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Abstract

The demographics of the US have changed over the years due to a rise in the number of immigrants in the United States. Despite the rise of immigrants, and the cultural diversity they bring, healthcare disparities remain in the United States for various culture groups. The aim of this paper is to provide an analysis of how increased cultural humility can mitigate healthcare disparities. Health care disparities effect minority groups regarding access to care and quality of care. The development of cultural humility can help mitigate disparities because it promotes self-awareness, reflection, and engagement in an on-going learning process. Implicit bias plays a role in healthcare disparities and this paper explores how increased awareness has the potential to decrease implicit bias, which is malleable to change. There are of essential cultural dimension measures that outlined to improve awareness. These measures include Hofstede's Cultural Dimensions Theory, Schwartz's Theory of Basic Values, and the differences in communication styles. These facets of cultural humility play a vital role in the valuing and understanding of healthcare disparities and act as a first step in change. Cultural humility also includes mindfulness, client-center care, and consciousness. The aspects of cultural humility are essential to help alleviate healthcare disparities and promote collaborative care.

Keywords: cultural humility, healthcare disparities, cultural dimensions

Introduction

The United States is a diverse nation; although there is a lot of diversity, not all people received equal treatment (Berwick, 2002). The marginalized groups in the United States are at risk of overuse, misuse, and underuse of healthcare services (Berwick, 2002). This paper provides an overview of demographics in the United States, the persistence of healthcare disparities, the meaning of cultural humility; it describes how increased awareness can decrease implicit bias, the essential aspects of cultures, and considerations to improve cultural humility.

Demographics

The changing demographics of the United States illustrates the diversity. According to the United States Census Bureau (2018) in 1940, the population numbered 132.2 million people; this number then increased to 308.7 million in 2010. They estimate that by year 2050, the total population will rise to 439 million people. Not only is the population increasing, but also the mix of races, ethnicities, and cultures. The Census Bureau (2018) estimated in 1970, people who represented minority cultures in the United States accounted for 16.5% of the total population. Minority representation expanded to 30.9% in 2000 and it is expected to continue to grow with minority cultures becoming the majority population at 50.1% of the total United States population in 2043 (United States Census Bureau, 2018). Immigration is one reason for growth. In 1850, 2.2 million immigrants traveled to the United States, about 10% of the total population (Zong, Batalova, & Hallock, 2018). The number of immigrants increased reaching 43.7 million individuals in 2016 (Zong et al., 2018). In 2016, immigrants to the US were from countries like India, China/Hong Kong, Mexico, Cuba, and the Philippines (Zong et al., 2018). Despite the increasing representation of cultural backgrounds in the United States populations, disparities in the healthcare services provided to minority cultures continues.

Healthcare Disparities

Healthy People 2020 define health care disparities as, "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage." Health care disparities affect members of minority cultures; individuals of minority cultures have a difficult time with access to care, which affects the quality in the care received resulting in healthcare disparities (AHRQ, 2008). Access to care includes many facets; obtaining health insurance, experiencing difficulties when receiving care, acquiring a primary source of care, and being able to receive care when wanted (AHRQ, 2016). Race, ethnicity, socioeconomic status, age, and sex all influence these facets. From the years 2010 to 2015, the African American and the Hispanic population had a higher uninsured rate of people than the Caucasian population, making it harder for them to receive health care services (AHRQ, 2016). The quality of care that individuals receive can lead to healthcare disparities. Quality of care includes "prevention, emergency treatment, behavioral health care, and chronic disease management" (AHRQ, 2016). Evidence of disparities showed that in 2013 African Americans, Hispanics, American Indians, and Alaskan Natives acquired a lower level of quality of care by roughly 40% than Caucasian individuals in the US (AHRQ, 2016). People of Asian cultural backgrounds had 20% lessened care than Caucasian's (AHRQ, 2016). Disparities regarding access to care and quality of care show many similarities for each ethnic group; however, healthcare disparities regarding access to care are encountered more often (AHRQ, 2016). Although some quality disparities are decreasing, the majority of them are not (AHRQ, 2016). The overall aim of the Agency for Healthcare Research and Quality (2016) is to improve care, promote healthy people and communities, and provide care that is more affordable. To make progress toward the overall aim, awareness of cultural humility should increase in healthcare providers.

