The Purnell Model for Cultural Competence

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The twenty-first century has ushered in an era of multiculturalism and diversity in health care. Cultural competence, an essential component within the multidisciplinary healthcare team, has become a major initiative. The Purnell Model of Cultural Competence is proposed as an organizing framework to guide cultural competence among multidisciplinary members of the healthcare team in a variety of primary, secondary, and tertiary settings. First, essential definitions for understanding culture and cultural concepts are introduced. A brief overview of the Purnell Model for Cultural Competence including purposes, underlying assumptions, and major components of the Model are presented. The primary and secondary characteristics of culture that determine the degree to which people adhere to their dominant culture are also included.

Cultural general knowledge and skills ensures that providers have a process for "becoming" culturally competent. This manuscript presents definitions of essential terminology for understanding culture and the Purnell Model for Cultural Competence.

KEY WORDS: Purnell Model; Primary characteristics; Secondary characteristics.

Healthcare professionals and healthcare organizations are avidly addressing multicultural diversity and racial and ethnic disparities in health. Almost every health journal now has articles addressing "cultural competence." Healthcare professional societies and organizations have some type of standards, initiative, or statement encouraging its members to become culturally sensitive and/or culturally competent. Moreover, one can now find workshops that address culturally sensitive and culturally competent care from a plethora of organizations and individuals. The stress on culture and diversity is good because cultural competence improves the health of the country's citizens. However, culture is an extremely demanding and complex concept, requiring providers to look at themselves, their patients, their communities, their colleagues, and their employment settings from multiple perspectives.

Increasing one's consciousness of cultural diversity improves the possibilities for healthcare practitioners to provide culturally competent care, and therefore improved care. Cultural competence is a conscious process and not necessarily linear. To add to the complexity of learning culture, no standardization of terminology related to culture and ethnicity exists. The definition of cultural sensitivity presented by one person or group is the same definition that another person or group defines as cultural competence or awareness. In an attempt to reach consensus and standardize definitions of these and other terms commonly used in health care, the American Academy of Nursing Expert Panel on Cultural Competence has been developing over the last two years a White Paper that addresses this issue. This manuscript presents definitions of essential terminology as a starting point for understanding culture and the Purnell Model for Cultural Competence.

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DEFINITIONS

Although anthropologists and sociologists have proposed many definitions of culture Purnell defines culture as

> ...the totality of socially transmitted behavioral patterns, arts, beliefs, values, customs, lifeways, and all other products of human work and thought characteristics of a population of people that guide their worldview and decision making. These patterns may be explicit or implicit, are primarily learned and transmitted within the family, are shared by most members of the culture, and are emergent phenomena that change in response to global phenomena. Culture is learned first in the family, then in school, then in the community and other social organizations such as the church. (Purnell, 2003, p. 3).

Within all cultures are subcultures, ethnic groups, or ethnocultural populations, groups who have experiences different from those of the dominant culture with which they identify; they may be linked by nationality, language, socioeconomic status, education, sexual orientation, or other factors that functionally unify the group and act collectively on each member with a conscious awareness of these differences (Purnell, 2003). Additionally, subcultures differ from the dominant cultural group and share beliefs according to the primary and secondary characteristics of culture (defined later in this manuscript). A specific example of how two people from the dominant American culture may vary follows:

> Susan Jones, age 62, is an uninsured, single, white Catholic lesbian who makes $20,000 a year and practices aromatherapy. William James, age 28, is an insured, heterosexual, married, white male with 4 children and makes $200,000 per year and believes strongly in high-technology health care.

While these two people both come from the "dominant American culture," their worldview is probably very different due to their subcultures and primary and secondary characteristics of culture such as age, gender, sexual orientation, marital status, parental status, and socioeconomic and insurance status.

