

Original Paper

Implementation of Cultural Competence Education into Athletic Training Programs: A Qualitative Report

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Received: December 15, 2020 Accepted: December 28, 2020 Online Published: February 5, 2021

doi:10.22158/grhe.v4n1p32

URL: <http://dx.doi.org/10.22158/grhe.v4n1p32>

Abstract

Cultural competence education is a foundational behavior of professional practice that Athletic Training Programs (ATPs) have been tasked to incorporate into their curriculums. Ten ATP faculty were individually interviewed to determine the current methods used to teach provision of culturally competent care. Four major themes were identified: 1) Barriers to cultural competence education implementation in a didactic setting, 2) Strategies for incorporation into an existing didactic curriculum, 3) Barriers to cultural competence education in a clinical setting, and 4) Strategies to implement cultural competence education into an existing clinical model. Further research is necessary to determine the effectiveness of specific strategies.

Keywords

diversity, multicultural care, professional education, practical application

1. Introduction

Within the United States, the lack of diversity within healthcare providers has been demonstrated to have a negative impact on the quality of healthcare provided to a highly diverse patient population (Lie et al., 2011). It has been shown that cultural differences between the provider and patient may create barriers to providing the best possible care, often times due to a lack of understanding (Renzaho et al., 2013; Cooper et al., 2012; Maurer-Starks, Clemons, & Whalen, 2008). In research within the field of health care, a link has been established between higher patient outcomes and culturally competent

health care professionals (Renzaho et al., 2013; Cooper et al., 2012; Lie et al., 2011; Maurer-Starks et al., 2008). The lack of understanding of the impact of an individual's culture on patient care seems especially problematic due to the lack of cultural competence seen in certified athletic trainers and athletic training students (Marra et al., 2010; Maurer-Starks et al., 2008; Volberding, 2014, 2015). Marra et al. (2010) demonstrated that athletic trainers are operating at lower levels of cultural competence according to scores on the Cultural Competence Assessment (CCA), even after self-reported high levels of cultural competence prior to measure. Athletic training students have also demonstrated the trend of high confidence in providing appropriate care yet lacking in the actual ability (Marra et al., 2010; Volberding, 2014, 2015). In an ongoing study, athletic trainers have also demonstrated the lowest scores across multiple health care professions on the modified Gay Affirmative Practice Scale (mGAP) when providing care to individuals who identify as gay, lesbian, or bisexual (Madrak, Volberding, Harris, Richardson, unpublished data 2015).

A number of approaches have been offered from researchers within the varying fields within health care as to how to make professionals more culturally competent (Crawford, Candlin, & Roger, 2017; Betancourt et al., 2016; Renzaho et al., 2013; Like, 2011). It has been suggested that the best way to increase the quality of healthcare provided to all patients is to attempt to increase the diversity of the practitioner population to be more reflective of the general patient population (Kirmayer, 2012). This was first suggested based on the theory that less barriers to understanding would present if there was a more common background between health care providers and the patients they are treating (Kirmayer, 2012). Historical demographics have demonstrated the profession of athletic training lacks diversity in the practitioner population (Pacquiao, 2007). The National Athletic Trainers' Association (NATA) demographics show that in September of 2018, only 20.1% of the professional population identified as an ethnicity other than white non-Hispanic (NATA, 2018), yet these individuals provide care to an extremely diverse patient population. Looking at current trends regarding career setting within athletic training, the profession is seeing a departing from the traditional collegiate setting and a branching out into other areas of patient care (NATA, 2018). The second most populated job setting for athletic trainers in in the secondary school setting, hosting 19.38% of our athletic training professional population (NATA, 2018). Clinic settings host the third most, at 12.89% (NATA, 2018). The US Census Bureau estimates that by the year 2060, approximately only 44% of the US population will identify themselves as non-Hispanic white (US Census Bureau, 2014), showing a major disparity between those providing care and those receiving care, should membership trends continue as they have previously. Combining the changing demographics within the United States with the career setting changes within the athletic training profession, practitioners are going to be caring for an ever diversifying and changing patient population more so now than ever before. Researchers do caution that there is no shown relationship between diverse populations and an increase in cultural competence at this time, further exploration will be necessary to determine effectiveness of increased diversity on cultural competence levels of practitioners (Pacquiao, 2007).

