Cultural Humility

Cultural humility is the tip of the pyramid of cultural competence (Fig.1). Therefore, it is our belief that this construct is a presumptive product of the literature review and henceforth, it is considered as the pious and spiritual outcome of becoming culturally competent. This construct is an eventual paradigm and develops as a dynamic, fluid, and constantly evolving. Cultural humility has innate tenets and subscales, such as cultural desire, cultural sensitivity, cultural empathy, cultural caring, and cultural compassion that make up the concept. Cultural humility is defined as being humble and "seeing the greatness in others and coming into the realization of the dignity and worth of others" (Campinha-Bacote, 2007, p. 25). Cultural humility was further defined as:

> *A process of inquisitiveness, self-reflection, critiquing, and lifelong learning. In contrast to the idea of cultural competence, cultural humility is never mastered, it's an ongoing process, shaped by every encounter we have with every person, as long as we maintain an open mind and heart (Fahlberg, Foronda, & Baptiste, 2016, p.1 4).*

Cultural humility is a consequence of mastering all the constituents of the process of becoming culturally competent. Indeed, it is a lifelong learning process by which learners move through the competence continuum from being unconsciously incompetent to become unconsciously competent in a humble manner while respecting and treating every person with dignity, compassion, caring, and empathy. Ultimately, learners develop cultural humility as a sequel of their commitment to lifelong learning and to their ascending transcendence in a higher hierarchy of becoming culturally competent.

Cultural desire is an integral subscale to both concepts of cultural competence and cultural humility. It is defined as "the motivation of the health care professional to "want to" engage in the process of becoming culturally aware, culturally competent; not the "have to" (Campinha-Bacote, 2007, p. 21). The culturally humble person seeks opportunities to interact with other cultures intentionally while respecting and valuing their cultural beliefs and values.

Another important subscale of cultural humility is cultural sensitivity, which is demarcated as having an awareness of our personal attitudes and not saying things that might be offensive to someone from a different cultural or ethnic background (Purnell, 2009, 2014). Accordingly, cultural sensitivity occurs:

> *When neutral language, both verbal and nonverbal, is used in a way that reflects sensitivity and appreciation for the diversity of another. It is conveyed when words, phrases, categorizations, etc. are intentionally avoided, especially when referring to any individual who may interpret them as impolite of offensive (Giger et al., 2007, p. 100).*

Moreover, cultural sensitivity "develops as one comes to appreciate experienced and respect, and value cultural diversity. In doing so, one also comes to realize how one's own personal and professional cultural identity influence practice" (Burchum, 2002, p. 10).

Another subscale of cultural humility is cultural empathy that has emerged in psychology to address the psychological needs of different ethnic clients. Cultural empathy is considered a skill that psychotherapists use during their cultural encounters. It requires the health care provider to be open, understanding, and willing to work with different cultures in a responsive and compassionate manner while respecting and valuing indifferences (Ridley & Lingle, 1996). Generally, empathy requires the person to imagine oneself in another person's place. It involves an emotional resonance with others, which might result in a deeper appreciation and understanding of how other persons feel. Undoubtedly, cultural empathy is viewed as an expression of one's emotional and cultural intelligence.

Cultural caring on the other hand is best described by Leininger's culture care theory. The main underpinning of her theory was the comparative practice of differences and similarities between cultures as they relate to the core of the concept of caring. She explains that caring, culture, and nursing are completely interrelated and interdependent on each other to produce cultural competence; she asserts that there can be no curing without caring (Abualhaija, 2019).

The last subscale of cultural humility is cultural compassion. Papadopoulos (2011) defined culturally competent compassion as " the human quality of understanding the suffering of others and wanting to do something about it using culturally appropriate and acceptable nursing/ healthcare interventions, which consider the patients' and the caregivers' cultural backgrounds as well as the context in which care is given (Papadopoulos & Pezzella, 2015, p. 2).

References, Antecedents, and Consequences

The second section of the data analysis is the concept's references, antecedents, and consequences.

References

References indicate the actual situations in which the concept is being applied (Rodgers & Knafl, 2000). In other words, they refer to the notion of "in reference to." The concept of cultural competence has been referred to as cultural sensitivity, cultural congruence, cultural diversity, and transcultural nursing.

