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Abstract

Diversity is being increasingly recognized as an area of emphasis in health care. The term cultural humility is used frequently but society's understanding of the term is unclear. The aim of this article was to provide a concept analysis and a current definition for the term cultural humility. Cultural humility was used in a variety of contexts from individuals having ethnic and racial differences, to differences in sexual preference, social status, interprofessional roles, to health care provider/patient relationships. The attributes were openness, self-awareness, egoless, supportive interactions, and self-reflection and critique. The antecedents were diversity and power imbalance. The consequences were mutual empowerment, partnerships, respect, optimal care, and lifelong learning. Cultural humility was described as a lifelong process. With a firm understanding of the term, individuals and communities will be better equipped to understand and accomplish an inclusive environment with mutual benefit and optimal care.

Keywords

cultural humility, nursing and cultural competence

Introduction

The value and understanding of the term diversity has evolved and progressed over the past several decades. Diversity has been increasingly recognized as an area of emphasis or core value in health care through leading organizations such as the Institute of Medicine (2010) and the National League for Nursing (2013). To attend to the increasing diversity in a globally connected society, there has been a movement of use of the terms cultural sensitivity and cultural competency to that of embracing cultural humility. Cultural humility has been endorsed as more profound and politically correct than cultural competency, but this shift begs the question, “What is cultural humility?”

Rodgers and Knafl (2000) advocated the importance to understand the meaning behind terms as they morph and change over time. Performing a concept analysis is one way to determine society's current meaning and understanding of a term. A concept analysis involves a systematic approach of reviewing the literature to tease out the antecedents, attributes, and consequences of a term. Concept analysis involves a search and exploration with the goal of achieving a definition. The aim of this article was to conduct a concept analysis and provide a current definition for the term cultural humility.

Background

In 1998, Tervalon and Murray-García suggested that cultural competency be distinguished from cultural humility. In this

sentinel document that has been cited over 600 times, the concept of cultural humility in the context of physician training was discussed. They summarized that “cultural humility incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations” (p. 123). They emphasized that cultural humility was a more suitable goal than cultural competence in multicultural medical education.

Campinha-Bacote (2002) developed a model of care called *The Process of Cultural Competence in the Delivery of Healthcare Services*. The constructs of the model included cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Cultural competence was deemed a process and applied across areas of practice including the clinical setting, administration, research, policy development, and education.

Chang, Simon, and Dong (2012) described cultural humility using the QIAN model influenced from the work of Chinese philosophers. They used the acronym QIAN, or “humbleness” in Chinese, to summarize the core values of cultural

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humility in health care professional education and training. The Q stood for the importance of self-questioning and critique, the I stood for bidirectional cultural immersion, the A stood for active listening, and the N stood for the flexibility of negotiation. They recommended cultural humility be incorporated into medical education to enhance cross-cultural clinical encounters.

Foronda (2008) performed a concept analysis of the term cultural sensitivity. She uncovered attributes of knowledge, consideration, understanding, respect, and tailoring. The antecedents of cultural sensitivity were diversity, awareness, and an encounter. The consequences were effective communication, effective intervention, and satisfaction. A formal concept analysis of cultural humility within the past 5 years was lacking within the literature; thus, this concept analysis was warranted.

Method

Search Strategy

The databases of CINAHL Plus, Academic Search Complete, Anthropology Plus, ERIC, Human Resources Abstracts; Humanities Full Text and PsycINFO were explored using the search terms of “cultural humility” or “culturally humble” yielding 123 citations. PubMed was investigated using search terms of “cultural” or “culturally” combined with “humility” or “humble” revealing 154 more citations. Duplicates were removed resulting in 206 articles. Articles published prior to 2009 were removed resulting in 116 articles published from 2009 to 2014. Book chapters and articles written in languages other than English were excluded. The remaining 108 articles were read for relevance and 46 more articles were excluded as they did not discuss cultural humility within them; thus, 62 total articles were included in the review.

Analysis

Rodgers and Knafl’s (2000) method of concept analysis was used to guide the process.

The articles were divided among the four team members for analysis. Each member read the articles, searching for keywords and phrases that related to cultural humility. These keywords and phrases were combined and sorted into a master grid having categories of antecedents, attributes, and consequences. After establishing findings independently, the team discussed repetitive keywords and phrases. Through an iterative process of synthesis and consolidation, the attributes of cultural humility surfaced.