While increasing the exposure to a more diverse patient population has been identified as the ideal method of improving culturally competent healthcare delivery, the most common method identified in the literature of improving a clinician's cultural competence is seen in the form of additional training. This training typically is in the form of continuing education after national certification has already been obtained (Barnes et al., 2013; Renzaho et al., 2013; Like, 2011). Though, Barnes et al. (2013) have demonstrated that the skills do not transfer when the clinician is placed in a work setting that does not support the continuing use of these skills. Within the fields of pharmacy, nursing, and medical education, research has demonstrated an increase in quality of health care provided once cultural competence education had been given (D. Kim, & S. Kim, 2013; Rowan et al., 2013; Long, 2012; Lie et al., 2011). Within the field of athletic training, athletic trainers with self-reported diversity training scored higher on the Cultural Competence Assessment (CCA), and its two subscales, the Cultural Awareness and Sensitivity Scale (CAS) and the Cultural Competence Behavior (CCB), than those that did not, suggesting that further cultural competence education is indicated for all health care professions to improve patient outcomes (Marra et al., 2010).

Beyond the post-certification education, research within the health care field on cultural competence education has found that there needs to be more emphasis on the education provided to students in health care fields throughout their curricula (Calvillo et al., 2009; Lipson & Desantis, 2007; Seeleman, Suurmond, & Stronks, 2009). Specific to athletic training, we are seeing research that suggests that students want more information on this topic to allow them to be more informed clinicians with better relationships with their patients (Nynas, 2015). In 2011-2012, The Commission on the Accreditation of Athletic Training Education (CAATE) and the NATA adapted and re-wrote their educational competencies to reflect the need for such education (CAATE, 2012; NATA, 2011). The fifth edition released in 2011, competencies listed in regards to cultural competence and diversity training are found under the foundations of professional practice (NATA, 2011). Educational programs are also being asked by the CAATE to provide proof of cultural competence education under the psychosocial content area found within the fifth edition of the competencies (NATA, 2011). When these governing bodies transitioned to the 2020 standards for Professional Master's Programs, the language changed from a direct statement surrounding cultural competence education to: "Communicate effectively and appropriately with clients/patients, family members, coaches, administrators, other health care professionals, consumers, payors, policy makers, and others" (CAATE, 2018). This reduction in the specific language was intended to be taken in the same spirit as previous versions of the content standards.

While cultural competence education has been deemed a necessity within health care education programs, limited research exists on cultural competence education and curriculum implementation. This project seeks to determine the current practices in educating a population with limited diversity to provide culturally competent care to patients of all racial/ethnic backgrounds. Our main questions included: How important do academic instructors feel cultural competence education is to the

profession of athletic training, how competent do academic instructors feel in delivering cultural competence education to athletic training students?, what barriers are seen in the delivery of cultural competence education within an existing athletic training curriculum?, what implementation strategies are currently being used in the delivery of cultural competence education within athletic training education? These research questions include both the didactic and clinical aspects of an education program.

2. Method

To best understand the different approaches that Athletic Training Programs (ATPs) are utilizing to educate students in cultural competence, the researchers selected a qualitative approach. This method allowed for rich, quality discussions in individual interviews. Confidentiality was ensured to capture personal thoughts and candid responses by informing participants that neither they nor their institution would be identified. All participants reviewed and gave verbal informed consent that was approved by an institutional review board. Two researchers with expertise in qualitative research design conducted all interviews. Nine of the 10 interviews occurred over the phone, and one occurred in person and lasted an average of 60 minutes. Interviews were preceded by a demographic questionnaire that included institutional and personal demographics, as well as a question designed to allow participants to indicate their level of perceived confidence in the delivery of cultural competence education on a Likert Scale from 1-5. Semi-structured interviews were guided by the questions identified in Table 1.

Table 1. Interview Questions

Questions
1) What is your definition of cultural competence?
2) Do you feel that cultural competence education is an essential component of an ATP and why?
3) What are the methods you are currently utilizing to educate your students in cultural competence in the classroom?
4) What are the best methods you are currently utilizing in the clinical setting to educate your students in cultural competence?
5) What in your program assists you in cultural competence education?
6) What in your program hinders your cultural competence education?
7) Do you feel that your current clinical instructors/ preceptors are well educated in cultural competence and able to demonstrate this to your students? Why or why not?

Interview questions were created and agreed upon by the research team based on current literature in cultural competence as well as in athletic training education prior to the solicitation of participants.

2.1 Participants

An *a priori* data saturation of faculty members from various athletic training programs from various institutional types and from across the country was set to establish geographical and institutional diversity. This target was met with 10 faculty members (four male, six female), representing institutions that spanned from undergraduate private religious to public doctoral research institutions and represented six of the ten NATA membership districts. Participants were not selected based on their cultural competence education experience, as they were meant to be representative of the larger population of athletic training educators. The full distribution of participants can be found in Table 2. The average number of years of teaching experience was 13.6 ± 7.41 .

