Critical Review
Transcultural Nursing as a Theoretical Framework in Support of Disaster Nursing

Theodoros Persiridis
Registered Nurse, MSc Community Nursing, General Hospital of Thessaloniki "Hippocratio"
Paraskevi Apostolara
Registed Nurse, MSc Community Nursing, Doctoral Candidate National Kapodistrian University of Athens, General Children's Hospital "Paidon" Pendelis
Community Nursing Laboratory U.O.A.: Managing Director, Dr. A. Kalokairinou

Key words: Nursing Theories, Nursing Models, Disaster Nursing, Cross-cultural nursing, Cultural Competence.

We would like to express our gratitude to Maria Gkika for sharing her experience in the case study and our teacher As. Prof. Panagiota Sourtzi whose stimulating suggestions and encouragement helped us to accomplish this review.

Intoduction: Today's nurses, in the framework of international humanitarian missions, are called on to provide care for individuals, families, and people of different cultural backgrounds. In order to respond effectively in this very important role, they are required to have knowledge of nursing theories and models emanating mainly from the fields of Disaster Nursing and Transcultural Nursing, which when rightly combined can be applied to wide scale disasters.

Data Sources: Sources of information include Electronic Libraries and Databases such as: Medline, Cinahl and Google.

Bibliography Review: A number of nursing theories and models that can have relevance for Disaster Nursing emerged from the bibliographic review. Models that have been formed specifically for the guidance of nurses so that they are capable of comprehending the content and the significance of Disaster Nursing, and models that describe significances different from those of Disaster Nursing which can be used in real situations if they are approached from the appropriate perspective. Important also are the models that refer to the development of cultural competence in nurses, such as the comprehension of culture of the population that has been affected and has requested humanitarian assistance.

Conclusions: Undeniably, in a multinational - multicultural environment there is an intense need for cultural competence to deal properly with mass causality incidences. The combination of models and theories is the better choice in disaster nursing so that the objective is achieved as well as the desirable result. After the application of the selected model is applied in this particular nursing situation, the evaluation will determine whether ultimately this model was indeed the correct choice.

Introduction

Globalization is a given. Today's nurses more than ever are being called upon to provide care to communities, to families, and to scores of people who have been injured in some catastrophic events, populations moving because of being forced from their homeland, or a confrontational situation, or that some kind of disaster has forced them to move to find food and shelter. So that nurses respond effectively in this role, they are required to have knowledge and skills that will allow them to provide care to individuals of different cultural origins as well as being able to collaborate with other professionals from different cultures within the framework of international humanitarian (Weiner et al, 2005). These abilities no only facilitate nurses in the providing of care to the injured, but also ensure in and of itself a more efficient collaboration at the international level.

With the birth of Nursing, a need was created for development of theories and models aimed at describing and comprehending phenomena in the field of individual care. Since the time of Florence Nightingale, when the first complete nursing theory was formulated, and even until today it has been the basis that has shaped important theories and given impetus for the development of Nursing Science in a wider respect (Apostolopoulou, 1999). More specifically in Disaster Nursing certain models have been developed aimed at guiding nurses through the process of comprehending the philosophy of Disaster Nursing.

The present work constitutes a bibliographic review of nursing theories and models emanating mainly from the spaces of Disaster Nursing and Trans-cultural Nursing, which can be implemented in wide scale disasters. Furthermore, an effort is being made here so that a universality of theories in all clinical nursing sectors as well as their interrelationship may emerge.

Bibliography Review

The Nursing Models must encompass all those subject variables at hand in addition to including valuable instructions for guidance in a real nursing situation (Meleis, 2005). There are a number of theories and Nursing Models that can find a place in Disaster Nursing. Models that have been formed specifically for the guidance of nurses so that they are capable of comprehending the content and the significances of Disaster Nursing and so that they can appreciate a disaster situation and provide care. Certain other models such as the Model of Providing Emergency Care by Air Transported Team (CCATT Model), have come about from the Medicaid sector of the armed forces but can also apply to the management of non military crises (Sariego, 2006). Nevertheless, models that describe relationships and significances that differ from those of Disaster Nursing can be used in real situations if they are approached from the correct perspective. The models that refer to the development of the cultural competence of nurses are of great value so as to cover the need for comprehension of: culture, cultural norms, values and convictions of the affected population requesting humanitarian assistance.

