Compelling Voices of Diversity, Equity, and Inclusion in Prelicensure Nursing Students

Application of the Cultural Humility Framework

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ABSTRACT
Background: Diversity, equity, and inclusion are increasingly recognized as core values for guiding nursing education, practice, and research. The conceptual framework of cultural humility has been adapted in a variety of health care settings, fostering a culture of diversity, equity, and inclusion through openness, supportive interaction, self-awareness, self-reflection, and critique.
Problem: Nurse educators have the opportunity, but may find it challenging, to teach students about the changing landscape of health care and the populations we serve.
Approach: This article describes the integration of the cultural humility framework into nursing curricula to teach principles of diversity, equity, and inclusivity. We provide a practical example of a diversity panel, with student and panelist reflections, exploring the intersectionality of experiences in health care and integration of personal accounts and perspectives.
Conclusion: Dialogue about diversity, equity, and inclusion is essential for preparing future nurses to deliver culturally competent care and promote health equity.
Keywords: cultural humility, curriculum, diversity, equity, inclusion, nursing education

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Internationally, health disparities challenge all health professionals to reflect both on modes of education and also on clinical practice, research, and policy. Importantly, the imperative that the nursing profession represent the communities it serves is acute. As a consequence, the values of diversity, equity, and inclusion (DEI) are core values found under the mission statements of most health care organizations in the United States. Building on the Institute of Medicine report *The Future of Nursing: Leading Change, Advancing Health*,[1] in 2018, the American Nurses Association released its latest position statement, *The Nurses Role in Addressing Discrimination: Protecting and Promoting Inclusive Strategies in Practice Settings, Policy and Advocacy*, a national effort to eliminate discrimination associated with race, gender, socioeconomic status, access to, and quality of health care.[2] The National League of Nursing (NLN) echoed this priority, identifying diversity as a key nursing value with a goal of attaining health equity.[3] The American Association of Colleges of Nursing (AACN) provides directional statements for adapting the Essentials in the nursing curriculum.[4]

Within the context of nursing curricula, diversity within the nursing student body and patient populations should reflect the landscape of health care and populations served.[4] Diverse perspectives are commonly represented by people of various racial and ethnic backgrounds, often within underrepresented and minority groups, sexual orientation, gender identity, and religions. Increasingly, voices of people who are disabled and those who live with chronic illnesses such as obesity[5] are also prioritized in conversations related to diversity.[6]

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To respond to diverse needs, it is important to draw on the core concepts of equity and inclusion, which go beyond acknowledgment of differences and seek to integrate care while addressing inequity, systemic racism, and divisions.[6,7] Systemic racism results from prejudiced policies and structures that marginalize groups and create iniquitous and harmful environments.[8] Examples would be school and occupational segregation and mass incarceration, which marginalize underrepresented minority groups. Thus, an added urgency for understanding diversity comes from data estimating that by 2050, the groups who are currently referred to as "underrepresented minorities" will be an emerging majority.[9] Current nursing mandates require acumen in the language of diversity and the importance of addressing social determinants of health and structural racism, for example, emphasizing that racism not race accounts for certain health disparities and highlighting the social and environmental factors that play a larger role in health outcomes.[10,11] Our ability to be inclusive in our nursing education, and further recognize the intersectionality (a theoretical framework explaining experiences of privilege and oppression by examining at a micro level, the intersection of multiple and complex aspects of an individual's identity[12]) of the needs of populations we serve, will be critical to gain and maintain the trust of the communities we serve.

Despite this, both nursing curriculum and the profession have suffered as a result of inadequate or absent consideration of DEI. For example, nursing has long been and continues to be a White female-dominated profession that has not adequately diversified in terms of race, ethnicity, or gender, especially in leadership roles.[13] This has been reflected recently in the spate of articles, blogs, and social messaging from the nursing community that has highlighted distressing experiences of racial abuse and aggressions sent in response to the homicide of George Floyd in the United States in May 2020.[14] Mr Floyd's horrific death, suffocated under the knee of a police officer, coupled with the disparities in COVID-19 health outcomes among Black, Indigenous, and People of Color (BIPOC) have been a galvanizing call to action for many in the nursing profession and beyond.[15,16] For others already working to address issues of DEI, it has been a stark reminder that ongoing work has much further to go. The purpose of this article is to describe the adaptation of the cultural humility conceptual framework[17] for formal integration of the 3 concepts of DEI into a nursing curriculum, with a case example and critique.

