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Application of Leininger's Culture Care Theory in Family Medical History

By

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ABSTRACT

Application of Leininger's Culture Care Theory in Family Medical History

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One of the very first interactions a patient has with medical staff is a one-on-one interview to ascertain family medical history. However, the practice of recording patient medical history has remained relatively unchanged for decades since the advent of modern medicine. This begs a question of if there is a way to improve the current status quo. Leininger's Culture Care Theory and Sunrise Model implement both an innovative and patient-centered focus that acknowledges and incorporates patients' cultural backgrounds into their healthcare plan. Combining Leininger's Culture Care Theory with the current process of recording family medical history will modernize a somewhat antiquated aspect of modern healthcare, benefitting both patients and healthcare professionals alike.

KEYWORDS: Leininger, Culture Care, Medical History, Globalization, Sunrise Model,

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INTRODUCTION

The technological boom of the 21st century has interconnected the world to an unprecedented extent. The side effects of this interconnectedness can be seen in the healthcare system. It is entirely plausible that a person may go from one side of the world to the other and find themselves in a hospital. Given the fact above, the United States (U.S.) healthcare system must be able to adapt and accommodate patients of different cultures and worldviews. Madeleine M. Leininger created her Theory of Culture Care and Sunrise Model to address the challenge globalization has placed upon healthcare in the United States. There are seven key influences on Culture Care within the Sunrise Model, one of which is Kinship and Social Factors. To the Western world, kinship may seem straightforward, referring to direct family members or blood relatives. However, in Eastern collectivist cultures, kinship takes on a much different meaning. Kinship can be made up of one's direct family ties as well as neighbors, friends, and extended family. Put into this context, this thesis seeks to elucidate how Leininger's Culture Care Theory can improve the current system of information regarding patient family medical history.

FAMILY MEDICAL HISTORY

According to the National Institute of Health, a family medical history is a record of health information about a person and their closest relatives. One's medical history can give clues to pathology, chronic illness, or potential risk factors for disease. Even so, it does not necessarily mean with certainty that a patient will develop a condition. Typically, family medical history is collected via a self-disclosing questionnaire by the patient or an interview with a medical professional. It is unclear precisely when recording family medical history became common, standardized practice. However, the discovery

of genetics and heritability most likely spurred the widespread examination of family history in medicine.

The concept of family medical history is not a novel one. Humanity has had the idea that things can be passed down from parents to children for centuries. A relatively recent example of this concept is the discovery of hemophilia in Queen Victoria's family in the 19th and 20th centuries. Coined as "Royal Disease", hemophilia was known to be spreading through royal bloodlines, but nobody quite knew the mechanisms behind how or why. The conclusion of the human genome project in 2003 was a pivotal moment where our understanding of human genetics increased exponentially, and the underpinnings of family heredity began to be truly be unraveled. Even then, it took another six years for Tsarevich Alexei, Rogaev et al. to discover in 2009 that Royal Disease was hemophilia B. In light of the aforementioned historical context, medical family history occupies a peculiar, yet universally important place in history and in our everyday lives. With the advent of modern genetic research, medical professionals can now identify risk factors for disease and pathology long before they manifest themselves within a patient.

The way in which medical professionals collect family medical history is typically through a self-reporting questionnaire or a one-on-one interview with their patients. This process has not changed notably since the conclusion of the human genome project. The most drastic change to the family history collection process has most likely been the incorporation of technology such as computers, patient databases, and online charting. Such changes have increased the ease of use and access to patient medical history for both patients and physicians, but the core process remains the same for every

patient that may find themselves in the U.S. healthcare system. In short, family medical history is a standardized process which is applied in the same fashion for every patient regardless of circumstances. One consequence of viewing patient family history through a standardized lens is that progressive changes in patient demographics are not accommodated for. But what is responsible for such sweeping changes in patient demographics such that healthcare has fallen behind? I propose the answer lies with globalization.

