Cultural Competency Models at the End of Life

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2.1 Introduction

Ethnic and cultural differences greatly influence the way healthcare services are used. Research indicates that minority ethnic groups underutilize end-of-life services. It became evident that in order to serve the unique needs of patients, healthcare professionals needed to understand the importance of cultural differences by valuing, incorporating, and examining their own values and beliefs, as well as their healthcare organizations in providing support and respect [1].

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It is absolute that there is an increasing requirement for cultural competency concerning improving end-of-life practices. Healthcare providers must clearly understand the cultural influences that affect a patient's attitudes, behavior, and preferences surrounding end-of-life care. Cultural influences impact the way patients and families react to the dying process. Open conversations about death and dying are not acceptable in many cultures, some believe it to be bad luck. In some Asian cultures, the dying loved one is protected from knowing the prognosis with the extended family participating in goals of care discussions and decision-making. Managing symptoms such as pain is also an important part of end of life care; however, beliefs that pain is a sign of a test of one's faith or punishment may prevent request for pain relief. It is also important to consider the role of faith and spirituality in the perception of death and dying and partner with spiritual leaders according to the patient's wishes.

Although it is essential to be cognizant that a person of an ethnic group does not always mean the beliefs of the associated group are practiced, also keeping in mind how long they have been in the United States, levels of education, and experiences. Cultural competency is essential in obtaining a thorough assessment to identify unique needs and how to address them appropriately.

Cultural competency is an evolving commitment and active participation in the process of cultural awareness, cultural knowledge, cultural skills, cultural collaboration, and cultural encounter, providing the opportunity to deliver individualized care within the cultural context of the patient [2]. According to [3], the following key elements are required for healthcare providers to commit to ongoing learning to enhance services: ***cultural desire, cultural awareness, cultural knowledge, cultural skill, cultural collaboration, and cultural encounter.*** The desire of becoming culturally competent, aware, and sensitive to cultural beliefs and practices, learning and understanding the various ethnic groups and their values, partnering with the patient and family, and active engagement in culture are essential elements to consider during assessment [3]. With the knowledge that culture is a significant influence in behavior towards illness and the provision of healthcare, these considerations will allow providers to treat patients with dignity, respect, and quality care [2].

End-of-life services involve healthcare providers having difficult conversations with patients that can be challenging due to a number of variables, including the comfort level of providers, their tenure, training, and expertise. More importantly, the challenge often stems from cultural differences between the patient and the healthcare providers, particularly surrounding end-of-life care. With this knowledge, the need for cultural competency became imperative and clear in delivering exceptional care.

Cultural competency models fall under two categories: those designed to teach healthcare professionals, and those designed to utilize in assessment of cultural backgrounds of patients [2]. The following are examples of Cultural Competence Models that are currently used in healthcare.

2.2 The Sunshine Model

The Sunshine Model was developed by a nursing theorist, Madeleine Leininger. Leininger was an administrator, author, educator, researcher, and theorist, whose concept of transcultural nursing created an impact in how we provide care for patients with different cultures and backgrounds. Through experience, Leininger observed that the recurrent behavioral patterns were culturally based. It was then realized that the lack of cultural and care knowledge that is essential in supporting patient compliance, healing, and wellness prompted Madeleine Leininger to develop the Culture Care Theory.

The **Transcultural Nursing Theory** or **Culture Care Theory** is used to evaluate, integrate knowledge, and understand various cultures related to healthcare practices, beliefs, and values. The concept allows the opportunity to provide meaningful care to patients emphasizing on caring behaviors, health values, and cultural beliefs.

The model demonstrates the cultural care worldview that flows into cultural and social structure dimensions of individuals, families, groups, communities, and institutions in healthcare systems. This knowledge provides a perspective of varying factors that affect decisions about care and health. The aspects of culture considered include religion, financial, educational, social, political, legal, as well as philosophical dimensions. Awareness of patients' physical, spiritual, and cultural needs contributes to desired clinical outcomes.

Avoiding the stereotyping of patients is critical, and to accomplish important goals the Leininger Sunshine Model uses three major culture care concepts: maintenance/preservation, accommodation/negotiation, and repatterning/restructuring.

Maintenance/Cultural Care Preservation includes supporting actions and decisions that will help preserve the individual's care values in order to maintain their well-being, face illness or death. *Cultural Accommodation/Negotiation* includes actions and decisions that help patients adapt or negotiate satisfying health outcomes with providers. The *Culture Care Repatterning/Restructuring* includes actions and decisions that help patients modify their way of life for beneficial healthcare pattern, while respecting patients' cultural values and their beliefs [4]. The goal of the theory is to deliver culturally congruent care that will help patients face illness, dying, or death [4].

2.3 Transcultural Assessment Model—Giger and Davidhizar

The **Transcultural Assessment Model** emphasizes the significance of recognizing that every individual is unique. Giger and Davidhizar indicate that there are six common elements to every culture: communication, space, social organization, time, environmental control, and biological variation [5]. *Communication* is defined as the holistic process of how humans interact and conduct themselves and can be verbal, nonverbal, and written. Trust is essential in patient-provider relationships and can only be achieved through dialogue and action. Language can

pose as a barrier to proper healthcare delivery due to a lack of transparency or unclear communication.

Personal space is the appropriate distance between individuals during interaction that differs according to each cultural background. It is essential to be mindful to avoid violating boundaries and causing unnecessary distress to the patient. *Social organization* is how individuals group themselves within their culture according to their family, beliefs, and duties. Acknowledgment that titles, coping management and sexual orientation are factors that influence behaviors towards healthcare. *Time* is subdivided into two: the clock-oriented group is fixated on time itself, mindful of appointments not being perceived as ill-mannered, while the socially oriented focuses on the present.

