BMJ Open

Applying 'cultural humility' to occupational therapy practice: a scoping review protocol

Hardeep Singh ,[1,2,3] Ruheena Sangrar ,[1] Sachindri Wijekoon,[1]
Erica Nekolaichuk,[4] Kristina Marie Kokorelias ,[5] Michelle L A Nelson,[6,7]
Sofia Mirzazada,[1,6] Tram Nguyen,[8] Holly Assaf,[2] Heather Colquhoun[1,3]

ABSTRACT

Introduction Cultural humility is becoming increasingly important in healthcare delivery. Recognition of power imbalances between clients and healthcare providers is critical to enhancing cross-cultural interactions in healthcare delivery. While cultural humility has been broadly examined in healthcare, knowledge gaps exist regarding its application in occupational therapy (OT) practice. This scoping review protocol aims to: (1) describe the extent and nature of the published health literature on cultural humility, including concepts, descriptions and definitions and practice recommendations, (2) map the findings from objective one to OT practice using the Canadian Practice Process Framework (CPPF), and (3) conduct a consultation exercise to confirm the CPPF mapping and generate recommendations for the practice of cultural humility in OT.

Methods and analysis We will search Ovid Medline, Ovid Embase, Ovid PsycINFO, Ebsco CINAHL Plus, ProQuest ASSIA, ProQuest Sociological Abstracts, ProQuest ERIC, WHO Global Index Medicus, and Web of Science databases. Published health-related literature on cultural humility will be included. There will be no restrictions on population or article type. Following deduplication on Endnote, the search results will undergo title, abstract, and full-text review by two reviewers working independently on Covidence. Extracted data will include descriptors of the article, context, population, and cultural humility. After descriptive extraction, data describing cultural humility-related content will be descriptively and interpretively analysed using an inductive thematic synthesis approach. The data will also be mapped to OT practice through deductive coding using the CPPF. Occupational therapists and clients will be consulted to further critique, interpret and validate the mapping and generate practice recommendations.

Ethics and dissemination Ethics approval was not required for this scoping review protocol. We will disseminate the findings, which can enhance understanding of cultural humility in OT, facilitate cross-cultural encounters between occupational therapists and clients and improve care outcomes through publications and presentations.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ A search for published health-related literature on cultural humility will be conducted on multiple databases.
⇒ An integrated knowledge translation approach will integrate key stakeholders' perspectives in the review, enhancing the relevancy and accelerating the uptake of findings.
⇒ A multidisciplinary research team with diverse experiences (eg, culture, ethnicity, age, research discipline, educational background and training) will enrich the review.
⇒ Cultural humility is inadequately indexed in databases, increasing the potential to overlook relevant studies.
⇒ This review will not capture organisational documents not publicly available.

INTRODUCTION

Health inequities are a growing concern in many countries.[1–11] They can be defined as 'systematic, avoidable, unfair and unjust' differences in healthcare access and quality of health outcomes between groups of people.[6 12] For example, a systematic review aimed at identifying the literature on the experiences of Indigenous communities in the Australian health system revealed negative healthcare experiences, including feelings of powerlessness, fear, uncertainty and intimidation related to communication and interactions with healthcare providers.[13] One factor contributing to exacerbated health disparities is healthcare providers' conscious or unconscious bias,[14] as evidenced by experiences of anti-black racism within the Canadian healthcare system.[15–17]

Improving healthcare provider–client relationships, including how healthcare providers navigate cultural differences with their clients, may improve health service delivery and the health outcomes of groups experiencing inequities.[18–22] Thus, much discourse has focused on healthcare professionals becoming culturally competent to reduce health inequities.[18 23] The concept of 'cultural competence' has been used for over 50 years within healthcare and is defined as 'a set of congruent behaviours, attitudes

and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations'.[24–26] While developing this competence is seen as a step in the right direction, critical perspectives indicate that cultural competence misinterprets culture as stagnant and homogenous; increasing cultural competency may be an elusive goal, as one can never be truly competent in understanding or interacting with another's culture.[27–30] In addition, this concept is devoid of considering the context and shifting power dynamics in the therapeutic relationship.[27–30]