GLOBALIZATION

Leininger's Theory of Culture Care is predicated upon the concept of a globalized world. For Leininger's Theory of Culture Care to be fully understood, globalization must first be clarified. Globalization has been around for centuries, even going as far back as the Renaissance (Mittelman 5). Globalization refers to the increasing transnational and transcultural circulation of goods, people, ideas, money, and information around the world driven most notably by the rapid expansion of technology in the twenty-first century (5). Highlighting the effect globalization has upon the U.S., the U.S. Census Bureau documented that in 1998 there was a total of approximately 26 million foreign-born U.S. residents which comprised 9 percent of the total U.S. population (Riche 16). However, the 2010 U.S. Census reports that approximately 13% of the U.S. population is now foreign-born residents (Grieco et al. 2). Put into the context of healthcare, this 4% change represents the possibility of millions more patients in the U.S. healthcare system from a wealth of different global cultures.

Along with political, economic, and educational institutions, hospitals are also a place where globalization's effects converge. However, the healthcare industry is unique

when compared to similarly globalized institutions. For example, healthcare is universal across all countries and cultures. Furthermore, healthcare is intertwined with political, social, historical, and religious factors in every global society. The convergence of all the aforementioned factors and globalization into the U.S. healthcare infrastructure poses a problem to physicians, challenging them to provide culturally sensitive treatment for a rapidly diversifying patient population. Leininger's Theory of Culture Care attempts to equip physicians and other healthcare professions with the tools and knowledge necessary to address this problem.

<div align="center">LEININGER'S THEORY OF CULTURE CARE (LTCC)</div>

In the United States, concerted efforts are being made in the last two decades in order to implement better cultural awareness in the healthcare field. Often referred to as "Cultural Competence", Leininger, a nursing theorist, from Omaha, NE, published her Theory of Culture Care in 1995 to revolutionize healthcare by incorporating, "cognitively based assistive, supportive, facilitative, or enabling acts or decisions that are mostly tailor-made to fit with individual's, group's, or institution's cultural values, beliefs, and lifeways" (McFarland and Wehbe-Alamah 5). In other words, Leininger's Theory of Culture Care (LTCC) seeks to standardize healthcare in such a way that would be appropriate, respectful, and decent for everyone that may find themselves in a globalized healthcare system regardless of their culture of origin. LTCC encompasses many aspects of culture such as religion, technology, education, politics, etc. The factors that LTCC influence, in turn, influence how healthcare systems address their patients' needs. As Albougami confirms in an analysis of LTCC, "These factors, along with language and social environment, significantly affect the services delivered by systems, whether

traditional or professional." (Albougami 1). Traditional medicine and traditional healthcare systems refer to systems that treat afflictions through herbal and spiritual means (Neba 133), whereas professional healthcare systems treat patients using learned knowledge and evidence-based practices (Albougami 1). What LTCC suggests is combining traditional medicine's cultural integration along with professional healthcare's objectivity to produce a healthcare system, which not only treats the patients' symptoms using evidence-based science but also respect the patients' cultural beliefs, values, and concerns.

While it is clear that LTCC functions as a whole to incorporate culture into healthcare, what exactly does the term "Culture Care" mean? At the time LTCC was created, Leininger believed that the predominant theories of healthcare are much too restrictive, introducing the Theory of Culture Care as a much more open and explorative approach to both culture and care. When Leininger created LTCC, the current trend in healthcare was towards standardization, where healthcare procedures are nearly identical for everybody. Leininger coined the term Culture Care to embody the movement away from standardization and towards personalization of healthcare. More specifically, Culture care refers to meaningful and therapeutic healthcare practices that are culturally-based (Leininger 9). Culture acts as a guide by which humans act and make decisions, including material and nonmaterial aspects of a group or individual (Leininger 6). In a way, culture is inseparable from healthcare. Insofar as culture acts as a guide by which humans base their actions, then it follows that culture has ubiquitous influence over nearly all aspects of life which includes patient-physician interactions in a healthcare setting. Leininger makes the claim that it is this very nature of culture is the basis for why

it should not be buried beneath standardization, but rather be brought to the forefront of healthcare.