Culture is largely unconscious and has powerful influences on health and illness. Healthcare providers must recognize, respect, and integrate clients' cultural beliefs and practices into health prescriptions. Thus, the provider must be culturally aware, culturally sensitive, and have some degree of cultural competence to be effective in integrating health beliefs and practices into plans and interventions. *Cultural awareness,* essentially the objective material culture, has more to do with an appreciation of the external signs of diversity, such as arts, music, dress, and physical characteristics. *Cultural sensitivity* has more to do with personal attitudes and not saying things that might be offensive to someone from a cultural or ethnic background different from the healthcare provider's. Moreover, culturally sensitive, politically correct language changes over time, within ethnic groups, and within the broader cultural group, creating uncertainties for healthcare providers. For example, what is the politically correct term: Hispanic or Latino? According to the Office of Minority Health (2004), both terms are acceptable. However, some individuals prefer the term Hispanic, others prefer the term Latino, and for others, neither term is apporpriate and the person self-identifies with another term more appropriate to the country of origin or ethnicity. Many times it is not necessary to label a person; however, when it is necessary, simply ask the person how he/she wishes to be identified.

Cultural competence has several characteristics and includes knowledge and skills as well as the following:

- Developing an awareness of one's own culture, existence, sensations, thoughts, and environment without letting them have an undue influence on those from other backgrounds;
- Demonstrating knowledge and understanding of the client's culture, health-related needs, and meanings of health and illness;
- Accepting and respecting cultural differences;
- Not assuming that the healthcare provider's beliefs and values are the same as the client's;
- Resisting judgmental attitudes such as "different is not as good;" and
- Being open to cultural encounters;
- Being comfortable with cultural encounters;
- Adapting care to be congruent with the client's culture;
- Cultural competence is an individualized plan of care that begins with performing an assessment through a cultural lens.

Organizational cultural competence is also important and essential for healthcare educational and service organizations. At a minimum, for an organization to be culturally competent, the following should be in place.

- The mission and philosophy must address diversity initiatives;
- Culture must be included in the orientation program of all new employees;
- Diversity workshops must be provided on an on going basis;
- Interpretation and translation services must exist, especially in the languages of the population they serve;
- Cultural brokers must include mentors for employees unfamiliar with the culture of the patients;
- Directional signs must be posted in languages of the populations who use the facility;
- Culturally congruent meals are provided for patients;
- An array of culturally diverse artwork and other objective signs of culture are displayed;

- The ethics committee has representation from the community and from the ethnocultural groups served;
- A concerted effort is made to recruit employees representative of the populations they serve; and
- Any number of culturally specific services: e.g. a hospital that serves the orthodox Jewish community programs elevator doors to open automatically and on each floor on the Sabbath and to provide kosher meals.

The word *race* has become a very controversial word, at least in the United States. The Human Genome Project (2004) demonstrates that all human beings share a genetic code that is over 99 percent identical. Some people minimize or dispute the concept of race and others stress its importance given the major initiatives addressing racial and ethnic dispartiies in health care. However, the controversial term race must still be addressed. Race is genetic in origin and includes physical characteristics that are similar among members of the group, such as skin color, blood type, hair and eye color. Difference among races is significant when conducting health assessments, investigating hereditary and genetic diseases, and prescribing medication. People from a given racial group may, but do not necessarily, share a common culture or subculture; e.g., most African Americans have black skin but a person with white skin and no ancestry with people with black skin may self-identify with the African American culture.

Healthcare providers must assess the patient's and family's beliefs for effective health maintenance and wellness, illness and disease prevention, and health restoration. A *belief* is something that is accepted as true, especially as a tenet or a body of tenets accepted by an individual or group. A common belief among cultures is that health, either good health or bad health, is "*God's Will.*" Beliefs do not have to be proven; they are consciously or unconsciously accepted as truths and must be included in the client's individualized plan of care, regardless of what the provider thinks about them.

All groups have similar or the same *values* but they vary in the degree and the intensity by which they are held by the group and by the individual. Values are principles and standards that have meaning and worth to an individual, family, group, or community. Major cultural values include individualism versus collectivism, being versus doing, hierarchial versus egalitarian status, youth versus elders, cooperation versus competetion, ascribed versus achieved status, change versus tradition, and formality versus informailty, to name a few. The more one's values are internalized, the more difficult it is to avoid the tendency *tow*ard ethnocentrism. *Ethnocentrism,* the universal tendency of human beings to think that their ways of thinking, acting, and believing are the only right, proper, and natural ways, can be a major barrier to providing culturally competent care. Ethnocentrism perpetuates an attitude in which beliefs that differ greatly from one's own are strange, bizarre, or unenlightened, and therefore wrong (Purnell, 2003). Most of the literature in nursing addresses only the negative aspects of ethnocentrism. However, there is a positive aspect of ethnocentrism from the patient's, family's, and community perspetives. Ethnocentrism is responsible for cultural self-survival and helps people maintain self-worth and self-survival. These positive attributes can be negative when one uses his/her own worth in relation to others who are perceived to be inferior (Walker & Avant, 1995).