Closing the Gap in DEI in the Curriculum

It is recommended that DEI content be integrated throughout the curriculum[6]; however, this has often meant inadequate discussion or positioning as a stand-alone topic. Our ethical and moral commitments as nurses also require us to have a sophisticated knowledge of DEI to enable us to care for all persons. Despite this, nursing schools continue to struggle with preparing nurses in DEI. Topics involving DEI are often integrated in curricula at the discretion of individual programs, therefore taking on the culture and climate of the organization and leadership. Historically, this has meant limited or missing content addressing nursing care for racially and ethnically diverse communities, potentially resulting in unmet, unrecognized patient care needs. Intensive work must be done to reconsider how every aspect of the content has been formulated, framed, and presented, as implicit bias must be recognized and addressed at every level, and regardless of the accrediting body and standards schools follow, DEI must be integrated systematically and not at the discretion of the individual program.

A Foundational Value

Since our beginning, in 1889, when the Johns Hopkins Hospital and the School of Nursing (SON) opened, nurses from Hopkins have been leaders in actualizing the vision and values of Johns Hopkins University. Similarly, it was Isabel Hampton Robb who insisted that Hopkins nurses be leaders and innovators.[18] However, as with many institutions, Johns Hopkins has a mixed history (eg, robbing graves for cadavers, acquiring a disproportionate number of African American cadavers, use of cancerous cells without consent [Henrietta Lacks]), and those of us who work in it must own and respond to this to make positive changes.[19]

Since 2015, we have increased our focus on social justice issues within our curriculum, school, and local community in response to concerns and public outcry over the trial after the murder of Freddie Gray while in police custody, resulting in the appointment of an Associate Dean for Diversity, Equity and Inclusion. In addition, a *Committee on Teaching and Learning as a Pathway to Diversity, Equity and Inclusion* was established to review and articulate the SON teaching and learning philosophy of inclusive excellence and the values of DEI as key priorities while modeling the profession's commitment to health equity and social justice. In the current social climate, there is now an increased opportunity to challenge the status quo related to inclusivity. There also is an enhanced organizational commitment to DEI. With this renewed and redefined focus on health disparities and social determinants of health, as educators we have increased our attention on the care of marginalized and underrepresented groups, such as BIPOC and lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) communities and persons with disabilities. Patients, families, society at large, and the profession demand that we do better in the space of DEI. The vision and commitment of our founders, coupled with our faculty, staff, students, alumni, and community at large, beg for a strategy for structural change. Through thoughtful and intentional activities, we are seeking to drive transformational change that moves us toward inclusive excellence.

Theoretical Foundation of Cultural Humility

The concept of cultural humility was first mentioned in 1998 by 2 female physicians to guide medical education.

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They emphasized that cultural humility is a more desirable goal than cultural competence.[20] As it is impossible to master truly or become competent in a culture,[13,21] cultural humility is a more realistic value and is a better approach for inclusive care.[17] In a concept analysis of cultural humility, Foronda et al[17] developed a framework to capture the essence of the attributes, antecedents, and consequences of cultural humility. The framework demonstrates that in a world of diversity and power imbalances, cultural humility is a process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willingly interacting with diverse individuals.[17] The resulting outcomes are lifelong learning, empowerment, mutual benefit, partnerships, optimal care, and respect.[11,17] This learning encouraged us to consider more than concepts of DEI, threading opportunities for practical learning and application of cultural humility within the context of DEI across the curriculum.

Practical Example and Critique: Diversity Panel

In the first semester of our prelicensure nursing program, all students are enrolled in a course titled Professionalism for Nursing in Health Care. The course focuses on the fundamental principles of nursing and addresses the role of the nurse using an ecological framework (Supplemental Digital Content, Figure, http://links.lww.com/NE/A994). The course is taught by faculty who have a background in health equity and disparities research and training. At a micro level, students are encouraged to consider their own understandings of morality and ethics and relate the concepts of DEI in relation to themselves, their backgrounds, worldviews, and intersectionality.[12,22] On the meso level, students focus on implications of explicit and implicit bias on patient outcomes. Within the context of DEI, on a macro level, students learn about the context of wider implications for health care systems.