SUNRISE MODEL

Leininger's Sunrise Model (Fig. 1) is a visualization of her Theory of Culture Care in the shape of a sunrise or half-circle.

CULTURE CARE

Worldview

Cultural & Social Structure Dimensions

Kinship & Social Factors

Cultural Values, Beliefs & Lifeways

Political & Legal Factors

Environmental Context, Language & Ethnohistory

Religious & Philosophical Factors

Economic Factors

Influences

Technological Factors

Care Expressions Patterns & Practices

Educational Factors

Holistic Health / Illness / Death

Focus: Individuals, Families, Groups, Communities or Institutions in Diverse Health Contexts of

Generic (Folk) Care

Nursing Care Practices

Professional Care–Cure Practices

Transcultural Care Decisions & Actions

Culture Care Preservation/Maintenance
Culture Care Accommodation/Negotiation
Culture Care Repatterning/Restructuring

Code Acute viral disease caused by the human

© M. Leininger 2001

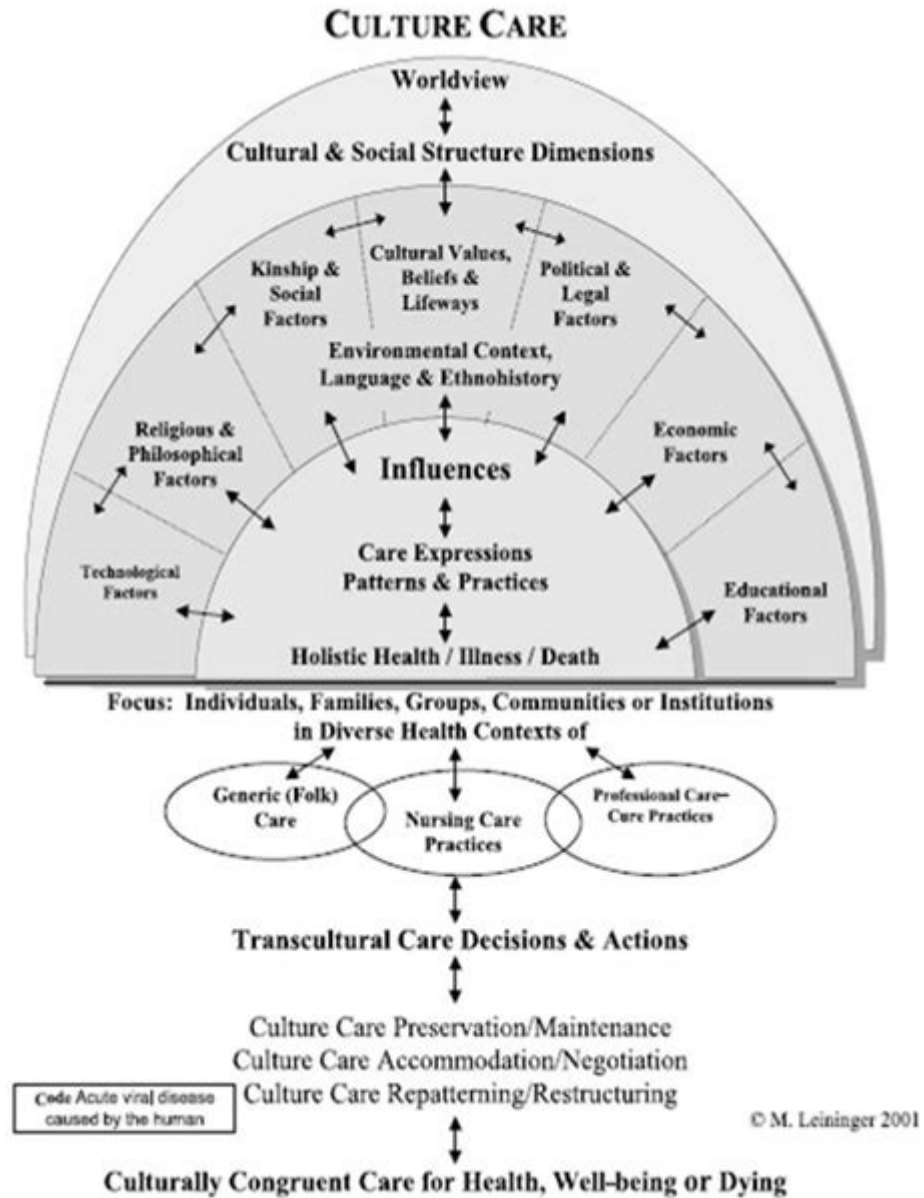**Culturally Congruent Care for Health, Well-being or Dying**

