The Czech Version of the Purnell's Model for Cultural Competence

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Abstract

Introduction: The motive of this work was to create standardized Czech version of the Purnell Model for Cultural Competence which could help non-medical healthcare personnel in providing care to clients from different cultural backgrounds.

Objective: The aim was to create a standardized Czech version of the Purnell Model for Cultural Competence and to provide a description of the back translation methodology.

Method: After obtaining consent from the author of the Model for Cultural Competence, Larry Purnell, a translation to the Czech language from the original version in English was carried out by experts from the fields of nursing and midwifery, healthcare English and by linguist. Back translation was carried out by a native speaker from the United States who has lived in the Czech Republic for fifteen years. The native speaker did not know the original version. Subsequently, his version was compared with the original version. Significantly different terms were discussed and subsequently incorporated into the final Czech version.

Results: Altogether, 89 terms were translated. Absolute agreement occurred in 37 (41.6%) cases. In eight cases (9%), the translated terms were significantly different, but agreeing on the resulting expression was seamless. In three cases (3.37%), the different Czech variants also differed significantly and the translation did not correspond to the context. Using the Czech and English interpreting vocabulary linguists, the resulting expressions were reworked. There were synonyms in 38 (42.7%) expressions, singular and plural differences in three translated terms (3.4%). All the differences that appeared in translations were probably due to the different active vocabulary of the individual translators, and in such cases the linguist was chosen as the variant that most corresponds to the original meaning and which is most acceptable for the stylistic and meaningful aspects of the Czech language.

Conclusion: The Model for Cultural Competence is a tool for collecting data from the members of varying cultures from all regions of the world and is widely used by healthcare providers as well as for instance by teachers, research workers and sociologists. The Model for Cultural Competence has been translated into Czech language and brought closer to the wider professional public. It will be subject to further verification under a more extensive study.

Keywords: back translation, focus group, multicultural/transcultural care, nursing model

Introduction

As of January, 2000, Act No. 326/1999 Coll., on Residence of Foreign Nationals on the Czech Territory (CR) (Czech), entered into force, making the entrance to and residence in the Czech Republic more restrictive for most foreigners. Certain provisions of this act were moderated by an amendment effective only as of July 1, 2001, resulting in a slight new increase of resident foreign nationals.

With the Czech Republic joining the European Union (EU) in 2004, the categories of residence were extended. Apart from permanent residence and visa for periods longer than 90 days, there is also long-term residence and temporary residence for EU citizens and their family members.

On June 30, 2016, there was a total of 480,191 foreigners registered on the territory of the Czech Republic and this figure continues to grow every day (Czech Statistical Office, 2016). This situation also results in the fact that Czech healthcare facilities are more and more frequently visited by clients from various cultural environments. Nurses, obstetricians and other non-medical healthcare personnel should be able to provide culturally differentiated, culturally competent and culturally sensible care. Culturally competent care means having certain elementary knowledge concerning the health-related traditions of several cultural groups. Providing culturally differentiated care requires care providers to have deeper knowledge of such minority groups that represent fellow citizens in the given country and/or region with substantially different cultural and historical background (Tóthová, 2010). There are nursing models dealing with the problem of multicultural/transcultural nursing and facilitating the planning and implementation of care for patients from various cultural environments. These include for instance models by Larry Purnell, Madeleine Leininger, Papdopoulos, Tilki and Taylor, Josepha Campinha-Bacote, Joyce Newman Giger and Ruth Davidhizar, Rachel Spector (Sagar, 2012).

Purnell's Model for Cultural Competence

The Purnell Model is classified as a holographic and complex theory because it comprises a model and an organizational framework that can be utilized by all healthcare providers in various branches. The Model for Cultural Competence provides a detailed, systematic and apposite framework for learning about and understanding a culture. The empirical framework of this model provides a basis for healthcare providers, teachers, researchers, managers and administrators in all healthcare branches. The objective of the model is to provide holistic, culturally qualified and therapeutic interventions, support of one's health and wellbeing, prevention of injuries and illnesses, and maintenance and restoration of one's health (Purnell, 2013). The Model for Cultural Competence consists of four circular lines and 12 circle sectors representing the various domains. The outer circular line represents global society, the second outer one community, the third one family and the inner circular line the individual. The inner circle is divided into twelve sectors or domains. These domains create the organizational framework of the model. Every single domain includes concepts that need to be considered while assessing patients (Kutnohorská, 2013). The dark centre of the circle represents an unknown phenomenon. At the bottom of the model, the saw-toothed line represents the non-linear concept of cultural consciousness (Purnell, 2013).