Environmental control suggests an individual's perception of society and factors such as beliefs and understanding of the pathophysiology of health conditions, its treatment, and management. Lastly, the sixth dimension, *biological orientation*, considers that certain races are prone to certain diseases. In addition, this model has a deeper understanding of nutrition preferences and pain tolerance which is essential to consider in end-of-life care.

2.4 Model for Cultural Competence—Purnell

The Purnell model focuses on creating a foundation for understanding the distinct characteristics of cultures, such as experiences and perception of healthcare and disabilities. There are twelve domains: overview of heritage, communication, family roles and organization, workforce issues, biocultural ecology, high-risk behaviors, nutrition, pregnancy, death rituals, spirituality, healthcare practices, and healthcare professionals [6].

The model shows a series of rings containing the development of cultural awareness and the continuous expansion from the family to global society. The first inner ring holds the person, the second holds the family, the third holds the community, and the outermost ring holds the global community. There are subsections within each ring that account for evolution within the individual's cultural competence including occupation, religion, education, politics, ethnicity and nationality, and gender.

All twelve domains are important considerations, though death rituals, spirituality, and healthcare practices are specific to end-of-life care. Each culture has a unique perception of death and what rituals are performed. Spiritually may include the use of prayer, religious practice, inner strength, the meaning of life, and how it relates to health. Healthcare practices include the responsibility for health as well as overcoming barriers to achieve successful outcomes. These practices may also include traditional practices, magical religious practices, treatment of chronic disease, mental health practices, and the roles of the sick.

The Purnell Model indicates that all subsections and rings continue until the individual accomplishes cultural competence. The model is flexible with fluency between domains, providing healthcare teams who are competent the ability to

evaluate, plan and intervene hence improving the health of the person, family, and community.

2.5 The Process of Cultural Competence in the Delivery of Healthcare Services; A Model of Care

This model by Josepha Campinha-Bacote views competency as the evolving growth and development in which healthcare providers continuously work towards the ability to effectively work within the cultural context of those we serve by consistently integrating cultural awareness, knowledge, and skill in our practice. The ever-changing demographics and economics around the world and long-standing disparities in health status among ethnic and cultural backgrounds challenged providers to consider cultural competence as a priority. This model can be utilized by healthcare providers as a foundation for establishing and implementing culturally sensitive healthcare services. The model consists of five (5) constructs:

- Cultural Awareness
- Cultural Knowledge
- Cultural Skill
- Cultural Encounters
- Cultural Desire.

Assumptions of the Model.

1. Cultural competence is a process, not an event.
2. Cultural competence consists of five constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.
3. There is more variation within ethnic groups than across ethnic groups (intra-ethnic variation).
4. There is a direct relationship between the level of competence of healthcare providers and their ability to provide culturally responsive healthcare services.
5. Cultural competence is an essential component in rendering effective and culturally responsive services to culturally and ethnically diverse clients.

The model considers cultural competence not as a consequence of certain factors but as a process. To achieve cultural competence, one must develop the capacity to deliver efficient and high-quality care using the five components. *Cultural awareness* is a process in which healthcare professionals consciously acknowledge their own cultural backgrounds, which helps them avoid biases toward other cultures. *Cultural knowledge*, is a process in which healthcare professionals open their minds to understand variations in cultural and ethnic traits related to patient attitudes toward illness and health. *Cultural Skill* is defined as obtaining the necessary information from patients via culturally appropriate conduct and physical

assessment. *Cultural encounter* is when stereotyping is avoided during the interaction between healthcare professionals and members of different cultures. During this process, overreliance on conventional views is discouraged. *Cultural desire* is the driving force for becoming educated, skilled, competent, and aware of culture; it also presumes a willingness to have transcultural interactions.

2.6 Culturally Competent Care Model—Kim Godwin

Reference [7] suggests that providing culturally competent care in the community is a significant challenge to nurses as existing models do not provide specific guidelines. Moreover, these models do not address the effects on populations in community settings. There was a need for a comprehensive model specifically providing culturally competent care in the community-based setting to reduce racial and ethnic health disparities. Similar to the other culturally competent care models, cultural sensitivity, cultural knowledge, and cultural skills are considered in providing care. This model's focus is on the relationship between competency and health outcomes for culturally diverse communities.

2.7 Summary

Over the course of history, we strove to build an ever-evolving society that is diverse in culture and ethnicity. According to the Universal Declaration of Human Rights (United Nations, n.d.), *recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice, and peace in the world.* It is of utmost importance that our society embrace the changes arising with such a multiethnic and culturally diverse collective of people. Our nation is increasingly becoming more diverse and in order for healthcare providers to deliver appropriate care to patients, it is imperative that they understand the importance of cultural considerations. Culture is a significant influence in the way patients respond to illness, treatments, and preferences surrounding end-of life care. Research indicates that end-of-life services are underutilized due to the lack of understanding of patients' culture and beliefs related to death and dying. In order for providers to tend to the unique needs of this patient population, medical professionals need to consider the cultural differences by making it a priority to understand the different values and beliefs, embrace them, and incorporate these considerations in creating an environment that is sensitive to the patients' and family's needs.

Healthcare providers must be cognizant of their own biases, as well as their institutions, and seek and respect patient's and family's beliefs and preferences related to death and dying. Understanding and navigating the complex cultural needs can be challenging but can be accomplished through thorough assessments. Involvement of family members is crucial in this process and it is important to

encourage clear communication of preferences and goals. The culturally competency models discussed in this chapter are used as teaching tools for healthcare providers as well as a guide for proper assessment of the unique needs in end-of-life care. The cultural practices can then be incorporated into the plan of care to ensure patients feel supported, valued, and dignified during the end of their life journey.

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