Cultural sensitivity was defined previously in this analysis. Nonetheless, Leininger and McFarland (2006) defined culturally congruent care as "culturally based care knowledge, acts, and decisions used in sensitive and knowledgeable ways to appropriately and meaningfully fit the cultural values, beliefs, and lifeways of clients for their health and wellbeing, or prevent illness, disabilities, or death" (p. 15). Likewise, cultural congruence is the process of effective interaction between the health care provider and the client. This process, however, considers the worldviews, values, perceptions, and expectations of the health care encounters (Schim & Doorenbos, 2010). Jeffreys (2006) distinguished between culturally congruent care and culturally congruent nursing care. Jeffreys defined culturally congruent care as "health care that is customized to fit the client's cultural values, beliefs, traditions, practices, and lifestyle" (p. 31). Meanwhile, culturally

congruent nursing care refers to the same definition that was articulated earlier by Leininger and McFarland (2002 & 2006).

Another concept that has been widely used is cultural diversity. This concept is a comprehensive and "includes variations in race, color, ethnicity, national, origin, and immigration status, religion, age, gender, sexual orientation, ability / disability, political beliefs, social and economic status, education, occupation, spirituality, marital and parental status, urban versus rural residence"(American Association of College of Nursing [AACN], 2008, p. 4). Cultural diversity is considered the cause of the birth of cultural competence. Various cultures, with their inimitable differences, are important for humans' sustainability, and because of cultural diversity nurses have to be culturally competent in order to render culturally safe nursing care. The United Nations Educational Scientific and Cultural Organization (UNESCO) (2001) stated in its 31st session that "cultural diversity is as necessary for humankind as biodiversity is for nature" (p. 62). The distinction between cultural diversity and cultural competence is that cultural diversity refers to populations' characteristic variations, whereas cultural competence is a consequential process of cultural diversity. Another term that has been used to refer to cultural competence is transcultural nursing, which is defined as "a discipline of study and practice focused on comparative culture care differences and similarities among and between cultures in order to assist human beings to attain and maintain meaningful and therapeutic health care practices that are culturally based" (Leininger & McFarland, 2006, p. 16).

Antecedents

Antecedents refer to instances that precede the concept (Rodgers & Knafl, 2000). Some of the instances, sentiments, and behaviors that were identified were cultural desire and cultural encounter. Cultural desire was defined previously in the discussion. Nonetheless, cultural encounter, a basic component of cultural skills is defined as "the act of directly interacting with clients from culturally diverse backgrounds" (Campinha-Bacote, 2007, p. 71). This encounter will refine or modify the health care providers' perceptions of other cultures, thus preventing prejudice and stereotyping. Examples of negative sentiments that might be displayed during a cultural encounter include ethnocentrism, cultural blindness, stereotyping, cultural generalization, and cultural imposition.

Ethnocentrism is the view that one's culture is superior to all other cultures, perpetuating the idea that the values and beliefs of the dominant culture are the standards by which all other cultures are measured and evaluated (Zander, 2007). Purnell and Paulanka (2008) defined ethnocentrism as "the universal tendency of human beings to think that their ways of thinking, acting, and believing are the only right, proper, and natural ways" (p. 6). Accordingly, cultural blindness is a product of ethnocentrism and is viewed as the inability to recognize cultural values, beliefs that exist among diverse people, and hence the provider becomes culturally blind (Jeffreys, 2006).

Another negative sentiment that might occur during a cultural encounter is stereotyping, which is defined as "the process by which people acquire and recall information about others based on race, sex, religion, etc." (AACN, 2008b, p. 4). Undoubtedly, stereotyping is considered an "oversimplified conception, opinion, or belief about some aspect of an individual or group (Purnell & Paulanka, 2008, p. 7). Meanwhile, cultural generalization another negative sentiment of cultural encounter is considered a process of "reducing numerous characteristics of an individual or group of people to a general form that renders them indistinguishable-made about the behaviors of any individual or large group of people is almost certain to be an oversimplification' (Purnell & Paulanka, 2008, p. 7). Consequently, cultural generalization leads to stereotyping, whereas cultural imposition:

> *... intrusively applies the majority cultural view to individuals and families. Prescribing a special diet without regard to the client's culture and limiting visitors to immediate family borders in cultural imposition. In this context, healthcare providers must be careful in expressing their cultural values too strongly until cultural issues are more fully understood (Giger et al., 2007, p. 100).*

All these negative sentiments or behaviors might precede cultural encounters, thus, nurses have to be cognizant of such biases and prejudices before interacting with culturally diverse clients and most definitely before planning and implementing their nursing care. Overcoming these culturally destructive sentiments is a skill that health care providers develop over time during their cultural encounters, and this skill is an important building block of the pyramid of cultural competence (Fig.1).

