THE IMPLICATIONS OF TRANSCULTURAL NURSING MODELS IN THE PROVISION OF CULTURALLY COMPETENT CARE

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Abstract: People belonging different cultures may have different kinds of demands in terms of health. It is an essential human right for everyone to express freely their own cultural values. People having different cultural values should be respected in terms of their cultural values and the health care they are to be given should be offered considering this fact. Transcultural nursing models are a good guide for nurses in getting acquainted with the cultural structure of the society and in evaluating it. Leininger and other nurse scholars continue to develop and refine a vast number of cultural theories, models, and assessment guides that are used internationally. Leininger has provided the basic foundation for practice today. Her theory is still to be used, to be tested, to be refined, to be changed, and to be directed in clinical activities by other modelists. Such modelists as Purnell, Campinha-Bacote, Giger and Davidhizar building on Leininger’s ideas and taking her theory to new dimensions contributed greatly to the studies in the field of culture/cultural care. The applicability of the theories put thirty by Purnell, Campinha-Bacote, Giger and Davidhizar is discussed below. According to the author, the reason why these models were selected is that their theories are extremely plain, comprehensible, and capable of being used in very different fields and branches.

The aim of the paper is to define four of the most commonly used models implemented in transcultural nursing, to stimulate the interest of the nurses with these models and thus to encourage them to use these models in order to make cultural definitions and evaluation in their own fields. Questionnaires, interview and observation forms may be prepared and used in collecting cultural data by using the main concepts of all of the four models defined in this research. The researcher has been currently conducting a research aiming to use these models in Turkish Society in evaluating the cultural structure of the society.

The researcher herself is also using in Turkey “The Giger and Davidhizar Transcultural Assessment Model”, which is one of these models, in order to make known and to evaluate the cultural structure of Turkish society.

Key words: Cultural competent care; Transcultural nursing, Transcultural nursing models.

1. INTRODUCTION

Today, nurses are becoming sensitive to and knowledgeable about cultural differences and similarities in people’s care (Dowd et al., 1998; Duffy, 2001; Leininger, 2002). They must recognize the values of all cultures, races and ethnic groups and respond to these differences (Dowd et al., 1998; Velioglu, 1999; Birol, 2000). Increasing diversity and mobility of society accentuate an important need for professional nurses to render holistic, culturally competent nursing care (Ryan et al., 2000). To be culturally competent, nurses must first be culturally aware and sensitive (Fletcher, 1997). Nurses are awakening to the critical need to become more knowledgeable and culturally competent to work with individuals from diverse cultures (Compinha-Bacote et al., 1997).

It is essential for the health professional to utilize knowledge gained from conceptual and theoretical models of culturally appropriate care (Giger and Davidhizar, 2002b). Providing culturally competent care is a dynamic, fluid, and continuous process whereby an individual, system, or health care agency finds meaningful and useful delivery strategies based on knowledge of the cultural heritage, beliefs, attitudes and behaviours of those to whom care is rendered to develop cultural competency.

Cultural competence has been defined as:

* Developing an awareness of one’s own beliefs, sensations, and thoughts without letting it have an undue influence on those from other backgrounds.
* Demonstrating knowledge and understanding of the client’s culture.
*Accepting and respecting cultural differences
*Adapting care to be congruent with the client’s culture (Mattson, 2000).

For nurses to practice transcultural nursing competently, their caring practices must be grounded in the knowledge base and science of transcultural nursing (Poss, 1999; Leuning et al., 2002). Transcultural nurses can make a tremendous contribution in this area in understanding the context of care (Boyle, 2000).

