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. © 2014 Elsevier Inc. All rights reserved.

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...


compentence 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 competence 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 competence 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 competence 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
immersion occurred during a 4-day fall break, where students attended community activities and provided school health screenings at a public school located on the reservation. The second group (Group 2) immersion was an option as part of a required nursing leadership course. During this experience, students resided on the reservation with a faculty mentor (the researcher) for 2 weeks, attended community activities, and completed an 80-hour clinical practicum at the Indian Health Service facility. The reservation’s population is 92% American Indian, with 39% of the population less than 18 years old and 6% more than 65 years old (U.S. Census Bureau 2010). The county’s per capita money income in 2010 was $7,772 (U.S. Census Bureau 2010), and 57% of children younger than 18 years live in poverty (South Dakota KIDS COUNT 2011). As faculty mentor of these experiences, the author has developed and sustained collaborative relationships with numerous members of the reservation community since 2006; these members, in turn, actively engage with the students during the immersion experiences.

Eleven senior nursing students (Group 1: n = 8; Group 2: n = 3) were eligible and elected to participate in this portion of the study. All were Caucasian women of traditional college age (21 to 23 years). The students attended our baccalaureate nursing program, which is part of a small Christian liberal arts college located in the state’s largest city. The population of the city and the state is relatively small compared with other metropolitan areas, with the city’s population just over 156,000 and the state’s roughly 824,000. Demographically, the city is 86.8% White and 2.7% American Indian, whereas the state demographics are 85.9% White and 8.8% American Indian (U.S. Census Bureau 2010). The city hosts two Magnet-recognized hospitals that care for a significant number of American Indian transfer patients from the surrounding reservations. Two of the students lived near reservation communities and reported negative past experiences with members of the American Indian community.

Procedure

This mixed-methods study assessed the quantitative data by using Campinha-Bacote’s (2007) “Inventory for Assessing the Process of Cultural Competence Among Health Care Professionals—Student Version” (IAPCC-SV). Students answered the questionnaires just before and immediately after the immersion experience.

For the qualitative portion of this study, students completed critical reflective journals before and immediately after the immersion. Ironside (2006) indicated that reflective journaling assists students in the practice of interpretive thinking; helping them to “unlearn past understandings and become a nurse who is adept at thinking from multiple perspectives and at challenging her own current assumptions and understandings” (p. 484). Participants were also required to read the book Neither Wolf nor Dog (Nerburn 1994/2002) before starting the immersion experience.

The institutional review board at the college approved the study. Students self-selected pseudonyms at the time of informed consent, with the students then using their pseudonym in their critical reflective journals and on the IAPCC-SV. Students were assured that their decision to participate or not to participate would not influence their grade in any of their nursing courses. Their imputed data were not analyzed until after grades were posted for the respective courses for the semester.

Data Collection

The IAPCC-SV is a 20-item instrument that measures four categories of cultural competence (proficient, competent, aware, and incompetent) and five constructs of cultural competence (desire, awareness, knowledge, skill, and encounters; Campinha-Bacote 2007). The instrument uses Likert-type questions such as, “I believe that there is a relationship between culture and health” and asks participants to mark what they feel is the best answer using a 4-point scale; scores range from 1 (strongly disagree) to 4 (strongly agree). Scores can range from 20 to 80, with higher scores indicating a greater degree of cultural competence. The IAPCC-SV has demonstrated face validity via review by transcultural experts and an initial acceptable Cronbach’s alpha of .78 (Fitzgerald, Cronin, & Campinha-Bacote 2009).

Students completed the IAPCC-SV before leaving for the reservation with the completed forms placed in a manila envelope and submitted to the department secretary; the same process was followed for the posttest. Students also responded to these questions in their journals: “What are your personal beliefs and biases regarding the American Indian population?” “Have any of your preconceived notions been challenged while reading the book? Why or why not?” After the immersion, students again reflected on their beliefs and biases (preconceived notions) and were asked if they had changed. If there were changes, the participants then described the moment during the immersion that they felt was the catalyst for the change. Levine (2009) indicated that as students become the minority culture during immersion experiences, they develop an enhanced awareness to the myriad of challenges that minorities experience when adjusting to a new environment. To assess student perceptions of Levine’s hypothesis, students were asked to respond to these questions: “Describe a moment during the experience when you felt vulnerable. What thoughts or feelings did this situation elicit for you? How did you cope? How has experiencing vulnerability on a personal level influenced your future practice when caring for vulnerable populations?” Upon completion of the immersion, students submitted paper copies of their journals to the department secretary.

Data Analysis

Descriptive statistics were calculated using SPSS Version 19 (SPSS Analytics, IBM Inc., Armonk, NY, USA) for each group to obtain the total levels of cultural competence. Comparisons of the two groups were done by use of
indicated by the thorough descriptions of the categories provided by Campinha-Bacote (2007), total scores of 41–59 indicate cultural awareness; 60–74, cultural competence; and 75–80, cultural proficiency.