Culture and Cultural Humility

It is key to understand the definition of culture. Culture is defined as, "the way of life of a particular people, especially as shown in their ordinary behavior and habits, their attitudes toward each other, and their moral religious beliefs" (Culture, 2018). Culture consists of unique interconnected facets and can be shaped by many outside forces such as technology and globalization (AOTA, 2018). Because culture is complex with many facets, there are different indexes that are common to various cultures. Hofstede's Cultural Dimensions Theory identifies these different indices (AOTA, 2018). Schwartz's Theory of Basic Values provides ten core values that are universal to all cultures. The values reflect desirable goals in individuals; they provide people with motivation so action can take place to reach the end goal (Schwartz, 2012) and are explored later in the paper. Understanding the characteristics that construct cultures are paramount in cultural humility.

Cultural humility is defined as the "ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]" (Waters & Asbill, 2013). Cultural humility is an on-going learning process throughout one's life, and it consists of three main aspects (Waters & Asbill, 2013). The first aspect is a lasting dedication to assessing oneself through self-evaluation and self-critique. This aspect requires one to be able to admit that there is knowledge they do not possess, and engaging in an ongoing learning process. The motivation to acquire more knowledge is essential (Waters & Asbill, 2013). The second aspect is to amend power imbalances. It is foremost that all people receive proper decorum because of the different values that each individual acquires (Waters & Asbill, 2013). The third aspect involves the importance of advocating through communities and groups (Waters & Asbill, 2013).

The Role of Implicit Bias

Increased awareness has decreased implicit bias (Devine, Forscher, Cox, & Austin, 2012). Implicit biases can be positive or negative; it is a way of thinking that affects one's understandings, behaviors, and conclusions reached in an unconscious manner (Staats, Capatosto, Wright, & Contractor, 2015). Individuals are not aware of the implicit biases they possess. Direct and indirect information, such as the things we are told, affect implicit bias; a person starts developing implicit bias at a very young age, due to learning experiences, creating subconscious affiliations on aspects like race, age, and ethnicity. Implicit biases affect everyone, although, they may not have a direct correlation with beliefs (Staats et al., 2015). Implicit biases in a healthcare professional affect their behaviors and judgments.

Blair, Steiner, and Havranek (2011) give the example of how these behaviors and judgments could result in a healthcare disparity. The behaviors and judgments can then affect medication and visit adherence (Blair, Steiner, & Havranek, 2011). Take a Caucasian clinician who worked with an elderly African-American patient, prescribed an antihypertensive medication, but still had problems with blood pressure. A negative bias toward African-Americans, can affect judgment on the patient. The physician may have believed that the African-American patient was uncooperative and therefore unlikely to comply with a more intensive drug regimen. The physician may also have been inclined to pay close attention to if the client could pay the pharmacy copay and judgmental if they could not. The negative implicit bias, that the physician may not be aware of, can result in the denial of a more intensified treatment regimen, and therefore hinder the patients' healthcare service received (Blair et al., 2011). A negative implicit bias in a healthcare professional can lead to issues in interpersonal communication and therefore affect treatment (Blair et al., 2011). Studies have shown that

individuals with negative implicit ethnic/racial bias engage in depleted levels of communication with patients of minority backgrounds. This compromised communication can adversely affect trust and commitment between patients and healthcare professionals. Inadequate adherence could be a result of compromised communication, and for that reason negatively affect treatment for the patient (Blair et al., 2011).

Increased awareness can decrease implicit bias because implicit biases are malleable (Staats et al., 2015). Boscardin (2015) states that for reduction of biases, self-reflection exercises are critical. If an individual is aware of their biases and makes a conscious effort to attenuate the biases, there will be positive results. In addition to exercises, implicit bias tests are a beneficial way to increase awareness. Researchers created a habit-breaking intervention with the main goal of mitigating implicit race bias (Devine et al., 2012). The researchers based their study on the claim that implicit biases resemble a habit, and as a habit, awareness of implicit bias, concern regarding the impacts of the biases and the application of strategies to decrease bias can help alleviate it. The hypothesis was correct; individuals in the study who received treatment to increase their awareness on their biases showed alleviation of implicit race bias (Devine et al., 2012). The participants in the study who showed concern about discrimination and participated in the strategies had the greatest results. The control group of this study did not yield the same results (Devine et al., 2012).