2. Transcultural Nursing

The concept of transcultural nursing appeared less than 30 years ago since Madeleine Leininger first began to develop a theory of transcultural nursing as part of a doctoral study in anthropology. Much has changed in that time, and nursing staff development and in-service educators need to provide educational offerings within a multicultural context in a timely manner. Cultural diversity is the standard in the mid-1990s, and those nursing staff development programs that are sensitive to this fact produce employees with advantages over those from settings that do not prepare staff for practice in a constantly changing world (Mahon, 1997). Leininger developed transcultural care as a domain of nursing science, and created her Culture Care Theory (Leininger, 1996, 1997, 1999). Transcultural Nursing was developed because of the need to work with people from widely divergent cultural atmospheres. People from various cultures and subcultures are more common in today’s world. These people are sensitive to the preservation of their cultural heritage and customs. It is critical that nurses, because of their direct patient care, understand and work effectively within this diverse cultural atmosphere. Transcultural scholars refer to care as a universal phenomenon that transcends cultural boundaries, and their aim is to incorporate transcultural nursing into nursing curricula and clinical practices through a research-based knowledge of cultures (Leininger, 1997).

Leininger (1999) defined transcultural nursing as “a legitimate and formal area of study, research, and practice, focused on culturally based care, values, and practices to help cultures or subcultures maintain or regain their health and face disabilities or death in culturally congruent and beneficial caring ways” (Leininger, 1999).

Leininger (1999) notes that the main goal of transcultural nursing is to provide culturally specific care. However, before transcultural nursing can be adequately understood, there must be a basic knowledge of key terminology such as culture, cultural values, culturally diverse nursing care, ethnocentrism, race, ethnography and culture shock.

- Culture: Norms and practices of a particular group that are learned and shared and guide thinking, decisions, and actions.
- Cultural values: The individual's desirable or preferred way of acting or knowing something that is sustained over a period of time and which governs actions or decisions.
- Culturally diverse nursing care: An optimal mode of health care delivery, it refers to the variability of nursing approaches needed to provide culturally appropriate care that incorporates an individual’s cultural values, beliefs, and practices including sensitivity to the environment from which the individual comes and to which the individual may ultimately return.
- Ethnocentrism: The perception that one's own way is best when viewing the world.
- Ethnic: A term that relates to races or large groups of people classified according to common traits or customs.
- Race: A term related to biology, since members of the same group share distinguishing physical features such as skin colour, bone structure, and blood group (Dowd et al., 1998).
- Ethnography: The study of a culture. The methodological approach of ethnographic research central to the nurse's ability to develop a heightened awareness of culturally diverse needs of individuals is to define a field for observation for study of the environment and its people as well as the reciprocal relationship that exists between the two (Tripp-Reimer and Dougherty, 1985).
- Culture shock: A disorder that occurs in response to transition from one cultural setting to another (Spector, 2000).

3. Transcultural Nursing Models

Transcultural nursing theories with a holistic and comparative perspective have led to culture-specific care. The Theory of Culture Care Diversity and Universality, which was developed in the mid-1950s, has been a major theory to advance the body of transcultural nursing knowledge (Leininger, 1999). It was stated by Leininger that nursing is essentially a transcultural phenomenon and that knowledge about patients’ cultural values, beliefs and practices is integral to providing holistic nursing care. It has been argued that transcultural theories and
perspectives have become imperative so nurses can practice and conduct nursing research effectively in a diverse cultural context (Pinikahana et al., 2003). Since 1960’s, patient care has been studied from the cultural perspective by several transcultural nurse researchers who were influenced by Leininger and her Culture Care Theory. Transcultural scholars challenge nurses to move from a unicultural perspective to a multicultural, holistic perspective. They have developed theoretical cultural care frameworks, the aim of which is to enable nurses to provide care that confirms the clients’ cultural perceptions of what care should be (Giger and Davidhizar, 1991; Baker, 1997). Transcultural scholars underline the identification of cultural factors and their effect on an individual’s behaviour in order to provide culturally appropriate care. They also stress the ethical aspects of nurse-patient encounters by stating that nurses need theoretical knowledge enabling them to understand their own cultural values, beliefs and practices in order to prevent cultural biases, cultural clashes, cultural pain and imposition of practices, major cultural conflicts, and unethical care. These scholars share the opinion that the nurse, when planning nursing care, should pay attention to gender, identity, roles, communication modes, language, interpersonal relationships, space, the patient’s subculture, and the environmental context (Giger and Davidhizar, 1991). Today Leininger and other nurse scholars continue to develop and refine a vast number of cultural theories, models, and assessment guides that are used internationally (Duffy, 2001). Leininger has provided the basic foundation for practice. Her theory is still to be used, to be tested, to be refined, to be changed, and to be directed in clinical activities by other modelists (Boyle, 2000). Beside Leininger’s studies, other studies have been conducted and other models have been suggested in the field of transcultural care by such modelists as Purnell, Paulanka, Campinha-Bacote, Andrews, Boyle, Spector, Giger, and Davidhizar building on her ideas and taking her theory to new dimensions, and by many others using her theory or specific concepts to guide theoretical ideas in a specific practice (Ryan et al., 2000; Campinha-Bacote et al., 2000; Boyle, 2000; Purnell, 2002; Giger and Davidhizars, 2002a; Leuning et al., 2002; Juntunen, 2004). Three of these models are given below.