The authors felt it was important to reveal select details that may have influenced their interpretation of the data in the interest of disclosing potential bias to enhance reader perspective. The research team comprised four nurses, three female and one male. The researchers self-identified as African (one

Black), Euro-American (two White), and Haitian (one Black). Diversity of the team in the areas of socioeconomic status, age, sexual orientation, and disability was lacking.

Results

The term cultural humility was used in a variety of contexts from individuals having ethnic and racial differences, to differences in sexual preference, social status, interprofessional roles, to health care provider–patient relationship. The following attributes were discovered: openness, self-awareness, egoless, supportive interactions, and self-reflection and critique. Cultural humility was described as a lifelong process (Figure 1).

Attributes

Openness. The first attribute identified was openness. An individual must have an open mind or be open to an interaction with a culturally diverse individual for cultural humility to take place. Openness is defined as possessing an attitude that is willing to explore new ideas. This word was expressed in contexts including physician-clinicians in a teaching capacity, social workers training child welfare workers, practicing medicine with diverse patients, physical therapist life histories, a minority occupational therapist working with patients of the majority group, and preparing nurses to work with lesbian, gay, bisexual, or transgendered patients (Beagan & Chacala, 2012; Brennan, Barnsteiner, de Leon Siantz, Cotter, & Everett, 2012; Dobransky-Fasiska et al., 2009; Hilliard, 2011; Mahant, Jovcevska, & Wadhwa, 2012; Ortega & Coulborn, 2011; Tilburt, 2010; Vogt, 2011). Descriptive phrases discovered were having an open-minded posture, being open, having openness, unpretentious openness, and an open stance or open-mindedness (Aghababaei, Wasserman, & Hatami, 2014; Beagan & Chacala, 2012; Brennan et al., 2012; Coulehan, 2011; Dobransky-Fasiska et al., 2009; Hilliard, 2011; Mahant et al., 2012; Ortega & Coulborn, 2011; Rew, 2014; Tilburt, 2010). Having openness was one of the initial steps in the process of cultural humility.

Self-Awareness. The second attribute was self-awareness. Self-awareness is defined as being aware of one’s strengths, limitations, values, beliefs, behavior, and appearance to others. The exact terms of awareness and self-awareness were noted repeatedly throughout the literature. Self-awareness was used in contexts including medicine, medical education, clinical research, nursing, nurse education, physical therapists, community health, psychotherapy, and social worker education (Alsharif, 2012; Brennan et al., 2012; Coulehan, 2010, 2011; Graham-Dickerson, 2011; Groll, 2014; Hilliard, 2011; Isaacson, 2014; Jennings et al., 2012; Ma, Li, Liang, Bai, & Song, 2014; Ortega & Coulborn, 2011; Rew, 2014; Ross, 2010; Tilburt, 2010; Vogt, 2011; Yeager & Bauer-Wu, 2013; Zanetti, Dinh, Hunter, Godkin, & Ferguson, 2014). Additional descriptors included understanding one’s abilities

and limitations and possessing self-knowledge (Jennings et al., 2012; Mahant et al., 2012). When working with others from different cultures, an individual must be aware of one's values, beliefs, and behaviors. After having this self-awareness, the individual can continue with the process of cultural humility.

Egoless. The third attribute was titled egoless. This heading encompassed various terms that referred to one requiring humbleness or throwing away ego. Descriptive terms included requiring modesty, being egoless, humble, down to earth, having neutrality, having humble attitude, being equitable, having a quiet ego, humility, approach (others) as equals, and lack of superiority (Aghababaei et al., 2014; Alsharif, 2012; Beagan & Chacala, 2012; Dobransky-Fasiska et al., 2009; Groll, 2014; Kesebir, 2014; Levi, 2009; Owen et al., 2014). Egoless is defined as being humble; viewing the worth of all individuals on a horizontal plane. The poignant descriptors illustrate a more grand concept than just humility; they illustrate one must enact a belief system of equal human rights and flatten any hierarchy or power differential.