Culture as a Process

Cultural competence is a process, not an endpoint (See figure 1). One progresses (a) from unconscious incompetence (not being aware that one is lacking knowledge about another culture), (b) to conscious incompetence (being aware that one is lacking knowledge about another culture), (c) to conscious competence (learning about the client's culture, verifying generalizations about the client's culture, and providing culturally specific interventions), and finally (d) to unconscious competence (automatically providing culturally congruent care to clients of diverse cultures). Unconscious competence is difficult to accomplish and potentially dangerous because individual differences exist within specific cultural groups. To be even minimally effective, culturally competent care (really an individualized plan of care) must have the assurance of continuation after the original impetus is withdrawn; it must be integrated into and valued by the culture that is to benefit from the interventions.

Each healthcare provider adds a new and unique dimension to the complexity of providing culturally competent care. The way healthcare providers perceive themselves as competent providers is often reflected in the way they communicate with clients. Thus, it is essential for healthcare professionals to take time to think about themselves, their behaviors, and their communication styles in relation to their perceptions of culture. *Cultural self awareness* is a deliberate and conscious cognitive and emotional process of getting to know yourself: your personality, your values, your beliefs, your professional knowledge standards, your ethics, and the impact of these factors on the various roles played when interacting with individuals who are different from yourself. The ability to understand oneself sets the stage for integrating new knowledge related to cultural differences into the professional's knowledge base and perceptions of health interventions. Even then, traces of ethnocentrism may unconsciously pervade one's attitudes and behavior.

STEREOTYPING VERSUS GENERALIZATION

Stereotyping, an over simplified conception, opinion, or belief about some aspect of an individual or group of people is a common occurrence among people, and occurs at the intra-individual level, inter-individual level,

and inter-group level (Stevens & Fiske, 1995). Stereotyping has both cognitive (categorization) and motivational components, which bolsters self-esteem (Baumeister, Smart, & Boden, 1996; Fiske, 2000; Turner, 1987). Stereotyping is a normal function and people accentuate differences between categories and minimize differences within categories (Capozza & Nanni, 1986). A stereotype can be positive, "all Asians are good in math," or negative, "all African American teenagers are sexually promiscuous." Obviously these statements are example of subjective essentialism and entitativity (Yzerbyt, Corneille, & Estrada, 2001) because not all Asians are good at math and not all African American teenagers are promiscuous. However, stereotyping has advantages, including saving perceivers' mental resources to allow them to operate under a cognitive load (Pendry, 1998). A stereotype is, however, an endpoint.

Given that stereotyping is a common occurrence, healthcare professionals must concentrate on impression management and validate cultural group generalizations. Generalization, rules that groups adopt about other groups, is a point, and the healthcare provider must see if the individual fits the cultural pattern. Impression management begins with self awareness and is a conscious process through which providers must cognitively engage to control stereotypical thinking (Pacquiao, 2000; Schneider, 1981). The value in making generalizations about cultural groups is that the healthcare provider knows what questions to ask. For example, in collectivist cultures, such as Korean, Chinese, Filipino, and Vietnamese to name a few, ingroup harmony is essential to ingroup loyalty and conformity to standards of behavior. If the provider automatically assumes that the previous statement is true, then that person is stereotyping the person based on the characteristics of east Asian cultures. Adopting such a generalization is a beginning point from which the provider must determine the extent to which the patient and/or family adheres to these cultural characteristics.