Table 2. Participant Demographics

<i>Pseudonym</i>	<i>Gender</i>	<i>Years Teaching[#]</i>	<i>Institution Type^{**}</i>	<i>NATA District</i>
Cathy	Female	6	Private UG- HBCU	3
Jessica	Female	4	Private Masters LP	5
Mary	Female	24	Public R3	2
Patti	Female	13	Public R2	5
Ryan	Male	13	Private R2	5
Sam	Male	21	Public R3	8
Sarah	Female	23	Public Masters LP	1
Steve	Male	14	Public Masters LP	2
Theresa	Female	14	Public Masters LP	5
Tim	Male	4	Public Masters MP	9

Note. R2: Higher research activity. LP: Large program (annually awarding 200+ masters degrees). MP: Medium program (annually awarding 100-199 masters degrees). UG-HBCU: Undergraduate Programs-Historically Black College or University.

**Based on the Carnegie Classification of Institutions of Higher Education.

#Years teaching in athletic training education.

2.2 Data Analysis

Quantitative data was analyzed by SPSS 23.0. The data analyzed included years of teaching experience and the self-rated item of perceived abilities. Qualitative data were transcribed and coded by a team of three experts using general inductive method of analysis (Thomas, 2006). Main themes were identified, data were categorized, and conclusions were formed using the constant comparative analysis method is “based on suggested techniques to ensure trustworthiness of the study” and utilized the stages of analysis as dictated by Brown et al. (2014). The team of experts first familiarized themselves with current literature on cultural competence in athletic training education and agreed on common words

and statements (Brown et al., 2014). Second, they each independently read the data and coded themes. The team then met to discuss and reach a consensus on overall themes. Fourth, they separately read and categorized statements or segments into the agreed upon themes from the previous meeting. Finally, the team discussed and reached a consensus on the coding for each statement or segment. Member checks were utilized throughout the process by discussing interpretations of themes and statements with members of the original participant groups.

3. Result

The four major themes that were identified within the data are: 1) Barriers to academic implementation of cultural competence education, 2) Strategies to incorporate cultural competence education into an existing curriculum, 3) Barriers to clinical implementation of cultural competence education, 4) Strategies to effectively incorporate cultural competence education into the clinical setting. Each of these themes is explained below, including supporting and explanatory quotes. Pseudonyms were used to protect the identity of participants.

3.1 Academic Implementation Barriers

Overarching barriers to academic implementation accounted for 22 different comments within the data and included subthemes such as: lack of diversity within the staff, institution, or surrounding population; discomfort in addressing the topic due to lack of perceived abilities; perceived ignorance as to how to incorporate cultural competence education; and time within the curriculum to implement material.

It was stated by multiple subjects that the diversity students encountered on their campuses was limited, with the academic program of athletic training often times hovering right at or below the campus wide percentage.

Sarah commented:

“I think one of the things that hinders would just be looking round at the faculty which we have, we’re all white... although I’m probably a bit more sensitive to issues because of my personal life, I can’t know everything there is to know and I still carry my own stereotypes with me. It’s not reflective in the people who study athletic training. We are still pretty much heavy white English speaking individuals who are studying it and my assumption is that we probably have the same reflection in the faculty who are teaching it and so knowing that the population is going to be shifting, we are going to be providing services and healthcare to a population that in some ways will be different of who we are and hence the some reason it’s imperative that we reach out and make sure we understand it, not just because that’s what’s going to be happening as far as the demographics but because that’s the right thing to do.

Another barrier that was discussed and presented as a consistent theme throughout the interviews with participants was the discomfort in addressing the topic due to a perceived personal lack of abilities. This was seen in both the statistical analysis of the Likert scale abilities score where the average

response for a Likert scale 1-5 question was a $3.15 \pm .75$ and in comments made by participants. Ryan commented, "This isn't something that people, in athletic training at least right now... where no one talks about this out loud".

Jessica added:

"I think the first step is me taking an active role in how to figure that out and then educating our preceptors and our other instructors on how to incorporate it as well, not necessarily dictate on that they do that in their classroom but encourage it... and give them tools to use on how to incorporate it".

An additional component that many stated as a barrier to implementation of cultural competence was having the time within the curriculum to address the topic.

Sam stated:

"What a lot of people would say is 'Time', how can I fit this in and I think also, the other thing that has hindered is getting other people in your program to understand the importance of it because I think some people, you need to get the 'buy in' and for some people they feel as though students will learn these things through experience, and yes they will get better through experience but I think they need a foundational understanding just like anything we teach them".

While barriers exist, the underlying theme to the discussion was the realization that if cultural competence is not addressed, it can lead to major problems down the road.

Mary stated:

"If we can't teach students to filter or be aware of the sensibilities that certain people are operating under, then we don't know what buttons might be pushed when working with them that can cause major damage to the professional relationship that we are trying to cultivate".