The model intends: to provide a framework for all healthcare providers for learning terms and cultural characteristics; to define the circumstances affecting human cultural world view in the context of historical perspectives; to provide a model connecting the most crucial relations of a culture; to identify a characteristic of a culture, to support concordance and to enable the provision of conscious, sensible and competent healthcare; to provide a framework reflecting human characteristics such as motivation, intention and opinion; to provide a structure for analysing cultural data, the perspective of an individual, family or group within their unique ethno-cultural environment.

Presumptions supporting the model

As Purnell (2013) puts it, these ideas are the main premise of the model: all professions providing healthcare need similar information on cultural variety; all professions providing healthcare share the metaparadigm of the concept of global society, family, person and health; one culture is not better than another culture, they are only different; differences exist inside and between cultures; cultures change slowly in the course of time; variants of cultural characteristics determine in how much one differs from the prevailing culture; if patients take part in their care and have the choice of goal in terms of health, plans and interventions, then their adherence and health results will be better; culture has a strong impact on the interpretation and responsibilities regarding healthcare provided to the individual; care providers need culturally generic and culture-specific information to provide a culturally sensible and culturally competent care; contact with every patient is a cultural encounter (Purnell, 2013).

Objective

The objective of the present paper was to create a Czech version of the Purnell Model for Cultural Competence and a description of the backward translation methodology.

Methodology

The aim of the translation was to translate Larry D. Purnell's cultural competency model from English to Czech. There are several publications dealing with translations. In our case, the Model was translated based on the methodology given in the article by Chen & Boore (2009) *Translation and back-translation in qualitative nursing research: methodological review.* Furthermore, our translation was influenced by articles by other authors, who dealt in particular with translations of questionnaires and scales, namely Švec et al. (2009), Blanar et al., (2014). Last, but not least, our translation was influenced by the recommended methodology for translating questionnaires and other research tools: problems and solutions (Behling and Law, 2000).

The first step to create a Czech version of the Model for Cultural Competence was obtaining a consent to translation from the author, Larry Purnell. The original version was then translated from English into Czech language by three independent experts specialized in nursing, obstetrics and healthcare English and one translation (the fourth version) was provided by a linguist and translatologist. All these four versions were compared and differences were discussed within a focus group consisting of the actual translators. The final version, which suits best the Czech language and the target group of users, was created out of the various versions. This version was then translated back into English by a native speaker from the United States of America, permanently residing in the Czech Republic. The native speaker did not know the original version. His version was subsequently compared with the original version. Expressions differing in their meanings were discussed and then implemented in the final Czech version (Blanař et al., 2014).

While creating the Czech version we endeavoured to make the translation comprehensible for the end users, i.e. personnel in healthcare services (obstetricians, general nurses), academic workers and university students in the selected fields and semantically correct, and to make sure that the final terminology is as identical as possible to the original version.

Results

As obvious, 89 expressions were translated in total. A full match was reached in 37 (41,6%) cases. In eight cases (9%), the translated terms were significantly different, but agreeing on the resulting expression was seamless. In three cases (3.37%), the different Czech variants also differed significantly and the translation did not correspond to the context. Using the Czech and English interpreting vocabulary linguists, the resulting expressions were reworked.