Supportive Interaction. The fourth attribute heading was supportive interaction. This term was chosen because it was broad enough to encompass the many different types of engagements and actions that occur when cultural humility is being implemented. Supportive interactions are defined as intersections of existence among individuals that result in positive human exchanges. The actions that fall under this heading include the following: interactions of two persons, interaction, intersectionality, sharing, taking responsibility for interactions with others, interactions, supportive interactions, engage, engaging, and engaged/active (American Association of Diabetes Educators, 2012; Beagan & Chacala, 2012; Butler et al., 2011; Groll, 2014; Hilliard, 2011; Isaacson, 2014; Kamau-Small, Joyce, Birmingham, Roberts, & Robbins, 2014; Metzl & Hansen, 2014; Nazar, Kendall, Day, & Nazar, 2014; Ross, 2010). A supportive interaction between individuals must occur as part of the process.

Self-Reflection and Critique. The final attribute was self-reflection and critique. This attribute is defined as a critical process of reflecting on one's thoughts, feelings, and actions. Terms used that fall under this heading included self-reflection, self-critique, thinking critically about one's self, self-evaluation and critique, self-reflection and discovery, self-questioning and critique, reflection, self-reflective process, knowledge acquisition and reflective practice, reflective openness, and introspection (American Association of Diabetes Educators, 2012; Chang et al., 2012; Clark et al., 2011; Coulehan, 2010; Fahey et al., 2013; Foster, 2009; Hammell, 2013; Hilliard, 2011; Isaacson, 2014; Ma et al., 2014; Miller, 2009; Morton, 2012; Nazar et al., 2014; Reynoso-Vallejo, 2009; Ross, 2010; Schuessler, Wilder, & Byrd, 2012; Vogt, 2011; Yeager & Bauer-Wu, 2013). The

self-reflection and critique was described as a journey or endless process of continual reflection and refinement.

Antecedents

Antecedents referred to the concepts or situations that preceded the instance of the concept of cultural humility (Rodgers & Knafl, 2000). Across the disciplines and contexts that surfaced in the literature review, the antecedents were diversity and power imbalance. Diversity, or multiculturalism, referred to the existence of many cultures in the broadest sense. Diversity was expressed in terms of values and belief systems, social group membership, social power, social class, social injustice, oppression, health disparities, different conceptualizations of sickness and health; health care demands, linguistic differences, multiple viewpoints, heterogeneity of attitudes, material privilege, various ideas, customs, lifestyles, taboo, and different ethnicities, religion, or group affiliation (Aghababaei et al., 2014; American Association of Diabetes Educators, 2012; Beagan & Chacala, 2012; Berg, 2014; Brennan et al., 2012; Butler et al., 2011; Chang et al., 2012; Clark et al., 2011; Jennings et al., 2012; Ma et al., 2014; Sheridan, Bennett, & Blome, 2013; Vogt, 2011; Zanetti et al., 2014).

The second antecedent identified was power imbalance. This attribute overlapped with diversity. The power imbalance was reflected in different venues of social injustice. The following terms were found that illustrate this worldview of power imbalance in the context of cultural humility: inequality, systemic oppression, social power, social group membership, inequity, nondominant culture, privilege, injustice, power, cultural imposition, stigma, superiority, stereotyping, biases, unequal distribution of power, entitlement, and power differential (American Association of Diabetes Educators, 2012; Berg, 2014; Chang et al., 2012; Hammell, 2013; Hilliard, 2011; Jennings et al., 2012; Ma et al., 2014; Metzl & Hansen, 2014; Owen et al., 2014; Reynoso-Vallejo, 2009; Ross, 2010; Schiff & Rieth, 2012; Schuessler et al., 2012; Tilburt, 2010).

Consequences

Consequences referred to what occurs after the event of cultural humility or as a result of achieving cultural humility. The following consequences were identified: mutual empowerment, partnerships, respect, optimal care, and lifelong learning. Respect, mutual empowerment, and partnerships overlapped and were reflected in the following descriptions: respect, respectful partnerships, connections, trust, sustainable partnerships, mutually beneficial relationships, beneficial partnerships, patient-clinical dynamic, building honest and trustworthy relationships, mutually respectful dynamic partnerships, mutual understanding, collaboration, professional relationship, care relationship, and advocacy partnerships (American Association of Diabetes Educators, 2012;