Some authorities believe that learning the charactristics of cultural groups and that research on cultural groups can reinforce stereotyping (Dreher & MacNaughton, 2002). These authorities maintain that the provider needs to only know a general cultural approach for assessments and may disregard cultural specific information. If the provider does not know cultural specific characteristics, e.g. Mexican clients may use curanderos, masajistas, and sobadores (folk healers) for generic health care, they would not know to specifically ask about them; and therefore, essential information may be missed. Knowing both the general and specific characteristics of the cultural group leads to an improved assessment allowing one to make an individualized plan of care.

THE PURNELL MODEL FOR CULTURAL COMPETENCE

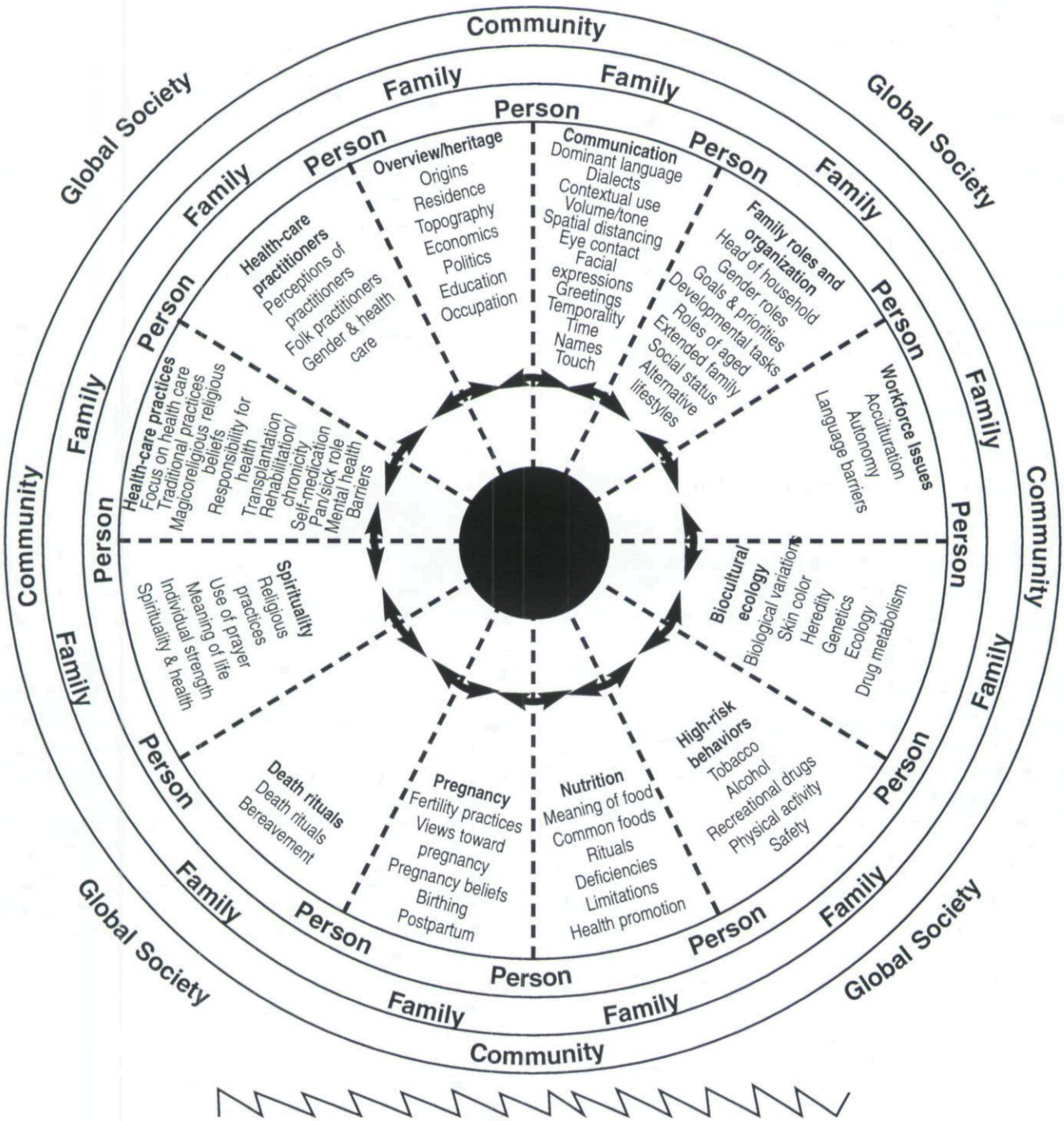
The Purnell Model for Cultural Competence (See Figure 1) started as an organizing framework in 1991 when the author was teaching undergraduate students and discovered the need for both students and staff to have a framework for learning about their cultures and the cultures of their patients and families. Comments from staff and students made it clear that ethnocentric behavior and lack of cultural awareness, cultural sensitivity, and cultural competence existed. The Purnell Model was designed as a wholistic organizing framework with specific questions and a format for assessing culture that could be used across disciplines and practice settings.

