

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

JOSEPHA CAMPINHA-BACOTE, PhD, RN, CNS, BC, CTN, FAAN
Transcultural C.A.R.E. Associates

Several models of service care delivery have emerged to meet the challenges of providing health care to our growing multi-ethnic world. This article will present Campinha-Bacote's model of cultural competence in health care delivery: The Process of Cultural Competence in the Delivery of Healthcare Services. This model views cultural competence as the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community). This ongoing process involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.

PRESENTATION OF THE MODEL

The changing demographics and economics of a growing multicultural world and the long-standing disparities in the health status of people from diverse ethnic and cultural backgrounds has challenged health care providers to consider cultural competence as a priority. Campinha-Bacote's model of cultural competence in health care delivery is one model that health care providers can use as a framework for developing and implementing culturally responsive health care services.

The Process of Cultural Competence in the Delivery of Healthcare Services (Campinha-Bacote, 1998a) is a model that views cultural competence as the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community). This model requires health care providers to see themselves as *becoming* culturally competent rather than already being culturally competent. This process involves the integration of cultural

awareness, cultural knowledge, cultural skill, cultural encounters, and 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 health care providers and their ability to provide culturally responsive health care services.
5. Cultural competence is an essential component in rendering effective and culturally responsive services to culturally and ethnically diverse clients.

KNOWLEDGE ANTECEDENTS

The developmental stages of this model began back in 1969, when Campinha-Bacote was pursuing her undergraduate nursing degree in Connecticut. During this time, there was unrest and conflict in the area of race relations. It was clear that one had to identify as being either Black or White. Being a second-generation Cape Verdean and raised in an exclusively Cape Verdean community, Campinha-Bacote, found herself not fitting in either group. This is when she began exploring the area of cultural and ethnic groups. Completing her baccalaureate, master's, and doctoral degrees in nursing, she extended her interest in cultural groups to the fields of transcultural nursing and medical anthropology. Her clinical background as a psychiatric nurse also led her to explore the field of multicultural counseling. It is the blending of these fields that led to the development of her model. *The Process of Cultural Competence in the Delivery of Healthcare Services* model blends the fields of transcultural nursing, medical anthropology, and multicultural counseling. The works of Leininger (1978) in the area of transcultural nursing and

Pedersen (1988) in the area of multicultural development were combined to develop the constructs used in the model.

DEFINITION OF THE CONSTRUCTS OF THE MODEL

The major constructs of the model *The Process of Cultural Competence in the Delivery of Healthcare Services* are cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. To fully understand this model, each construct will be defined and discussed.

Cultural Awareness

Cultural awareness is the self-examination and in-depth exploration of one's own cultural and professional background. This process involves the recognition of one's biases, prejudices, and assumptions about individuals who are different. Without being aware of the influence of one's own cultural or professional values, there is risk that the health care provider may engage in cultural imposition. Cultural imposition is the tendency of an individual to impose their beliefs, values, and patterns of behavior on another culture (Leininger, 1978).

Cultural Knowledge

Cultural knowledge is the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups. In obtaining this knowledge base, the health care provider must focus on the integration of three specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy (Lavizzo-Mourey, 1996). Obtaining cultural knowledge about the client's health-related beliefs and values involves understanding their worldview. The client's worldview will explain how he/she interprets his/her illness and how it guides his thinking, doing, and being.

Disease incidence and prevalence among ethnic groups is the second issue the health care provider must address when obtaining cultural knowledge. This requires obtaining knowledge concerning the field of biocultural ecology. Disease incidence varies among ethnic populations, and health care providers who do not have accurate epidemiological data to guide decisions about treatment, health education, screening, and treatment programs will not be able to positively impact on health care outcomes. Treatment efficacy is the third issue to address in the process of obtaining cultural knowledge. This involves obtaining knowledge in such areas as ethnic pharmacology. Ethnic pharmacology is the study of variations in drug metabolism among ethnic groups. In obtaining cultural knowledge, it is critical to remember that no individual is a stereotype of one's culture of origin but rather a unique blend of the diversity found within each culture, a unique accumulation of life experiences, and the process of acculturation to other cultures. Therefore, the health care provider

must develop the ability to conduct a cultural assessment with each client.