Cultural humility, which emerged around 1998, is a more recent concept than cultural competence.[31] Cultural humility is defined as 'a process of openness, self-awareness, being egoless and incorporating self-reflection and critique after willingly interacting with diverse individuals'.[32] Some scholars recommend that health professions adopt cultural humility because it embodies an ongoing practice of learning about the communities that providers interact with and self-reflecting on power dynamics and the intersectionality of provider–client relationships.[27 31 33 34] Cultural humility is now promoted across health disciplines, such as nursing,[20 35] medicine,[31] public health and social work[27] since it facilitates effective engagement between providers and clients, reduces power imbalances and yields better health outcomes. While positive outcomes may be produced from health professionals adopting a practice of cultural humility at an individual level, a critique is that system-level changes, including resources and supports,[36] are also needed to address power imbalances effectively.[34] The varied nature of practicing cultural humility based on one's individual identities, such as belonging to a marginalised group, is also being recognised.[36] Therefore, cultural humility is a process-oriented approach used to enhance healthcare providers' ability to deliver client-centred care, while cultural competence is a content-oriented approach aimed at increasing healthcare providers' knowledge, confidence and self-efficacy in communicating with and treating diverse clients.[37]

It is important to note that other adjacent and overlapping terms and concepts to cultural humility have been used across health disciplines,[24] including cultural safety, which is closely related to cultural humility.[24] Cultural humility and cultural safety overlap in healthcare providers engaging in critical consciousness to acknowledge shifting power imbalances attributed to social classes and structures within therapeutic relationships.[24 32 38] Scholars have indicated that cultural safety requires 'healthcare professionals and their associated healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery…acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided'.[24 38] Cultural safety is 'self-oriented' as it tends to focus on self-reflection of internalised biases,

assumptions and prejudices.[24] However, culturally safe care is, importantly, defined by the recipient of care/the client and their communities.[24] In contrast, cultural humility is 'other-oriented' as it focuses on providers' navigating culturally dynamic relationships with clients.[38] Health authorities/councils[39–41] and professions,[42–46] including the occupational therapy (OT) profession,[47] have made commitments to enhancing cultural humility and cultural safety. While both concepts warrant closer attention, this review has focused on cultural humility as a concept that providers can consciously integrate into their practice process while considering client factors.

As occupational therapists work in various practice settings and with diverse clients, cultural humility is inherently fundamental to their ethical foundation.[48 49] The OT profession emphasises respect for every person's dignity and worth and the notion that clients are diverse and unique.[48 49] Moreover, occupational therapists must recognise power dynamics among themselves, clients, reimbursement structures and institutions to build rapport with clients and provide client-centred care.[33] By enhancing their practices to promote cultural humility, occupational therapists can understand and redress power dynamics over time, enhance cross-cultural clinical encounters, hold systems accountable to engage in client-centred practice[33] and ultimately reduce health inequities.[21 33] However, the application of cultural humility is underexplored in OT research.[33]

The prior literature has highlighted the need for healthcare providers to learn about and practice cultural humility,[20 21 27–30 32 33 50] but to our knowledge few have applied this concept directly to OT practice (eg, [33 51–53]). For instance, Foronda *et al*[32] conceptually analysed cultural humility, yielding a general understanding of the concept in healthcare,[32] and Mosher *et al*[50] performed a 'brief review' of the empirical literature to create a framework that guides the application of cultural humility in psychotherapy.[50] Applying the concept to their unique disciplines allows therapists to learn from their clients and for clients to become equal partners in the care decisions.[50] Cultural humility in relation to OT practice was analysed by Agner[33] with a review to support the argument for a paradigm shift from cultural competence to humility in OT; however, the study was limited to 'preliminary research' and did not include comprehensive details of their review methodology, limiting replicability and rigour. Other scholars, such as Reberg,[51] Mahoney and Kiraly-Alvarez[52] and Hammel,[53] analysed cultural humility and advocated for its application in OT practice but did not perform a comprehensive and systematic review of the current cultural humility knowledge base. As such, a comprehensive knowledge synthesis is needed to understand how cultural humility might guide the clinical rapport building process, client-centred goal setting and treatment planning, as well as how occupational therapists engage these principles when conducting functional evaluations and/or implementing interventions. While analyses and advocacy of

cultural humility in OT practice[51–53] have undoubtedly advanced our understanding of cultural humility, there remain knowledge gaps related to applying the concept to OT practice. Therefore, we propose a plan to conduct a scoping review of the cultural humility knowledge base and a consultation exercise to promote its application to OT practice.

The specific objectives of the planned review are to objective 1: describe the extent and nature of the published literature across health settings on cultural humility, including key concepts, descriptions and definitions and practice recommendations; objective 2: map objective 1's findings to OT practice using the Canadian Practice Process Framework (CPPF); and objective 3: conduct a consultation exercise to confirm the CPPF mapping and generate a final set of recommendations for the practice of cultural humility in OT.

METHODS AND ANALYSIS
Design
This is a protocol for a scoping review to synthesise the current extent and nature of the evidence on cultural humility and package it for application in OT practice. The methods will be guided by Arksey and O'Malley[54] as well as the methodological enhancements proposed by Levac *et al.*[55] Our proposed methods will adhere to the six stages of these frameworks, as described below. In addition, we will follow the reporting guidelines from the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (see online supplemental material 1).[56] We will begin this review in Fall 2022 and anticipate completion within a year (ie, Summer 2023).

