

Review

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Pediatricians and Pediatric Nurses in the Delivery of Culturally Competent Care: A Scoping Literature Review to Investigate Progress and Issues around Culturally Diverse Care in Pediatrics

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ABSTRACT

The demographics in the United States are rapidly changing. In 2012, 47.2% of the children who lived in the United States were of color. However, three out of four physicians identified themselves as White non-Hispanic and approximately 83% of nurses are White, non-Hispanic. The changing demographics and increasing diversity of the population has an impact on care and quality of care being delivered by pediatric healthcare providers to children and their families. In 2005, The Office of Minority Health reported that the main ingredient in closing the gap in health care disparities is cultural competency. This scoping literature review investigated how pediatricians and pediatric nurses were progressing with their delivery of culturally competent care. The studies in the review revealed that the delivery of culturally competent care by pediatric health care providers has been a slow and difficult process and that there are identified areas of improvement. Pediatricians, pediatric nurses, other pediatric health care providers and families whose children received health care services from these providers were participants in the studies reviewed. Health care providers reported that more cultural competence training and education was necessary. Families in several studies identified communication/linguistics and the provider's ability to be more open and aware as areas where more cultural education and training are needed.

KEYWORDS: Cultural competence; Diversity; Pediatrician; Pediatric nurses; Health disparity; Communication; Openness.

INTRODUCTION

Limited research has been found in the literature to inform pediatric health care providers, specifically physicians and nurses on their progress of delivering culturally competent care to their patients and families and what are the issues that arise when they are caring for diverse patient populations. However, a vast amount of literature exists stating why it is important and necessary to provide culturally competent care for all patient populations. A key factor in the necessity to provide culturally competent care is the rapidly changing demographics across the United States. According to Humes, Jones, and Ramirez¹ data from the 2010 Census revealed a 32% increase since 2000 in people reporting they belonged to two or more race categories. Two races that reported the greatest growth in ten years were the Asian and the Hispanic populations. The Asian population experienced the fastest rate of growth that increased 43.3% from 2000. Today, the Asian population comprises almost 5% of the total population in the United States. The Hispanic population grew by 43% between 2000 and 2010, accounting for approximately half of the total population growth in those ten years and comprising 16%

of today's total population. The White only population experienced the slowest rate of growth, with only 1.2% increase between 2000 and 2010. The overall population of those reporting White only decreased from 69% to 64% in that ten year period.

In 2012 there were 73,728,088 children who lived in the United States.² Of those children 47.2% were of color. The largest percentages reported being Hispanic children (23.9%), Black children (13.9%) and Asian children (4.6%). Additionally, 3.9% of children reported being of two or more races.

While the demographics of the population in the United States are rapidly changing, the demographics of nurses and physicians do not reflect this rapid change. Findings from the "2008 National Sample Survey of Registered Nurses"³ reported that the population of nurses from minority racial/ethnic groups has increased by 54% between 2000 and 2008. However, even with the 54% increase, minority racial and ethnic nurses only comprised 16.8% of the total nurse population in the United States. According to the "2008 National Sample Survey of Registered Nurses", 5.8% of nurses stated they were Asian and 3.6% of nurses stated they were Hispanic. An overall, 83.2% of nurses reported being White, non-Hispanic, an indication that nurse represented a primarily homogeneous workforce.

In examining physician demographics, The Center for Studying Health System Change⁴ reported that "three out of four physicians identified themselves as white, non-Hispanic, while 3.8 percent were black, non-Hispanic, 5.3 percent were Hispanic, and 17.2 percent were Asian or other races. Among physicians under age 40, about two-thirds were white and 33 percent were minority - black (4%), Hispanic (5.4%), and Asian or other race (24%)".⁴

In Pediatrics, the Official Journal of the American Academy of Pediatrics, Goodman⁵ stated that one of the challenges facing pediatric healthcare providers is that it still fails to reflect the growing racial and ethnic diversity of the United States even with strategies in place to expand medical school opportunities for underrepresented minority groups including black, Hispanic, and American Indian/Alaska Natives. Additionally, "the disparity in race and ethnicity is anticipated to grow substantially by 2025, reflecting the combination of high minority population growth rates and an assumption of slow increases in enrollment rates of individuals of minority groups in medical education".⁵

The changing demographics and increasing diversity of the population has an impact on care and quality of care being delivered by healthcare providers.⁶ In 2005, The Office of Minority Health⁷ reported that the main ingredient in closing the gap in health care disparities is cultural competency.

