belong to several cultural groups.
11. Each individual has the right to be respected for his or her uniqueness and cultural heritage.
12. Caregivers need both general and specific cultural information to provide sensitive and culturally competent care.
13. Caregivers who can assess, plan, and intervene in a culturally competent manner will improve the care of their clients.
14. Learning culture is an ongoing process and develops in a variety of ways but primarily through cultural encounters (Campinha-Bacote, 1999).
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 patterns.

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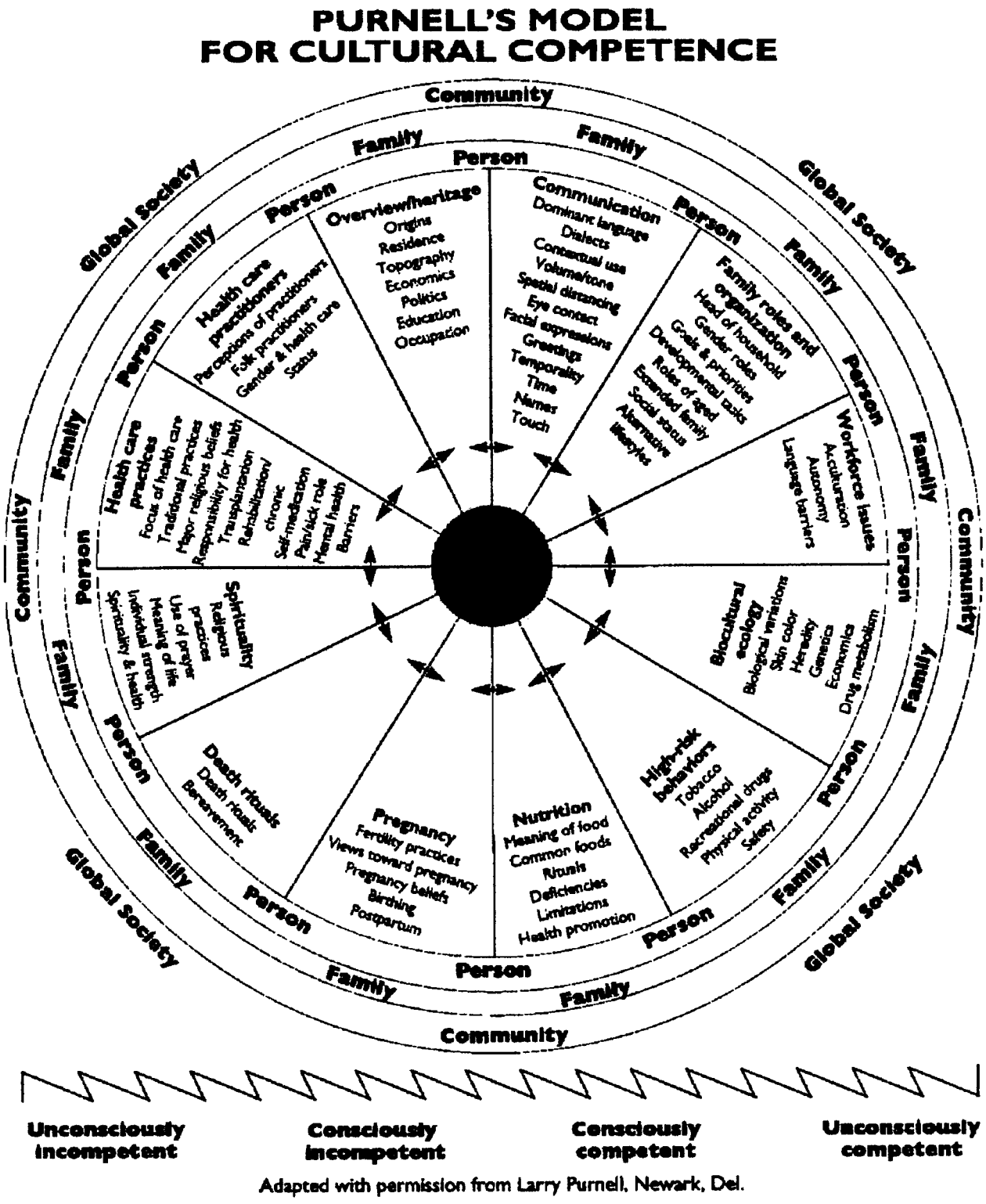

FIGURE 1. Purnell's Model of Cultural Competence.