Theoretical approach
Integrated knowledge translation (IKT)
An IKT approach, which entails collaboration between researchers and knowledge users, will guide the conduct of this scoping review, ensuring research relevance through integrating feedback from knowledge users to facilitate the uptake and impact of research.[57] We will examine the partnering process through the principles of IKT (engagement of knowledge users throughout the research process as equal and equitable partners) to share lessons learnt.

Patient and public involvement
In line with IKT, this protocol, including the research objectives and plan, was created in collaboration with occupational therapists, OT researchers, rehabilitation researchers, OT educators and a medical librarian on our research team. Furthermore, occupational therapists and OT clients will be consulted during the consultation exercise (stage 6) to help produce specific research outputs.

Social constructionism paradigm
A social constructivist paradigm[58 59] will be adopted as it aligns with this review's interpretive nature and co-construction of knowledge by members of the research team. This paradigm posits that knowledge is socially constructed by the researchers based on their individual culture, experience and understanding, allowing the team to apply an intersectionality lens to the qualitative analysis and ongoing reflexive practice.[60–62]

Stage 1: identifying the research question
The planned review will answer the following questions to advance our current understanding of cultural humility and its implications for OT practice:

► What is the extent (ie, how many articles and article types) and nature (ie, journals, authors, countries, publication discipline/field, area of healthcare, the definition of cultural humility, type of study, descriptions of how to apply cultural humility/what it looks like in practice, practice recommendations, training/educational suggestions, guiding theories and frameworks) of the health literature on cultural humility?
► How do the key concepts, descriptions, definitions and recommendations related to the cultural humility literature align with OT practice?
► What recommendations can be made for the practice of cultural humility in OT?

Stage 2: identifying relevant studies
Inclusion criteria
The inclusion criteria were created using the population, concept and context framework.[63] Studies meeting the inclusion criteria described below will be included in this review.

► Population: no restrictions in terms of population, age, health condition or gender will be required.
► Concept and context: any study with a primary objective to discuss, define, debate and test the concept of 'cultural humility'[32] will be included. The studies must explicitly state the term 'cultural humility' to be included within this review. As we expect limited OT-specific literature based on our preliminary searches, we have decided to search the concept broadly to any health-related topics (eg, health services, health discipline, health education).
► Type of studies: we will include peer-reviewed publications. No design (eg, essays, reviews and concept papers), date or language limitations will be applied for comprehensiveness.

A preliminary search strategy based on the inclusion criteria has been developed by EL (a medical librarian) in consultation with HS to inform the search strategy to identify the relevant literature. The preliminary search was trialled on OVID Medline on 23 March 2022. The search will be peer-reviewed according to the peer review of electronic search strategies[64] and then executed on relevant databases, including Ovid Medline, Ovid Embase, Ovid PsycINFO, Ebsco CINAHL Plus, ProQuest ASSIA,

ProQuest Sociological Abstracts and ProQuest ERIC. A preliminary search was conducted on all databases using a single-term search strategy; single-term search strategies have been used to synthesise the literature on a broad topic to produce a high specificity/direct and feasible search.[65 66] The results retrieved from each database can be found in the supplementary material (online supplemental material 2). We will supplement our database search by searching the reference lists of the articles included in this review to identify additional studies that may not have been captured within the database search results.[67] Finally, we will identify relevant conference proceedings from Embase, Web of Science and Proceedings First for Conference Proceedings.

Stage 3: study selection

We will deduplicate the search results using Endnote, a reference management software. Non-English articles retrieved in the search will be translated using Google Translate, a low cost but effective strategy used in previous reviews.[68] Covidence software will be used to screen the titles and abstracts and perform the full-text review. We will pilot test our inclusion criteria on a random set of search results[69] to ensure strong inter-rater reliability among screeners.[70] Following this, two reviewers will independently screen titles and abstracts of all articles against the inclusion criteria. The two reviewers will independently conduct a full-text review on all studies deemed eligible at the title and abstract screening. A third reviewer will resolve any disagreements relating to study eligibility at the full-text review stage.

Stage 4: charting the data

A purely descriptive data-charting form will be developed collaboratively by the research team to extract data with information relevant to the research questions and objectives:

▶ Study, context and population characteristics: article type, journals, authors, countries, publication discipline/field, area of healthcare, client/participant (if applicable), provider(s) involved (if applicable).

▶ Concepts, descriptions, definitions, recommendations, training/educational suggestions, relevant theories and frameworks related to cultural humility.