Fig. 1. Leininger, Madeleine M., and Marilyn R. McFarland. *Culture Care Diversity and Universality: a Worldwide Nursing Theory*. 2nd ed., Jones and Bartlett, 2006.

The two-sided arrows throughout the Sunrise Model represent two regions interacting with one another. At first glance, the Sunrise Model appears to have two-sided arrows going between every level. This is quite deliberate, as it depicts the codependency of the various factors of LTCC. Each factor in the Sunrise Model affects all other factors around it. The Sunrise Model begins with an individual's overarching worldview. A person's worldview encompasses the entirety of the Sunrise Model, indicating that it is the foundation by which a person frames their healthcare experiences. Below "Worldview" is "Cultural & Social Structure Dimensions". The dimensions of Social Structure and Culture envelopes the rest of the Sunrise Model much like "Worldview" does, conveying that it unilaterally affects all aspects of Leininger's Sunrise Model. The wedges that constitute the bulk of the Leininger's Sunrise Model are labeled: technological factors, religious and philosophical factors, kinship and social factors, cultural values - beliefs and lifeways, political and legal factors, economic factors, and educational factors. Each of these factors interact with one another to produce a complex system of reciprocal interactions. At the very bottom of the Sunrise is "Holistic Health/Illness/Death", which takes the culmination of all the previous factors and relationships and relates them to healthcare. In essence, the Sunrise Model visually demonstrates how Leininger's Culture Care Theory links culture to healthcare.

THE FACTOR OF KINSHIP

Next are the kinship factor of Leininger's Theory and Sunrise Model. In short, kinship refers to familial ties that an individual experiences. This is different from family

in the sense that kinship includes both the familial unit as well as the relationships that are connected to that specific family. Most often, when someone refers to his or her kin they typically mean their direct blood relatives within their familial unit. However, kinship may not be so black and white as it seems. The definition of a family varies greatly between cultures. One of the best observable instances of culture changing the interpretation of kinship is the contrast between individualistic and collectivist cultures.

Collectivism and individualism are best described as cultural syndromes which differentiate cultures in terms of beliefs, attitudes norms, roles values, and behaviors (Triandis 50). With such intrusive effects upon the framework societies, collectivism and individualism determine how healthcare institutions, employees, and patients interact with one another. From the very beginning, culture shapes peoples' expectations of who is kin and who is not. Individuals that work within the healthcare system are no different, delivering healthcare with the pre-defined cultural pretenses. This ingrained cultural expectation of kinship is expressed when a physician collects family medical history from patients. Imagine that a doctor from a different culture with a different definition of kin goes through the same process of collecting family medical history. The culture-defined parameters of kin determine how medical professionals shape their family medical history interviews with their patients and the lens in which they view it. Therefore, it is apparent why different expectations of kinship can yield dramatically different results in the scope of medical family history. In order to fully explicate how individualism and collectivism frame the definitions of kin and family, a contrast and comparison of each one and how they manifest themselves in cultures will be explored, resulting in varied family definitions.

WESTERN INDIVIDUALISM

To begin, Western cultures generally value individualism while eastern cultures value collectivism. Individualism places a high amount of value on the freedom of individuals, promoting people that are self-motivated, self-directed, and with a comparatively unrestricted ego (Realo et al. 164). In addition, individuals are, in general, more autonomous, independent, self-contained, success-oriented, and calculative (Triandis 909). Individualistic societies' ego-centrism is manifested in healthcare in a variety of ways, one of which being the cultural parameters of family and kinship. With more emphasis upon the self, individualistic cultures use the nuclear family as the primary familial unit, which focuses upon one central parental couple and typically includes children as well as grandparents (Zimmerman 109). Western patients' family medical history follows the same pattern, where information exclusively concerning the nuclear family unit (including grandparents and children) is examined while other extended family members are excluded from consideration in most cases.