The prevalence of healthcare disparities in minority cultures and the vital importance of cultural humility in the United States are the two main aspects of this paper. It is essential that healthcare providers advance on the continuum of cultural humility. The development of an advanced knowledge of cultural humility can allow better communication (Nishimura, Nevgi, & Tella, 2008). The following paragraphs will explain important aspects and differences in

cultures, ways to address those aspects and differences, and cultural exploration to support the

claim that increased cultural humility can reduce healthcare disparities.

Essential Measures of Cultural Dimensions

Hofstede's Cultural Dimensions Theory (Hofstede Insights, 2018), highlights the

different indices (power distance, uncertainty avoidance, time orientation, individualism, and

masculinity) present in all cultures (see Figure 1). This theory is a systematic framework that

explains five cultural dimensions that contribute to different essential cultural measures. Power

distance index is one piece to the five cultural dimensions. The power index focuses on less

powerful members of a specific society and their perception of inequalities (Hofstede Insights,

2018). The high rating in the power distance displays that the people living in countries such as

China are more accepting of power inequalities within their population. Populations with a

lower power distance rate do not accept power inequalities. A difference in power distance can

cause a patient to be too compliant and not self-advocate in a healthcare setting. This can occur

when a patient believes respect equals compliance. It is important the healthcare professional

and client understand these differences to provide accommodations to reduce inequities and

inequalities.

Another cultural dimension that is part of Hofstede's Cultural Dimensions Theory is

uncertainty avoidance. Uncertainty avoidance is the degree to which people of a certain culture

are intimidated by ambiguous or unfamiliar situations. It also includes the beliefs and practices

that cultures have created to abstain from these situations (Hofstede Insights, 2018). Individuals

with a high uncertainty avoidance, for example, Hispanic cultures, are likely to feel threatened

by ambiguous situations and rely on rules and orthodox behaviors. The other side is populations

open to new ideas or opinions and populations who engage in unknown activities (Hofstede

Insights, 2018). Healthcare professionals need to keep this index in mind to create a comfortable environment for their patients.

Individualism index is a personal cultural dimension. When a culture has a high individualism index, the people believe that they are required to care solely for themselves and their immediate family. Many times, cultures with a high individualism index do not have a tight social framework (Hofstede Insights, 2018). The opposite is collectivism when society value places emphasis on the collective rather than the individual. In these cultures, the population trusts that their groups, such as relatives, clans, and organizations, will bolster and take a personal interest in them in exchange for loyalty (Hofstede Insights, 2018). The different values in individualism versus collectivism can lead to healthcare disparities because they can affect treatment options. Individuals who favor individualism over collectivism will offer treatment options that may not be successful in a patient who favors collectivism.

Masculinity index is another extension of Hofstede's Cultural Dimension Theory. A high score in the masculinity index would express that a cultures motivation comes from competition, achievement, and success (Hofstede Insights, 2018). The opposite of this is femininity. In cultures that value femininity, the dominant values include treasuring others and a high quality of life (Hofstede Insights, 2018). The difference in ratings of masculinity index can express how people of different cultures are motivated, and motivation is essential to reach goals of treatment.

The fifth cultural index is time orientation; how a culture preserves their past while also preparing for the obstacles in the present and future (Hofstede Insights, 2018). Long-term orientation is in cultures that boost modern education because it can bolster the future; it is a more pragmatic approach (Hofstede Insights, 2018). Long-term orientated countries focus on the future. Short-term orientation cultures prefer to withhold traditions and norms (Hofstede

Insights, 2018). These cultures focus more on the present or the past. This index can help