Florence Nightingale's *The Theory of Environment*

The theory of Environment of Nightingale came about from her experience in the Crimean war (Selanders, 1995). She attributes the illness and the death of soldiers to the unsanitary environmental circumstances, which also can certainly apply today in terms of mass causality incidences. It focused on the environment stressing that "clean air, potable water, a good sewage system, cleanliness and light can transform an unsanitary environment to a healthy one" and that there is a need that certain variables be modified in this, so that individuals recover (Apostolopoulou, 1999). In catastrophic events the environment contains a plethora of dangers such as a lack of: potable water, food, sewage disposal and poses living under intensely stressful conditions that can harm the victims and the nurses. Disaster Nursing focuses on the recognition of such dangers and develops planning and interventions for their elimination.

***The Disaster Management Nursing Model* by A.Jennings**

The Disaster Management Nursing Model by Jennings (2004) was created in order to help the Community nurses in the planning and management of disasters and incorporates four stages that are connected to time sequences. The first stage (Before the Disaster Occurs) concerns in the estimate of risks and availability of community resources. The second stage (Disaster Incident) is the point in time when the disaster happens and refers to the development of the nursing role as tutor, instructor and administrator of the situation. In the third stage (After Disaster Incident) there is an effort to assess the planning regarding the care that was dispensed. The impossible and possible points of planning are located; the weaknesses of planning are recorded in a scientific way in the bibliography and a new effort is being made to re-design the model. Leading to the fourth stage (Consequence for the Population /Customer) Jennings stresses that the actions that took place in the previous stages will be able to produce a positive outcome in the health condition of the population. Through indicators such as the reduction of mortality, the reduction of cost of care and also by the improvement of the level of health and nursing knowledge concerning disaster issues, there will be an effort made to record the outcome of planning with measurable indicators.

The Disaster Nursing Timeline by T.Veenema

Another model was developed by Veenema, through which the idea of "continuous" planning for disasters emerges. The model includes three time moments that are interrelated. Phase I is the moment before the disaster and contains the planning, the preparation, the prevention and the warning signs. Phase II spans from the zero hour when the beginning of disaster is comprehended until 72 hours after and includes the response, the emergency management of the crisis and the normalization of the situation. And Phase III, the third day after the disaster: re-establishment, rehabilitation, restructuration and evaluation efforts begin (Veenema, 2007).

***Cultural Care Diversity & Universality: A Theory of Nursing* by M. Leininger**

From an examination of Transcultural Nursing, M. Leininger first formulated the theory for the Cultural Diversity and Universality of Care supplemented by the Sunrise Model as an example for the application of the theory and later by the Ethno Nursing Research Method as a research method that serves the objectives of the theory (Leininger, 2002). The Transcultural Theory of Leininger can also be applied to Disaster Nursing, as it has a complete guide on the study

and the analysis of variables in the various cultures. The central purpose of her theory is to be discovered, to be argued, to be interpreted, and the multiple factors that they influence to be explained. That these things elucidate care from a holistic point of view will contribute to the health and the prosperity of people (Leininger, 1997).

Case Study: Application of a Trans-cultural Nursing Theory in Providing Health Care in Mass Casualty Incidents.

G.M. is clinical infectious disease registered nurse and works in the Hellenic N.H.S. In the text that follows it mentions her experience, in almost complete devastation, that would take place in the holds of a slave ship after fire had burst out. G.M. was a member in the unit of an interdisciplinary team of scientists that the Greek Government had sent.

"Beginning of November 2001: Aground in Zakynthos, called the "boat of shame" by the press". Seven hundred fifty (750) immigrants are transported from the slave trader in sordid hygiene and living conditions. Simultaneously, with the Doctors without Borders, the Doctors of World, the Greek Red Cross and others from non governmental organizations the Hellenic Center for Infectious Disease Control (KEELPNO) sends a unit initially made up of nine individuals, of which, eight were doctors and one an infectious disease nurse. A team of sociologists and psychologists follow later. In the mission, I participate as the nurse of the unit. Most of the male immigrants have been transported to a closed gym, while women, children, and families are in hotel space.