Independent samples t tests were conducted to compare the differences in these pre–post levels of cultural competence scores for the two groups. Pre-immersion t tests revealed a significant difference in scores between Group 1 (M = 64.88, SD = 5.38) and Group 2 (M = 59.33, SD = 2.08), with more participants in Group 1 indicating perceptions of cultural competence than Group 2; however, the unequal sizes of the two groups may account for this result. The post-immersion t tests reflect the shift in the students' reported levels of cultural competency and again identified significant differences between Group 1 (M = 57.63, SD = 3.74) and Group 2 (M = 71.33, SD = 2.52, P = .000).

To evaluate the impact of the immersion and the noted shift in the students' reported levels of cultural competency scores, I completed paired samples t tests. There was a statistically significant decrease in the total levels of cultural competency in Group 1 from pre-immersion (M = 64.88, SD = 5.38) to post-immersion (M = 57.63, SD = 3.74, P = .008). In Group 2, there was a statistically significant increase in reported levels of cultural competency pre-immersion (M = 59.33, SD = 2.08) to post-immersion (M = 71.33, SD = 2.52, P = .045).

Qualitative Results

The participants' critical reflective journals revealed a paradox, especially when compared to the results of their beginning levels of cultural competence. Students wrote initially of their often negative preconceived thoughts regarding the American Indian population, while at the same time, their reported levels of cultural competence were mostly in the category of considering themselves culturally competent (Group 1, n = 6; Group 2, n = 2). After the immersion, these reflections broadened and revealed an increased understanding of the daily struggles experienced by the indigenous people, which was reflected in a downward shift in the IAPCC-SV scores; Group 1 (n = 6) was no longer in the category of culturally competent but was now culturally aware, and Group 2 (n = 3) participant scores increased to the category of being culturally competent.

The themes identified in this hermeneutical analysis demonstrate the reshaping of the students' personal horizons as their enhanced knowledge transformed their thinking. The three themes were as follows: seeing with closed eyes, seeing through a fused horizon, and disruption to reshaping.

**Theme 1: Seeing With Closed Eyes**

The undergraduates participating in the cultural immersions came from the majority population. For several participants, their exposure to American Indians was limited to caregiving opportunities in the hospital or community setting, where power imbalances are certain. Several students reported during debriefing sessions on the reservation that they had obtained as their foundational knowledge of this population from either a high school American history class or reruns of Western movies on television. A few had this foundation somewhat reframed by participating in a college course specific to American Indians. Nurse educators must help students see and understand their preconceived notions about cultures other than their own by reflecting on their worldview. By first contemplating their personal backgrounds, students are more willing to grapple with “overcoming strangeness” (Moran 2000, p. 279). Acknowledging this “strangeness” helps students keep their horizons of understanding open to new possibilities.
(Gadamer 2004). The students’ writings about their preconceived notions revealed many judgmental comments. Universally, they thought the culture was lazy, poor, and drank and smoked a great deal, yet many acknowledged that they were ashamed by the treatment American Indians have and continue to receive in our society. One student’s pre-immersion reflection clearly identified these stereotypes:

My beliefs stem from what many non-Native American people believe, in that a lot of Native Americans are lazy, alcoholics, and live off the government. There are government houses that are built for the Native American population for free... I think it is unfair that Native Americans get these houses built for free... I have also seen the alcoholic part of the Native American population. Not only did I see it while I lived... but I see it every week now on our clinical unit... the renal unit... and the majority of the patients on the unit are of Native American descent and have a background of alcohol abuse... I just don’t understand how people can be so unappreciative of the things that are given [student emphasis] to them.

Another shared:

When thinking of about the American Indian negative stereotypes come to mind. I seem to involuntarily assume every American Indian drinks heavily. There are also statistics saying that they have a high suicide rate, and that they are poor. Sometimes people say, “If they would only get a job.” This is hard because of the struggles involved with living on the reservation. Ultimately, both positive and negative beliefs and biases come to mind... I hope to change these beliefs and develop my own by actually immersing myself in their culture.

These writings epitomize the misperceptions that students and many health care providers harbor regarding the American Indian population. Students initially saw others superficially, viewing them “through closed eyes” and relying on family perspectives or one-sided writings in school texts to form their labels. Labeling stigmatizes individuals and creates invisible barriers where persons considered different or other may not receive services or seek services simply because of the color of their skin. Canales (2000) described this stigmatization as “exclusionary othering,” which “is often influenced by the visibility of one’s Otherness: skin color, accent, language, physical abilities, gender, or age” (p. 23).