These Models are:
1. The Giger and Davidhizar Transcultural Assessment Model
2. Purnell Model for Cultural Competence
3. Campinha-Bacote’s Model of Cultural Competence in Health Care Delivery

According to the author, the reason why these models were selected is that their theories are extremely plain, comprehensible, and capable of being used in very different fields and branches.

3.1. The Giger and Davidhizar Transcultural Assessment Model
This model was developed in 1988 in response to the need for nursing students in an undergraduate program to assess and provide care for patients that were culturally diverse. Although all cultures are not the same, all cultures have the same basic organizational factors (Giger and Davidhizar, 1998, 2002a, 2002b). The metaparadigm for the Giger and Davidhizar model includes:
1. Transcultural nursing
2. Culturally competent care
3. Culturally unique individuals
4. Culturally sensitive environments

Giger and Davidhizar have identified six cultural phenomena that vary among cultural groups and affect health care. These are environmental control, biological variations, social organization, communication, space, and time orientation. These six phenomena serve to present the diversity that exists between cultural groups (Giger and Davidhizar, 2002a) (Figure 2).
3.1.1. Communication: Communication is the means by which culture is transmitted and preserved. Both verbal and nonverbal communications are learned in one’s culture (Davidhizar and Giger, 1994; Giger and Davidhizar, 2002a). Verbal and nonverbal patterns of communication vary across cultures, and if nurses do not understand the client’s cultural rules in communication, the client’s acceptance of a treatment regimen may be jeopardized (Davidhizar and Giger, 1994; Degazon, 1996). Accurate diagnosis and treatment is impossible if the health-care professional cannot understand the patient. When the provider is not understood, he or she often avoids verbal communication and does not realize the effect of nonverbal communication, which is all too often the painful isolation of patients who do not speak the dominant language and who are in an unfamiliar environment. Consequently, the patient experiences cultural shock and may react by withdrawing, becoming hostile or belligerent, or being uncooperative (Spector, 2000). Culture not only determines the appropriateness of the message but also influences all the components of communication. Thus, an assessment of communication should consider 1) dialect, 2) style, 3) volume, including silence, 4) touch, 5) context of speech or emotional tone, and 6) kinesics, including gestures, stances, and eye behavior (Bechtel, 2004). For example, most Afghans can be expressive, warm, others orientated, shy and modest. Male-to-male communication is permissive in this culture, whereas female-to-male communication is contraindicated unless with the husband, son, or father of the women involved (Giger and Davidhizar, 2002b). Another example is that many Asians consider it disrespectful to look someone directly in the eye, especially if that person is a nurse, not because of disinterest or dishonesty. An Asian patient may avoid eye contact out of respect for the superior status of the nurse. Many Middle Easterners see direct eye contact between a man and a woman as a sexual invitation. Knowing what the norm within the culture is will facilitate understanding and lessen miscommunication (Giger and Davidhizar, 1991).