Two reviewers will test the form by independently extracting data from the same 5–10 articles and their extractions will be compared to ensure the form captures all data relevant to answering the research questions.[55] The form will be updated continually during data extraction to capture all relevant information needed to answer the research question. In addition, regular team meetings will be held to resolve any uncertainty during extraction and ensure timely progress.

Stage 5: collating, summarising and reporting the results

A multistaged analysis is planned for collating, summarising and reporting the results (see figure 1).

Objective 1

The findings related to the extent and nature of data will be aggregated on Microsoft Excel using summary statistics (eg, number of studies by publication year, design, country[57]) and descriptive (eg, type of studies) summaries to generate an overview of the data. This information will allow us to comprehensively describe the extent and nature of the literature on cultural humility. Data pertaining to the concepts, descriptions and definitions of cultural humility and practice recommendations (eg, training/educational suggestions) will be critically examined by the research team with an interpretive epistemological perspective. We will follow Thomas and Harden's thematic synthesis approach[71] to move beyond descriptions of the data to infer new insights (eg, implications for practice) or critiques (eg, what is missing) about the topic. This analysis will be accomplished by research team members independently generating inductive themes from the extracted data and then refining the themes through team discussions and theme comparisons.[71]
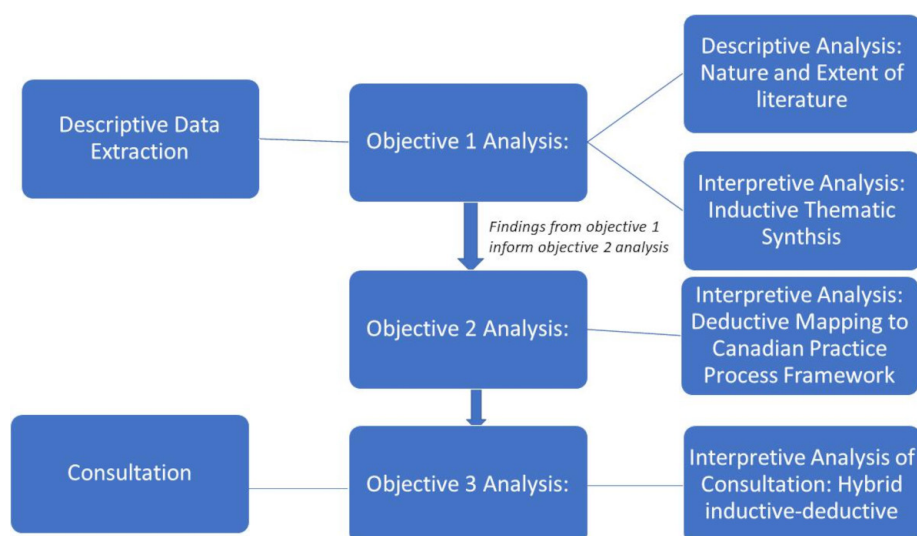

Figure 1 Overview of planned analyses.

Table 1 Description of the deductive codes informed by the Canadian Practice Process Framework (CPPF)

Deductive codes from the CPPF[72]	Brief description of the deductive codes from the CPPF[72]
Action points	
Enter/initiate	Occupational therapist identifies client/stakeholder after receiving referral, gathers informed consent, forms therapeutic relationships (first point of contact), provides client with information to enable them to make informed decisions and provide informed consent
Set the stage	Occupational therapist discusses client's occupational history/life course narrative to understand occupational issues and goals, builds rapport with client, client and occupational therapist share rules/expectations, roles, responsibilities, expectations
Assess/evaluate	Occupational therapist conducts an in-depth assessment of the person, environment and occupational factors impacting client's occupational issue/goals and shares possible recommendations based on the assessment and determines if further intervention is needed
Agree on objectives and plan	Occupational goals, objectives and a plan are collaboratively developed by client, occupational therapist and other relevant stakeholders
Implement the plan	Plan is implemented
Monitor/modify	An ongoing evaluation is conducted to monitor the plan with respect to the objectives, modifications to the plan may be made
Evaluate outcome	Attainment of occupational goals is evaluated, and further goals may be identified
Conclude/exit	The therapeutic relationship is concluded, client may be referred to other resources and information regarding re-entry is shared
Contextual elements	
Societal context	Broader societal context may include cultural, institutional, physical and/or social environment that individuals are situated within
Practice context (embedded within societal context)	Occupational therapist and client's personal (eg, health, age, gender, ethnicity) and environmental (eg, physical, social, cultural, institutional) context
Frames of reference	Any theories, constructs, concepts that can guide understanding of occupational challenges and clinical decision-making processes