17. Differences in race and culture require adaptations to standard interventions.
18. Cultural awareness improves the caregiver's self-awareness.
19. Professions, organizations, and associations have their own cultures, which can be analyzed using a grand theory.

DESCRIPTION OF THE MODEL

The model is a conceptualization based on multiple theories and a research base gained from organizational, administrative, communication, and family development theories as well as anthropology, sociology, psychology, anatomy and physiology, biology, ecology, nutrition, pharmacology, religion, history, economics, political science, and linguistics. A cultural group's objective cultural attributes, such as art and music, are important and are included as implied assumptions.

The primary and secondary characteristics of culture, developed from and expanded upon from Hage's (1972) variable and nonvariable concepts are nationality, race, color, gender, age, and religious affiliation. Secondary characteristics are 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, reason for migration, and immigration status.

The schematic depicting the model (see Figure 1) 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, the metaparadigm concepts. The interior of the concentric circles is divided into 12 pie-shaped wedges depicting cultural domains (constructs) and their concepts. Domains do not stand alone; each domain relates to and is affected by all other domains. The center of the model is empty, which represents unknown aspects about the cultural group. Along the bottom of the model is an erose (saw-toothed) line representing the concept of cultural consciousness. This line relates primarily to the health care provider, although organizations may also be represented on this nonlinear line according to their stage of cultural competence as an organization. Because these metaparadigm concepts are defined from a broad perspective, they do not reflect particular national, cultural, or ethnic beliefs and values. It is recognized that some cultures do not have directly translatable words for these concepts. Therefore, the health care professional may need to adapt these concepts according to the culture of the care recipient. For example, person may be defined differently between collectivistic and individualistic cultures. In Western cultures, a person usually stands alone as a unique individual. In other cultures, a person may be defined in terms of the family or another group.

THE 12 DOMAINS

Although the 12 domains and their concepts flow from more general phenomena to more specific phenomena, the order in which the care provider uses the domains may vary. Following is a brief description of the 12 domains and their major concepts.

Overview/heritage includes concepts related to the country of origin, current residence, the effects of the topography of the country of origin and current residence, economics, politics, reasons for emigration, educational status, and occupations.

Communication includes concepts related to the dominant language and dialects; contextual use of the language; paralanguage variations such as voice volume, tone, and intonations; and the willingness to share thoughts and feelings. Nonverbal communications such as the use of eye contact, facial expressions, touch, body language, spatial distancing practices, and acceptable greetings; temporality in terms of past, present, or future worldview orientation; clock versus social time; and the use of names are important concepts.

Family roles and organization includes concepts related to the head of the household and gender roles; family roles, priorities, and developmental tasks of children and adolescents; child-rearing practices; and roles of the aged and extended family members. Social status and views toward alternative lifestyles such as single parenting, sexual orientation, childless marriages, and divorce are also included in this domain.

Workforce issues include concepts related to autonomy, acculturation, assimilation, gender roles, ethnic communication styles, individualism, and health care practices from the country of origin.

Biocultural ecology includes variations in ethnic and racial origins such as skin coloration and physical differences in body stature; genetic, hereditary, endemic, and topographical diseases; and differences in how the body metabolizes drugs.

High-risk behaviors include the use of tobacco, alcohol, and recreational drugs; lack of physical activity; nonuse of safety measures such as seatbelts and helmets; and high-risk sexual practices.

Nutrition includes having adequate food; the meaning of food; food choices, rituals, and taboos; and how food and food substances are used during illness and for health promotion and wellness.

Pregnancy and childbearing practices include fertility practices; methods for birth control; views toward pregnancy; and prescriptive, restrictive, and taboo practices related to pregnancy, birthing, and postpartum treatment.

