

# The Sunrise Model: a Contribution to the Teaching of Nursing Consultation in Collective Health

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**Abstract** This paper aims to report the experience about a teaching process of nursing consultation in Collective Health using the Sunrise Model with nursing students (baccalaureate level). This teaching experience was conducted between August and December 2011 at a private university in Southeast Brazil during the course “Nursing Practice in Collective Health” offered in the sixth semester of the nursing general curriculum. This course lasted 100 hours, divided into 60 hours of theoretical classes, and 40 hours of practical classes. A four-stage process was developed to teach nursing consultation: Theory of Culture Care; Nursing Consultation in Collective Health; Practice of nursing consultation in Primary Care Centers; Evaluation. In this teaching program students were able to develop abilities and competencies to identify and understand the multiple factors that influence care, as well as comprehend it from a holistic-humanistic perspective.

**Keywords:** *community health nursing, nursing education, practical nursing, nursing process, nursing models*

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## 1. Introduction

In Brazil, Collective Health is both a scientific field and an ideological movement which contributed to the creation of the National Health System (SUS). This scientific field includes three integrated areas: epidemiology, management of health policies, and social sciences applied to health. Unlike Public Health, Collective Health contains analysis of social science perspectives and its theoretical and methodological framework in the health-illness process.

In order to implement the SUS principles, which are universality, equity, and integrality, in 1994 the Brazilian Health Ministry propounded a national government strategy, called Family Health Program (FHP), which was elaborated to restructure primary care services. Its focus is pointed primarily on the family, as to understand the physical and social structure concerning the health-illness process. The FHP structure is normally formed of teams composed of one physician, one registered nurse (RN), two auxiliary nurses and five to six community health workers. These teams operate each in one specific geographical location and their main priorities are to: care for up to one thousand local families; conduct health-illness surveillance; develop appropriate actions after having identified problems and issues [1].

The FHP demands discussion about the RNs’ practice with the intention of qualifying and capacitating them with appropriated tools and knowledge, putting RNs in direct contact with cultural and social structure dimensions which guide care practices of individuals or groups in the

community. [2] Resultantly, during the nursing consultation in the FHP, RN need to understand and consider the symbolic and material elements which compose the worldview of individuals, or of one particular group. However, in Brazil’s context, nursing practice has been based on the principles of biomedical model [3].

With reference to the teaching process of nursing consultation, those principles have been of important influence. As a result, the following challenge was faced: how to learn the holistic-humanistic perspective about health and nursing care - observing the cultural and social structure dimensions - when it is applied to Collective Health nursing consultation? In fact, this challenge reflects the students’ difficulties to understand the “social” and/or “cultural” factors and how they influence the health and care phenomena.

In an effort to deal with this challenge, Madeleine Leininger’s Theory of Culture Care Diversity and Universality [4] was chosen, amongst the theories of nursing available, owing to its anthropological view. [5] Based on the assumption that the RN’s practices along with FHP teams take place in the communities with the locals’ cultural values are eminent - along with their social, political and economic structure - nursing education should consider the inhabitants’ aspects in the teaching process. Using this logic, the goal of the Theory of Culture Care Diversity and Universality was to provide culturally congruent-care intending to contribute to the health or well-being of people, or to help them face disabilities, or death [6].

In view of the challenge, a particular contribution was considered the most important feature and assumption of

the theory: the belief that worldwide, social-structure factors, environmental contexts, ethnohistory, language usage, and generic and professional care, along with three types of nursing actions and decisions (culture care preservation/maintenance, culture care accommodation/negotiation, and culture care repatterning/restructuring) could offer nurses new knowledge and insights that had not been tapped in the past, in a systematic and focused way [6].

One element of this theory, the Sunrise Model (Figure 1) is the focus of analysis in this article. Although the Sunrise Model was developed as a conceptual holistic research guide and facilitator to help researchers discover multiple dimensions related to the theoretical tenets of the Theory of Culture Care, [6] it was employed as a guide to conduct the teaching process of nursing consultation in Collective Health.