Theme 2: Seeing Through a Fused Horizon

The students’ initial narratives regarding the American Indian population revealed their narrow personal horizons, which are similar to the views of many practicing health care providers and researchers (Warne 2006). It was this researcher’s hope to challenge these misperceptions through guided immersions on the reservation, helping them to see in a new way. The students’ journals revealed a transformation in their personal perspectives on the American Indian culture. They discovered that many of their preconceived notions were inaccurate and learned that even though they may not look like or speak the same language as the culture, being human links us as people. This fusion of horizons opened their initially closed view of seeing to one of inclusivity, with many remarking that their “eyes were opened.”

Reflecting on my pre-conceived beliefs I see I was off the mark. After being in the Native American culture as a minority I experienced many things differently. Almost every Native American was extremely generous during the experience. They were not hateful or down trodden. While many of the people did not have the best homes or even a reliable means of transportation they appeared to be happy. Not only were they generous with their food and homes but they were generous with their wisdom and experiences... I also learned to look at the whole situation and to be understanding of the high stress the Native Americans experience.

These cultural immersions challenged the students to reconsider their preconceived notions and re-envision their personal horizons. As they listened to the stories told from the American Indian perspective, they reshaped their “horizon of meaning” (Dowling 2004, p. 35) and opened their eyes to new understanding by fusing the two. This fusion facilitated their transformation into a practice of “inclusionary othering,” where they “take on the role of the other... and begin to see the world from the other’s perspective” (Canales 2000, p. 25). This learning to see and work with others from the perspective of inclusion rather than exclusion elevated the students’ awareness of the power imbalances between the two cultural groups.

Theme 3: Disruption to Reshaping

Although on the reservation the students’ roles changed from being the dominant population to that of the minority. This shift in the power structure disrupted the students’ ways of interpreting their worlds. Kavanagh (2006) described this disruption as positive, where new questions are generated and we begin to understand differently. Students learned the importance of developing relationships and acknowledged on a personal level that others exist. Their journals captured this growth process in their reflections on becoming vulnerable.

It was intimidating walking into a room full of people and trying to feel like I belonged there. I felt like it was better to stay on the fringe and out of the people’s way. It must be what minorities feel sometimes in my society. It was easy to cope though because after a few minutes they were forcing food on us and it was just like being at home... Feeling vulnerable opened my eyes to minority feelings. I believe that this will influence
my future practice...[by] making sure that they receive the care that they deserve and not whatever leftovers we can throw their way.

Another shared:

I felt vulnerable when...all of a sudden we were surrounded by all of these...people, a people of a different culture, and we were not able to sit next to one another...I was nervous about how I really needed to focus on demonstrating proper respect...I felt my actions would be more noticeable in such a small space. I then was struck by the thought that this must be the way they felt off the reservation. They must feel like the stranger, awkward and out of place, afraid of making a move that the local people might see as offensive. Then I reflected on the warmth and kindness that I had so far experienced...and realized that I just needed to relax. Part of me knew that people appreciate consideration of their own unique needs and background, but the way that the...people reached out to make us comfortable in their homes made me realize just how comforting even small gestures of familiarity and acceptance are.

As nurse educators, we teach our students about vulnerable populations. We describe to undergraduates the powerlessness that exists within these populations, but do they ever truly understand what it means? How must those that we consider as strangers feel when they walk into our health care system and we do not acknowledge or appreciate their uniqueness; instead, we try to mold them to fit into our cookie cutter models of practice? These students' narratives capture how cultural immersion experiences cause students disruption and help to reshape their understanding regarding the power imbalances in health care.

**Discussion**

Before leaving for their immersion experiences, students overwhelmingly indicated that they were culturally competent via the IAPCC-SV. However, after analyzing their narratives regarding their preconceived notions, it was evident that students actually lacked cultural competence specific to this American Indian population. By reviewing the quantitative and the qualitative data together, this study sheds new light on what it means to be culturally competent.

Analysis of the pre–post IAPCC-SV scores identified a shift in reported levels of cultural competency, specifically in the group completing the 4-day immersion (Group 1). Post-experience, most of these students reported being culturally aware instead of culturally competent. According to Campinha-Bacote (2007), cultural awareness is an essential building block toward cultural competency, where persons consciously reexamine their preconceived notions about those who differ from them. This shift to becoming more culturally aware is important and perhaps related to the use of the critical reflective journals. By writing specifically about their stereotypes and then reevaluating these biases after meeting the people, student thinking was transformed by looking inward and seeing not with their eyes closed, but with enhanced understanding. Yet even though the journal reflections for all participants were similar, it is important to note the differences in seeing captured post-immersion by the IAPCC-SV in Group 2. This group's levels of cultural competence significantly increased with all participants' scores in the culturally competent category. These differences may be attributed to the length of the experience (2 weeks versus 4 days), the sample size was smaller (n = 3), each student in Group 2 was partnered with a nurse in the Indian Health Service facility, worked more intimately with the local population, and received more individualized attention from the faculty mentor than the students in Group 1. Nurtured by the trusting relationships these students developed with the nurses and many of their patients, their confidence increased in their ability to adequately care for this population.