Death rituals include how the individual and the culture view death, rituals and behaviors to prepare for death, and burial practices. Bereavement behaviors are also included in this domain.

Spirituality includes religious practices and the use of prayer, behaviors that give meaning to life, and individual sources of strength.

Health care practice includes the focus of health care such as acute or preventive; traditional, magicoreligious, and biomedical beliefs; individual responsibility for health; self-medicating practices; and views toward mental illness,

chronicity, and organ donation and transplantation. Barriers to health care and one's response to pain and the sick role are included in this domain.

Health care practitioner concepts include the status, use, and perceptions of traditional, magicoreligious, and allopathic biomedical health care providers. In addition, the gender of the health care provider may have significance.

APPLICATION TO THEORY, RESEARCH, PRACTICE, AND ADMINISTRATION

Practice

The model has relevance for all health care providers in diverse environmental contexts. With its emphasis on managed care, case management, and a team approach, today's health care system can benefit from a model that is applicable to a multidiscipline staff. Cultural-specific information can be generalized and applied to sociological and anthropological reasoning and health care practice. The model can guide the development of assessment tools, planning strategies, and individualized interventions. Because the model is intended for use by all health care providers, the nursing process or other strategies to organize care are not explicitly defined. Nurses, physicians, physical therapists, and social workers in the United States, Canada, Central America, and Europe have used the model in acute care, long-term care, and home health. In Panama, nurses and physicians are using the model and assessment guide to begin compendiums of cultural beliefs, values, and practices among diverse indigenous Indian groups. Of particular note is that the Oncology Nurses Society has used the model to develop their standards. A hospital in New Jersey has placed chapters from the textbook *Transcultural Health Care: A Culturally Competent Approach* (1998) on their intranet so that staff can access culturally specific information about their clients.

Education

Nurses, nutritionists, physicians, physical therapists, anthropologists, and social workers have used the model in staff development and in academic settings. One university uses the model to teach population-based care in which students apply the information in community health settings. The model is simplistic enough that students in beginning classes do not need to have an in-depth understanding of conceptual models and theories for incorporating the concepts into practice. The model and organizing framework have been a valuable resource to guide the study of cultural practices and lifeways of clients during short-term immersion courses both in the United States and abroad.

Administration

Culture is not limited to clients and families; it includes educational, health care, and professional organizations. Because the model includes the domain workforce issues, it can be used to assess organizational culture and cultural issues among staff. Organizational culture reflects the social structure, historical antecedents, values, traditions, management processes, policies and procedures, and evaluation processes that reveal the degree to which diversity in thinking, reflecting, and behaving are encouraged or tolerated. Managers have used the model and organizing framework to promote staff acceptance in multicultural and multinational populations in the workforce. An ethics committee has used the model to look at "clients' compliance" and "appropriateness of care" from clients' and staff's perspectives. A long-term care facility used the model to guide care plan development for their Jewish residents because many non-Jewish care providers were unaware of Orthodox Jewish practices.

Research

Sociologists, anthropologists, nurses, physical therapists, and physicians have used the Model to conduct ethnographic, ethnomethodological, and constitutive ethnographical research. The primary and secondary characteristics are used to collect demographic data. Selected domains and concepts under each domain have been used to develop research questions for qualitative research. The model has been used to guide data collection for master's and doctoral students' theses, dissertations, and scholarly projects in the United States, Brazil, and Central America.

FURTHER DEVELOPMENT

The Purnell Model is in its infancy. Continued use over time will determine the value and significance of the model to the health professions in the future. A need exists to more clearly explicate how each health profession can use the model and apply the concepts in practice. The implicit assumptions also need to be more clearly defined. The model shows promise for future testing through critical reasoning, descriptions of personal experiences, and application to practice and administration.

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Larry Purnell is a professor in the Department of Nursing at the University of Delaware. He received his PhD in administration from Columbia Pacific University. Areas of interest include administration and transcultural health care.