In three cases, the various Czech versions showed semantic differences and the translation did not match the context. The linguist subsequently used Czech and English monolingual dictionaries to reformulate the corresponding terms. Three terms in our translation raised the most intensive discussion. The first term is called "Spatial distancing" in the original and is part of the Communication domain. The various translations were "udržování prostorové vzdálenosti", "odstup v prostoru", "prostorový odstup". Finally, we decided for "Komunikační vzdálenost" (*translator's note [TN]*: "Communication distance") as we think it reflects the given context the best. The second discussed term was "Temporality", again in Communication domain. The various translations were "církevní statky", "temporalita", "duchovní statky". In the focus group, we tried to find the most suitable term because everyone may imagine something else and not everybody perceives the terms the same way. A monolingual dictionary provides the following definition: "a traditionally linear course in the past, present and future. In social sciences it stands for human perception of time and social organization of time". In his original work, Purnell (2013) describes in the relevant chapter that every culture has a different perception and understanding of time. Some cultures are rather past-oriented, some more present-oriented and some rather future-oriented. Therefore we did not use either of the proposed translations and adopted the final expression "Průběh minulosti, přítomnosti, budoucnosti" (*TN:* Course of the past, present and future). The third and last expression discussed was "Deficiencies" in the Nutrition domain. The various expressions were: "nedostatky" and "nedostatky / dietní chyby". This translation appears relatively clear and the final term could be "nedostatky". However, compared with the comments in Purnell's original work (2013), "deficiencies" are understood more as "differences". Therefore, the final translation is "Rozdíly" (*TN:* "differences"). There were synonyms in 38 (42.7%) expressions, singular and plural differences in three translated terms (3.4%). All the differences that appeared in translations were probably due to the different active vocabulary of the individual translators, and in such cases the linguist chose that option that most corresponds to the original meaning and that is the most acceptable one from the stylistic and meaningful viewpoint of the Czech language. The aim of the Czech version was to avoid the use of professional expressions, but in some cases their use was necessary. The native speaker received the final Czech version, according to which he made a translation into the English language. He did not know the original text. The individual non-conforming terms are given in Table 1. It shows the final Czech expressions on which the discussion group agreed. The final version of the translation is shown in Figure 1.

Discussion

To provide a culturally competent care, it is indispensable to obtain as much good-quality information on the given culture as possible. With the increasing number of international and multicultural research projects, there is a growing need to adapt research tools to the population and the language in which they will be used (Beaton et al., 2000). Retroreflection is a method that serves to preserve the meaning between the original version and the language translation. Brislin's classical retranslation model is widely used for translation of research

tools, and Brislin (1970) recommends repeated translations by several independent bilingual translators. One interpreter translates the research tool from the original language into the target language and the second interpreter translates this version from the target language back to the original language. Both versions are then compared and differences are detected. If a significant difference is discovered, the translation will be done by another independent interpreter. This process is repeated until there is a consensus among the members of the translation team. Jones et al. (2001) presents a combination of translation techniques that are used in a group approach when applying backward translation methods in bilingual texts. First, two bilingual experts will prepare two translated versions of the original original language into the target language. Subsequently, these two versions are translated back into the original language by two other specialists. These four translators will then come together and, through group discussion, identify the differences between the original and the translated version and try to find a consensus and create the final version. These versions are again translated by two other bilingual persons, and differences are compared and discussed. If significant deviations are found, translations are carried out until the group comes to a consensus. There are many factors that can affect the quality of translation in nursing research. These include, for example, translators and their language skills, reverse translation, culture and the language itself. Beaton et al. (2000) recommend that a text from the original language be translated into a target by at least two interpreters for comparisons. In our case, the translators were four and were made up of various nursing, linguistics and English specialists. It is important for the translating translator to speak fluently both in the language in which the original text is and in the language in which it is translated (Chen & Boore, 2009). It is essential that the individual translators are also experts in the field of linguistics. During the translation itself, different versions are produced that may vary or differ. It is necessary to be careful whether there are differences at the synonym level, or whether the meaning of words is changing. Imperfect translations may cause non-acceptance in the target user group and may alter the intention of the translated tool (Švec et al., 2009). A relatively large number of synonymous disagreements in our rewriting are attributed to differences in the active vocabulary of individual translators, education, and professional background.