Butler et al., 2011; Chang et al., 2012; Clark et al., 2011; Foster, 2009; Graham-Dickerson, 2011; Groll, 2014; Gruppen, 2014; Hilliard, 2011; Hook, Davis, Owen, Worthington, & Utsey, 2013; Isaacson, 2014; Kools, Chimwaza, & Macha, 2014; Levi, 2009; Morton, 2012; Rew, 2014; Reynoso-Vallejo, 2009; Schuessler et al., 2012; Vogt, 2011; Yeager & Bauer-Wu, 2013). The consequence heading of optimal care was chosen as cultural humility resulted in effective treatment, decision making, communication, understanding, quality of life, and improved care (Aghababaei, 2014; Alsharif, 2012; American Association of Diabetes Educators, 2012; Brennan et al., 2012; Butler et al., 2011; Carter & Swan, 2012; Chang et al., 2012; Chun, Jackson, Lin, & Park, 2010; Clark et al., 2011; Ellis, 2012; Fahey et al., 2013; Groll, 2014; Hammell, 2013; Hilliard, 2011; Hook, Owen, Worthington, & Utsey, 2013; Karnieli-Miller, Frankel, & Inui, 2013; Kools et al., 2014; Ma et al., 2014; Morton, 2012; Ross, 2010; Schiff & Rieth, 2012).

The final consequence heading was lifelong learning. Lifelong learning encompassed terms including transformation, lifelong commitment to self-evaluation, and self-critique; reflection, self-reflection, and reflexivity (American Association of Diabetes Educators, 2012; Clark et al., 2011; Coulehan, 2011; Dietsch & Mulimbalimba-Masururu, 2011; Ellis, 2012; Kools et al., 2014; Kutob et al., 2013; Loue, 2012; Morton, 2012; Rew, 2014; Schiff & Rieth, 2012; Vogt, 2011; Yeager & Bauer-Wu, 2013). Lifelong learning overlapped with the attribute of self-reflection and critique. The literature emphasized cultural humility entailed a continuous process of self-reflection and learning.

Antonyms

An unexpected finding, the authors gleaned a better understanding of the term cultural humility by viewing what it was not. That is to say, powerful words were noted in relation to cultural humility specifically when the opposite of it occurred. Some antonyms used were prejudice, oppression, intolerance, discrimination, stereotyping, exclusion, stigma, inequity, marginalization, misconceptions, labeling, mistrust, hostility, misunderstandings, cultural imposition, judgmental, undermining, and bullying (American Association of Diabetes Educators, 2012; Beagan & Chacala, 2012; Berg, 2014; Chang et al., 2012; Clark et al., 2011; Hyde, Kautz, & Jordan, 2013; Jennings et al., 2012; Kutob et al., 2013; Loue, 2012; Ma et al., 2014; Metzl & Hansen, 2014; Ortega & Coulborn, 2011; Tilburt, 2010). Discussing the antonyms was beneficial to fully understand the concept of cultural humility.

Definition

In a multicultural world where power imbalances exist, cultural humility is a process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after

willingly interacting with diverse individuals. The results of achieving cultural humility are mutual empowerment, respect, partnerships, optimal care, and lifelong learning.

Model Case

To provide an example of cultural humility in action, the following case is presented in the context of interprofessional diversity. A nurse calls to notify a physician about a subtle change in patient status and suggest an order for a medication. The nurse feels uncomfortable providing a suggestion to the physician due to a perceived hierarchy and having less education, but she was trained to provide a thorough report including a recommendation when communicating with physicians. The physician hears the nurse's report and is frustrated because the nurse is taking too long to get to the point and disagrees with the recommendation. However, the physician considers the power imbalance and recognizes that physicians and nurses have different training. With a sense of cultural humility, the physician recognizes the nurse has more face-to-face or "front-line" interaction with the patient and is open to hearing her opinion. She is aware of the nurse's position in the hierarchy and takes care to exude an egoless, approachable demeanor. The physician addresses the nurse's concern. Although she disagrees with the nurse's recommendation, she provides rationale and educates the nurse in a nonthreatening manner. After the interaction, the physician reflects about her actions and how the nurse responded. The physician reflects and notes what went well and what could be improved in the interaction. Based on this reflection, she continually modifies and tailors her communications with nurses in a demonstration of lifelong learning. The nurse and physician feel empowered because they have strengthened their partnership, have respect for each other, and have reached a plan of optimal care for the patient.