healthcare providers know if their patients are more inclined to goals with immediate
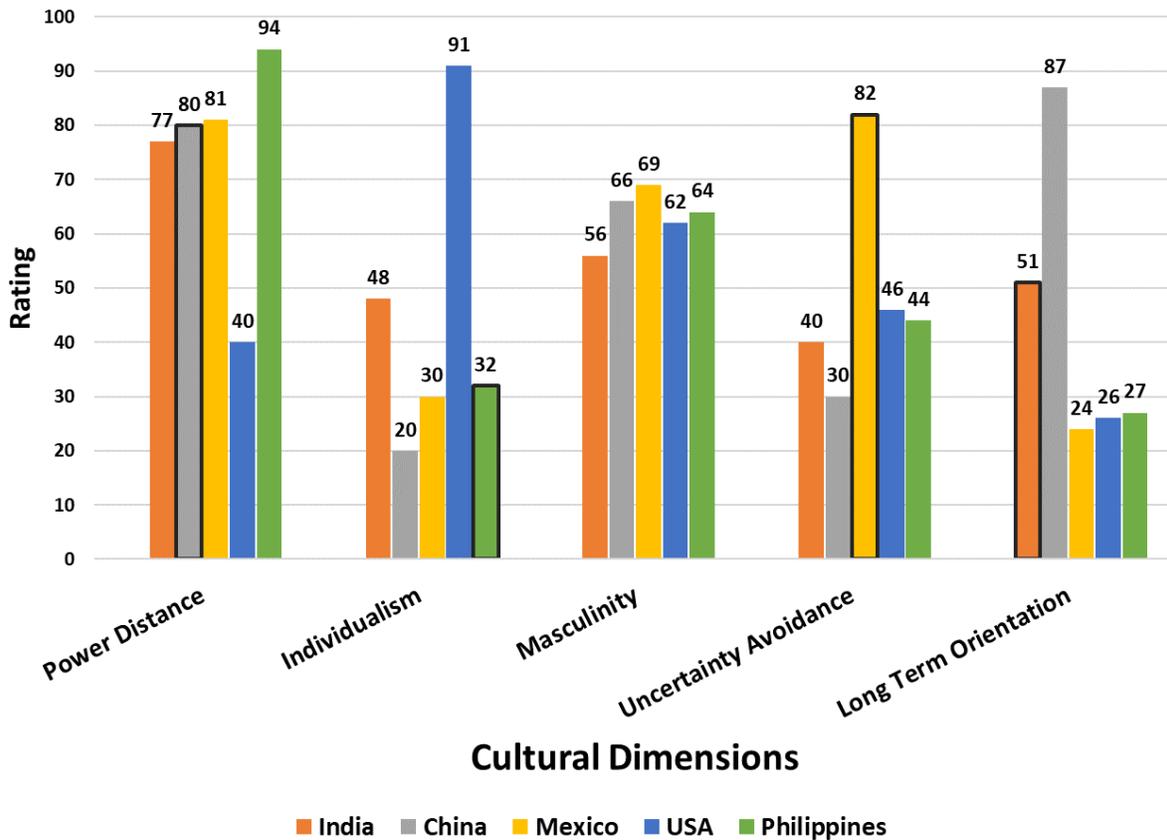
gratification or goals aimed toward the future.

Figure 1. Cultural dimensions of India, China, Mexico, USA, and Philippines (Hofstede
Insights, 2018).

As exhibited through Hofstede's Cultural Dimensions Theory, there are many different

facets of culture. Cultural humility acknowledges the differences and states that people should

educate themselves on the different elements when necessary (Waters & Asbill, 2013). As

shown above, different indices shape an individual based on their cultural background and

attention to cultural background is fundamental. Cultural humility aspires advocacy for

minorities; it aspires that power imbalances be fixed (Waters & Asbill, 2013). This implies that

patients, their cultural backgrounds, and the indices that shape them should be recognized and respected.

Along with Hofstede's Cultural Dimension Theory, Schwartz's Theory of Basic Values also illustrates important aspects of different cultures. Schwartz's Theory of Basic Values symbolizes ten values that are universal to all cultures. Values are defined as, "the regard that something is held to deserve; the importance, worth, or usefulness of something" (Value, 2018).

Schwartz highlights self-direction as a value. This stresses the importance of autonomy and independence, while also showing the importance of control and mastery. Stimulation is another value; individuals have the desire of an audacious life. Hedonism is one of the ten values, indicating that people of all cultures find worth in appreciating oneself. Achievement is a value that highlights personal success when an individual is able to show that they are qualified in understanding the norms and standards around them. Power is a value that displays the merit in having control. Security is one of the ten values, which exhibits the worth in feeling certain and protected in society, relationships, and within oneself. Conformity is another value, which reveals individuals do not value activities that break standards. The value of tradition is the acknowledgment and approval of the norms of a culture. Benevolence is another value that shows individuals stride to promote the welfare of the people whom they encounter the most. Lastly, universalism is the promotion of the greatest welfare of all people and for nature (Schwartz, 2012).

