CONCEPT ANALYSIS

Culturally Competent Interprofessional Pediatric Care: A Concept Analysis

Fiskvik Boahemaa Antwi, RN, MN[1,*]

Abstract

The American Academy of Pediatrics describes culturally effective care in a policy statement as the provision of care in the sense of appropriate provider awareness, understanding, and appreciation of cultural differences that contribute to optimal health outcomes. Therefore, clinicians must develop cultural competence to enhance patients' care satisfaction and outcome. Although culturally effective pediatric care has been discussed in the literature, there remains a gap in the process on how an interprofessional health care team can provide culturally congruent care in a pediatric setting. Being part of an interprofessional pediatric care team, nurses hold the responsibility of communication and coordination to ensure culturally competent care by every member of the health care team. Hence, this paper adapts Walker and Avant's (2011) concept analysis process in which the theory, culturally competent pediatric care would be derived. The concept analysis methodology from Walker and Avant (2011) would define the concept, attributes, antecedents, consequences, and cases that would describe culturally competent pediatric care. Cultural diversity and family dynamics are ever-changing. The concept analysis proposes a framework for culturally competent interprofessional care in which culturally competent care is an ongoing team approach. Ultimately, the concept concluded that to provide culturally competent care in pediatric practice, there should be a framework in which the interprofessional team follows, using the principle of cultural humility and illustrating cross-cultural communication to provide culturally appropriate care.

Keywords: *culturally competent care, pediatric practice, interprofessional health care team*

Introduction

The American Academy of Pediatrics describes culturally effective care in a policy statement as providing care in the sense of appropriate provider awareness, understanding, and appreciation of cultural differences that contribute to optimal health outcomes. Therefore, clinicians must develop cultural competence to enhance patients' care satisfaction and outcome (Dabney et al., 2015).

Although culturally effective pediatric care has been discussed in the literature, there remains a gap in the process on how an interprofessional health care team can provide culturally congruent care in a pediatric setting. Being part of an interprofessional pediatric care team, nurses hold the responsibility of communication and coordination to ensure culturally competent care by every member of the health care team. Hence, this paper adapts Walker and Avant's (2011) concept analysis process in which the theory culturally competent interprofessional pediatric care would be derived.

Definition and Use of Concept

The concept of transcultural care views cultural competence in healthcare as the ability of healthcare professionals to identify and care for people with different cultural preferences, traditions, attitudes, and practices. Dabney et al. (2015) defined cultural competence as a set of congruent awareness, knowledge, and behaviors allowing effective interaction in cross-cultural contexts. Flores (2004) described cultural competence as a collection of congruent attitudes and actions of health professionals and policies within a program or organization promoting successful intercultural practice. With this definition, cultural competence is a concept that includes issues of attitudes or actions at the individual level, as well as concerns of policies or practices at organizational or institutional levels (Flores, 2004).

Horn (2013) defined cultural competence as the capacity of health care professionals to provide patients with appropriate, reliable, and compassionate care based on an appreciation of differences and similarities in or between specific cultural groups. Such capacity includes the incorporation of comprehensive information and understanding into effective strategies to tackle the issues culturally diverse communities face. Using this ability, healthcare practitioners can indicate each client's cultural context and experience (Kodjo, 2009).

[1] PhD student, Graduate School, School of Nursing, Saint Louis University- Baguio Philippines
* Corresponding author email: fiskvikantwi12@gmail.com

These definitions of cultural competence summarized suggest that cultural competence is an end outcome that healthcare providers should meet. Accordingly, Campinha-Bacote viewed cultural competence as an endpoint whereby the healthcare provider consistently strives to achieve cultural awareness to cultural encounters (Campinha-Bacote & Campinha-Bacote, 1999).

According to Stocker et al. (2016), Interprofessional care denotes the collaboration of health care workers from different professional backgrounds to provide culturally competent pediatric care. Instead of cultural competence being an individual process, culturally competent care is an interdisciplinary approach or a team-based approach. All members of the healthcare team provide culturally congruent care. Hence, Culturally Competent Interprofessional Pediatric Care is defined as a concept that embraces interprofessional collaboration and intercultural communication in pediatric practice as an ongoing process through cultural humility in the provision of transcultural care. Furthermore, this concept focuses on culturally competent care to the pediatric patient and the family as the decision-makers utilizing cultural humility at the center of interprofessional care and communication.