3.1.2. Space: Space refers to the distance between individuals when they interact. All communication occurs in the context of space (Giger and Davidhizar, 2002a). There are four distinct zones of interpersonal space: inmate zone (extends up to 1 ½ feet), personal distance (extends from 1 ½ to 4 feet), social distance (extends from 4 to 12 feet) and public distance (extends 12 feet or more). Rules concerning personal distance vary from culture to culture. The extreme modesty practiced by members of some cultural groups may prevent members from seeking preventive health care (Spector, 2000). For instance, some Afghans prefer closeness in space with others and particularly with the same sex. When comfortable with others, these individuals prefer to be in close proximity to build trusting relationships (Giger and Davidhizar, 2002b). Particularly the comfort level is related to personal space - comfort in conversation, proximity to others, body movement, perception of space. Eye contact, space, and touch practices may be very different from one’s sphere of reference (Giger and Davidhizar, 1991).

3.1.3. Social organization: The social environment in which people grow up and live plays an essential role in their cultural development and identification. Children learn their culture’s responses to life events from the family and its ethnoreligious group. This socialization process is an inherent part of heritage-cultural, religious,
and ethnic background. Social organization refers to the social group organizations with which clients and families may identify (Spector, 2000). Family structure and organization, religious values and beliefs and role assignments may all relate to ethnicity and culture (Giger and Davidhizar, 2002a). Countless social barriers, such as unemployment, underemployment, homelessness, lack of health insurance, and poverty can also prevent people from entering the health-care system (Spector, 2000). For example, in the African-American culture, family may include individuals who are unrelated or remotely related. Members of families depend on the extended family and kinship networks for emotional and financial support in times of crises. Mothers and grandmothers play significant roles in African-American households and should be included in health care decisions (Degazon, 1996).

3.1.4. Time Orientation: Time is an important aspect of interpersonal communication. Some cultures are considered future oriented, others present oriented, and still others past oriented (Degazon, 1996; Giger and Davidhizar, 2002a). People who are future-oriented are concerned with long-range goals and with health-care measures in the present to prevent the occurrence of illness in the future. They prefer to plan in making schedules, setting appointments, and organizing activities. Others are oriented more to the present than the future and may be late for appointments because they are less concerned about planning to be on time. These differences in time orientation may become important in health-care measures such as long-term planning and explanations of medication schedules (Spector, 2000). For instance, most Afghans are more past and present than future time oriented, but generally they tend to follow two different time concepts (Giger and Davidhizar, 2002b). Another example is that Latin Americans, Native Americans, and Middle Easterners are present oriented cultures and may neglect preventive health care measures. They may show-up late or not at all for appointments (Giger, Davidhizar, 1991). United States and Canada tend to be future oriented (Spector, 2000).

3.1.5. Environmental control: Environmental control refers to the ability of the person to control nature and to plan and direct factors in the environment. Some groups perceive man as having mastery over nature; others perceive humans to be dominated by nature, while others see harmonious relationships between humans and nature (Giger and Davidhizar, 2002a). This particular cultural phenomenon plays an extremely important role in the way patients respond to health-related experiences, including the ways in which they define an illness and seek and use health-care resources and social supports (Spector, 2000). For example, Asians and Native Americans may perceive that illness is a disharmony with other forces and that medicine is only capable of relieving the symptoms rather than curing the disease. These groups are likely to look for naturalistic solutions, such as herbs and hot and cold treatments to resolve or cure a cancerous condition (Degazon, 1996).

3.1.6. Biological variations: Biological variations are (1) body structure, (2) skin colour, (3) other visible physical characteristics, (4) enzymatic and genetic variations, (5) electrocardiographic patterns, (6) susceptibility to disease, (7) nutritional preferences and deficiencies, and (8) psychological characteristics (Giger and Davidhizar, 1991). For instance, Western-born neonates are slightly heavier at birth than those born in non-Western cultures (Degazon, 1996).