Consequences

Consequences refer to instances that happen after the concept and are considered a thrilling unit of the data analysis. It is in this section that the health care professional can improve clients' health outcomes, and it is also in this section that the health care provider can expose any concealed racial prejudices, false assumptions, and destructive sentiments or behaviors. In this specific analysis phase, consequences were divided into two sections; these are patient-centered consequences and nurse / healthcare provider-centered consequences.

Patient-Centered Consequences

The patient-centered consequences that have been recognized in healthcare due to cultural diversity are: exposing the obscured health and healthcare disparities facing racial minorities and illuminating the light on the gap of achieving social justice in accessing healthcare. Geiger et al. (2007) sketched a very sad story portraying the consequences of health disparities faced by racial minorities by stating that "a modern, yet familiar adage is that when America catches a cold, minority and other vulnerable groups get pneumonia. The adage addresses the disparate burden of illness for ethnic minorities, the underserved, and other vulnerable populations in the United States" (p. 96).

Health disparities among racial minorities are still mounting. According to the Institute of Medicine's (IOM) 2002 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*," sources of these disparities are complex, are rooted in historic and contemporary

inequalities and involve many participants at several levels, including health systems, their administrative and bureaucratic processes, utilizing managers, healthcare professionals, and clients" (Anderson et al., 2003, p. 70). Indeed, there are evident health inequalities in cardiac procedures, analgesic management, cancer treatment, and HIV treatment. Subsequently, "minorities are still burdened with disparities, higher rates of diseases, disability, and even death and tend to receive a lower quality of health care than non-minorities even when access-related factors, such as insurance status and income are taken into account" (Anderson et al., 2003, p. 69). Additionally, this report concluded that ethnic minorities were less likely than Whites to receive health services, even when insurance and ability to pay were equivalent.

Another patient-centered consequence is the truancy of achieving social justice in accessing health care by racial/ethnic minorities. The AACN (2008a) defined social justice as "acting in accordance with fair treatment regardless of economic status, ethnicity, age, citizenship, disability, or sexual orientation" (p. 28). Douglas et al. (2011) explicated that social justice denotes to nurses' role in gaining knowledge different than their own so that they are able to distinguish and address racial inequalities in health care access, treatment, and outcomes. Moreover, nurses' advocacies for achieving health equalities are rooted in the nursing profession's values and standards of practice. The American Nurses Association (ANA) (2010) echoed in its position statement the need to intentionally focus more on social justice in health care. Additionally, The Commission on Social Determinants of Health (CSDH) (2008) affirmed that "social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death" (p. 3). Therefore, preparing culturally competent and humble nursing and health care cadre has many benevolent rewards that go beyond the scope of just superficially educating nurses on cultures.

Nurse/Healthcare Provider-Centered Consequences

The positive outcomes of cultural competence that were identified as nurse/healthcare provider-centered consequences are cultural desire, cultural humility, cultural knowledge, skills, and transcultural self-efficacy. Earlier in this inquiry, all the before-mentioned terms were explained except transcultural self-efficacy. Transcultural self-efficacy (TSE) is defined as "the perceived confidence for performing or learning transcultural nursing skills. It is the degree to which individuals perceive they have the ability to perform the specific transcultural nursing skills needed for culturally competent and congruent care" (Jeffreys & Dogan, 2012, p. 188). This concept is theoretically based on Bandura's social cognitive theory (SCT), which delineates the connection between learning and motivation. Bandura's social cognitive learning theory assumes that learning is "a cognitive skill that can be acquired via modeling and observation and within social contexts and via vicarious reinforcement by employing both internal and external motivators" (Abualhaija, 2019, p. 5). Incidentally, transcultural self-efficacy calls for the integration of culturally competent skills across the three learning domains of cognitive, practical, and affective.

Identifying Related Terms of the Concept

Related terms are words that have something in common with the concept, yet they do not possess the same characteristics and attributes (Tofthagen & Fagerstrom, 2010). Related concepts that were identified are cultural diversity, cultural sensitivity, and cultural humility. The explanations of all of these terms were addressed earlier.

Model Case or Exemplar

Model cases or exemplars are useful tools in clarifying the concept. Since Rodgers' approach is inductive in nature, it is vital to find real-life examples to provide a practical demonstration of the concept (Rodgers & Kanfl, 2000). The following is an exemplar of the concept. Cai et al. (2017) conducted a qualitative exploratory study using semi-structured interviews to identify the constituents of cultural competence from the perspective of Chinese nurses. A purposive sample of 20 female nurses was included in the sample. Using thematic data analysis, four cultural themes emerged: cultural awareness, attitudes, knowledge, and skills.