Culture and family dynamics are ever-changing and it is affected by technology, innovation, globalization, education, and social influence (Harkness & Super, 2020). . According to Bhattacharya et al., (2019), culture affects the family's health-seeking behaviors, health practices, and health beliefs. Given the complexities of multiculturalism, it is essential to consider cultural competency as a process instead of a result. Cultural humility is one framework for recognizing competency and cultivating a process-oriented approach. It denotes the concept of an ongoing process instead of an endpoint. It takes into account individualized culture instead of gaining factual knowledge of a cultural group.

Pediatric care focuses on the health of infants, children, and adolescents from the age of birth until the age of 18. Tavallali et al. (2016) suggested that pediatric care involves two recipients, including the pediatric patient as the primary recipient of care and the family as the secondary recipient of care. Among pediatrics, a child's culture is influenced by their parents. Hence, their worldview is the norms, beliefs, and practices at home. Parents in diverse cultures also play a significant role in molding the behavior and thought patterns of children. Parents are usually the role models that train the child to communicate with broader society. The engagement of children with their parents often functions as the archetype as to how to act around others-learning a variety of socio-cultural rules and expectations (Harkness & Super, 2020).

Related Concepts

Related concepts are concepts similar to cultural competence and interprofessional care but with subtle distinctions closely studied in the literature. The most widely listed related terms for cultural competence include cross-cultural competence, cultural safety, and culturally effective pediatric health care. Terminologies for interprofessional pediatric care include team-based pediatric care and culturally effective pediatric health care.

Cross-cultural competence is characterized as the ability of an individual to function efficiently within a specific culture. This typically means comparing two or more cultures or contrasting them. One should identify or appreciate cultural differences. Cross-cultural awareness facilitates cultural skills development (Kaihlanen et al., 2019).

The absence of discriminatory practices characterizes cultural safety; thus, all healthcare providers and consumers are valued and active in a healthcare service's decision-making processes (Lestishock et al., 2018). Thus, cultural safety falls under the framework of cultural competence and a central part of it.

Culturally effective pediatric health care is defined as providing care within the provider's expertise, knowledge, attitude, and understanding of cultural considerations that affect optimal health outcomes among children and families. (Colman et al., 2018).

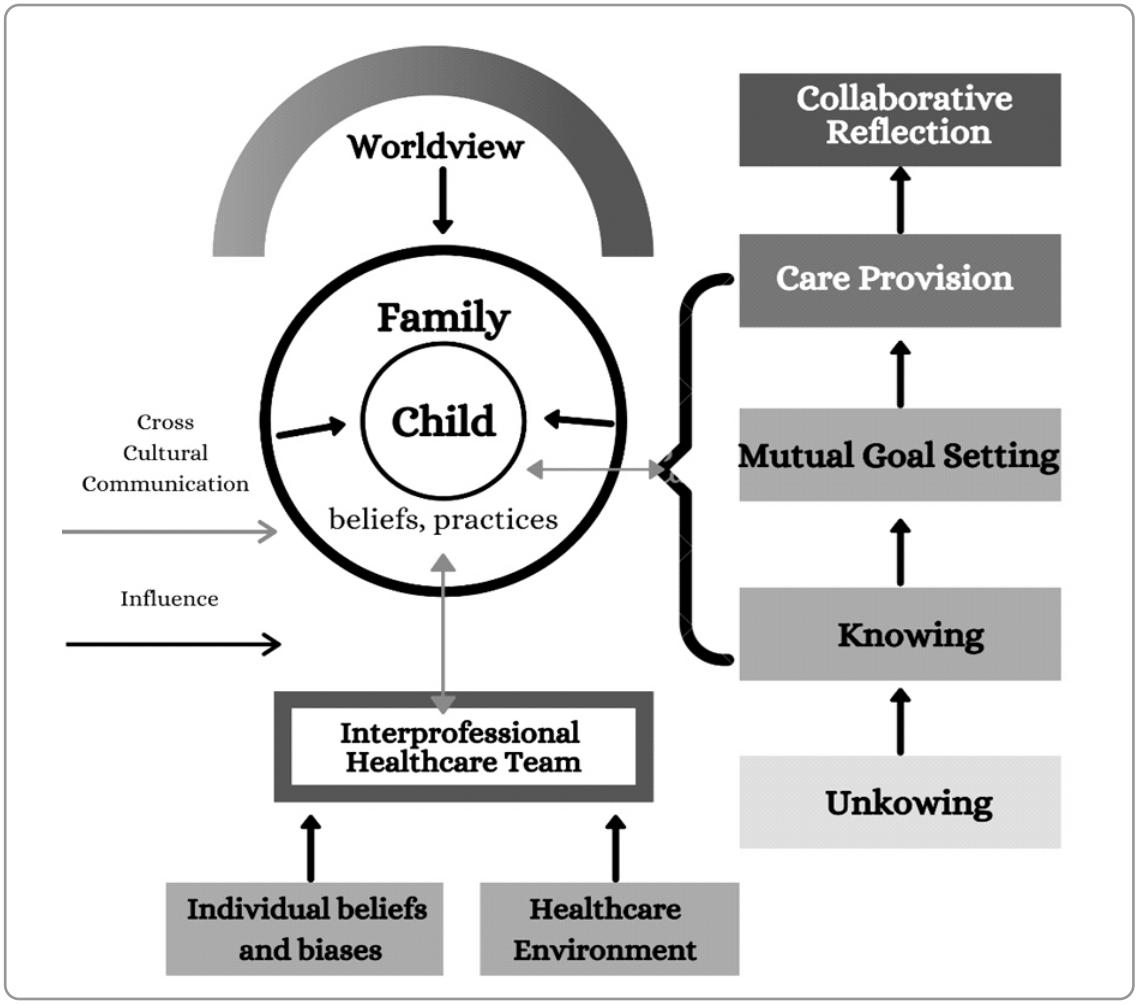
Pediatric team-based care is a health care approach that promotes the relationship of children and families operating in different contexts with one or more health care providers and other team members define, organize, and resolve common priorities that serve the needs of the child (Lunsford & Mikovich, 2018).