Objective 2

To address objective 2, extracted data pertaining to the concepts, descriptions and definitions and recommendations of cultural humility (ie, findings from objective 1), including training/educational suggestions, relevant theories and frameworks, will be re-examined. The extracted data will be recoded deductively onto the CPPF,[72] a framework that guides evidence-based OT practice,[73] to frame cultural humility within clinical OT interactions. The CPPF is suitable for this analysis of the study findings because it is a globally recognised and implemented approach to OT practice across practice settings.[72] The CPPF outlines eight action points that an OT engages in with a client (ie, enter/initiate; set the stage; assess/evaluate; agree on objectives and plan; implement the plan; monitor/modify; evaluate outcome; and conclude/exit) and three contextual factors that inform OT practice and the therapeutic relationship (ie, societal and practice context and frame of reference), which will serve as codes (see table 1).[72] For example, any text relating to obtaining consent for a health service, building a relationship with the client and determining the appropriateness of referral will be coded in code 1 of the CPPF (ie, enter/initiate).[72] Two reviewers with a background in OT will carefully review, interpret and independently code the relevant data on Nvivo (a qualitative analysis software).[74]

The researchers will compare their coding schemes, consolidate any differences in coded data through discussion and confirm that all relevant content has been coded.[74] The findings will be presented to the entire research team, including occupational therapists and OT scholars, who will critique the findings and the literature.

Stage 6: consultation (objective 3)

As the study findings from objective 2 aim to enhance understanding of cultural humility in relation to OT practice, we will consult with 10–15 occupational therapists and OT clients. The expected outcomes of the IKT consultation exercise will be: (1) confirmation of the CPPF mapping from stage 5 and (2) generation of a final set of recommendations for the practice of cultural humility in OT practice, addressing objective 3. By consulting occupational therapists and OT clients, we anticipate we will enhance the relevance of these research outputs.[57]

Occupational therapists and clients from diverse practice settings and cultural backgrounds will be invited to participate in an hour-long group consultation meeting. During the consultation, the researchers will present the CPPF mapping from stage 5 to participants and then ask them to provide their feedback using semistructured, open-ended interview questions. For example, we will ask occupational

therapists how the findings resonate with their unique clinical settings and roles. After this, we will work with participants to derive practice recommendations based on the review findings using an interpretive analysis approach, wherein the consultations will be conducted, recorded and transcribed on Zoom, and then analysed using a qualitative hybrid inductive-deductive thematic analysis.[75]

Strengths and limitations

The strengths of this review include the following. First, this review will entail a rigorous and peer-reviewed search for the cultural humility literature. Second, the review will use an IKT approach to ensure key stakeholders' perspectives have been represented in this research (eg, methodology and findings) and enhance the relevancy and accelerate the uptake of findings. Third, we will consult with practicing occupational therapists and OT clients as they are the primary knowledge users of this work. Fourth, multiple researchers will be involved in data collection and analysis, enhancing the review's quality.[55] Finally, we have a large research team with diverse experiences in terms of self-identifying as belonging to marginalised groups, as well as diversity in culture, ethnicity, age, research discipline, educational background and training, which will enrich the review analysis and findings.

This review will include the following limitations. First, the term cultural humility is not adequately indexed in databases, increasing the potential to overlook relevant studies in our search. Second, the database search will be limited to the literature that has explicitly used the English term cultural humility within their bibliographic record (eg, titles or abstracts) for feasibility. However, this will increase the risk of excluding relevant studies that may have used the term in their full text but not their title or abstract. Third, our review will be limited to the publicly available literature; thus, this review will not capture cultural humility as outlined in organisational documents not publicly available. Fourth, this review will not examine the cultural safety literature as it is outside the scope of the current review. Thus, future research will be needed to explore the practice of cultural safety across the practice process and develop a better understanding of how it might be diverse from cultural humility in OT. Finally, while translating non-English articles using Google Translate will enable us to include non-English articles, there is a risk of inaccuracies within translated material.[68]

Ethics and dissemination

Ethics approval was not required for this scoping review protocol. Ethics approval will be obtained from the Research Ethics Board of the University of Toronto prior to the consultation exercise. The findings from the planned review will be shared with the following targeted audiences: (1) occupational therapists, (2) OT scholars and educators, (3) rehabilitation scholars, (4) lay and public audiences and (5) health service administrators through peer-reviewed publications (eg, the first manuscript reporting objective 1 and second reporting objectives 2 and 3) and presentations at OT conferences and local organisations where occupational therapists work.