Awareness

This theme emphasized the significance of recognizing our awareness in nursing. Cultural awareness starts with the person's reflecting on his or her own cultural biases, assumptions, and stereotypes toward other cultures. Consequently, this promotes cultural sensitivity and limits cultural imposition.

> *We should learn what culture is and why it is important in nursing care. Clients' culture can no longer be ignored. I think current medical disputes are related to overlooking the clients' cultural background more or less, which results in conflicts with clients' healthcare needs. (159)*

Attitudes

The theme of attitudes conveys many notions. For example, nurses should accept different cultures, feel comfortable during cultural encounters, value every client, treat them equally, and safeguard their rights and interests. It also includes the sub-themes of appreciation of cultural diversity and respect for clients.

Subtheme: Appreciation of cultural diversity. Nurses reiterated that cultural diversity is inevitable and nurses should have the passion to respect and learn for their culturally dissimilar patient.

> *I would like to communicate with clients from other areas and other cultures about their customs or health beliefs. (159)*

> *Instead of feeling awkward, I appreciate the help from colleagues or family members who can talk in the client's language to make communication and nursing care easier. (159)*

Subtheme: Respect for clients. Participants accentuated the need to respect their culturally diverse patients and to treat everyone with dignity and respect in their daily interactions.

A patient receiving chemotherapy in our ward is taking the folk medicine 'Five Red Soup' to prevent leucopenia. We respect his choice to try this. (160)

Knowledge

This theme pertains to nurses' knowledge of health-related socio-cultural and medical information about the culturally diverse patient. Furthermore, it includes knowledge of the theoretical bases of cultural care.

Qidong County, Jiangsu province has a high incidence of liver cancer partly due to residents' intake of aflatoxin B1 from food items such as corn. Having this knowledge can help us in health education and disease prevention. (160)

Skills

This theme indicated that nurses should have the capability of collecting relevant data regarding clients' current health problems while considering clients' views of health and illness in a culturally congruent manner.

For people from a minority group with special diet needs, we will communicate with a nutritionist... arrange a nursery room for mothers who would like privacy while breastfeeding... (161)

Once I offered steak and cold water to an American client because of my assumption of Western food traditions. However, he was upset, because he is a vegetarian and he told me he never drinks cold water. (160)

Implications for Further Inquiry

Implications for further inquiry are considered one of the most important contributors to concept analysis; this heuristic function is viewed as a significant outcome to the analysis process (Rodgers & Knafl, 2000). Many competing concepts to cultural competence exist; however, most researchers agree that cultural competence is an ongoing, dynamic, fluid, and multidimensional journey that ultimately has gratifying outcomes. The continuous progression of cultural diversity in the U.S. poses a moral and an ethical obligation on health care systems, providers, and leaders to deliver culturally competent care in order to reduce health disparities faced by ethnic minorities. Implications for nursing science are discussed in relation to nursing practice, education, and research.

Exploring cultural competence in nursing practice provides an insight into the complex and multifaceted dynamics of the concept of cultural competence. Hence, providing conceptual clarity is very beneficial as it provides a clinical framework for practicing nurses. Successively, when nurses explore the complexity of such contextual scope, they will have a deeper understanding and appreciation of patients' concealed cultural values and beliefs that are necessary elements in planning nursing care. This outcome has the propensity of reducing some of the health disparities encountered by racial minorities. Accordingly, nursing education would also benefit from clarifying the concept of cultural competence. Conceptual clarity can promote consistency among students and educators and can increase nursing educators' conscious effort of intentionality incorporating cultural competence education in their pedagogies. This concept analysis article stresses the need for continuing and increasing nursing research on cultural competence as cultural multiplicity continues to rise. For example, underlining and outlining the importance of addressing ethnobiology, ethno-pharmacology, and ethno-genomics as objectives for nursing research and education would produce better understanding and appreciation among users and eventually improves clinical outcomes among ethnic minorities.

SUMMARY

Cultural diversity and multicultural convergence are proliferating locally and globally. This, however, has resulted in incongruences among nursing and health care professionals on how to incorporate and use the concept of cultural competence. Rodgers & Knafl (2000) evolutionary method was used to provide some conceptual clarity and to affirm that this concept is dynamic and never belonged to an essentialist philosophical position. There is consensus between nursing and other professions regarding the crucial elements that make up cultural competence. Cultural competence is a vibrant and energetic journey that healthcare providers should travel to ensure delivering safe care and embracing social justice nirvana.

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