The previous DEI content of the course comprised content around classroom discussion with several interactive components. These components included (1) an activity focused on identifying characteristics and differentiating personal identity from clinical characterization, and (2) discussions on personal experiences of implicit and explicit bias, and on navigating bias care dynamics with incarcerated patients. However, as we learned about discrimination that many of our students experience in practice (eg, having patients reject student care because of the race of the student), we recognized that we needed to do more than teach facts. We needed to provide a space to highlight a range of experiences and perspectives within a health care context that would enable a deeper ongoing discussion and understanding within the student body. Although underpinning facts, figures, and definitions are still provided, the section of the course now leads up to a panel discussion with a question-and-answer section. Although a panel discussion is not in and of itself an unusual approach for discussing DEI, the uniqueness lies in the reflective range of experiences and perspectives with a focus on intersectionality.

The course faculty invite potential panelists who represent an intentionally diverse range of experiences, but who are not speaking as experts of the populations they represent but as experts on their own unique intersection of identity. The panel is composed of 6 to 9 students, staff, and faculty members from the school and is moderated by the course faculty. Panelists are invited to share their experiences of being a patient, family caregiver, and/or health care provider, drawing on the intersectionality of their identities with regard to age, race, ethnicity, gender, disability (including mental health), religion, and/or political beliefs. The panel typically lasts about 90 minutes for this session. About 20 minutes is spent hearing from panel members as they introduce themselves, with approximately 60 minutes for further discussion of core questions, discussion between panel members, and questions from students. The questions and processes of the panel were developed by the first group of panelists and have been refined across subsequent iterations. The panel is introduced to the class with the purposes of (1) giving students the opportunity to witness and engage in a safe and professional discussion with a range of people with different experiences and backgrounds, developing skills in communicating about diversity and inclusivity in health care, and (2) providing an opportunity for people to share key experiences and messages that will enhance inclusivity in health care.

Panelists are invited to introduce themselves using whatever terms and methods they prefer and are comfortable with. The moderator then asks the panelists to take turns to complete the following sentences:

1. My biggest concern from people who are different from me is…
2. As a health care provider/user, the biggest challenge I encounter is…
3. As a health care provider/user, the best thing I have found (or learned, or experienced) is…
4. My main suggestion for how to improve inclusivity for people like me in our institution, health care, and general are…, or a positive experience/encounter I had was…
5. One thing I want tell people…

Given how potentially emotive the session can be, we highlight that a frank and open discussion is imperative but emphasize and model respectful and professional communication. Students are also reminded with the details of counseling services available through the university. To manage the classroom dynamics, we provide several directions. First, we ask people to listen: students are encouraged to observe for patterns, relationships, similarities, and differences between panelists' experiences and perspectives and to consider how the nurses should process and respond to this in their care. For example, in 1 panel, 3 of the panelists had experience with physical disabilities. One of the panelists objected to being described as "disabled" and explained to the class his or her reasons. The other 2, however, felt the

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term applied to their situations and explained why they were comfortable with it. This was then used to show how different preferences exist within populations and the importance of asking thoughtful questions and personalizing the care we provide.

We also encourage everyone to pay attention to what we have termed the "ouch" rule. If anyone hears something that makes them feel uncomfortable or offended, we ask them to consider why they felt that way. We hold student questions until the end of the panel but encourage discussion about those moments of being hurt or experiencing discomfort.

Diversity Panel Critique

We invited panelists and students to provide anecdotal feedback on their experiences of participating in the panel discussions to guide future refinement and improvements for using a mechanism like this panel in nursing education (Supplemental Digital Content 2, Table, http://links.lww.com/NE/A995). Although some students were initially hesitant about a focused session on diversity, the main benefit was the effectiveness of hearing a range of voices and experiences respectfully shared in a safe venue. This experience was often as impactful on the panelists as on the students. However, from the critique, we also identified the need to tie the panel to a reflection assignment as not all students wanted to engage, and the topic of DEI is one that can make people uncomfortable.