INDIGINOUS COLLECTIVISM

While the cultural framework of the west is focused on the self, collectivism prioritizes the benefits, needs, and wants of a group before that of an individual's own. Collectivism is generally associated with eastern, developing societies and countries with tribal governments. For example, the definition of who is kin is expanded in traditional African villages. Close neighbors, friends, and allies may all be considered as kin. But how is this so, and where does this belief stem from? The answer resides in the spirituality of traditional African tribes. One of their primary beliefs is that people have all descended from the same ancestors. While most African peoples are able to trace their

genealogical families through unilineal descent, either through a line of fathers or a line of mothers, they are all members of a clan where the constituents are under the understanding that they are somehow all related (Siegel 5). This is the basis for what is called sociological ancestry, where the members of the village all are able to define genealogical ancestry, but this does not necessarily With a broader cultural definition of family, the lines between who is included in one's family medical history may become more blurred than those in an individualistic society.

In summation, more individualistic cultures interpret kinship more literally with strict adherence to bloodline kin only. Traditional collectivist cultures, on the other hand, believe in an expanded kinship to include close family friends, business partners, or even entire villages.

<center>LTCC'S KINSHIP FACTOR AND FAMILY HISTORY</center>

Now that the intricacies of kinship have been explored, what kind of relationship does kinship share with family history? Kinship, as explained previously, sets the standard by which family is defined. This due to the contribution of a variety of factors, most notably one's culture. Culture defines the expectations of kin within societies. For instance, the expectation of kin in the U.S. consists of the nuclear family plus grandparents, strictly adhering to blood relation. Family medical history operates within this overarching expectation, such that its own definition of kin and family align to the expectation of kin as established by culture.

Additionally, kinship and family medical history are nearly synonymous with one another and both operate similarly within LTCC. One of the most apparent similarities between the two is how both can change definition depending on its cultural context. At

the most fundamental level, a family medical history is simply a health record about a person and his or her close relatives. However, one's culture defines the extent by which family and kinship are interpreted. Therefore, the two share a common overlap within the culturally-bound definitions of family.

INCORPORATING LTCC INTO FAMILY MEDICAL HISTORY

To fully explain how LTCC is compatible with the current healthcare system and family medical history, I believe it is beneficial to explore the overarching historical background of recording medical family history. In the last half-century, healthcare has experienced a marked increase in standardization. The primary reason for this is the possibility that variation in care can pose risks to patient safety and increase costs (Rozich, et al. 1). While it remains unclear precisely when or why family medical history become standard practice, it seems as though family medical history is a product of the standardization movement coupled with the discovery of heritability as mentioned previously. Prior to 1965, the United States government had largely stayed out of the medical practice of medical physicians. With the introduction of Medicare and Medicaid in 1965, the federal government began implementing "Conditions of Participation" which outlined the basic expectations and standards that were deemed necessary for hospital operation. These conditions included: staff credentials, 24-hour nursing services, and utilization review (Bohmer 2009). As a result, a committee was founded to ensure hospital compliance to the new regulations. It was from that point, a great many more committees, review boards, and standards of care were developed. Therefore, it is reasonable to extrapolate that the modern standardization of healthcare began in the years

following 1965 and the federal government's implementation of Medicare and Medicaid, inserting itself into the healthcare field. Standardization in medicine along with the understanding of the human genome project has created the cornerstones which guide modern medical family history. At first glance, LTCC seems to conflict with the standardization movement. As it has already been established, LTCC recognizes the importance of personalizing one's healthcare plan and aims to incorporate individuals' cultures into their healthcare plan. Rather, I propose that it LTCC and standardization can coexist within healthcare. It is important to remember that the spectrum of standardization versus personalization is not an all-or-nothing system. For example, healthcare can be standardized regarding critical medical procedures and emergent situations that warrant overlooking cultural and societal norms. Conversely, personalization can be implemented in physicians' bedside manner, interactions with patients, and non-emergent medical situations.