Cultural Competency

The National Center for Cultural Competence (NCCC)

as cited in Ahmann,⁸ stated one of the important reasons for promoting culturally competent care is to improve the quality of services and health outcomes. Furthermore, OMH⁷ reported that "health care services that are respectful of and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse patients can help bring about positive health outcomes". Additionally, culturally competent care provided by health care providers increases the satisfaction of the person and family receiving the services and lends itself to a more rewarding interpersonal experience. In order to provide culturally competent health care services critical factors must be included:

- An understanding of the beliefs, values, traditions and practices of a culture.
- Culturally defined, health related needs of individuals, families, and communities.
- Culturally- based belief systems of the etiology of illness and disease and those related to health and healing.
- Attitudes toward seeking help from health care providers.⁸

Many health care institutions and academic settings (schools of medicine, nursing and health related science schools) provide training and include curriculum around cultural competence, but limited research was located focusing on pediatric physicians and nurses and if strides have been made in delivering culturally competent care to their patients and families.

Review of the Literature 2005-2014: Methods

The literature review presented here uses a scoping review methodology as described by Armstrong, Hall, Doyle and Waters.⁹ A scoping method was used to identify research gaps and to summarize findings of research. Standage and Randall¹⁰ stated a "scoping review allows for a broader approach and attempts to capture all the literature irrespective of the quality of the data or method".

The two research questions guiding this literature search were: Are pediatric physicians and nurses delivering culturally competent care to their patients and families? What do pediatric physicians and nurses report are the issues related to providing culturally competent care to their patients and families as addressed in the research between the years 2005-2014? The data bases used were CINAHL, ERIC, and Academic Search Premier. The English language and published research relevant to the research question was included. The keywords used were cultural competence, children, pediatric nurse, pediatrician, pediatric health care providers and health care providers. Forty-five were retrieved, of which 35 were rejected because they did not contain methodologically based research. Eight of the rejected articles detailed programs on how to provide cultural competence training; another 20 articles did not include pediatric patients, health care providers or cultural competence; five articles detailed methods to do research or suggestions on how to capture culturally competent care; three articles were either letters to the editor,

Author	Country Based	Method	Data Collection	Participants	Key Findings
Berlin, Nilsson, & Tornkvist (2010)	Sweden	Quantitative	Survey questionnaire	51 Swedish Pediatric nurses who worked at a primary child health-care center: 24 nurses in the intervention group received cultural competence training 27 nurses in the control group did not receive training	Statistically significant improvements in the areas of cultural knowledge, cultural skill, and cultural encounters in the intervention group participants following training. Additionally 92% of the intervention group participants increased their desire to learn more about culturally competent health services
Davies, Larson, Contro, & Cabrera (2011)	USA	Qualitative	Interviews	13 Mexican-American Families whose children were treated for a life-limiting illness at two children's hospitals in Northern California	Participants perceived discrimination across a variety of settings (including the two hospitals in the study, other hospitals and community clinics) where their children received care.
Johnson, Clark, Goree, O'Connor, & Zimmer (2008)	USA	Qualitative	Focus Groups	38 Healthcare Providers: 13 WIC Educators, 9 Registered Nurses, 8 Medical assistants, 3 WIC Dieticians, 3 Pediatricians, Physician Assistants who worked in well-established Mexican American communities and newer Mexican immigrant communities in the Denver metropolitan area.	Five overarching themes were identified that represented provider's perceptions of Mexican American families' practices as related to early weight and growth and a sixth theme identified providers' reflections about their practice with this population: 1) a chubby baby is a healthy baby 2) Complementary foods are introduced earlier than recommended 3) Extended family influences feeding practices 4) Mothers offer high-calorie, low-nutrient dense food choices 5) Mothers delay weaning from the bottle 6) What's a provider to do? Role confusion
Kerfeld, Hoffman, Ciol, & Kartin (2010)	USA	Quantitative	Survey questionnaire	750 Families who had Children with Special Health Care Needs	Patients who were White non-hispanic perceived the providers of healthcare for their Child with Special HealthCare Needs as providing more culturally competent care compared to other race/ethnic group. Forgone/delayed care was more often reported by White Hispanics, followed by Multiple/Other Hispanics and Black Hispanics
Pergert, Enskar, & Bjork (2008)	Sweden	Qualitative	Interviews	12 Swedish Pediatric Nurses who worked on a pediatric oncology unit	Pediatric hospital nurses who were faced with overwhelming emotional expressions by families with a foreign background were found to override their professional preparedness on account of a distinguishing difference between the expression and the norm.
Tavallali, Kabir, & Jirwe (2014)	Sweden	Qualitative	Interviews	14 Swedish Parents with a child in the hospital who had minority/ethnic nurses	Nurses' ethnicity did not have much impact on parents' satisfaction related to the care of their child. Parents attached great importance to the nurses' language skills, to their adaptation to and awareness of the Swedish culture and to their professional knowledge and personal attributes.
Whitman, Davis & Terry (2009)	USA	Quantitative	Survey Questionnaire	1,429 Rural and urban public school nurses in Alabama	Participants located in both urban and rural areas of Alabama have witnessed an increase in the number of English-as-a-second-language (ESL) students and a third have experienced difficulty communicating with these children. Over half have experienced difficulty communicating with the parents of the ESL students. Use of the student as a translator when speaking to parents was reported in over half of urban schools and nearly 47% of rural schools.