Cultural Skill

Cultural skill is the ability to collect relevant cultural data regarding the client's presenting problem as well as accurately performing a culturally based physical assessment. This process involves learning how to conduct cultural assessments and culturally based physical assessments. Leininger (1978) defined a cultural assessment as a "systematic appraisal or examination of individuals, groups, and communities as to their cultural beliefs, values, and practices to determine explicit needs and intervention practices within the context of the people being served" (pp. 85-86). Cultural skill is also required when performing a physical assessment on ethnically diverse clients. The health care provider should know how a client's physical, biological, and physiological variations influence her ability to conduct an accurate and appropriate physical evaluation. Examples include differences in body structure, skin color, visible physical characteristics, and laboratory variances.

Cultural Encounters

Cultural encounter is the process that encourages the health care provider to directly engage in cross-cultural interactions with clients from culturally diverse backgrounds. Directly interacting with clients from diverse cultural groups will refine or modify one's existing beliefs about a cultural group and will prevent possible stereotyping that may have occurred. However, health care providers must be aware that interacting with just three or four members of a specific ethnic group will not make them an expert on this cultural group. It is possible that these three or four individuals may or may not represent the stated beliefs, values, or practices of the specific cultural group encountered by the health care provider. This is due to intra-ethnic variation, which means that there is more variation within a cultural group than across cultural groups.

Cultural encounters also involve an assessment of the client's linguistic needs. Using a formally trained interpreter may be necessary to facilitate communication during the interview process. The use of untrained interpreters, friends, or family members may pose a problem due to their lack of knowledge regarding medical terminology and disease entities. This lack of knowledge can lead to faulty and inaccurate data collection.

Cultural Desire

Cultural desire is the motivation of the health care provider to *want* to, rather than *have* to, engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful, and familiar with cultural encounters. Cultural desire involves the concept of caring. It has been said that