Combining Leininger's Culture Care Theory with the already established system of family medical history can revolutionize how hospitals, doctors, and other medical professionals treat their patients. Integration of a transcultural healthcare can better accommodate patients from across the world, especially those from collectivist cultures and those that come from a country that practices traditional medicine. As previously discussed, Leininger's Theory aims to unilaterally increase the cultural awareness of healthcare professionals. I propose that the introduction of heightened cultural awareness to the family medical history recording process will not only help physicians better treat patients, but also accommodate a wider variety of world cultures.

Suppose a man from a traditional African culture takes an airplane to America but soon finds himself in a hospital. Western medical knowledge will most likely tell the doctor the illness of the man. However, what medical knowledge will not tell the doctor is that traditional African cultures typically believe that illness may be the manifestation of evil spirits in the body. While medical knowledge can cure the man of this illness, it cannot mitigate the importance patients place upon their cultural beliefs. Likewise, traditional medicine and cultural beliefs alone cannot heal the man's condition. In such a situation, LTCC bridges the shortcomings between traditional and professional medicine. By incorporating LTCC into healthcare, doctors will be able to construct a more complete and accurate family medical history while respecting cultural beliefs and boundaries. With a more culturally aware family medical history, physicians can make more informed and accurate decisions about healthcare interventions without insult to patients' cultural beliefs and values in the process.

For healthcare institutions to effectively implement LTCC, it is important to ensure that administration and staff are adequately trained. While there is yet to be a definitively "correct" way of training staff to be proficient with LTCC, I propose that there are a few general guidelines to ensure its successful application in healthcare. As stated previously, the ultimate goal of applying LTCC is not to place an unreasonable expectation upon healthcare providers with knowing everything about every culture. The first and arguably most important guideline to train employees is to open a dialogue with the patient. This is not to say that physicians should simply ask their patients what their culture is. A conversation can be indirectly spurred by prompting the patient with a brief short answer question asking the patient to specify any cultural accommodations that they

require. From there, the physician can use the provided answer to open a conversation with the patient about how they can better adapt their practice for their patient to be comfortable. This question can be easily incorporated into the family medical history form and can be filled out by the patient. Beginning a conversation with a patient is a skill that every physician should already have. However, talking about culture is not something they may know how to do. The training for LTCC should guide physicians about how to talk about culture with their patients so that both patient and physician understand each other's expectations of one another.

The second guideline in training LTCC to employees is to make sure that all patient care are also trained alongside physicians. Focusing on physicians is important for the success of LTCC, but because nurses, patient care technicians, and other patient care roles are all interacting face to face with patients it is important that they are also on-board with Culture Care so that there is consistency with patients across all care pathways.

The third and final guideline I propose is to allow flexibility in how medical professionals approach Culture Care in their practices. One of the greatest strengths of LTCC is that it personalizes healthcare in an era of standardization. Allowing medical professionals flexibility in how they approach their patients is not only in the spirit of LTCC, but it also will help avoid the perception that it will become an extra burden. Approaching LTCC in a customizable, personalized way will encourage healthcare professionals to approach it with their own motivation to provide the best quality care for their patients.

Next, I will discuss the challenges of implementing Leininger's theory into the current family medical history procedure. As discussed previously, the United States healthcare system has been becoming increasingly more standardized since 1965. Proponents of standardization claim that standardizing healthcare increases the efficiency and application of healthcare interventions as well as simplify communications between healthcare professionals (Wears 2). However, Leininger's theory opposes the current push for widespread standardization, instead promoting a more personalized healthcare strategy by incorporating each individual's culture into their care plan. Therefore, one of the most stringent challenges facing the implementation of Leininger's theory is the current sentiments of the healthcare industry itself. To address such a challenge, it will take a concerted effort to dissociate standardization from the presumed higher quality of care. By doing so, a degree of customization to an individual's care will be more likely to be accepted by the medical community and thereby will allow Leininger's Theory of Culture Care to be implemented.