Similarly, the nurse reflects on how the communication transpired, considers the rationale provided as well as how she felt afterward. She has learned to make future communications more concise and will continue to attempt to frame her communications in a way that physicians will appreciate. Because the physician responded in a respectful manner, the nurse feels empowered to continue to communicate with physicians regarding her patients' needs. As cultural humility is a process, the physician and nurse will continue to learn, modify, and build in their respective knowledge-bases throughout their journey as practitioners.

Contrary Cases

The following example is provided to illustrate when cultural humility is not exuded. As noted above, the nurse calls the physician to notify of a patient's change in status. This time, the physician becomes annoyed at the nurse's lengthy report and cuts her off saying, "Get to the point already." The nurse, who already feels disempowered states her recommendation.

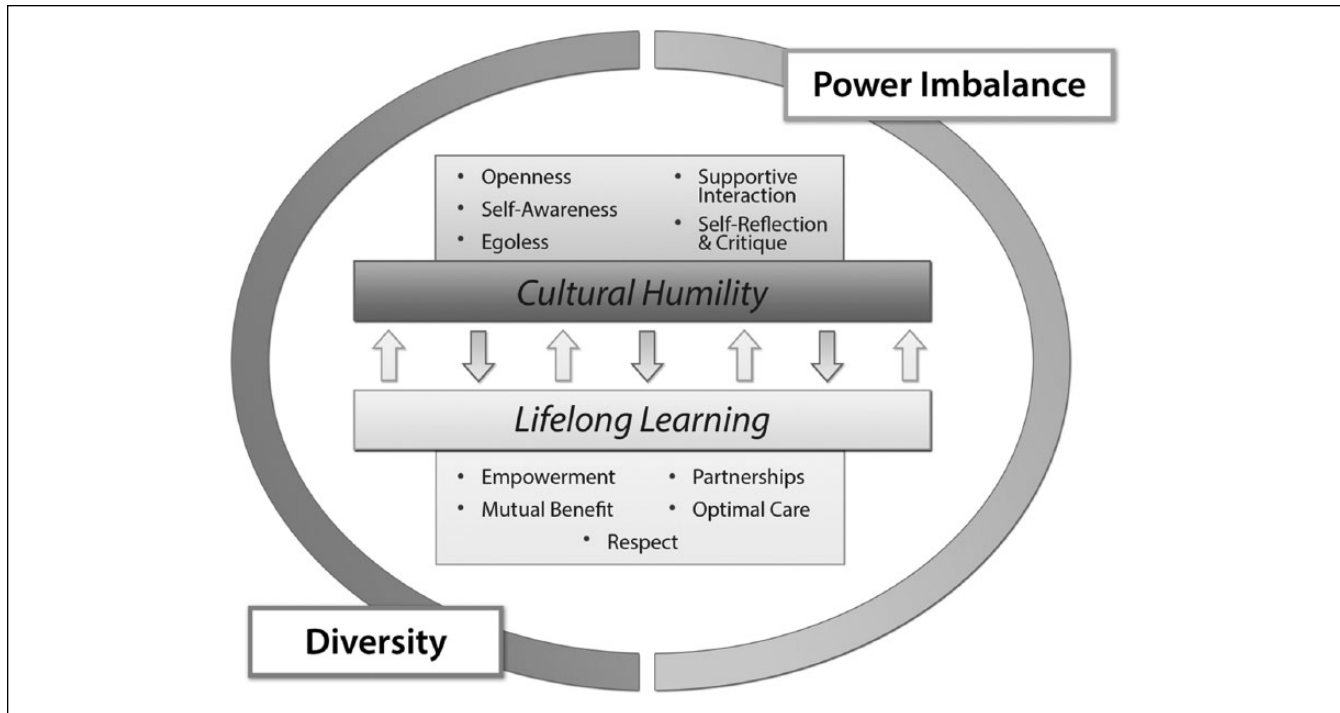


Figure 1. A concept analysis of cultural humility.

The physician disagrees with her recommendation and gives her orders for a different medication followed by ending the call abruptly without explanation. The nurse loses confidence, reflects, and has learned to avoid calling the physician and avoid providing recommendations. The physician reflects and determines that nurses are incapable of drawing out the critical information to convey.