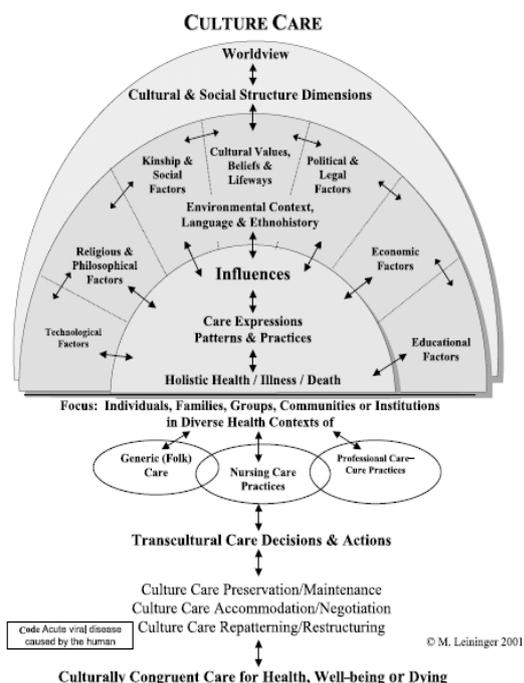


Figure 1. Leininger's Sunrise Model to Discover Culture Care [4]

In accordance with the theorist, "in developing and using the theory of Culture Care, it was evident that nurses needed to greatly expand their worldwide and incorporate new dimensions such as social structure factors, ethnohistory, generic care, language uses, environmental contexts, and other areas to arrive at a comprehensive, holistic, and accurate data-base to understand cultural care phenomena" [6].

Nevertheless, nurses do not forget to inquire about biological and emotional aspects, but encourage patients to talk about specific meaning and expressions of care [6].

The Sunrise Model is relevant to the teaching of nursing consultation in Collective Health, specifically in the FHP, because it enables students to develop critical and complex thoughts towards nursing practice. These thoughts should consider, and integrate, cultural and social structure dimensions in each specific context, besides the biological and psychological aspects involved in nursing care.

Therefore, the objective of this article is to report one experience about the teaching process of nursing consultation in Collective Health using the Sunrise Model with nursing students (baccalaureate level).

## 2. The Context

This teaching experience took place at a private university in Southeast Brazil, and was conducted between August and December 2011. The activities related to this pedagogical experience occurred during the course "Nursing Practice in Collective Health" offered in the sixth semester of the undergraduate nursing curriculum. The aim of this course was to develop students' competencies and abilities required to perform the nursing practices in public health programs in the FHP context. This course consisted of 100 hours, divided into theoretical section (60 hours) and practical section (40 hours) in public primary care centers. The course was organized in two regular five-hour weekly meetings. The faculty members were composed by one professor and five auxiliaries. Also there were 30 students attending the course in that semester.

The requirements and grading were: a) Class participation (20%): first and foremost, engaged and thoughtful participation in class discussion was chief, so students were to come to class having read and understood the assigned class readings, as required; b) Exams (40%): two tests were given in that semester. The first test was scheduled to October, and the second to December. These exams were designed to evaluate critical thinking and theoretical skills. Students were expected a grade no lower than seven (7.0) in each test; c) Practical Performance (40%): students were to be continually evaluated during theoretical and practical sections. In this subject, faculty members evaluated the following skills: theoretical background; critical thinking; communicative skills; and interpersonal skills.

## 3. The Teaching Experience

A four-stage proceeding was developed for the teaching process of nursing consultation in Collective Health, using the Sunrise Model:

### 3.1. Theory of Culture Care (Theoretical Section)

This stage was conducted on August. During the classes an overview of the theory and model was given and a table was developed in which students and faculty members created sub-items for each cultural and social structure dimension of the Sunrise Model (Table 1) [1-7].

This table aimed to increase students' comprehension of social and cultural aspects that, according to the Theory of Culture Care, influence the health-illness process and care practices. In summary, this table directs a transformation from 'an abstract to a concrete' perspective in cultural and social structure dimensions.