Table 1: Selected papers in scoping literature review

editorials or briefs; and two articles were literature reviews. The remaining seven articles formed the basis of this review (Table. 1).

Literature Review 2005-2014: Findings

Of the seven studies reviewed three used a quantitative research design in incorporating survey questionnaires. The other four studies utilized a qualitative research design incorporating focus groups or interviews. Participants from four of the studies were pediatricians, pediatric nurses, or other health care providers who worked with children. The participants from the remaining three studies were families whose children had received care in hospitals or community settings. Three of the studies were performed in Sweden and four were performed in the United States.

Thematic analysis of the data produced the essential theme that pediatric health care providers are still lacking in cul-

tural competence and significant progress still needs to be made in this area when caring for children and their families. In the studies, specific cultural competence issues were seen around communication/linguistics (including language barriers) and provider openness and awareness. Strategies that were identified in the studies that would possibly increase cultural competence are: training, education and increased resources.

Communication: Research done by Betancourt, Green and Carrillo¹¹ found that the “provision of culturally competent care may be hindered because of (a) nurses’ own linguistic and culturally diverse backgrounds (b) hospitals’ poorly designed patient support systems for culturally diverse patients an (c) providers’ poor communication skills”. Four of the studies in this literature review cited at least one of these factors as a hindrance in providing culturally competent care.

In the research done by Tavallali, Kabir, and Jirwe¹² Swedish parents reported communication between them

and the minority ethnic nurse was one of the most important aspects and a key indicator of good, quality nursing care. All of the parents in the study expressed the importance of the minority ethnic nurse having Swedish language skills and lack of this language skill reduced parents' satisfaction with the care provided by the minority nurse. Kerfeld, Hoffman, Ciol and Kartin¹³ supported this thought in their study of dissatisfaction with care among parents of Children with Special HealthCare Needs. "Negotiating complex communication in a clinical encounter is a more difficult task and might be associated with increased dissatisfaction with care". Similarly, in the study done by Davies, Larson, Contro and Cabrera¹⁴ Mexican American families perceived poor quality of care and discrimination by their pediatric health care providers as a result of language barriers.

Public school nurses in Alabama reported on the communication challenges they faced with their growing English-as-a-Second-Language (ESL) student population.¹⁵ A third of the nurse respondents reported difficulty communicating with the students while over half reported difficulty communicating with parents of the students. Nearly 50% of the nurses stated they used the students as interpreters when speaking to their parents, even though interpreter services were available. "This raises serious concern over the quality and accuracy of the communication between the school nurse and the parents".¹⁵ The study related possible internal structural issues or lack of knowledge on the nurse's part related to the lack of use of interpreter services. The researchers saw this language barrier as a serious impediment in the nurses' efforts to care for ESL student and their parents. Furthermore, the authors stated that by providing school nurses with interpreter services barriers to access and health disparities can be significantly reduced

Each of the four articles recommended cultural competence training, education or both in order to increase the knowledge and skill of pediatric health care providers in the area of communication. Kerfeld et al.¹³ and Whitman et al.¹⁵ emphasized the importance of training pediatric nurses and health care providers in culturally and linguistically congruent communication techniques. Davies et al.¹⁴ stated, "training and continuing education must include language proficiency and cultural competence". Additionally, education may be focused on available resources such as the use of interpreter services for school nurses or learning specific cultural facts and cultural norms of certain groups.^{15,14} Kerfeld et al.¹³ advised that health care providers educate themselves on what is important to the children and families they serve in relation to their health and illness.