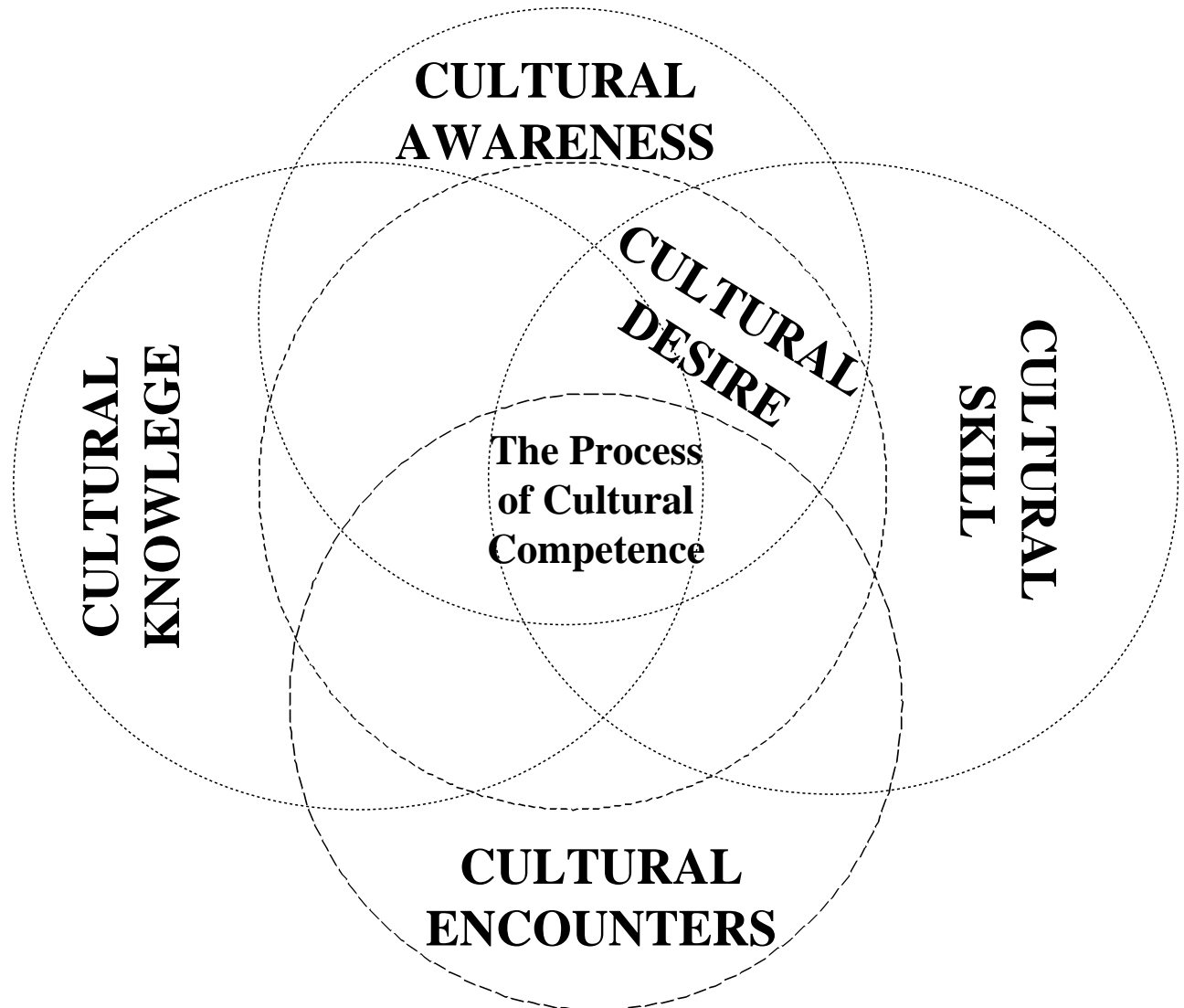


FIGURE 1. The Process of Cultural Competence in the Delivery of Health Care Services.
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people don't care how much you know, until they first know how much you care (Campinha-Bacote, 1999). It is not enough for the health care provider to merely say they respect a client's values, beliefs, and practices or to go through the motions of providing a culturally specific intervention that the literature reports is effective with a particular ethnic group. What is of grave importance is the health care provider's real motivation or desire to provide care that is culturally responsive. Cultural desire includes a genuine passion to be open and flexible with others, to accept differences and build on similarities, and to be willing to learn from others as cultural informants. This type of learning is a lifelong process that has been referred to as "cultural humility" (Tervalon & Murray-Garcia, 1998).

Relationship Between Constructs

The constructs of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire have an interdependent relationship with each other, and no matter when the health care provider enters into the process, all five constructs must be addressed and/or experienced. Health care providers can work on any of these constructs to improve the balance of all five. However, it is the intersection of these constructs that depicts the true process of cultural competence. As the area of intersection of the constructs becomes larger, health care providers more deeply internalize the constructs on which cultural competence is based (see Figure 1).

Campinha-Bacote's model of cultural competence is a model for health care providers in all areas of practice, includ-

ing clinical, administration, research, policy development, and education. Specifically, it has been suggested as a model for conducting culturally sensitive research (Campinha-Bacote & Padgett, 1995); for clinical competence in specialty areas such as psychiatric and mental health services, rehabilitation nursing, case management, community services, and home care (Campinha-Bacote, 1999; Campinha-Bacote, 2001; Campinha-Bacote & Munoz, 2001; Campinha-Bacote & Narayan, 2000); and for health professions education (Campinha-Bacote, 1998b; Campinha-Bacote, Yahle, & Langerkamp, 1996). It has also been recommended as a framework for policy development (Campinha-Bacote, 1997) and a guiding framework for management and administration (Campinha-Bacote, 1996). In addition to the model's practice applications, it has been used as a framework for health care organizations to provide culturally relevant services (Campinha-Bacote & Campinha-Bacote, 1999).

Area for Further Development

Developing a model of cultural competence is one way to pursue the concept of cultural competence; however, measuring cultural competence is also an area of interest to the author. Based on the model *The Process of Cultural Competence in the Delivery of Healthcare Services*, Campinha-Bacote developed the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals (IAPCC). The IAPCC is a 20-item instrument that measures the model's constructs of cultural awareness, cultural knowledge, cultural skill, and cultural awareness. The IAPCC does not measure the construct of cultural desire. This is an area for further development.

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Josepha Campinha-Bacote is president of Transcultural C.A.R.E. Associates in Cincinnati, Ohio. She received her PhD in nursing from the University of Virginia. Research and clinical interests include biocultural ecology, ethno and ethnic psychopharmacology, ethnic music therapy, and transcultural psychiatry.