Applying the Model

The Giger and Davidhizar Transcultural Assessment Model provides a process for assessing clients from differing cultures in order to be aware of differences and to plan appropriate strategies (Davidhizar and Giger, 1997). It was used to identify cultural beliefs from the six cultural phenomena previously described by Giger and Davidhizar. This Model, which also included interview questions and observational guidelines, was used for structural interviews. The model can enable the nurse in assessing individuals who are culturally diverse in order to provide culturally competent care (Giger and Davidhizar, 2002a, 2002b). It is broad enough in scope to be applied by other health-care professions such as medical imaging (professions of radiography, nuclear medicine, and ultrasonography), dentistry, education and hospital administration (Dowd, et al., 1998; Davidhizar, et al., 1998; Giger and Davidhizar, 2002b).

Critical Appraisal of the Model

No available literature regarding the applicability of this model or criticizing it has been encountered. However, the author believes that what is covered by the six phenomena identified in this model does
not fully cover the full range of cultural descriptions since there are numerous diversities throughout the world.

3.2. Purnell Model for Cultural Competence

The Purnell Model for Cultural Competence was originally developed to provide an organizing framework for nurses to use as a cultural assessment tool. The model can be used in primary, secondary, and tertiary prevention. Purnell Model for Cultural Competence includes a circular representation of global society, community, family, and the person. The model is a conceptualization from multiple theories and a research base gained from organizational theories, anthropology, sociology, anatomy and physiology, biology, psychology, religion, history, linguistics, nutrition, and the clinical practice settings in nursing and medicine. The Purnell Model includes the traditional metaparadigm concepts of the health professions. The model is generalizable to all practice settings in nursing and can be used by other health-related disciplines (Purnell, 1999, 2000, 2001, 2002).

Purnell Model for Cultural Competence 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 interior of the concentric circles is divided into 12 pie-shaped wedges depicting cultural domains and their concepts. Following are these 12 domains:

3.2.1. Overview/heritage [origins, residence, topography, economics, politics, education and occupation].
3.2.2. Communication [dominant language, dialects, time, names, touch, facial expressions, body language, spatial distancing practices, volume, tone, eye contact].
3.2.3. Family roles and organization [head of the household, gender roles, priorities, child-rearing practices, developmental task, roles of the aged, social status, lifestyle].
3.2.4. Workforce [autonomy, acculturation, assimilation, language barriers]
3.2.5. Biocultural ecology [biological variations, skin colour, heredity, genetics, economics, drug metabolism]
3.2.6. High-risk behaviours [tobacco, alcohol, recreational drugs, physical activity, safety].
3.2.7. Nutrition [meaning of food, common foods, rituals, deficiencies, limitations, health promotion]
3.2.8. Pregnancy and childbearing practices [fertility practices, views toward pregnancy, pregnancy beliefs, birthing, postpartum]
3.2.9. Death rituals [death rituals, bereavement]
3.2.10. Spirituality [religious practices, use of prayer, meaning of life, individual strength, spirituality health].
3.2.11. Health care practice [focus of health care, traditional practices, major religious beliefs, responsibility for health, transplantation, rehabilitation, self medication, mental health, and barriers]
3.2.12. Health care practitioner [perceptions of practitioners, folk practitioners, gender health care status] (Purnell, 1999, 2000, 2002), (Figure 3).