Defining Attributes

The worldview influences the family's norms, beliefs, and practices. The family's standards, ideas, and practices affect the child's worldview. Healthcare providers possess their personal world view; and, the healthcare environment, which includes evidence-based knowledge, influences healthcare providers' beliefs, practices, and care provision. In providing culturally competent care, there should be cross-cultural communication between the healthcare providers and the family.

There are stages in the provision of transcultural interprofessional pediatric care. The steps include knowing, mutual goal setting, care provision, and collaborative reflection. Unknowing is the act of removing knowledge from prior cross-cultural encounters and experiences that leads to assumptions. Unknowing illustrates the use of cultural humility as the principles

Figure 1. *Culturally Competent Interprofessional Pediatric Care*



of care provision. Knowing is the act of communicating and performing a cultural assessment to demonstrate cultural awareness and knowledge of the child and family. Mutual goal setting is the process of assessing and identifying mutual goals for care provision. Care provision is the process of collaboratively providing culturally congruent care to the pediatric patient and family. Finally, collaborative reflection is the process of reflecting on the cultural encounter to improve cultural care.

Each stage influences the progression towards the next step in the provision of culturally competent pediatric care. Communication and cross-cultural communication allows the progression of the family and the healthcare providers to move to the next stage as a unit.

Antecedents

Cultural diversity among pediatric patients and families is one antecedent that should occur. Cultural diversity calls for culturally competent interprofessional pediatric care. The second antecedent is a cultural encounter, where there is an interaction between a pediatric patient and family and healthcare providers of different cultural backgrounds.

Consequences

The first consequence due to the occurrence of culturally competent interprofessional pediatric care is the improvement of health disparities among pediatric patients and families. Secondly, healthcare providers can understand and implement a process in providing culturally competent care among pediatric patients. Thirdly, the healthcare organization would have culturally competent pediatric health care providers who can provide care to the growing diversity of pediatric patients and families.

Model Case

Mr. and Mrs. Oiterong and their 7-year old daughter from Puerto Rico were admitted to the pediatric unit with a medical diagnosis of acute lymphocytic leukemia. The pediatric patient and family were under the care of an oncology nurse, an oncologist, a

hemato-oncologist, -R-general surgeon, and a nutritionist. Upon admission to the pediatric ward, the family is not communicating or cooperating. The oncologist and oncology nurse has had a previous encounter with a Latino family before understanding their culture. However, instead of basing their care on assumptions, the oncology nurse and the healthcare team culturally assess the child and family's needs.