All healthcare disciplines value communication and need to know their client's ethnocultural beliefs. Although physicians, nurses, nutritionists, therapists, technicians, morticians, home health aides, and other caregivers need similar culturally specific information, the manner in which the information is used may differ significantly based on the discipline, individual experiences, and specific circumstances of interacting with the client. Each discipline has its own unique knowledge base to support its ways of knowing its clients as well as techniques, roles, norms, values, ideologies, attitudes, and beliefs, which interlock to make a reinforced and supportive system within its defined practice. An understanding of ethnocultural diversity improves the effectiveness of all healthcare providers.

The Purnell Model has been classified by three well-known nurse theorists as holographic and complexity theory because it includes a model and organizing framework that can be used by all healthcare providers in various disciplines and settings. Additionally, these nurse theorists early in 1998 confirmed that the Purnell Model was not a conceptual framework, but rather a grand theory. Although the professional community recognizes that scholarly controversy exists in distinguishing between a conceptual framework and grand theory, the value and utility of the Purnell Model has been documented in developing cultural competence across disciplines and in stimulating further inquiry and knowledge quest.

The Model 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 circle is divided into 12 pie-shaped wedges depicting cultural domains and their concepts. The dark center of the circle represents unknown phenomena. Along the bottom of the model is a jagged line representing the nonlinear concept of cultural consciousness. The 12 cultural domains (constructs) provide the organizing framework of the model.

Figure 1 - The Purnell Model for Cultural Competence



Unconsciously Incompetent - Consciously incompetent - Consciously competent - Unconsciously competent

Primary characteristics of culture: age, generation, nationality, race, color, gender, religion

Secondary characteristics of culture: educational status, socioeconomic status, occupation, military status, political beliefs, urban versus rural residence, enclave identity, marital status, parental status, physical characteristics, sexual orientation, gender issues, and reason for migration (sojourner, immigrant, undocumented status)

Healthcare providers can use this same process to understand their own cultural beliefs, attitudes, values, practices, and behaviors.

The purposes of the Purnell Model are to

- Provide a framework for all healthcare providers to learn concepts and characteristics of culture;
- Define circumstances that affect a person's cultural worldview in the context of historical perspectives;
- Provide a model that links the most central relationships of culture;
- Interrelate characteristics of culture to promote congruence and to facilitate the delivery of consciously sensitive and competent health care;
- Provide a framework that reflects human characteristics such as motivation, intentionality, and meaning;
- Provide a structure for analyzing cultural data; and
- View the individual, family, or group within their unique ethnocultural environment.

The explicit assumptions upon which the Model is based are

- All healthcare professions need similar information about cultural diversity.
- All healthcare professions share the metaparadigm concepts of global society, family, person, and health.
- One culture is not better than another culture; they are just different.
- Core similarities are shared by all cultures.
- Differences exist within, between, and among cultures.
- Cultures change slowly over time.
- The primary and secondary characteristics of culture determine the degree to which one varies from the dominant culture.
- If clients are coparticipants in their care and have a choice in health-related goals, plans, and interventions, their compliance and health outcomes will be improved.
- Culture has a powerful influence on one's interpretation of and responses to health care.
- Individuals and families belong to several cultural groups.
- Each individual has the right to be respected for his or her uniqueness and cultural heritage.
- Caregivers need both cultural-general and cultural-specific information in order to provide culturally sensitive and culturally competent care.
- Caregivers who can assess, plan, intervene, and evaluate in a culturally competent manner will improve the care of clients for whom they care.
- Learning culture is an ongoing process that develops in a variety of ways, but primarily through cultural encounters (Campinha-Bacote, 2004).
- Prejudices and biases can be minimized with cultural understanding.
- 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.
- Differences in race and culture often require adaptations to standard interventions.
- Cultural awareness improves the caregiver's self-awareness.
- When individuals of dissimilar cultural orientations meet in a work or therapeutic environment, the likelihood for developing a mutually satisfying relationship is improved if both parties in the relationship attempt to learn about each other's culture.
- Culture is not border bound. People bring their culture with then when they migrate.
- Professions, organizations, and associations have their own culture, which can be analyzed using a grand theory of culture.

