Clarifying Concepts: Cultural Humility or Competency

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Cultural competency in the delivery of health care to diverse population groups has become an urgent need in the United States. Yet, despite the incorporation of cultural competency education into nursing curricula, inequities in health care remain. The purpose of this mixed-method study was to identify if differences in perceptions of cultural competence were present in senior nursing students ($N = 11$) before and after cultural immersion experiences on an Indian reservation. Preimmersion results revealed that the majority considered themselves culturally competent, whereas after immersion, there was a downward shift in scores. Triangulation of the quantitative results alongside a hermeneutic phenomenological analysis of the students' reflective journals revealed a paradox. Students perceived themselves as culturally competent, yet their journals demonstrated many negative stereotypes. Three common themes emerged: seeing with closed eyes, seeing through a fused horizon, and disruption to reshaping. These combined results revealed the misperceptions regarding the concept of cultural competency. Efforts must be made in nursing education to teach students the importance of adopting an ethic of cultural humility, where we emphasize attentive listening and openness to other cultures, and stress the importance of self-reflection and self-critique in our interactions with others. (Index words: Cultural humility; Cultural competency; Immersion; Qualitative; Mixed methods; Nursing students) J Prof Nurs 30:251–258, 2014.

THE UNITED STATES history of immigration demonstrates an acceptance of individuals from diverse cultural backgrounds with members from Northern Europe tending to dominate the cultural landscape. Over the past several decades, this dominance has begun to gradually shift away from the non-Hispanic White population to becoming a nation of color. It is projected that by the year 2050, those listed as non-Hispanic White will decrease to 47%, compared to 67% in 2008; other population groups are predicted to increase more rapidly (Passel & Cohn 2008). As these minority populations increase, so do concerns about health inequities (Institutes of Medicine [IOM], 2012).

Added to this are concerns that the nursing workforce is not reflective of this broad range of races and ethnicities. The U.S. Department of Health and Human Services, Health Resources and Services Administration (2010) identified that 16.8% of all nurses are from minority racial/ethnic groups. The Sullivan Commission (2004) asserted that inequities in health treatments and outcomes are intertwined with the underrepresentation of minorities working in health care professions. The IOM (2003) advocated for the inclusion of cultural competency standards in education of health professionals. The American Association of Colleges of Nursing [AACN] (2008) produced a framework with competencies and resources for programs to ensure that baccalaureate nursing students are culturally competent upon graduation.

What does it mean to be culturally competent when providing nursing care? Is cultural competency the same as cultural sensitivity or awareness? When a nurse achieves cultural competency with a specific culture, is that nurse now culturally competent with all persons of that particular cultural background? Crigger, Brannigan, and Baird (2006) expressed concern that use of the term

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competence would indicate that the nurse meets the requirements to care for all cultures and therefore "implies an outcome and this may lead to misunderstanding about the approach to learning about a culture and its people" (p. 16). The purpose of this article is to present findings from a study where senior nursing students' perspectives regarding their cultural competency were explored quantitatively and qualitatively before and after a cultural immersion experience.

Literature Review

Many variations exist in defining cultural competence. The AACN (2008) stated that it is "the attitudes, knowledge, and skills necessary for providing quality care to diverse populations" (p. 1). Campinha-Bacote (2002) identified cultural competence as a process involving the attributes of cultural awareness, knowledge, skill, encounters, and desire. Others described cultural competence specifically in relation to care, noting that competency requires sensitivity on the part of the health care professional to a host of differences in the person, such as culture, sexual orientation, and socioeconomic status (Cuellar, Brennan, Vito, & de Lion Siantz 2008). Jeffreys and Dogan (2012) acknowledged the multifaceted nature of cultural competence and indicated that persons develop transcultural skills and transcultural self-efficacy with the proposed outcome to provide culturally congruent care. Crigger et al. (2006) described cultural competence as a "dynamic ongoing process" and suggested that *collaboration* may be a better term to reflect its dynamic nature (p. 16). Racher and Annis (2007) wrote that cultural competence implied that one knows or has mastered another's culture, and this "knowing can lead to decreased efforts to learn" (p. 265).

For many in health care, the term *competency* indicates mastery or successful completion of a skill set, similar to the concerns expressed by Racher and Annis (2007). In 1998, Tervalon and Murray-Garcia challenged the notion of competency as illusive and unattainable and advocated that medical education should focus instead on teaching the concept of cultural humility. To practice cultural humility, health care providers should consider a person's culture from the individual's specific view and to be aware and humble enough to "say that they do not know when they do not know" (Tervalon & Murray-Garcia 1998, p. 119).

Cultural humility "goes beyond the concept of cultural competence…[and] that it is impossible to be adequately knowledgeable about cultures" that are not your own (Levi 2009, p. 97). Cultural humility requires that we take responsibility for our interactions with others, by actively listening to those from differing backgrounds while at the same time being attuned to what we are thinking and feeling about other cultures; cultural humility encourages self-reflection and self-awareness (Clark et al. 2011; El-Askari & Walton 2005; Minkler 2012). Cultural humility does not have an end point of understanding; it mandates a lifelong commitment where the health care professional "relinquishes the role of *expert* [of the patient's culture] to the patient, becoming the *student* of the patient with a conviction…of the patient's potential to be a…full partner in the therapeutic alliance" (Tervalon & Murray-Garcia 1998, p. 121).

Cultural humility illustrates the importance of including the patient's views in the interpretation of culture, while cultural competence implies that the health care professional has an a priori understanding of the person's culture before engaging with the patient. The AACN identifies the importance of the practice of cultural humility; however, it is felt that this concept is more appropriate for graduate-level nurses (Clark et al. 2011). From the review of the literature and the continued widening of health inequities (IOM, 2012), it is evident that a lack of clarity currently exists in the interpretation of what it means to be culturally competent in the provision of health care. It is concerning that students (and health care professionals) may overestimate their cultural competency and that, perhaps, we are remiss by focusing our educational efforts on cultural competency instead of humility. Calvillo et al. (2009) acknowledged the complexity of cultural competency and advocates that we evaluate student learning using a combination of quantitative and qualitative methods. Although many studies quantitatively assess cultural competency and others employ qualitative methods for evaluating student perceptions, there are limited data present that combine the two methods of assessment. This study was thus undertaken to evaluate if students' quantitative assessments of cultural competency are similar to their personal reflections of understanding a particular culture before and immediately after a cultural immersion experience.

Method

Study Design

This mixed-methods study design was used to examine senior nursing students' perspectives of cultural competency before and immediately after a cultural immersion experience. Specifically, this study used hermeneutic phenomenology to interpret narrative data from the students' reflective journals, while descriptive and inferential statistics were used to analyze the Likert-response item questionnaires. The data reported here are part of a larger study conducted by our nursing program to evaluate the value of cultural immersion experiences for students currently completed in Norway, Germany, Ecuador, the Dominican Republic, and an American Indian reservation on the Northern Plains of the United States.

Sample and Setting

The study was implemented using a convenience, purposive sampling method by inviting senior nursing students registered for cultural immersion experiences during the 2009–2010 academic year to participate. The findings presented are from two groups of undergraduate senior students electing to attend the Northern Plains reservation immersion experience. The first group