Provider Openness and Awareness: In the study done by Davies et al.¹⁴ the Mexican American parents that participated in the study perceived discrimination as a result of their race/ethnicity, limited English proficiency, socioeconomic status, or appearance. While these parents did not perceive that all healthcare providers discriminated against them, their specific encounters in the study were with individual pediatric nurses and physi-

cians that had long-lasting and deep effects on them. When these parents were asked for suggestions on how to decrease these incidences of discrimination, one mother recommended hiring healthcare providers who are "more sensitive. Who can accept people from everywhere".¹⁴

Similarly, the Swedish parents that participated in the study by Tavallali et al.¹² reported that in order to have a successful encounter with children and their families from a different culture the nurses needed to be sensitive to the patient's needs. This involved having the knowledge about the family's particular culture. The parents felt that if the healthcare provider had knowledge about the patient's culture it would allow them to treat patients the way they wanted to be treated. The parents from this study stressed what comes with sensitivity towards patient's cultural needs is the ability of the healthcare provider to be open to cultural differences. To these parents it was simply a question of mutual respect and understanding. Johnson, et al.¹⁶ supported this thought stating that maintaining openness to learning about cultural practices will allow healthcare providers to respond better to the needs of children and their families.

Being open to learning about cultural practices stems from the health care providers true motivation or desire to provide care that is culturally responsive.

Health care providers must possess the genuine desire and motivation to work with ethnically diverse clients. It includes a genuine passion to be open and flexible with others, to accept differences and build on similarities.¹⁷ Davies et al.¹⁴ stated that providing opportunities to change healthcare providers beliefs and behaviors is essential to developing cultural competence.

Learning around cultural practices and cultural competence has been done in a variety of ways including lectures, seminars, and in-services. Berlin, Nilsson and Tornkvist¹⁸ recommend a combination of approaches since cultural competence involves value judgments. The authors recommend specific approaches such as case methodology, or seminars and activities. These approaches include participatory learning that will facilitate active and reflective learning to help develop critical thinking and problem solving.

Javier, Hendriksz, Chamberlain and Stuart¹⁹ suggested an alternative strategy for training pediatric residents in cross-cultural education through the use of a patient-centered template approach. The authors projected this strategy will provide physicians with broadly applicable skills, knowledge, and attitudes so they can approach all patients individually by trying to understand their unique contexts in which they exist. "The core principle is that trainees are taught to treat all patient encounters as cross-cultural and to consider all patients' unique cultural beliefs and practices on an individual bases".¹⁹ Kerfeld et al.¹⁹ recommended the same practice when working with all families and their children. Family-centered culturally competent care should

be provided to all families regardless of race, ethnicity, values or beliefs, which will help alleviate health disparities and dissatisfaction with care.

DISCUSSION

This scoping literature review was guided by the following two research questions: Are pediatric physicians and nurses delivering culturally competent care to their patients and families? What do pediatric physicians and nurses report are the issue related to providing culturally competent care to their patients and families? With the growing diversity of our society, being culturally competent is crucial yet studies have shown this is proving to be an extremely difficult task with slow progress to date. The theme of culturally competent communication is vitally important in the delivery of culturally sensitive pediatric health care. In the studies performed by Tavallali et al.¹² Davies et al.¹⁴ and Kerfeld et al.¹³ families reported decreased satisfaction with care as a result of communication that was not culturally competent. Culturally competent communication not only includes the ability of the health care provider to interact with the patient and family in their primary language (a basic right of the patient), but it also includes an awareness of their cultural practices and beliefs. All of which will lead to increased satisfaction of patient-provider care.

The study reporting an increase in cultural competence of Swedish pediatric nurses following training¹⁸ is an indication that training has an effect on cultural competence, but other studies in this review revealed that discrimination and health disparities still exist.^{14,13} Whitman et al.¹⁵ stated that as a result of the increasing diversity in Alabama, school nurses are now in need of necessary cultural and linguistic training and resources to provide culturally sensitive care to their students and families. Cultural competence education and training for pediatric health-care providers has not kept up with the growing diversity of our population.

While the literature revealed that cultural competence is progressing slowly and that pediatric physicians and nurses need to be culturally and linguistically trained, limited information was found in this review that discussed how pediatric health care providers can enhance and support their ability to provide culturally competent care. The following discussion explores two potential solutions to help in the delivery of culturally competent care with pediatric patients; cultural mediation and family-centered care.