Schwartz's Theory of Basic Values points out the ten universal values; however, it is important to understand that different cultural backgrounds will have a different prioritization of these values. A patients set of values play a vital role in "client factors" (AOTA, 2014, p. S7) because they can influence the patient's performance. A greater understanding of the patient can

be had if the healthcare professional is informed on the principles, standards, and qualities that

the patient finds beneficial, which presents the relevance of engaging in meaningful and

transparent communication with clients to gather information on their values (AOTA, 2014).

Communication styles vary greatly between cultures. If individuals are aware of the

differences in communication styles, results can yield higher comprehension, fewer

misunderstandings, and a greater mutual respect (Nishimura et al., 2008). The two main types of

communication are high-context cultures and low-context cultures. High context cultures engage

in ambiguous conversions. Communication between high context cultures typically has a hidden

message, because the speaker does not directly say or write all of the information. The listener

has to gather unsaid information, and this is possible because of their background knowledge.

Another aspect of high context cultures is that the speaker is not interrupted often (Nishimura et

al., 2008). This differs from a low context culture in many ways. In low context cultures, all of

the information comes directly from the speaker. The listeners expect explanations on opaque

information (Nishimura et al., 2008). The conversions that occur in low context cultures are

many times verbose, reliant on feelings or intentions, and direct (Gudykunst, Ting-Toomey, &

Chua, 1988).

High context cultures tend to be short-term orientated. These cultures are slow to change

and are permanent; the people of these cultures have confidence in their history, relationships,

and traditions (Nishimura et al., 2008). This differs from low context cultures that value

individualism. Values in high-context versus low-context cultures are another important

classification. For example, the two cultures differ on the value of politeness. Individuals of low

context cultures find it acceptable to ask questions that may be too personal and improper to high

context cultures (Nishimura et al., 2008). High context cultures include Japan, Arab Countries,

and Greece. Low context cultures are German-speaking Countries and North America (Hall &

Hall, 1990).

The Prevention of Health Disparities with Cultural Humility

The preceding paragraphs have pointed out many differences between cultures. The

differences can lead to misunderstandings and miscommunications impairing healthcare services.

The next paragraphs will give a deeper understanding of these different cultural norms and

examples on what these differences look like. To explain the differences, the indices of India,

China, Mexico, and the Philippines are compared to the United States (see Figure 1). It is of

paramount importance that healthcare providers are aware of these differences in an

amalgamation of consciousness and mindfulness. Mindfulness, client-centered care, and

consciousness are all a part of cultural humility. Mindfulness is, 'being able to attend to an

experience such as a conversation, a clinical procedure or an administrative activity without

being distracted, hurried or reactive in a way that compromises our understanding, decision

making, caring and skillful actions" (Bober & Davison, n.d.). Client-centered practice is, "an

approach to service which embraces a philosophy of respect for, and partnership with, people

receiving services" (Tickle-Degnen, 2002). Lastly, consciousness is, "the quality or state of

being aware especially of something within oneself," (Consciousness, 2018). The coalescence of

these three, mindfulness, client-centered practice, and consciousness can take action in palliating

health care disparities.

The target outcome of healthcare providers is to increase the health and well-being of

others. Patients, who receive advocacy paired with self-advocacy, improve in health, well-being,

and occupational participation (AOTA, 2014). The American Occupational Therapy Association

(AOTA) defines advocacy as "efforts directed toward promotion occupational justice and

empowering clients to seek and obtain resources to fully participate in daily life occupations"
(AOTA, 2014). It is important to acknowledge the differences within the power distance index
to provide efficacious advocacy and treatment. In 2016, there were roughly 160,200 immigrants
from China in the US (Zong, Batalova, & Hallock, 2018). The increasing numbers of human
beings in the United States from a Chinese culture increase the probability that a healthcare
provider will interact with a patient of Chinese cultural background. The difference in the power
index between a Chinese patient and American healthcare provider could hinder the targeted
outcomes if not addressed. Chinese culture has high respect and gives a lot of power to
healthcare providers. Chinese clients may be timid in disagreeing with the healthcare provider
because they believe it is rude or could create a disharmony (Communicating with Your Chinese
Patient, 2007). The strong compliance of the patient could result in an unbeneficial amount
advocacy from the doctor, which takes away from what the patients will do and decided for
themselves. Chinese cultures are a high-context culture, which means that their relationships
occur slowly and are reliant on trust; it also means voice tone, gestures, and facial expressions
assemble the majority of their communication (Halverson, 1993). The Chinese culture
prioritizes the value of power and has a less explicit communication style all of which could
impede on the effectiveness of advocacy resulting in a lower efficacy of care, a healthcare
disparity.

