# Cultural Humility

## Retraining and retooling nurses to provide equitable cancer care

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**BACKGROUND:** Cancer outcome disparities exist among Black, Indigenous, and people of color despite advancements in screening, detection, and treatment. In addition to racial and ethnic diversity, the U.S. population is experiencing shifts in sociodemographics, including a growing aging population, sex and gender identities, spiritual and religious belief systems, and divides between high- and low-income households.

**OBJECTIVES:** This article provides a foundation for cultural humility as a clinical competency in nursing to improve the quality of cancer care.

**METHODS:** CINAHL®, PubMed®, Google Scholar, and grey literature were searched using keywords, including *cultural humility, cultural competence, nursing, nursing pipeline, nursing workforce,* and *health*.

**FINDINGS:** Retraining and retooling the nursing workforce promotes multiculturalism in oncology care and increases opportunities to provide more appropriate, patient-centered care to those living with cancer. Increasing the diversity of nursing faculty and staff, enhancing nursing curricula and education, and creating equitable relationships to support patient-centered care are initiatives to ensure high-quality care.

**KEYWORDS**
cultural humility; diversity; health equity; nursing education; nursing workforce

**DIGITAL OBJECT IDENTIFIER**
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**DESPITE ADVANCEMENTS IN SCREENING, DETECTION, AND TREATMENT,** cancer outcome disparities exist among Black, Indigenous, and people of color (BIPOC), as well as among other minoritized populations, such as individuals identifying as lesbian, gay, bisexual, transgender, or queer (LGBTQ+), those living in rural areas, and those living in poverty. These populations are disproportionately participating in healthy lifestyle behaviors, diagnosed at later stages of disease, and undertreated for cancer pain, among others, as compared to non-Hispanic White people (Diamant et al., 2000; Haynes & Smedley, 1999; Shay et al., 2012; Stein et al., 2016). Disparities are largely influenced by inequitable, intersectional, and multilevel social determinants of health (e.g., structural racism and discrimination, implicit and explicit biases, unequal access to care, unequal access to physical and built environment amenities) (Alcaraz et al., 2020). As such, the presence of these inequities equates to a patient safety issue, which can result in unnecessary patient deaths. For example, Black people living with colorectal cancer in racially segregated counties are more likely to die than their White counterparts (Poulson et al., 2021). High-quality cancer care is warranted for all patients with cancer, regardless of the intersecting identities or cultures with which they exist (Crenshaw, 1991; Hewitt et al., 2005; Levit et al., 2013). In health care, there are many opportunities to negate negative social determinants of health. One of the most tangible opportunities to promote health equity lies in approaching the care of all patients in a culturally humble manner, which involves acknowledgment and reduction of biases.

As evidenced by national and international reviews, most healthcare providers, including nurses, exhibit implicit and/or explicit biases (FitzGerald & Hurst, 2017; Hall et al., 2015; Zestcott et al., 2016). Healthcare providers can see skin color; hear inflections, tones, and languages spoken; and sense other differences from patient to patient. In fact, in one study of 245 nurses at Johns Hopkins Hospital—80% of whom identified as White—Haider et al. (2015) reported that more than 80% of nurses exhibited racial biases, and 90% exhibited classist biases as measured by Harvard's Implicit Association Test. Biases toward such differences, whether implicit or explicit, can affect patient care and perceptions in a number of ways (e.g., patient–provider interactions, treatment decisions and adherence, health outcomes) (Hall et al., 2015; Maina et al., 2018). For example, Black breast cancer survivors believed that their racial identity was associated with discriminatory actions in the healthcare setting (Campesino et al., 2012). Some individuals who identify as LGBTQ+ delay cancer screening because of fear of discrimination, but also because of other factors, such as the wrongful assumption that screening is only for cisgender individuals and a discomfort