Author affiliations
[1]Department of Occupational Science & Occupational Therapy, Temerty Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada
[2]Toronto Rehabilitation Institute, University Health Network, Toronto, Ontario, Canada
[3]Rehabilitation Sciences Institute, Temerty Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada
[4]Gerstein Science Information Centre, University of Toronto, Toronto, Ontario, Canada
[5]Department of Medicine, Geriatrics Program, Sinai Health and University Health Network, Toronto, Ontario, Canada
[6]Bridgepoint Collaboratory for Research and Innovation, Lunenfeld-Tanenbaum Research Institute, Sinai Health System, Toronto, Ontario, Canada
[7]Institute of Health Policy, Management & Evaluation, University of Toronto, Toronto, Ontario, Canada
[8]March of Dimes Canada, Toronto, Ontario, Canada

Twitter Kristina Marie Kokorelias @kmkokorelias

ORCID iDs
Hardeep Singh http://orcid.org/0000-0002-7429-5580
Ruheena Sangrar http://orcid.org/0000-0002-4207-9066
Kristina Marie Kokorelias http://orcid.org/0000-0002-1277-472X

REFERENCES

1 Ruckert A, Huynh C, Labonté R. Reducing health inequities: is universal basic income the way forward? *J Public Health* 2018;40:3–7.
2 WHO. Health inequities and their causes, 2018. Available: https://www.who.int/news-room/facts-in-pictures/detail/health-inequities-and-their-causes [Accessed 04 Mar 2022].

3 National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, *et al*., editors. *Communities in action: pathways to health equity. The root causes of health inequity*. Washington (DC): National Academies Press, 2017. https://www.ncbi.nlm.nih.gov/books/NBK425845/

4 Exworthy M, Bindman A, Davies H, *et al*. Evidence into policy and practice? Measuring the progress of U.S. and U.K. policies to tackle disparities and inequalities in U.S. and U.K. health and health care. *Milbank Q* 2006;84:75–109.

5 Government of Canada. Key health inequalities in Canada: a national portrait – executive summary, 2018. Available: https://www.canada.ca/en/public-health/services/publications/science-research-data/key-health-inequalities-canada-national-portrait-executive-summary.html

6 Kirst M, Shankardass K, Singhal S, *et al*. Addressing health inequities in Ontario, Canada: what solutions do the public support? *BMC Public Health* 2017;17:7.

7 Kim PJ. Social determinants of health inequities in Indigenous Canadians through a life course approach to colonialism and the residential school system. *Health Equity* 2019;3:378–81.

8 Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security. Reducing Health Disparities - Roles of the Health Sector: Discussion Paper, 2005. Available: https://www.phac-aspc.gc.ca/ph-sp/disparities/pdf06/disparities_discussion_paper_e.pdf [Accessed 02 Mar 2022].

9 Markham R, Hunt M, Woollard R, *et al*. Addressing rural and Indigenous health inequities in Canada through socially accountable health partnerships. *BMJ Open* 2021;11:e048053.

10 Global News. Coronavirus pandemic exposing health inequities among Canadians experts say, 2020. Available: https://globalnews.ca/news/6980483/canada-coronavirus-socioeconomic-factors/ [Accessed 02 Mar 2022].

11 Government of Canada. Health inequalities in Canada, 2019. Available: https://www.canada.ca/en/public-health/services/video/health-inequalities-canada.html [Accessed 02 Mar 2022].

12 Braveman P, Gruskin S. Defining equity in health. *J Epidemiol Community Health* 2003;57:254–8.

13 Jones B, Heslop D, Harrison R. Seldom heard voices: a meta-narrative systematic review of Aboriginal and Torres Strait Islander peoples healthcare experiences. *Int J Equity Health* 2020;19:222.

14 Riley WJ. Health disparities: gaps in access, quality and affordability of medical care. *Trans Am Clin Climatol Assoc* 2012;123:167–74.

15 Waldron I. *The impact of inequality on health in Canada: a multi-dimensional framework*, 2010.

16 Dryden O, Nnorom O. Time to dismantle systemic anti-black racism in medicine in Canada. *CMAJ* 2021;193:E55–7.

17 The Black Experiences in Health Care Symposium Planning Committee. Black experiences in healthcare symposium, 2020. Available: https://static1.squarespace.com/static/5a0d40298dd041f9a60bb3a7/t/5ea9a317983eca78fd95ee6d/1588175652047/Full+Report-+Black+Experiences+in+Health+Care+Symposium+2020.pdf [Accessed 02 Mar 2022].

18 Brach C, Fraser I. Reducing disparities through culturally competent health care: an analysis of the business case. *Qual Manag Health Care* 2002;10:15–28.

19 AHRQ. Improving cultural competence to reduce health disparities for priority populations, 2014. Available: https://effectivehealthcare.ahrq.gov/products/cultural-competence/research-protocol [Accessed 02 Mar 2022].

20 Hughes V, Delva S, Nkimbeng M, *et al*. Not missing the opportunity: strategies to promote cultural humility among future nursing faculty. *J Prof Nurs* 2020;36:28–33.