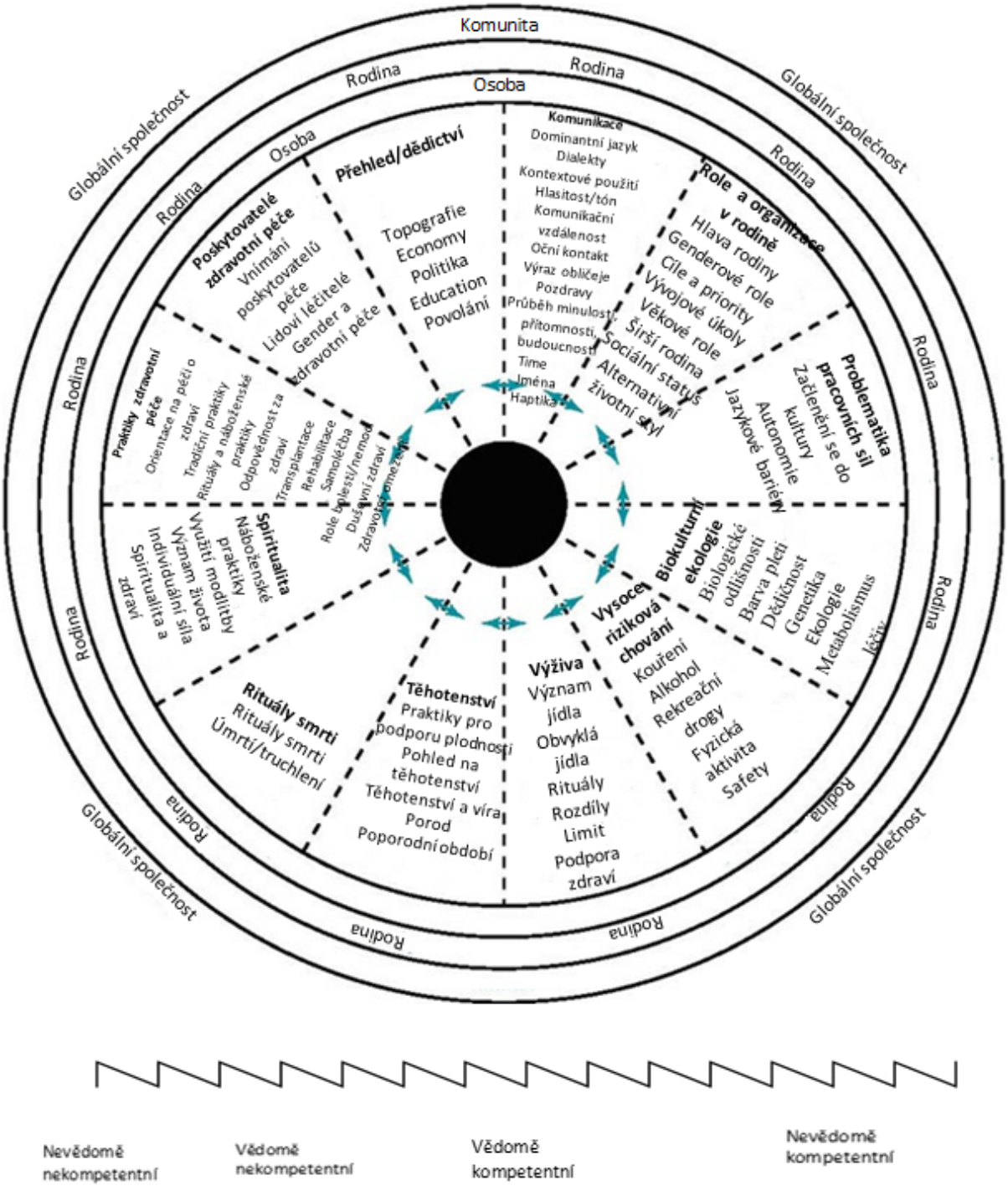

Fig. 1 **The Czech version of the Model for Culture Competence. Translated by the authors, from Purnell (2013).**