Applying the Model

The Purnell Model has broad relevance for nurses and other health care providers in diverse environmental contexts. Health care providers who can assess, plan, and intervene in a culturally competent manner have increased opportunities to improve the health of the person, family, or community under their care. The Model can guide the development of assessment tools, planning strategies, and individualized interventions. It is intended for use by all health care providers such as nurses, physicians, physical therapists, nutritionists, anthropologists, and social workers. The Model has been used in an integrated nursing curriculum by including an overview of culture and the model in a beginning course, followed by specific units that concentrate on selected domains that can be integrated into clinical courses, such as maternity nursing. It has been used by managers in organizing framework to promote staff acceptance in multicultural, multinational populations in the workforce. The Model has been used to guide data collection and research as well as for masters and doctoral student’s theses, dissertations, and scholarly projects (Purnell 2000, 2002). 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 (Purnell, 2002). 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 (Purnell, 2000).

Critical Appraisal of the Model

Purnell's model (1998, 2002) is comprehensive in content and is very abstract. It has logical congruence, conceptual clarity, it demonstrates clinical utility and espouses the experiential-phenomenological perspective. It
provides a comprehensive, systematic and concise framework to assist health care professionals in providing individualised, culturally competent and appropriate care to clients. It can be used in practice to assess individuals, a family, community or society.

The model's philosophical claim is explicit and the model reflects more than one contrasting worldview. Additionally, it is easy to apply and is relevant to any culture or setting. It has been used in staff development and academic settings in many countries. Lastly, the model was used to guide ethnographic, ethno methodological and constitutive ethnographical research studies [Brathwaite, 2004].

3.3. Campinha-Bacote's Model of Cultural Competence in Health Care Delivery

Campinha-Bacote’s framework of cultural competence is delineated in the process of cultural competence in the delivery of the Health Care Services Model. In this model, cultural competence is viewed as a process, and not an endpoint, in which one continually strives to achieve the ability to effectively work within the context of an individual, family, or community from a diverse cultural-ethnic background [Campinha-Bacote, 1997]. The Model identifies cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire as constructs of cultural competence. The five constructs have an interdependent relationship and all five constructs must be addressed [Campinha-Bacote 1997, Ryan et al. 2000]. This model was also utilized in the development of the transcultural nursing standards [Campinha-Bacote, 1998]. The brief description of these constructs:

3.3.1. Cultural awareness is defined as the process of conducting self-examination of one’s own biases towards other cultures and the in-depth exploration of one's cultural and professional background. Cultural awareness also involves being aware of the existence of documented racism in healthcare delivery.

3.3.2. Cultural knowledge is defined as the process in which the healthcare professional seeks and obtains a sound information base regarding the worldviews of different cultural and ethnic groups as well as biological variations, diseases and health conditions and variations in drug metabolism found among ethnic groups (Biocultural ecology).

3.3.3. Cultural skill is the ability to conduct a cultural assessment to collect relevant cultural data regarding the client’s presenting problem as well as accurately conducting a culturally-based physical assessment.

3.3.5. Cultural encounters is the process which encourages the healthcare professional to directly engage in face-to-face cultural interactions and other types of encounters with clients from culturally diverse backgrounds in order to modify existing beliefs about a cultural group and to prevent possible stereotyping.

3.3.6. Cultural desire is the motivation of the healthcare professional to "want to" engage in the process of becoming culturally aware, culturally knowledgeable, culturally skilful and seeking cultural encounters; not the "have to." Cultural desire is the spiritual and pivotal construct of cultural competence that provides the energy source and foundation for one’s journey towards cultural competence. Therefore, cultural competence can be depicted as a volcano, which symbolically represents that it is cultural desire that stimulates the process of cultural competence [Campinha-Bacote, 2002a]. An example of such a situation might arise when a nurse is asked to care for an Arab patient whose political and/or religious beliefs are in direct contrast to his/her beliefs. In this case, too, commitment to the process of cultural desire requires the nurse to be available to care for patients, even when there may be a natural instinct to resign oneself from the nurse-patient interaction [Campinha-Bacote, 1999].