### 3.2. Nursing Consultation in Collective Health (Theoretical Section)

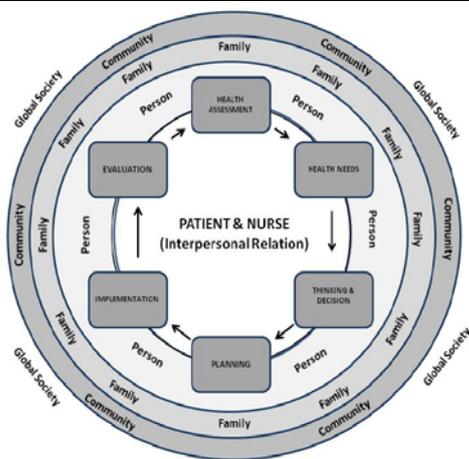
Theoretical classes about nursing consultation in parallel with others contents were conducted in September. Principles of nursing consultation were approached theoretically and methodologically, with its specificities in the context of FHP; this practice is based on the Theory of

Culture Care. In theoretical classes, a flowchart, guiding the use of Leininger’s concepts and contained elements of cultural and social structure dimensions, was elaborated

(Figure 2). In addition, case studies were held with the aid of the flowchart.

**Table 1. Sub-items for the Cultural and Social Structure Dimensions of the Leininger’s Sunrise Model**

Dimensions	Descriptions
Technological Factors	Access to technologies of information, access to means of communication, access to media and press, access to electronic advices at residence, access to health services and technologies, and others.
Religious and Philosophical Factors	Religious practices, consultation to traditional healers, meanings of life, individual strength, beliefs, spirituality and health, personal values, norms and religious beliefs, freedom of thinking and expression, institutional values, priorities and goals, social roles, intra-institutional communication, inter-sector communication, inter-institutional communication, and others.
Kinship and Social Factors	Familiar structure, birth position in the family, family values, roles of the aged, head of household, composition of family, developmental tasks, social status, bereavement of parents, family disease, family kinship/relations, friendship relations, emotional-sexual relationships, emotional situation, networks and social supports, access to culture, leisure and sports, migration, gender relations, social norms, public security, citizenship, access to means of transportation, conjugality, violence, and others.
Cultural Values, Beliefs and Ways of Living	Beliefs, responsibility for health, folk practices of cure and care, perception of official health system, perception of health professionals, spirituality and health, cultural references, sexuality, race and ethnic group, access to culture and information, knowledge, attitudes, behavior, tobacco, alcohol, recreational drugs, physical activities, safety, interests, common foods, hygiene, world views, entertainment and leisure, alternative lifestyles, and others.
Political and Legal Factors	Access to public policies (security, health, education, environment, job, transports, social), access to justice, citizenship, political participation, freedom to think and express, intra-institutional communication, inter-sector communication, inter-institutional communication, and others.
Economic Factors	Familiar outcomes, informal job, formal job, outcome, social class, material situation (goods), work conditions, housing conditions, occupation/profession, buyout of consumer goods, cost of living, and others.
Educational Factors	Knowledge, access to education, literacy (read and write), reading and writing habits, type of school (private or public), schooling, access to information, school violence, intellectual performance, solution of problems, attention, and others.
Environmental Context	Destination of waste, public illumination, access to electricity grid, natural ventilation, drain, asphalt/pavement, septic tank, drinkable water, pollution (air, water, visual, noise), presence of vegetation or forest areas, presence of animals, goods supply (local commerce, to go to other locality, economic self-sufficiency), relations with the natural resources, access to drinking fountain, exposition to pesticide or fertilizers, exposition to chemical, physical agents etc., and others.
Language	Dominant language, contextual use, tone/volume, spatial distancing, eye contact, facial expressions, greetings, touch, language, dialect, and others.
Ethnohistory	Community history, population history, life history, total time living in the community, sense of belonging, social participation in the community, and others.



**Figure 2.** Flowchart for guide critical thinking in the teaching process of nursing consultation in collective health

With cultural and social structure dimensions in mind, and the comprehension that patient-nurse relations take place into multidimensional levels (global society, community, family, and interpersonal), students were encouraged to develop nursing processes into nursing consultation in Collective Health.