A high rating in uncertainty avoidance decreases the likelihood that an individual will
seek healthcare services. The norms in the Hispanic-American culture differ in many ways from
the American culture; it is imperative to recognize these norms to decrease healthcare disparities.
Healthcare settings and appointments can be intimidating to all people, especially those who are
a part of a culture with a high uncertainty avoidance rating. Structures such as the head of the

household, typically the father or the oldest male, being the spokesperson in all healthcare

settings can be unfamiliar to people of American culture (Healthcare Chaplaincy, 2013).

Cultural backgrounds, such as Hispanic Americans value tradition greatly. Most individuals of

this culture are short-term orientated; they do not stray far from the standards. Although this

may differ for individuals of the American culture, it is important healthcare providers are

conscious of the differences to alleviate the intimidation Hispanic-Americans and other minority

groups with a high uncertainty avoidance index feel in healthcare settings. According to the

tenets of the Hispanic-American culture, it is common for the family of the recipient of care to

want to protect the patient from obtaining information on their illness in fear that it will worsen

the patients' health status (Healthcare Chaplaincy, 2013). This implies that Hispanic Americans

have a high value of benevolence; this is their way of caring for and promoting the best welfare

for a family member. Respect and adherence to the differences in cultural norms will create a

relaxed environment, mitigating stress and anxiety, and in return increasing the likelihood that

individuals of minority cultures seek out healthcare services.

The strong value of individualism in the American culture can lead to a difficult time

understanding others points of view or feelings. People from cultural backgrounds where

collectivism is valued, such as the Philippines or Chinese cultures, have less trouble preserving

the attitudes of people around them whereas people from cultural backgrounds where

individualism is valued have a more difficult time preserving other people's attitudes. These

differences in individualism versus collectivism can create a clash in social situations (Harms,

2007). The differences in these values have led to problems for Occupational Therapists (OT)

and their clients in the past (Pooremamali, Persson, & Eklund, 2010). To have success in

therapeutic interventions, it is important that the goals of the client and of the therapist equally

align; this is not possible if individualist view, supporting the autonomy and responsibility,

versus the collectivist view, stressing the support and help of others, are not recognized. The

OT's encouragement of independence in daily occupations will create a conflict if the patient

expects care from others. The clashes between patients and healthcare professional can lead to

frustration and uncertainty, impeding on therapeutic interventions (Pooremamali et al., 2010).

Along with the differences in worldviews, variances in communication styles can influence the

clashes as well. Low context cultures typically have a higher rating of individualism (Nishimura

et al., 2008). Not only does this entail differences between communication styles, but also

differences in elements such as how people perceive time. High- context cultures are likely to

believe that the entirety of life features have their own time; many people of high-context

cultures do not believe change is something that will happen quickly (Halverson, 1993). These

are important aspects for healthcare professionals to gather in the consultation process to support

the therapeutic relationship, attenuating negative feelings in healthcare settings and exhibiting

culture humility.

Masculinity index explains how individuals of different societies are motivated. Time

orientation analyzes if individuals focus more on the future, postponing short-term successes, or

the past/present, desiring immediate gratification (Hofstede Insights, 2018). These two indices

provide prominent knowledge for healthcare professionals to obtain when working with a client.

In East Indian cultures, there is a strong belief that physical, mental, and spiritual health is all key

factors in health and treatment. Most individuals of this culture participate in the use of herbs

and other complementary treatments to help cure illnesses. If an illness does become terminal,

the majority of individuals of this cultural background engage in rituals and prayers. This

specific society welcomes Western Medicine; however, it is vital to include spiritual healing

(Healthcare Chaplaincy, 2013). India is a spiritual country, with a high tolerance for religious views. The individuals of this culture find motivation in success and power specifically in their workplace (Hofstede Insights, 2018). India is a high-context culture. High-context cultures, such as India, favor collectivism. These cultural backgrounds are inclined to believe that relationships with others will influence how things happen, and they strongly value security in their groups. To mitigate health care disparities, it is important healthcare professionals are aware of these unique aspects and incorporate them into the intervention plan and intervention implementation. These actions support a dynamic intersection of the patients' principles.