The team tries to record the medical and pharmaceutical needs. Planning follows the subsequent course:

- Populations are not uniform. A common language of communication should be found. From the team 5 speak English, 3 French, 1 German. We put up signs with the introductive question in each language and we wait for whoever of the refugees will respond. After someone responds, we learn their country of origin and we make them head of their team of compatriots. The doctors are assigned to three rough surgeries (3, 2, 2), while one of the doctors and a nurse carry out the initial estimate of needs and send the patients to the appropriate surgery according to the translator's language. Thus begins a common code of communication.
- Serious general medical problems must be faced immediately. Contagious diseases, which are the responsibility of the unit, and their spreading must be anticipated and dealt with. Directives are given to the refugees-translator to announce the symptoms on the basis that whoever has the symptoms must take precedence. Doctor and nurse go around in the space and check clinical symptoms and macroscopic points become an education for the immigrants concerning simple rules of cleanliness and hygiene while necessary sanitation materials are dispersed.
- Blood examinations and the issuing of medicines are necessary. The population is ethnologically and religiously non-homogeneous. The statistical analysis later showed that the immigrants were Kurds from Iran and Iraq, as well as Palestinians, Indians, Pakistani, and residents of Eritrea. The greater part of population consisted of Sunni Muslim women. The time period happened to coincide with the celebration of Ramadan. Which of the existing nursing theories was most suitable to be implemented? The theory of Madeleine Leininger could be applied. Her central point being that the culture promotes the decisions. Thus, any hygiene decision had to pass through cross-cultural procedures. Blood examinations were transported after sunset, while at the same time there was an effort being made to have as many medicines as possible transported in a timely manner. The respect of morals and customs of both the refugees shown by the team led to the acceptance and the respect of sanitation rules, while just before the unit's departure, there was a touching celebration that had been organized by the immigrants.

***A Culturally Competent Model of Care* by Campinha-Bacote**

In 1991 Campinha-Bacote, in the "Model for Cultural Competence" defines cultural competence as "the process, in which health care professionals continuously attempt to acquire the competence to work effectively within the cultural framework of the individual, family or community that comes from a different cultural/national background as a basis" (Campinha-Bacote, 1998). It is a revised model (1998) consisting of five constructs (cultural awareness, cultural knowledge, cultural skills, cultural conflicts and cultural desires) with the interdependent relation of one with the other, which make up the strengthening of cultural competence electing it as the central purport and also offering a valuable theoretical framework to the subject of Disaster Nursing (Campinha-Bacote, 1999). The model requires the health care providers via what is not a simple process, but a dynamic journey- which in 2002 was symbolically represented as a volcano – to consider themselves as "becoming" culturally competent as opposed to "already being" cultural competent (Campinha-Bacote, 2002, Campinha-Bacote, 2007).

***The PTT Model of Developing Cultural Competence* by Papadopoulos, Tilki, and Taylor**

Finally, also I. Papadopoulos, M. Tilki, and G. Taylor in the PTT Model that they formulated in 1994 set cultural competence to be of central significance that is to say that the capacity to provide effective health care takes into account cultural beliefs , behaviors, needs of a customer, and at the same time recommends a procedure and a

result. The result comes from the synthesis of knowledge and skills which the nurse acquires, and furthermore this experience evolves and enriches his personal life during his professional career (Papadopoulos, 2003). This undeniably constitutes a challenge for the health care professional when his education has been based on Western philosophy and culture. Ignoring any such matters in Disaster Nursing is sure to end in failing to meet the objective, which is none other than the providing of quality care. If a health care professional responds in a culturally sensitive way, and a way that is specifically targeted to the community, this shows that he respects the culture of the people he has been called on the provide care services to. The underpinning value that differentiates this model is the emphasis that it places on human rights. (Papadopoulos, 2005). According to this model, the process of acquiring cultural competence includes four stages. The first stage of the model is cultural awareness (personal examination of our values and convictions); second is cultural knowledge (significant contact with persons from different ethnic groups in order to strengthen knowledge about their beliefs and behavior); the third stage is cultural sensitivity (the way in which professionals perceive the individuals that they are attending). The achievement of the fourth stage (cultural competence) requires the synthesis and the implementation of the three previous stages, that is to say awareness, knowledge, and sensitivity (Papadopoulos, 2003). And finally, accordingly to the model, cultural competencies can be both specific and general. Specific Cultural Competencies refer to knowledge and skills that have to do with a certain cultural group while general cultural competencies are set as the acquisition of knowledge and skills that are applicable to the all cultural groups. So as to allow a Disaster Nurse to cope in today's role and be considered culturally competent, it is deemed essential to develop both types of competencies in that they share a dynamic and spiral process. (Papadopoulos and Gerrish, 1999, Papadopoulos and Lees, 2002).