METAPARADIGM CONCEPTS

The macro aspects of this *Model* include the traditional nursing metaparadigm concepts of global society, community, family, and person. Although not all nurse theorists support the nursing metaparadigm concepts (Leininger, 1997), this author has found them to be immensely valuable because they provide a wholistic and global perspective. The theory and model are conceptualized from biology, anthropology, sociology, economics, geography, history, ecology, physiology, psychology, political science, pharmacology, and nutrition as well as theories from communication, family development, and social support. The Model can be used in clinical practice, in formal and continuing education education, in research, and in the administration and management of healthcare services.

Phenomena related to a global society include world communication and politics; conflicts and warfare; natural disasters and famines; international exchanges in education, business, commerce, and information technology; advances in the health sciences; space exploration; and the expanded opportunities for people to travel around the world and interact with diverse societies. Global events that are widely disseminated by television, radio, satellite transmission, newsprint, and information technology affect all societies, either directly or indirectly. Such events create chaos while consciously and unconsciously forcing people to alter their lifeways, worldviews, and acculturation patterns.

In its broadest definition, community is a group of people having a common interest or identity and living in a specified locality. Community includes the physical, social, and symbolic characteristics that cause people to connect. Bodies of water, mountains, rural versus urban living, and even railroad tracks help people define their physical concept of community. Today, however, technology and the Internet allow people to expand their community beyond physical boundaries. Economics, religion, politics, age, generation, and marital status delineate the social concepts of community. Sharing a specific language or dialect, lifestyle, history, dress, art, or musical interest are symbolic characteristics of a community. People actively and passively interact with the community, necessitating adaptation and assimilation for equilibrium and homeostasis in their worldview. Individuals may willingly change their physical, social, and symbolic community when it no longer meets their needs.

A *family* is two or more people who are emotionally connected. They may, but do not necessarily, live in close proximity to each other. Family may include physically and emotionally close and distant consanguineous relatives as well as physically and emotionally connected and distant non-blood-related significant others. Family structure and roles change according to age, generation, marital status, relocation or immigration, and socioeconomic status, requiring each person to rethink individual beliefs and lifeways.

A *person* is a biopsychosociocultural being who is constantly adapting to his or her environment. Human beings adapt biologically and physiologically with the aging process; psychologically in the context of social relationships, stress, and relaxation; socially as they interact with the changing community; and ethnoculturally within the broader global society. In highly individualistic Western cultures, a person is a separate physical and unique psychological being and a singular member of society. The self is separate from others. However, in highly collectivist Asian cultures, the individual is defined in relation to the family, including ancestors, or another group rather than a basic unit of nature.

Health, as used in this article, is a state of wellness as defined by people within their ethnocultural group. Health generally includes physical, mental, and spiritual states. The concept of health, which permeates all metaparadigm concepts of culture, is defined globally, nationally, regionally, locally, and individually. People can speak about their personal health status or the health status of the nation or community. Health can also be subjective or objective in nature.

In the center of the Purnell Model is an empty circle. This circle represents unknown phenomena, practices, and characteristics of the individual or the group. In the case of healthcare providers, this circle can expand or contract depending upon the providers cultural self awareness and the knowldege and skills they possess for working with cultually diverse clients, families, and communities.