21 Chang E-shien, Simon M, Dong X. Integrating cultural humility into health care professional education and training. *Adv Health Sci Educ Theory Pract* 2012;17:269–78.

22 Stubbe DE. Practicing cultural competence and cultural humility in the care of diverse patients. *Focus* 2020;18:49–51.

23 Blackburn F. 'Cultural Competence is for Everyone': Cultural Competence in the United States Library and Information Sector. In: *Is It Relevant to Australian Libraries? Australian Academic & Research Libraries*. , 2015: 46, 176–93.

24 Curtis E, Jones R, Tipene-Leach D, *et al*. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *Int J Equity Health* 2019;18:174.

25 Cross TL, Bazron BJ, Dennis KW, *et al*. Towards a culturally competent system of care, 1989CASSP Technical Assistance Center. Available: https://spu.edu/-/media/academics/school-of-education/Cultural-Diversity/Towards-a-Culturally-Competent-System-of-Care-Abridged.ashx [Accessed July 16 2022].

26 Shen Z. Cultural competence models and cultural competence assessment instruments in nursing: a literature review. *J Transcult Nurs* 2015;26:308–21.

27 Greene-Moton E, Minkler M. Cultural competence or cultural humility? moving beyond the debate. *Health Promot Pract* 2020;21:142–5.

28 Isaacson M. Clarifying concepts: cultural humility or competency. *J Prof Nurs* 2014;30:251–8.

29 Murray-García J, Tervalon M. The concept of cultural humility. *Health Aff* 2014;33:1303.

30 Lekas H-M, Pahl K, Fuller Lewis C. Rethinking cultural competence: shifting to cultural humility. *Health Serv Insights* 2020;13:117863292097058.

31 Tervalon M, Murray-García J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor Underserved* 1998;9:117–25.

32 Foronda C, Baptiste D-L, Reinholdt MM, *et al*. Cultural humility: a concept analysis. *J Transcult Nurs* 2016;27:210–7.

33 Agner J. Moving from cultural competence to cultural humility in occupational therapy: a paradigm shift. *Am J Occup Ther* 2020;74:7404347010p1–7404347010.

34 Waters A, Asbill L. Reflections on cultural humility, 2013. Available: https://www.apa.org/pi/families/resources/newsletter/2013/08/cultural-humility [Accessed 28 Jun 2022].

35 Foronda C, Prather S, Baptiste D-L, *et al*. Cultural Humility Toolkit. In: *Nurse educator*. Publish Ahead of Print, 2022.

36 Moon SH, Sandage SJ. Cultural humility for people of color: critique of current theory and practice. *J Psychol Theol* 2019;47:76–86.

37 Rivera PM G-GC. Diversity training: an overview. In: Edwards S, Sellers TS, Cheon HS, *et al*, eds. *A practice beyond cultural humility*. New York: Routledge, 2020.

38 Hook JN, Davis DE, Owen J, *et al*. Cultural humility: measuring openness to culturally diverse clients. *J Couns Psychol* 2013;60:353–66.

39 First Nations Health Authority. #itstartswithme Creating a Climate for Change. Available: https://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf [Accessed 16 Jun 2022].

40 Fraser Health. Cultural safety and humility, 2022. Available: https://www.fraserhealth.ca/health-topics-a-to-z/aboriginal-health/cultural-safety-and-humility#.YquD_HbMK0w [Accessed 16 Jun 2022].

41 BC Patient Safety & Quality Council. Cultural Safety & Humility, 2022. Available: https://bcpsqc.ca/improve-culture/cultural-safety-and-humility/

42 Division of Family Practice. Cultural safety and humility, 2022. Available: https://divisionsbc.ca/victoria/resources/cultural-safety-and-humility-resources [Accessed 16 Jun 2022].

43 College of Physical Therapists of British Columbia. Cultural safety and humility, 2022. Available: https://cptbc.org/cultural-safety-humility/

44 College of Dieticians of British Columbia. Cultural safety and humility, 2022. Available: https://collegeofdietitiansofbc.org/cultural-safety-and-humility-qa/ [Accessed 16 Jun 2022].

45 College of Pharamists of British Columbia. Our commitment to cultural humility, 2022. Available: https://www.bcpharmacists.org/humility#Commitment [Accessed 16 Jun 2022].

46 Ariano E, Dueck L, Raposo T. Enhancing cultural humility and culturally safer practices for Indigenous clients in occupational therapy, 2021. Available: msot.mb.ca/wp-content/uploads/2021/09/1-MSOT-Cultural-Humility-Resource-FINAL-2021.pdf [Accessed 16 Jun 2022].