This second example is provided in a public health context. An American nurse visits a developing country with the interest of providing health care screening to a community. The nurse approaches an individual to ask about participation. The native inhabitant becomes irritated with the nurse and refuses to communicate; thus, removing himself from the opportunity. The nurse becomes frustrated and feels like returning to her home country. In this case, the native inhabitant viewed the nurse as someone different. She was an outsider with privilege and due to historical precedents of injustice, pain, and oppression, viewed this person as someone to be distrusted and avoided. The nurse recognized the diversity and power imbalance in the vein of socioeconomic status, however, she failed to respect the cultural values of the community and attend to the process of obtaining the approval of gatekeepers. She was not fully self-aware, open, or supportive in her interactions because of this unintentional ignorance. Although there are additional complex phenomena that are oversimplified in these examples, the outcomes of mutual empowerment, partnerships, respect, optimal care, and lifelong learning are clearly impeded when cultural humility is not achieved.

Discussion

Implications and Recommendations

After constructing a concept analysis and definition of the term cultural humility based on society's usage of the term throughout the literature, the authors purport that instead of focusing on skills and information about various cultures, the movement toward cultural humility implies one must strive for learning at the highest level of learning; that of transformation (Mezirow, 1991). Cultural humility involves a change in overall perspective and way of life. Cultural humility is a way of being. Employing cultural humility means being aware of power imbalances and being humble in every interaction with every individual. This process will not happen immediately, but it is speculated that with time, education, reflection, and effort, progress can be made.

After achieving a better understanding of the concept through this concept analysis, it was clear that further work in the area is needed. The term was mostly used in relation to racial and ethnic differences; however, this concept should be applied more broadly to encompass the pillars of diversity and beyond. Cultural humility must occur within the work environment intraprofessionally and interprofessionally. Those of higher power status including administration and individuals of all ranks must attempt to be humble to move forward in this effort. Cultural humility should be employed daily with all individuals in the basic interest of kindness, civility, and respect.

Development of a framework for cultural humility is recommended to serve as a foundation for education and research purposes. Cultural humility is difficult to accomplish unless both individuals or groups are open to working together. When one party is open and the other is closed due to pain and resentment, anger and hostility persist and progress is halted. For this reason, education and cultural humility training in the workforce and community is important. Leaders must consider evaluation methods and continuous improvement in the area of cultural humility within organizations. Guides and instruments to measure and evaluate cultural humility are lacking but necessary.

Strengths

A strength of this concept analysis was the diverse range of disciplines and contexts covered through the broad search strategy. Articles represented disciplines from medicine, nursing, pharmacy, physical therapy, social work, and others. This approach resulted in a broad and general understanding of society's meaning of the term. Additionally, cultural humility was used in a variety of contexts including the lesbian, gay, bisexual, and transgender community, battered yet economically privileged spouses, faculty–student relationships, minority occupational therapist serving patients in a majority group, nurse–physician relationships, and patient–physician relationships. Of note, many articles described cultural humility from the standpoint of ethnic and racial diversity. It was possible the general meaning of cultural humility was mostly thought of in a narrow light with respect to ethnic and racial diversity. Last, the diversity inherent in the research team was deemed a strength to bring a varied perspective regarding cultural humility.

Limitations

The research team noticed many articles referred to Tervalon and Murray-García's (1998) definition of cultural humility; thus, some of the keywords that consistently arose in relation to cultural humility such as power imbalance, self-awareness, reflective process, and lifelong learning were from the repetition of this sentinel work instead of individual commonalities and may be overrepresented. On the other hand, the analysis indicated that this work continues to be reflected today and is applied in many contexts so it supports understanding of society's current meaning of the term. The research team comprised all nurses and this may have led to some similar viewpoints and limited interpretation as nursing is a historically oppressed group. Although diverse in some ways, the research team was limited in diversity in other ways including age, socioeconomic status, and sexual orientation.

Conclusion

Through white papers, mission and value statements, and national directives, the need to encourage and value diversity

was evident. This article served to provide an analysis of the concept of cultural humility with a proposed definition to attend to the needs of an increasingly connected multicultural society. With a firm understanding of the term, individuals, health care providers, and communities will be better equipped to understand and accomplish an inclusive environment with mutual benefit and optimal care. Realizing cultural humility is possible when one is open, self-aware, humble, reflective, and supportive with others.

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