Further, one of the biggest challenges may come from the medical professionals themselves. Leininger's Culture Care Theory is heavily dependent upon doctors, nurses, and other healthcare professionals being knowledgeable, educated, and sensitive about cultures other than their own. In short, it adds an entirely new dimension to healthcare, such that healthcare professionals may be slow to embrace Culture Care. As Leininger's Theory would suggest, if a physician sees twenty patients per day then he or she should be familiar with each patient's cultural background in order to render the highest quality healthcare. In this case, the physician may view the implementation of Culture Care to be

an unnecessary burden to their practice, where they must not only investigate a medical concern but also familiarize themselves with the cultural intricacies for every patient they see. A counter-argument to this claim is that, while it would be optimal for doctors to know about all of their patients' cultures, there is an implicit assumption that physicians should familiarize themselves with the cultures of their patients to a general extent rather than complete comprehension.

Another challenge to LTCC is in its implementation into the present healthcare system so that every medical professional will be proficient at Culture Care. At the individual level, implementing Leininger's Theory faces a relatively steep learning curve in order to achieve its intended effect. Being mindful of cultures around the world is an abstract concept and not something that can be taught easily to each person. Rather, it must be gained through exposure to different cultures, a willingness to understand, and an open mind about changing the status quo. Alone, Leininger's Theory may not be able to directly instill such personal values within individuals. However, its implementation serves as a necessary first step to normalize heightened cultural awareness in the U.S. healthcare system. After implementing LTCC, healthcare companies could look into giving employees cultural exposure opportunities to supplement gaps in personal experiences, thereby eliminating possible individuals' deficits in Culture Care proficiency.

A third challenge stems from the hypothetical argument that implementing LTCC can potentially hinder the care of patients. This argument stems from the assumption that, due to the additional cultural expectations of medical professionals operating within LTCC, the additional time commitment and resources being dedicated to learning many

patients' cultures will detract from the ability and focus of medical professionals to treat

their patients. While it is true that medical professionals will be required to make efforts

in order to be more mindful of their patients' cultural backgrounds, it will not be to an

unreasonable extent such that it would interfere with their ability to provide medical

treatment. The spirit of LTCC is not to burden healthcare professionals with learning

about every culture imaginable. Rather, it is meant to foster a reasonable and attainable

level of cultural mindfulness, respect, and cognizance within healthcare professionals.

CONCLUSION

While the beginnings of recording family medical history are unclear, what is

clear is that the process of recording family medical history has remained relatively

consistent for decades. Since the advent of standardized modern medicine and the

discovery of heritable genetic information. In addition, the world has experienced an

exponential increase in globalization since the establishment of recording family medical

history, drastically changing patient population demographics. As such, it is important to

update the methods behind the practice, so that it can better serve modern day patients in

a globalized world. Leininger's Theory of Culture Care serves as an important first step

to accomplishing this aim.

At its core, LTCC seeks to transform the way doctors and patients interact by

incorporating culture into patient-physician interactions. The movement of the world

towards globalization has put pressure on the medical systems of the world to respond

quickly and appropriately to a rapidly evolving patient population. Family medical

history holds a unique place in the medical practice. It has been around for decades since

the discovery of heritable genetic information. As such, it is important to adapt the

system in order to better meet the needs of a diversifying patient base. LTCC provides

healthcare professionals and institutions with the tools, understanding, and cultural

awareness in order to do this most effectively.

Looking to the future, LTCC can be expanded outside of the traditional family

medical history format. Rapid advancements in technologically-driven patient data

collection can be combined with LTCC to construct a matrix of patient medical

information such that regional, cultural, familial, and individual risk factors for pathology

and disease can be consolidated into a medical profile by which physicians can use to

better guide their decisions. However, further research must be done in order to fully

explore this possibility.

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