Another comment noted the potential of the panel to draw out wider improvement opportunities within the institution, for example, updating the traditional curriculum and nursing education pedagogy (Supplemental Digital Content 2, Table, http://links.lww.com/NE/A995). One potential option is the development of a panel series across the whole curriculum to enable a greater number of voices and experiences to be heard as students move through their education. We found that many students want to be part of these conversations and also benefit from hearing multiple views; thus, the timing and structure of events and efforts such as these panels require careful consideration. The level of engagement from participants and feedback suggest that there is a need for us to address sensitively and thoughtfully DEI and cultural humility throughout the nursing curriculum. Efforts like these represent only a tiny portion of the work needed to change an embedded history of systemic racism and marginalization of many groups. A single panel discussion, however diverse in nature, will not be sufficient to change views and perspectives, but it is a starting point in challenging and providing an opportunity for reflection and learning in a safe environment. One example is this article, inspired by an ongoing desire for collaboration and discussion from panelists and students, and our author team that is composed of faculty, staff, and students who have all been on the panel or taken the course.

Schoolwide Efforts to Enhance the Nursing Curriculum

In addition to efforts such as the diversity panel, other efforts to enhance DEI in the nursing curriculum are developing a strategy that focuses on inclusive excellence and recognizes that expertise and insight can come from multiple sources. For example, there are concerted efforts to ensure more inclusive language in lectures and communications, provision of Spanish language classes, and provision of SafeZone training and spaces (focused training in LGBTQ terminology, needs, and support). Students are also encouraged to establish affinity and interest groups, such as those provided in Supplemental Digital Content 3, Table, http://links.lww.com/NE/A996. These groups lead activities and hold focused events, often over a set period, to coincide with national efforts such as Heritage Month Activities. For example, the Black Student Nurse Association has a month of focused event to coincide with Black History Month. Faculty also have made continuous efforts to foster DEI by integrating these concepts through faculty interest groups. In particular, the Health Equity and Cardiometabolic Health interest groups work with students in guiding research, learning opportunities, and publications that address social determinants of health, disparities, and social inequities.

Reflection and Implications for Practice

Schools of nursing nationwide are responding to the call for integration of DEI content within nursing curricula from the NLN, AACN, and other health care organizations. There are limited studies offering strategies for incorporating DEI or measuring its impact on the development of cultural competence in nursing education. Current nursing literature highlights recommendations for integrating DEI education across the curriculum through cultural immersion experiences, stand-alone courses, and diversifying participants in simulation.[23] In addition, quality improvement studies have successfully measured cultural competency and knowledge of diversity in health care among students and faculty after implementing enhanced cultural competence curriculum.[23-25] However, we need to consider the changing landscape of health care with regard to health disparities, social justice, health inequities, and the impact of COVID-19 on health outcomes among patient populations experiencing poor outcomes as a result of social determinants of health.[11,26,27] These trending issues present a more complex sphere in health care that requires close attention from nurses and nursing students alike.

Although successful, the panel discussion has not gone without challenges, specifically among those who may be resistant to learning about different viewpoints of diverse persons or groups. Student resistance has come in several forms including reduced attendance and lack of engagement. In response, we integrated a reflective assignment that asks students to consider a moment from the panel where they learned about someone who is different from them in terms of identity or values, and to reflect on how this is relevant to their nursing care in terms of diverse populations. This addresses the purpose of such activities, along with our integration of the cultural humility framework by encouraging openness, self-reflection, and engaging with diverse individuals.

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We present in this article a call to address the gaps in knowledge, communication, and understanding related to DEI within the context of health care as providers and recipients. Through the DEI panel, participants experienced a renewed motivation to address the facilitators and barriers to integrating DEI in teaching and were empowered to address these issues with the SON leadership. The next steps in this endeavor include reaffirming, in the current social climate, the voices who have been muted to enhance and address disparities in our nursing curriculum that may have inadvertently led to suffering and harm. A practical application for this is improved communication across faculty about specific course activities, such as this type of panel, which faculty can then continue to refer to and encourage students to build upon across the curriculum. It also may be beneficial to consider mechanisms to measure such changes, although we recommend caution: first, to ensure that metrics accurately capture real change and what is meant by that (qualitative and mixed-methods measure may be of use), and second, to ensure that measures embrace a more diverse, inclusive, and just understanding of change.

A Beginning, Not a Conclusion

Nurse educators are privileged with the opportunity to teach students about the changing landscape of health care and the populations they serve. The opportunity to initiate the dialogue about DEI is essential for educating future nurses who will be engaged in the delivery of culturally competent care and promote health equity. We believe the cultural humility framework provides a safe and thoughtful framework for appraising nursing curricula. In addition, we have found that activities that encourage engagement, address intersectionality, and reflect multiple perspectives can strengthen the learning experience for educators, potentially "opening the door" for embedding such approaches in the curriculum.

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