CONSTRUCTS AND CONCEPTS

On a micro level, the Model has an organizing framework consisting of 12 domains, constructs, and their concepts, which are common to all cultures, subcultures, and ethnic groups. These 12 domains are interconnected and have implications for health. The utility of this organizing framework comes from its concise structure, which can be used in any setting and applied to a broad range of empirical experiences and can foster inductive and deductive reasoning in the assessment of cultural domains. They can be used to formulate questions and statements for conducting research. Once cultural data are analyzed, the practitioner can fully adopt, modify, or reject healthcare interventions and treatment regimens in a manner that respects the client's cultural differences. Such adaptations improve the quality of the client's healthcare experiences and personal existence.

THE 12 DOMAINS OF CULTURE

The 12 domains and their concepts essential for assessing the cultural attributes of an individual, family, or group are as follows:

- Overview, inhabited localities, and topography 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, and value places on education.

- Communication includes concepts related to the dominant language and dialects; contextual use of the language; and paralanguage variations such as voice volume, tone, intonations, reflections, and 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; clock versus social time; and the use of names are also important communication variables.

- 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; childrearing practices and roles of the aged and extended family members. Individual and family social status in the community; and views toward alternative life styles 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, and healthcare practices from the country of origin.

- Biocultural ecology includes variations in specific ethnic and racial origins such as skin coloration and physical differences in body stature; genetic, hereditary, endemic, and topographical diseases; and the differences in the way drugs are metabolized by the body.

- High-risk behaviors includes the use of tobacco, alcohol, and recreational drugs; lack of physical activity; increased calorie consumption; nonuse of safety measures such as seatbelts, and helmets; and engaging in risky sexual practices.

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

- Pregnancy and childbearing practices includes fertility practices; culturally sanctioned and unsanctioned methods for birth control; views toward pregnancy; and prescriptive, restrictive, and taboo practices related to pregnancy, birthing, and postpartum.

- Death rituals includes 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.

- Healthcare practices 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, rehabilitation, and organ donation and transplantation. Additionally, one's response to pain and the sick role are shaped by culture. Barriers to health care are included in this domain.

- Healthcare practitioners concepts include the status, use, and perceptions of traditional, magicoreligious, and Western biomedical healthcare providers. Additionally, the gender of the healthcare provider may have significance in some cultural groups.

PRIMARY AND SECONDARY OF CULTURE

Major influences that shape peoples' worldview and the degree to which they identify with and adhere to their cultural group of origin are called the primary and secondary characteristics of culture. The primary characteristics are nationality, race, color, gender, age, and religious affiliation. Primary characteristics cannot easily be changed. If these characteristics such as religion or gender are changed, a significant stigma may attach to the individual from society.

The secondary characteristics include 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 (sojourner, immigrant, or undocumented status), and length of time away from the country of origin. People who live in ethnic enclaves and get their work, shopping, and business needs met without learning the language and customs of their host country may be more traditional than people in their home country. Immigration status influences a person's worldview. For example, people who voluntarily immigrate generally acculturate more willingly; i.e., they modify their own culture as a result of contact with another culture. Moreover, acculturation has different degrees in different contexts. For example, a person my acculturate in the workforce in terms of language and practices, but speak their native language and adhere to traditional practices when at home. Similarly, they assimilate, that is, gradually adopt and incorporate the characteristics of the prevailing culture more easily than people who immigrate unwillingly or as sojourners. Sojourners, who immigrate with the intention of remaining in their new homeland only a short time, or refugees, who think they may return to their home country, may not perceive the need to acculturate or assimilate. Additionally, undocumented individuals (illegal aliens) may have a different worldview from those who have arrived with work visas as "legal immigrants."

CONCLUSION

Today, each subgroup has the right to be respected for its unique individuality. Most health-related educational programs and service providers have statements addressing multicultural diversity. Organizations and individuals who understand their clients' cultural values, beliefs, and practices are in a better position to be co-participants with their clients and provide culturally acceptable care. Accordingly, multidisciplinary healthcare professionals can use the Purnell Model as a guide for assessing, planning, implementing, and evaluating interventions. Through a systematic appraisal for each client and individualizing care, improved opportunities for health promotion, illness and disease prevention, and health restoration occurs. To this end, healthcare providers need

both general and specific cultural knowledge. One cannot possibly know all the diverse world cultures and their characteristics. Cultural general knowledge and skills ensures that providers have a process for "becoming" culturally competent.

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