Cultural mediation has been used in a variety of settings including business and law. European countries utilize cultural mediation more widely in health care to help immigrants from other countries access and use health care services.²⁰ Martin and Phelan²⁰ stated differences exist between medical interpreters and cultural mediators. Cultural mediators are essential when advocacy for the patient is needed, and not just for interpretation

of a language. Martin and Phelan²⁰ stated, "Cultural mediation is required when lack of cultural awareness and understanding of the system is the main impediment for the migrant population to access and benefit from health services."

Cultural mediators help in the facilitation of a therapeutic relationship between the patient and the healthcare provider by assessing the situation and participating in the plan of action with both parties. Cultural mediators help healthcare providers understand the patient's cultural practices and beliefs that may have an impact on their health, illness and health services. Additionally, cultural mediators inform patients on the health care system and how to access services they are entitled to.

Even when healthcare providers and patients speak the same language this is not insurance that the patient's needs are being understood or met. An English speaking Hispanic person living in the United States may have limited knowledge of how the health care system works. Additionally, the patient may have different cultural beliefs of health and illness and practices than the health care provider. In situations such as this, conflicts may arise between the health care provider and the patient. Cultural mediators serve as negotiators, or cultural brokers bridging the differing views, beliefs and practices between the two parties.

Martin and Phelan²⁰ stress the important role that cultural mediators have as motivators for patients, and how they are a source for empowering patients to voice their needs and concerns. Cultural mediators also help healthcare professionals monitor the progress of the patient and ensure that there is follow-up. "Cultural mediators could become agents in bringing about change in the healthcare services by fostering equality and fairness. By steering healthcare users to use the proper services and healthcare providers to better understand needs, cultural mediators also help to increase effectiveness in healthcare."²⁰

The study performed by Kerfeld et al.¹³ examined the association between parents' reported delayed care and dissatisfaction with care for their child with special healthcare needs with the parent's perception of cultural competence of their child's healthcare provider. One of the findings of the study was that there was no consistent association between racial or ethnic groups and their perceptions of provider cultural competence. As a result of this finding, the authors recommended that focus of the healthcare provider should be on family centered care.¹³ Family-centered care can be defined as "placing the needs of the child, in the context of their family and community, at the center of care and devising an individualized and dynamic model of care in collaboration with the child and family that will best meet these needs."²¹ Health care providers who are family-centered practitioners understand and acknowledge the essential role that families play in ensuring the health and well-being of their children, or any aged family member.²¹ Family-centered health care providers understand that emotional, psychosocial, and developmental supports are key factors in health care. It is

a mutually beneficial partnership that promotes the health and well-being of individuals and families and in turn restores dignity and control to families.

The Institute for Family-Centered Care²² states that family-centered care leads to better health outcomes, better allocation of resources and greater patient and family satisfaction. One of the core concepts of family-centered care is dignity and respect where health care providers listen to, value and honor the family's perspectives, choices and decisions. The family's knowledge, values, beliefs and cultural background are incorporated into the planning and delivery of care.²² By following this core principle of family-centered healthcare providers focus on the individual family and their individual values, beliefs, and practices regardless of their race and ethnicity.

Future research in the areas of cultural mediation and family-centered care is needed to explore if these two strategies increase the level of culturally competent care provided by pediatric physicians and nurses.

CONCLUSION

There is evidence from this review that pediatric health care providers, specifically physicians and nurses are still coming up short in delivering culturally competent care and that significant progress still needs to be made in this area when caring for children and their families. Literature from this review showed that awareness of cultural competence issues are being brought forward for particular groups such as Mexican Americans, families of Children with Special HealthCare Needs and Alabama school nurses. However, culturally competent care needs occur with every child and family that pediatricians, pediatric nurse and pediatric healthcare providers interact with.