The Process of Cultural Competence in the Delivery of Health care Services Model is a model of cultural competence that defines cultural competence as "the process in which the nurse continuously strives to achieve the ability and availability to effectively work within the cultural context of a client individual, family or community" [Campinha-Bacote 1998, 2002a]. The nurse may have recognized this incompetence by attending workshops on cultural diversity, reading articles or books on the topic, or having direct cross-cultural experiences with patients from culturally diverse backgrounds. These nurses possess "the knowledge, but not the 'know how' knowledge"[Campinha-Bacote, 1998].

Applying the Model

This model is useful in caring for all people, because in reality we all belong to the same race-the human race, with all the same basic needs. However, it is important to remember that these needs may be expressed differently, and that "quality health care services" may mean something different for each patient [Marcinkiw, 2003; Campinha-Bacote, 2002b].
Nurse educators can assist nursing students in acquiring cultural competence using the model created by Campinha-Bacote entitled "The Process of Cultural Competence in the Delivery of Healthcare Services: A Culturally Competent Model of Care". The model contributes to the development of cultural competence in the nursing profession by providing a concrete guide that is useful for teaching and implementing cultural competence in nursing education (Marcinkiw, 2003). Literature has shown that this model was also utilized in the development of the transcultural nursing standards (Leunuing et al., 2002).

Critical Appraisal of the Model

Campinha-Bacote's model is comprehensive in content, it has a high level of abstraction, conceptual clarity, and logical congruence; it also demonstrates clinical utility (Figure 3). The model advocates the experiential-phenomenological perspective of culture. Nurse educators can use the model to teach nurses how to deliver culturally competent nursing care by incorporating all its constructs in an education program.

Figure 3: Campinha-Bacote's Model of Cultural Competence in Health Care Delivery (Brathwaite, 2004).

The model's philosophical claim is explicit and it reflects more than one contrasting world view. For example, it reflects more than one field of knowledge (skill acquisition, transcultural nursing, medical anthropology, and multicultural counselling), which are combined in a consistent manner (Campinha-Bacote, 2002). Furthermore, the sources of knowledge are congruent with nursing world view. Lastly, this model has provided direction for empirical research using pre-test post-test designs and the development of interventions (Brathwaite, 2004).

Lastly, Campinha-Bacote's model (1998, 2002) embraces the experiential-phenomenological perspective, which guided and shaped the contents on culture that were included in the intervention. For example, no specific culture was studied in detail but a variety of examples were cited from many cultures to demonstrate the beliefs and practices of some individuals or groups from these cultures. Additionally, the experiential-phenomenological perspective assisted the reviewer in delineating principles/processes (Brathwaite, 2004).

4. Conclusion

In this study, the author aimed to define the four most common models used in transcultural nursing, to raise interest of the nurses to make use of these models in their field of service by determining and evaluating diverse cultures.
It is thought that using models will prove beneficial for nurses in getting deeply acquainted with and evaluating the society in terms of culture, in reaching the cultural data in more systematic and standard ways, and in improving knowledge in the field of transcultural nursing. The fact that nurses have enough acquaintance of the cultural structure of the society they are to offer service will play an important role in improving the quality of health care. Transcultural nurses can assist in modifying the delivery of care. It is well known that the meaning of health and illness is different for various cultural groups. Transcultural nurses are in an ideal position to demonstrate how the provision of culturally congruent care will shape health care in the future. It may be said that these models can be used in all fields of nursing to collect and evaluate cultural data in the light of the literature viewed in this study.

The author has successfully evaluated the cultural construct of a village using the Giger and Davidhizar Transcultural Assessment Model.

Nurses need educational preparation to provide themselves with the knowledge, skills, and attitudes essential to work with people from different cultures. Moreover, the cultural profile of the nursing profession should approximate those served. Nurses today must recognize these critical needs and be committed to provide transcultural nursing care.

It may be suggested, as a result of this research (according to the findings of the present research), that nurses use transcultural nursing models in defining and evaluating the cultural structure of the society and that they share with their colleagues the cultural data they obtained.

References
http://www.transculturalcare.net/Cultural_Competence_Model.htm