Conclusions

The permanently alternating content of wide scale disasters on a world scale sparks both continuous research and the improvement of nursing care at an international level. Wide scale disasters constitute henceforth complex situations of emergency care, influencing human existence in sectors such as health and well-being, culture and spirituality, and also economic prosperity. Nursing models and theories contribute more to the esteem of the needs of a customer - patient and the pursuit of appropriate care despite the effort to explain some nursing phenomenon. At times criticisms have been accepted with the reasoning that by limiting the critical thought of a nurse, this would to trap the nurse within a rigid framework. Let us note that Nursing Models were created in order to give added perspectives and dimensions to nursing, that is, changing from the customarily accepted care in to evidence based nursing (Fawcett, 1992).

Dilemma can result from such a large reservoir of theories, more specifically for each point of the theory. However, it would be hard to find anyone that has not been confronted with this dilemma over each and every nursing theory that can be applied in a period of crisis after some disastrous event. Undeniably, in a multinational - multicultural environment there is an intense need for development of cultural competence in the confrontation of disasters that demand international assistance. A combination of models and theories is possibly the better choice in Disaster Nursing so that the desired result and objective are achieved.

The evaluation following the implementation of a model that was selected and applied to a particular nursing situation is the one that will determine if finally it was the correct choice. Through this process the two-way relationship that exists between a conceptual model and Clinical Nursing also emerges. Models ought to be designed so as to give guidance and transform Nursing Practice while concurrently those models must be improved and readjusted by way of Clinical Nursing needs (Speedy, 1989).

BIBLIOGRAPHY

Apostolopoulou, E. 1999. Θεωρίες της Νοσηλευτικής. Αθήνα.

Campinha-Bacote, J. 1998. The Process of Cultural Competence in the Delivery of Healthcare Services (3rd Ed.). Cincinnati, OH: Transcultural C.A.R.E. Associates.

Campinha-Bacote, J. 1999. A model and instrument for addressing cultural competence in health care. Journal of Nursing Education 38 (5), 203-207

Campinha-Bacote, J. 2002. The Process of Cultural Competence in the Delivery of Healthcare Services: a model of care. J Transcult Nurs 13,181-184

Campinha-Bacote, J. 2007. The Process of Cultural Competence in the Delivery of Healthcare Services: The Journey Continuous. Cincinnati, OH: Transcultural C.A.R.E. Associates.

Fawcett, J. 1992. Conceptual models and nursing practice: the reciprocal relationship. Journal of Advanced Nursing 17, 224 – 228.

Gerrish, K., Papadopoulos, I. 1999. Transcultural competence: the challenge for nurse education. British Journal of Nursing 8 (21), 1453-1457.

Jennings – Sanders, A. 2004. Teaching disaster nursing by utilizing the Jennings Disaster Nursing Management Model. Nurse Educator in Practice 4, 69-76.

Leininger, M. 1997. Overview of the theory of culture care with the ethnonursing research method. J Transcult Nurs 8, 32–52.

Leininger, M., McFarland, M. 2002. Tran cultural Nursing: Concepts, Theories, Research and Practices. 3rd Edition. McGraw-Hill, New York.

Meleis, A.2005. Theoretical nursing: Development and progress. Philadelphia: Lippincott Williams & Wilkins.

Papadopoulos, I., Lees, S. 2002. Developing Culturally Competent Researchers. Journal of Advanced Nursing 37 (3), 258-264.

Papadopoulos, I. 2003. The Papadopoulos, Tilki and Taylor Model for the development of Cultural Competence. Journal of Health Social and Environment Issues 4 (1), 5-8.

Papadopoulos, I. 2005. Transcultural Health and Social Care. Development of Culturally Component Practitioners. Churchill Livingstone: Elsevier, xi.

Sariego, J. 2006. CCATT: A Military Model for Civilian Disaster management. Disaster Manage Response 4, 114 - 117.

Selanders, L. C. 1995. Florence Nightingale: An environmental adaptation theory. In C. Metzger – McQuiston & A.A. Webb (Eds.), Foundations in nursing theory: Contributions of 12 key theories. London: Sage.

Speedy, S. 1989. Theory – practice debate setting the scene. Australian Journal of Advanced Nursing, 6(3), 12 - 20.

Veenema, T. 2007. Disaster Nursing and Emergency Preparedness for Chemical, Biological and Radiological Terrorism and other Hazards. 2nd Edition, Springer Publishing Co, New York, pp. 9.

Weiner, E., Irwin, M., Trangenstein, P., Gordon, J. 2005. Emergency Preparedness Curriculum in Nursing Schools in the United States. Nursing Education Perspectives 26 (6), 334 – 339.