The students that participated in these cultural immersions learned the importance of adopting an “ethic of attention” by listening attentively and becoming comfortable with being present (Coulehan 2006, p. 817). They developed partnerships, willingly engaged others and saw the similarities in values and beliefs (Foster 2009), and appreciated the differences of the cultures, cultivating what Levi (2009) and others call cultural humility.

The AACN acknowledges the importance of teaching cultural humility, but delay introduction of the topic until graduate education. The question then arises, is it too late to wait until nurses seek graduate education? For example, Adamschick and August-Brady's (2012) study demonstrated the shift in thinking that occurred in their registered nursing (RN) students after a cultural immersion experience. These practicing RNs voiced concerns regarding “working in a practice world often devoid and deficient in the core nursing values” (Adamschick & August-Brady 2012, p. 195) and felt that the nursing profession must reconnect with its original purpose to deliver holistic care to all populations. By teaching cultural humility to undergraduates, we may negate this current void by promoting self-awareness and openness to learning from our patients, fostering respectful partnerships (DeBruyn 2010; Juarez et al. 2006).

The nursing staff at many facilities receive cultural competency training annually, but that perhaps gives a false sense of security. Health care institutions can demonstrate that staff receives cultural competence training, yet in reality, staff may lack awareness, and their unresponsiveness to those from differing cultures has the potential to impact patient safety. We need to adjust our thinking and training from competency to humility. Minkler (2012) writes that “cultural humility is the notion that while we can't be competent in another's culture, we can engage in self-reflection, learning our own biases, being open to others' cultures, and committing ourselves to authentic partnership and redressing
Power imbalances” (p. 6). This study demonstrates that undergraduates are capable of learning cultural humility. Their reflective journals revealed a deepening awareness of the American Indian population as noted in the transformation of their preconceived biases to understanding the difficulties faced by the people. Similarly, the results from Group 1 indicated that their perceived cultural competency before the immersion had decreased to cultural awareness, indicating that the students realized that they truly were not competent in this culture.

Strengths and Limitations

A strength of this study is the use of the participants’ voices in the telling of their initial impressions to their final reflections of experiencing disruption to the reshaping of their understanding. An additional strength is in the comparison of the quantitative findings to the qualitative results, showing how qualitative data add an additional dimension and urging us to really see what the numbers do not necessarily tell us.

Limitations exist in this study. The researcher knew the participants, potentially influencing their reflections. The sample size was small with the student population homogenous and from the same college campus. Because of the limitations, these results are not generalizable; however, the results are transferable as noted by the detailed descriptions provided about the sample and the setting.

Conclusions

According to the literature, cultural competency is supposed to be dynamic and evolving. This study’s results identified the evolution that these nursing students experienced while immersed in an American Indian reservation community, demonstrating that while persons may think they are competent in a particular culture, in reality, they may harbor negative stereotypes, potentially impacting their ability to provide culturally competent care. The growth process of these participants revealed that they recognized their stereotypes and lack of understanding about the culture, and they became culturally humble by “-reaching into the space between self and other” (Racher & Annis 2007, p. 265) and seeing the differences alongside the similarities (Kim 2005).

This study has implications for nursing education. With increasing ethnic diversity occurring nationwide, it may become overwhelming for students and nurses to answer the call for cultural competence. This study demonstrates that students initially reported levels of cultural competence before the immersion, yet their narratives regarding preconceived notions demonstrated stereotyping and racial biases. Galanti (2006) wrote that “stereotyping patients can have negative results” (p. 97) and may cause health care providers to make assumptions about persons from different cultures that are untrue. These assumptions can lead to misunderstandings and potential devastating results in the delivery of services. The students in this study learned the value in self-reflection and listening and discovered what Heidegger described as “being possible” (as cited in Blattner 2006, p. 13). Through reflective writing and cultural immersion, the undergraduates confronted their biases (being possible) and learned to be more open and sensitive to the difficulties a minority culture experiences when seeking health care. This study illustrates that undergraduates, guided by faculty, are capable of deep reflective thinking. Efforts must be made to teach student nurses 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.

Additional research must be conducted in education and practice on the concepts of cultural humility and competency. Further studies that are multisite with larger sample sizes and greater diversity will extend the findings from this study. It is essential that these studies also incorporate both quantitative and qualitative measures corroborating the numerical data with participants’ actions and voices. Nurses must be prepared to provide care in this changing landscape by entering each interaction with others with great humility, understanding that we do not know what we do not know.

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