REFERENCES

- Humes KR, Jones NA, Ramirez RR. Overview of race and hispanic origin. Website: <http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf> 2010; Accessed 2011.
- Children's Defense Fund. Children in the States. The United States. Washington, DC: *Children's Defense Fund*. 2014
- U.S. Department of Health and Human Services Health Resources and Services Administration. The registered nurse population. Findings from the 2008 National Sample Survey of Registered Nurses. Website: <http://bhpr.hrsa.gov/healthworkforce/rnsurveys/rnsurveyfinal.pdf> 2010; Accessed 2014.
- Health System Change. A snapshot of U.S. Physicians: Key findings from the 2008 Health Tracking Physician Survey. Washington, DC: *Center for Studying Health System Change*. 2009.
- Goodman D. The Pediatric workforce: Current status and future workforce. *Pediatrics*. 2005; 116(1): e156-e173. doi: [10.1542/peds.2005-0874](https://doi.org/10.1542/peds.2005-0874)
- Betancourt JR, Green AR, Carillo JE, Park ER. Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs*. 2005; 24(2): 499-505.
- Department of Health and Human Services Office of Minority Health. The Office of Minority Health. What is cultural competency? Website: <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=31> 2005; Accessed 2014.
- Ahmann E. Developing cultural competence in health care settings. *Pediatric Nursing*. 2002; 28(2): 133-137.
- Armstrong R, Hall B, Doyle J, Waters E. Cochrane update. 'Scoping the scope' of a cochrane review. *Journal of Public Health*. 2011; 33(1): 147-150. doi: [10.1093/pubmed/fdr015](https://doi.org/10.1093/pubmed/fdr015)
- Standage R, Randall D. The benefits for children's nurses of overseas placements: Where is the evidence? Issues in *Comprehensive Pediatric Nursing*. 2014; 37(2): 87-102. doi: [10.3109/01460862.2014.880531](https://doi.org/10.3109/01460862.2014.880531)
- El-Amouri S, O'Neill S. Supporting cross-cultural communication in culturally competent care in the linguistically and culturally diverse hospital settings of UAE. *Contemporary Nursing*. 2011; 39(2): 240-255. doi: [10.5172/conu.2011.240](https://doi.org/10.5172/conu.2011.240)
- Tavallali A, Kabir Z, Jirwe M. Ethnic Swedish parents' experiences of minority ethnic nurses' cultural competence in Swedish paediatric care. *Scandinavian Journal of Caring Science*. 2014; 28: 255-263. doi: [10.1111/scs.12051](https://doi.org/10.1111/scs.12051)
- Kerfeld C, Hoffman J, Ciol M, Kartin D. Delayed or forgone care and dissatisfaction with care for Children with Special Health Care Needs: The role of perceived cultural competency of health care providers. *Maternal Child Health Journal*. 2010; 15: 487-496. doi: [10.1007/s10995-010-0598-3](https://doi.org/10.1007/s10995-010-0598-3)
- Davies B, Larson J, Contro N, Cabrera A. Perceptions of discrimination among Mexican American families of seriously ill children. *Journal of Palliative Medicine*. 2011; 14(1): 71-76. doi: [10.1089/jpm.2010.0315](https://doi.org/10.1089/jpm.2010.0315)
- Whitman M, Davis J, Terry A. Perceptions of school nurses on the challenges of service provision to ESL students. *Journal of Community Health*. 2009; 35: 208-213. doi: [10.1007/s10900-009-9211-3](https://doi.org/10.1007/s10900-009-9211-3)
- Johnson S, Clark L, Goree K, O'Connor M, Zimmer L. Healthcare providers' perceptions of the factors contributing to infant obesity in a low-income Mexican American Community. *Journal for Specialists in Pediatric Nursing*. 2008; 13(3): 180-190. doi: [10.1111/j.1744-6155.2008.00152.x](https://doi.org/10.1111/j.1744-6155.2008.00152.x)
- Campinha-Bacote J. The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing*. 2002; 13(3): 81-184.
- Berlin A, Nilsson G, Tornkvist L. Cultural competence among Swedish child health nurses after specific training: A randomized trial. *Nursing and Health Sciences*. 2010; 12: 381-391. doi: [10.1111/j.1442-2018.2010.00542.x](https://doi.org/10.1111/j.1442-2018.2010.00542.x)

19. Javier J, Hendriksz T, Chamberlain L, Stuart E. Cross-cultural training in pediatric residency: Every encounter is a cross-cultural encounter. *Academic Pediatrics*. 2013; 13: 495-498. doi: [10.1016/j.acap.2013.09.001](https://doi.org/10.1016/j.acap.2013.09.001)
20. Martin M, Phelan M. Interpreters and cultural mediators - Different but complementary roles. *Translocations: Migration and Social Change*. 2009. Retrieved from: http://doras.dcu.ie/16481/1/Martin_and_Phelan_Translocations.pdf
21. MacKean G, Thurston W, Scott C. Bridging the divide between families and health professionals' perspectives on family-centered care. *Health Expectations*. 2004; 8: 74-85. doi: [10.1111/j.1369-7625.2005.00319.x](https://doi.org/10.1111/j.1369-7625.2005.00319.x)
22. Institute for Patient-and Family-Centered Care. (n.d.). *Patient-and family-centered care Core Concepts*. Website: <http://www.ipfcc.org/pdf/CoreConcepts.pdf>