Through communication and cultural assessment, the healthcare team understood that the family had a fatalistic view about health and illness. During the assessment, the healthcare team understood that the family's tradition is to manage all diseases with non-pharmacologic management. The healthcare team was able to educate the family on cancer and the best oncological care for the child as the primary care recipient. Through this, mutual goals were set between the family and the healthcare team. Along with the medical treatment, the family requested to give the child coconut massages, as it is their practice at home. Additionally, the family asked for the visitation of their pastor to pray three times a day as they go through the oncology care.

With this mutual goal setting, both medical and nursing care was provided. The healthcare providers understood their roles and communicated through verbal and technological-assisted communication tools so that all healthcare team members are frequently updated to promote team-based cultural congruent care. The family, being part of the care, was involved in the care process through communication. Upon discharge, the healthcare providers came together to evaluate the care provided, and each of the healthcare members would express their experiences during the care of the patient and the provision of culturally competent care.

Analysis

This case reflects the attributes of culturally competent interprofessional pediatric care. First, the family's practices were influenced by their culture and worldview. According to Bhattacharya et al. (2019), culture affects the family's health-seeking behaviors, health practices, and beliefs. Hence, educating the family on the medical condition and treatment plan while incorporating the family's culture plays a pivotal role in this phase. Second, due to evidence-based practice and research utilization, the healthcare team understood the need for the child to receive immediate care. Third, the healthcare team emulated the concept of unknowing by removing previous experiences to minimize assumptions. Communication led to knowing, mutual-goal setting, and care provision. Lastly, collaborative reflection allows healthcare providers to reflect on the care provided as they continue to provide culturally competent care. Collaborative reflection provides improvement and development of cultural skills.

Borderline case

Mr. and Mrs. David and their 8-year old daughter from China were admitted to the pediatric unit with a medical diagnosis of type 1 diabetes. The pediatric patient and family are under the care of a nurse, doctor, and nutritionist. The healthcare team has had a previous encounter with Chinese patients. However, the nurse advocated that they remove their assumptions and prior experiences and encounters. Therefore, the entire healthcare team went to the patient to understand the family's cultural background. Through communication and cultural assessment, the family expressed that a person is selected to be ill and nothing can be done. Through this, the healthcare providers were able to educate the family about diabetes and diabetic care. The family understood and requested that a priest visit and pray daily. The next day, the family decided on discharge-against-medical-advice to find a second opinion from other healthcare professionals.

Analysis

In this case, the process of unknowing, knowing, and mutual goal setting occurred. However, care provision and collaborative reflection did not occur due to the patient's request for discharge. According to Macrohon (2012), the phenomenon of discharge against medical advice (DAMA) in pediatric practice results in discontinuity of care and decreased quality of care. Therefore, in this scenario, the dynamic process of culturally competent interprofessional pediatric care did not occur.

Opposite case

A Muslim family and 10-year-old son were admitted to the hospital with fever, vomiting, and diarrhea. The pediatric patient was dehydrated and placed under the care of a pediatric doctor, nurse, and nutritionist. The pediatric doctor, nurse, and nutritionist had already cared for Muslim patients and families. Therefore, they informed the cafeteria that the family does not eat Pork and scheduled time for the family to pray before communicating with the family. The healthcare team spoke with the families about the immediate care of the child. The care was provided, and the family and child were discharged.

Analysis

This case reflects the absence of the attributes. It showed that previous encounters and knowledge lead to assumptions. Although one may argue that the care was culturally congruent, beliefs of what the family would need based on previous experience do not emulate cultural humility. Assumptions in the clinical setting lead to a lack of cultural sensitivity, missed diagnosis, and treatment (Kobo-Greenhut et al., 2017). Additionally, there was a lack of mutual goal setting and collaborative reflection to improve culturally competent care.

Empirical Referents

Empirical referents show the occurrence of a concept. There are instruments that measure the concept of cultural competence which includes the Cultural Competence Assessment Instrument, and Nurse Cultural Competence Scale. However, research should be done to construct an instrument that assesses the provision of culturally competent care by an interprofessional team in pediatric care.