The many differences in culture attest to the importance of client-centered care, an example of what cultural humility looks like. When healthcare providers participate in client-centered care, rapport and working alliance are present. Rapport occurs when individuals create a relationship and start to view the other person with positive characteristics, such as being warm, respectful, and understanding (Tickle-Degnen, 2002). Working alliance is when the healthcare provider and recipient of care work together to create the target outcomes, sharing the responsibility of engaging in activities that will promote the success of these goals. To develop rapport, it is important that both the healthcare professional and client gather information on one another, and do it in a way that bolsters openness and friendliness to mitigate disputes between them (Tickle-Degnen, 2002). The healthcare provider can use evidence on how to successfully gather the optimum amount of information about the client based on their tenets; this will show the client that the healthcare professional is aware of their unique needs, giving them a sense of power as well (Tickle-Degnen, 2002). This relationship allows discussion on intervention effectiveness evidence. The relationship of rapport will allow the healthcare professional and client to focus on duty of treatment, how they will address success and failure, and develop a

relationship where they work together (Tickle-Degnen, 2002). The process of client center care

can create an unbiased environment which will allow healthcare professionals and patients to

talk transparently about client factors, performance skills and patterns, occupations, and contexts;

resulting in the most desirable and accurate occupational profile. This will allow the most

effective treatment because cultural humility has the potential to improve collaborative

communication and partnerships in care, which helps the client advocate for themselves and

improve outcomes.

Conclusion

This paper displays the essential aspects of different cultural backgrounds. A valuable

contradicting argument is that an increased cultural humility is not necessary because not all

immigrants in the US come from such contrary cultural backgrounds. Although there are many

countries who share similarities with the United States, the countries focused on throughout this

paper, China, Mexico, Philippines, and India, are the four of the main countries that people

currently travel to the United States from (Zong et al., 2018). There have been many salient

obstacles in healthcare highlighted that result from the different cultural backgrounds of these

countries, which is why an increase in cultural humility is paramount.

In many cases, the goals of the healthcare professional and the goals of the client line up,

the differences are the approaches taken to reach the goals. Take for example a doctor who

believes the best option is to remove the ventilator in a patient, but the family insists that life and

death are only up to God, and death will happen when God believes it is time. There is a strong

dependence on a higher power in situations like this. It is important to allow time for the family

to participate in prayers, rituals, or any valued behaviors. If healthcare professionals take the

time to understand different values and demonstrate empathy to the families, they will be able to

engage in candid communication. The communication can allow the healthcare professional the

ability to explain the role that the families' beliefs, values, and spirituality played in the overall

care of the patient, reassuring them that their cultural background matters. This communication

has allowed families in the past to realize that their main desire is peace for the patient and that it

is God's will to allow the patient to pass on (Fahlberg, Foronda, Baptiste, 2016). Processes that

involve communication that demonstrate cultural humility can help alleviate healthcare

disparities.

Healthcare disparities are present in the United States. The prevalence of healthcare

disparities has made them a national priority. Cultural ignorance has assisted in the prevalence

of the disparities (Harris, 2010). Healthcare disparities create a vicious cycle; when individuals

receive compromised care, the chances of illness and death increase. Furthermore, the minority

populations that suffer from these disparities have much higher rates of death and illness

compared to the rest of the society (Harris, 2010).

Future areas of study should focus on the education system and a way to teach towards a

sufficient advancement on the cultural humility continuum for future healthcare professionals.

There have been studies done that conclude that the current education system is not properly

teaching multiculturalism (Pooremamali et al., 2010). It is vital that research focuses on ways

the education system can provide a satisfactory advancement on the continuum and the most

beneficial way to do this. Aspects such as cost and time are important for consideration.

Opportunities currently exist that promote cultural humility, such as study aboard. Future

research should collect data on how many college students and what type of students participate

in study aboard and other cultural exploration experiences.

   The changing of the demographics, the presence of healthcare disparities in the US, and

the essential aspects of different cultures all support cultural humility. There are alterations that

lie between the US and other countries regarding the power index, uncertainty avoidance,

individualism, masculinity, and time orientation. There are also anomalies in the prioritization of

values and variation of communication styles. All of these distinctions correlate with healthcare

disparities. In order to subside these healthcare disparities, there needs to be an increase in

cultural humility to understand and accompany patients of these vulnerable cultures.

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