47 Ariano E, Dueck L, Raposo T, *et al*. Enhancing cultural humility and culturally safer practices for Indigenous clients in occupational therapy, 2021Manitoba Society of Occupational Therapists. Available: http://www.msot.mb.ca/wp-content/uploads/2021/09/1-MSOT-Cultural-Humility-Resource-FINAL-2021.pdf [Accessed July 16 2022].

48 COTO. Code of ethics, 2011. Available: https://www.coto.org/docs/default-source/pdfs/code-of-ethics-2020.pdf?sfvrsn=ec605359_24 [Accessed 23 Mar 2021].

49 American Occupational Therapy Association. Educator's guide for addressing cultural awareness, humility, and dexterity in Occupational Therapy Curricula. *Am J Occup Ther* 2020;74:7413420003p1–7413420003.

50 Mosher DK*et al*. *Cultural humility: A therapeutic framework for engaging diverse clients*. US: Educational Publishing Foundation, 2017: 221–33.

51 Reberg J. *The importance of cultural humility in occupational therapy*. Western Michigan University, 2019.

52 Mahoney WJ, Kiraly-Alvarez AF. Challenging the status quo: Infusing non-Western ideas into occupational therapy education and practice. *The Open Journal of Occupational Therapy* 2019;7:1–10.

53 Hammell KRW. Occupation, well-being, and culture: Theory and cultural humility / Occupation, bien-être et culture : la théorie et l'humilité culturelle. *Can J Occup Ther* 2013;80:224–34.

54 Arksey H, O'Malley L. Scoping studies: towards a methodological framework. *Int J Soc Res Methodol* 2005;8:19–32.

55 Levac D, Colquhoun H, O'Brien KK. Scoping studies: advancing the methodology. *Implement Sci* 2010;5:69.

56 Tricco AC, Lillie E, Zarin W, *et al*. PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. *Ann Intern Med* 2018;169:467–73.

57 Gagliardi AR, Berta W, Kothari A, *et al*. Integrated knowledge translation (IKT) in health care: a scoping review. *Implement Sci* 2016;11:38.

58 Crotty MJ. *The Foundations of Social Research : Meaning and Perspective in the Research Process*. 1st ed. Newbury Park, California: Sage Publications Ltd, 1998.

59 Burr V. *Social Constructionism*. London, UK: Routledge, 2015.

60 Hutchinson JR, Huberman M. Knowledge dissemination and use in science and mathematics education: a literature review. *J Sci Educ Technol* 1994;3:27–47.

61 Thomas A, Menon A, Boruff J, *et al*. Applications of social constructivist learning theories in knowledge translation for healthcare professionals: a scoping review. *Implement Sci* 2014;9:54.

62 Abrams JA, Tabaac A, Jung S, *et al*. Considerations for employing intersectionality in qualitative health research. *Soc Sci Med* 2020;258:113138.

63 Peters M. *Guidance for the conduct of JBI scoping reviews*, 2017.

64 McGowan J, Sampson M, Salzwedel DM, *et al*. PRESS Peer Review of Electronic Search Strategies: 2015 Guideline Statement. *J Clin Epidemiol* 2016;75:40–6.

65 Luan H, Wang M, Sokol RL, *et al*. A scoping review of WeChat to facilitate professional healthcare education in mainland China. *Med Educ Online* 2020;25:1782594.

66 Holland JL, Wilczynski NL, Haynes RB, *et al*. Optimal search strategies for identifying sound clinical prediction studies in EMBASE. *BMC Med Inform Decis Mak* 2005;5:11.

67 Richards D. Handsearching still a valuable element of the systematic review. *Evid Based Dent* 2008;9:85.

68 Balk EM *et al*. *AHRQ methods for effective health care, in assessing the accuracy of Google translate to allow data extraction from trials published in non-English languages*. Rockville (MD: Agency for Healthcare Research and Quality (US), 2013.

69 Landis JR, Koch GG. The measurement of observer agreement for categorical data. *Biometrics* 1977;33:159–74.

70 McHugh ML. Interrater reliability: the kappa statistic. *Biochem Med* 2012;22:276–82.

71 Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Med Res Methodol* 2008;8:45.

72 Townsend E, Polatajko H. *Enabling occupation II: Advancing an occupational therapy vision for health, well being & justice through occupation*. Ottawa, ON: CAOT Publications, 2007.

73 Fazio K, Hicks E, Kuzma C. The Canadian practice process framework: using a conscious approach to occupational therapy practice. In: *OT now 10*, 2008: 6–9.

74 Bengtsson M. How to plan and perform a qualitative study using content analysis. *NursingPlus Open* 2016;2:8–14.

75 Fereday J, Muir-Cochrane E. Demonstrating rigor using thematic analysis: a hybrid approach of inductive and deductive coding and theme development. *Int J Qual Methods* 2006;5:80–92.