Table 1 **Translated expressions**

Translators	T1	T2	T3	T4
Differences in meaning	Ekonomika	Ekonomika	Ekonomika	Ekonomie
	Biologické variace	Biologické odlišnosti	Biologické změny	Biologické odlišnosti
	Metabolismus léků	Metabolismus léčiv	Metabolismus léčiv	Metabolismus léků
	Kouření	Tabák	Tabák	Tabák
	Truchlení	Úmrtí/truchlení	Úmrtí	Úmrtí blízké osoby
	Magicko-náboženské víry	Rituály a náboženské praktiky	posvátné náboženské víry	Magicko-náboženská a náboženská přesvědčení
	Lidoví léčitelé	Lidoví léčitelé	Lidoví lékaři	Lidoví léčitelé
	Pohlaví a zdravotní péče	Zdravotní péče u různých pohlaví	Zdravotní péče u různých pohlaví	Gender a zdravotní péče
Different; in a discussion	Prostorový odstup	Odstup v prostoru	Odstup v prostoru	Udržování prostorové vzdálenosti
	Temporality	Duchovní statky	Církevní statky	Temporalita
	Nedostatky	Nedostatky/dietní chyby	Nedostatky	Nedostatky
Singulars and plurals	Purnellův model kulturních kompetencí	Purnellův model kultruní kompetence	Purnellův model kulturních kompetencí	Purnellův model kulturní kompetence
	Dotyky	Dotyk	Dotyk	Dotyk
	Rekreační drogy	Rekreační drogy	Rekreační droga	Rekreační drogy
Synonyms	Povolání	Povolání	Povolání	Zaměstnání
	Dominantní jazyk	Převládající jazyk	Převládající jazyk	Dominující jazyk
	Nářečí	Nářečí	Nářečí	Dialekty
	Výraz tváře	Výraz tváře	Výraz obličeje	Výrazy obličeje
	Pozdravy	Pozdravy	Zdravení	Pozdravy
	Jména	Názvy/jména	Názvy	Jména
	Genderové role	Role pohlaví	Role pohlaví	Genderové role
	Vývojové úkoly	Rozvojové cíle	Vývojové úkoly	Rozvojové úkoly
	Sociální status	Sociální postavení	Sociální status	Sociální postavení
	Barva pleti	Barva pleti	Barva kůže	Barva kůže
	Výživa	Výživa	Výživa	Strava
	Význam jídla	Význam potravin	Význam potravin	Význam jídla
	Běžné potraviny	Obvyklá jídla	Obvyklá jídla	Běžné potraviny
	Duchovno	Duchovno	Duchovno	Spiritualita
	Smysl života	Význam života	Význam života	Smysl života
	Individuální síla	Osobní síla	Osobní síla	Individuální síla
	Duchovno a zdraví	Duchovno a zdraví	Duchovno a zdraví	Spiritualita a zdraví
	Role bolesti/nemoci	Úloha bolesti a nemoci	Úloha bolesti a nemoci	Role bolesti/nemoci
	Mentální zdraví	Mentální zdraví	Duševní zdraví	Duševní zdraví
	Vnímání poskytovatelů péče	Postřeh (vnímání) zdravotníků	Postřeh (vnímání) zdravotníků	Vnímání poskytovatelů péče
	Pohlížení na těhotenství	Názory na těhotenství	Pohled na těhotenství	Pohled na těhotenství
	Bydliště	Bydliště	Bydliště	Pobyt
	Rodinné role a organizace	Role a organizace v rodině	Role v rodině a organizace	Rodinné role a organizace
	Hlava domácnosti	Hlava rodiny	Hlava rodiny	Hlava domácnosti
	Věkové role	Role věku	Role věku	Role starých lidí
	Rozšířená rodina	Širší rodina	Širší rodina	Širší rodina
	Problematika pracovní síly	Problémy pracovní síly	Problémy pracovní síly	Problematika pracovních sil
	Akulturace	Začlenění se do kultury	Začlenění se do kultury	Akulturace
	Autonomie	Samostatnost/samospráva	Autonomie	Autonomie
	Praktiky plodnosti	Praktiky plodnosti	Praktiky plodnosti	Praktiky pro podporu plodnosti
	Těhotenství a víra	Víra/přesvědčení v těhotenství	Víra v těhotenství	Přesvědčení ve vztahu k těhotenství
	Poporodní období	Poporodní péče	Období po porodu	Poporodní péče
	Modlení	Využití motlitby	Využití modlitby	Užití modlitby
	Praktiky zdravotní péče	Praktiky zdravotní péče	Praktiky zdravotní péče	Zdravotnická praxe
	Zaměření na zdravotní péči	Zaměření na zdravotní péči	Zaměření na zdravotní péči	Orientace na péči o zdraví
	Zodpovědnost za zdraví	Zodpovědnost za zdraví	Zodpovědnost za zdraví	Odpovědnost za zdraví
	Samoléčba	Samoléčba	Sebeléčba	Samoléčení
	Omezení	Zdravotní omezení	Zdravotní bariéry	Omezení

Conclusion

Our aim was to translate the Cultural Competence Model into the Czech language by means of a retrospective translation and to bring it closer to the wider professional public. The model of cultural competences has a wide range of uses. It is applicable in education, research, pedagogical sciences, doctors and non-medical healthcare professionals, physiotherapists, psychotherapists and other professions.

Ethical aspects and conflict of interest

No risk of ethical conflict has been identified. The present work is part of a project approved by the Ethical Committee of the Faculty of Health Studies, University of Pardubice.

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