Conclusion

Cultural diversity and family dynamics are ever-changing. Pediatric practice is a specialized field where care is rendered to the child and family. The concept analysis using Walker and Avant's (2011) approach proposes a framework for culturally competent interprofessional care in which culturally competent care is an ongoing team approach. Ultimately, the concept was able to conclude that, to provide culturally competent care in pediatric practice, there should be a framework in which the interprofessional team follows, using the principle of cultural humility and illustrating cross-cultural communication to provide culturally appropriate care.

References

Bhattacharya, S., Kumar, R., Sharma, N., & Thiyagarajan, A. (2019). Cultural competence in family practice and primary care setting. *Journal of Family Medicine and Primary Care*, *8*(1), 1. https://doi.org/10.4103/jfmpc.jfmpc_393_18

Campinha-Bacote, J., & Campinha-Bacote, D. (1999). A framework for providing culturally competent health care services in managed care organizations. *Journal of Transcultural Nursing*, *10*(4), 290-291. https://doi.org/10.1177/104365969901000404

Colman, N., Figueroa, J., McCracken, C., & Hebbar, K. (2018). Simulation-based team training improves team performance among pediatric intensive care unit staff. Journal of Pediatric Intensive Care, 08(02), 083-091. https://doi.org/10.1055/s-0038-1676469

Dabney, K., McClarin, L., Romano, E., Fitzgerald, D., Bayne, L., Oceanic, P., Nettles, A., & Holmes, L. (2015). Cultural competence in pediatrics: Health care provider knowledge, awareness, and skills. International Journal of Environmental Research and Public Health, 13(1), 14. https://doi.org/10.3390/ijerph13010014

Flores, G. (2004). Culture, ethnicity, and linguistic issues in pediatric care: Urgent priorities and unanswered questions. Ambulatory Pediatrics, 4(4), 276. https://doi.org/10.1367/1539-4409(2004)4<276:cealii>2.0.co;2

Harkness, S., & Super, C. M. (2020). Why understanding culture is essential for supporting children and families. *Applied Developmental Science*, *25*(1), 14-25. https://doi.org/10.1080/10888691.2020.1789354

Horn, B. (2013). Transcultural nursing scholars' corner. Journal of Transcultural Nursing, 24(4), 418-418. https://doi.org/10.1177/1043659613493331

Kaihlanen, A., Hietapakka, L., & Heponiemi, T. (2019). Increasing cultural awareness: Qualitative study of nurses' perceptions about cultural competence training. BMC Nursing, 18(1). https://doi.org/10.1186/s12912-019-0363-x

Kobo-Greenhut, A., Sakas, J., Magnezi, R., & Ben Shlomo, I. (2017). Stop! Check your initial assumptions. *Medicine*, *96*(50), e9280. https://doi.org/10.1097/md.0000000000009280

Kodjo, C. (2009). Cultural competence in clinician communication. Pediatrics in Review, 30(2), 57-64. https://doi.org/10.1542/pir.30-2-57

Lestishock, L., Daley, A. M., & White, P. (2018). Pediatric nurse practitioners' perspectives on health care transition from pediatric to adult care. Journal of Pediatric Health Care, 32(3), 263-272. https://doi.org/10.1016/j.pedhc.2017.11.005

Lunsford, B., & Mikovich, T. A. (2018). Interprofessional team-based care. Oxford Medicine Online. https://doi.org/10.1093/med/9780190466268.003.0029

Macrohon, B. C. (2012). Pediatrician's perspectives on discharge against medical advice (DAMA) among pediatric patients: A qualitative study. *BMC Pediatrics*, *12*(1). https://doi.org/ 10.1186/1471-2431-12-75

Stocker, M., Pilgrim, S., Burmester, M., Allen, M., & Gijselaers, W. (2016). Interprofessional team management in pediatric critical care: Some challenges and possible solutions. *Journal of Multidisciplinary Healthcare*, 47. https://doi.org/10.2147/jmdh.s76773

Walker, L. O., & Avant, K. C. (2013). *Strategies for theory construction in nursing: Pearson new international edition* (5th ed.). USA: Pearson.

ABOUT THE AUTHOR

Fiskvik Boahemaa Antwi is a registered nurse in Trinidad and Tobago. She obtained her Bachelors of Science in Nursing at the University of the Southern Caribbean and a Masters in Nursing degree at the Adventist University of the Philippines. Currently, she is pursuing her Ph.D. in Nursing at Saint Louis University in the Philippines. Her passion for research is anchored in improving the field of evidence-based practice and research utilization among nurses.