In the health assessment, patient interviews and physical assessment were conducted to identify health needs and technical proceedings: patients were weighed, blood pressures were taken, and blood glucose levels were measured. In the next step, patients’ health-needs had to be defined. The decision steps required critical thinking as a skill to identify nursing diagnosis (or health-needs) and

collaborative problems. In this step the following nursing care decisions and actions were used: cultural-care preservation/maintenance; cultural-care accommodation/negotiation; cultural-care repatterning/restructuring [4,6].

Once the nursing diagnoses were identified, the planning component began. This step entailed the following: assigning priorities to nursing diagnoses and collaborative problems; specifying expected outcomes; specifying the immediate, intermediate, and long-term goals of nursing action; identifying specific nursing actions appropriated for attaining the outcomes; identifying interdependent actions; documenting in the plan of nursing care or in the health records; communicating to appropriate personnel any assessment data that pointed to health needs which could best be met by other members of the healthcare team.

The implementation phase of the nursing process involved carrying out the proposed plan of nursing care. In the context of FHP, generally, the plan of nursing care is carried out at home by the patient and their families. For this reason, performance of care practices and nursing actions, however, may be carried out by the patient and their families, as afore mentioned, by other members of the nursing team, or by members of FHP team, as suitability allows. Lastly, evaluation - the final step of the nursing process - allows nursing student/nurse to determine patients’ response to the nursing interventions and the extent to which the objectives were achieved.

### 3.3. Practices of Nursing Consultation in Primary Care Centers (Theoretical and Practical Sections)

This stage was conducted in parallel with the theoretical classes in which other contents, in consideration to the nursing practice in Collective Health, were given. These classes were held from October to December. Under the supervision of faculty members, students were divided in six groups of 5 persons to undergo practical classes in four primary care centers. During these meetings, nursing consultation was performed according to the health programs (mother and child health, and adult health) available in the primary care centers. In addition, group discussions about some cases were conducted amongst students, faculty members, and the RNs of the primary care centers.

### 3.4. Evaluation

In conformity with the requirements and grading topic specified above, a systematic and continuous evaluation process was addressed. The following aspects were measure through two tests and rating of the practical performance in Primary Care Centers: theoretical background, critical thinking, communicative skills, and interpersonal skills. To evaluate the students during the practical sections, an instrument was developed by the university members. This instrument was composed of three parts: 1) Attitudinal aspects: assiduity, responsibility, timekeeping, and interesting for the activities; 2) Relational aspects: team work ability, and relationship between student-student, student-university members, student-patients; and 3) Scientific aspects: ability to develop the activities proposed, ability to formulate critical questions and propositions, and personnel improvement.

### 4. Study Limitations

This study had two main limitations: the pedagogical experience needs to be replicated in other educational contexts and in other semesters at the same university; assessment tools to compare student's performance were not used, either with or without the Sunrise Model.

### 5. Conclusion

During this teaching program we were able to foster the students' abilities and competencies to identify and understand the multiple factors that influence care, as well as comprehend it from a holistic-humanistic perspective.

In this manner, the students who attended the course had their "minds opened" in order to discover others aspects which have strong influence on care, wellness, health, and illness beyond the biomedical and psychological dimensions.

At the end of that semester, students evaluated the course. According to their feedback, the theoretical framework and the pedagogical strategies were adjusted to fulfill the learning outcomes. Regarding the use of the Sunrise Model as a guide for nursing consultation in Collective Health, they were positive that this tool offers an integrative point of view about the patient, their health-needs, and care practices. In addition, the flowchart consists of a systematic form to guide the interpersonal relationship between patient and nurse in the clinical setting. When they compare this pedagogical experience with their past experiences, all students highlighted the development of their ability to understand the meaning of words (like "social" and "culture") frequently used by RNs and other professionals through an anthropological and sociological perspective.

This teaching experience features the important contribution of the Leininger's Theory and the Sunrise Model in the interest of providing culturally congruent care in the FHP context in Brazil. Finally, we emphasized it as a powerful strategy of teaching.

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