Tim commented:

"[It's] Essential the idea of bringing in not only other cultures in your athletic training program, but within in the realm of athletic training in general, how to interact with other cultures so we can treat more effectively, treat more accordingly"

3.2 Academic Implementation Strategies

Academic implementation strategies encompassed a wide range of ideas totaling 38 different suggestions within the data; however, a major subtheme was weaving cultural competence education throughout the entire curriculum, which accounted for 13 of the 38 suggested implementation strategies. An idea expressed by multiple subjects was the option of having subscribed implementation method; however, it was suggested more as a way to help educators to weave cultural competence into multiple areas of a curriculum over time.

Steve stated:

"It almost seems like it's one of those things we need to learn some foundational information about but we also need to think about it through our entire curriculum. It's almost like the way

we look at writing at this point, it's not just something you do in an English class, it's something that goes throughout the curriculum".

Cathy added:

"You have to integrate your cultural competency through everything they do. That's why we talk about it in Gen Med and eval. And we talk about it in the clinical classes. It isn't a stand-alone anything because in practice it's not a stand-alone anything. You have to be culturally competent in everything you do".

Actively working to vary in-class examples was discussed as a way that these educators were already incorporating cultural ideas into their current curricula. These ideas included such ideas as: finding ways to incorporate a wider range of cultural backgrounds into visuals and in-class scenario examples and addressing cultural issues in specific discussions to create a rich dialog.

Theresa gave the example:

"In all of my examples, not just present pictures of a Caucasian male when I'm talking about a male, I try to show different races, different genders, different skin types in the pictures so that people can understand not every bruise is black and green or black and yellow or blue and yellow. Different skin colors show up differently, so, just hitting up on the things like that".

Sarah replied:

"I have them [students] write a little reflection piece up to say what did you learn from this? And we learn about stereotyping and we dialogue in class, where do we get it from and how do we change those 'tape record messages' that have given to use through family, church, media, etc. Trying to get us to, whenever we bring up examples in the classroom, try to make sure that we bring up specific examples that might hit on a specific population in".

3.3 Clinical Implementation Barriers

Overarching barriers to implementation of cultural competence education in the clinical setting accounted for 23 different comments within the data and included subthemes such as: current lack of diversity in both preceptor and treated populations, lack of cultural competence in clinical staff, and lack of focus on cultural competence education as a goal within clinical education experiences.

It was stated by multiple educators that the amount of diversity most students encountered on their campuses and within their clinical rotations was limited, especially due to the regional area in which they were housed. Institutional demographics seemed to play a large role in the diversity of the treated population and subsequent preceptors to which students were assigned.

Patti commented:

"We don't have a lot of diversity, we are very rural in a lot of things we do... we're very small town people compared to some of the things that people are exposed to out on the coast".

Theresa said:

"We're not a very diverse program, college, or even the larger community is not very diverse. So it's sometimes hard to go out and find those examples because everybody is serving as a

mentor for students or a preceptor for our students”.

Jessica stated:

“Because the sites we use are highly Anglo-Saxon. We use 3-4 public high schools who serve a pretty affluent community and then we use two private high schools who are very affluent communities”.

Cathy was able to give a unique aspect to this particular barrier to cultural competence education within their program housed at a Historically Black College/University (HBCU):

“There is a private high school, high SES [socio-economic status] students in our area and they’ve actually been one of the biggest supporters of our program, but it definitely means that my African American students on campus where they are the only African Americans, often times, for miles, when they cover these games”.

The idea was expressed by many that there was a focus to attempt to diversify the clinical experiences of the students to allow for exposure to a wide range of patient populations and preceptors. The participants indicated that the challenge in this was that the demographics of the program preceptors matched fairly closely to the demographics of the surrounding area in the lack of diversity.

Theresa responded:

“They do their best, but again they are in a non-diverse setting themselves. So many of them came from settings that are non-diverse, so they’ve never had the real world experience with differences”.

Mary said:

“They [students] struggle and that’s okay because I wasn’t them to struggle and I want them to know what it feels like to perhaps be uncomfortable and trying to get the frustration of, I don’t speak the language of this person, how can I help them? The reality is that, in some of our school districts, we do have some people who are speaking languages that the athletic trainer doesn’t know and the whole thing then is, how do we handle this?”

Another barrier to cultural competence education was that many participants indicated that there was a lack of cultural competence in the preceptors that are used by the programs. One participant in particular, Mary, gave a very poignant example of this barrier.

“None of our preceptors are fluent Spanish and some of them have been in that job for 10-12 years now. Over that time it hasn’t been important enough to really learn the language and as you know the last person to get a translator is the athletic trainer later in the afternoon, that’s one of the issues and they’re not seeing that and I try to tell them it’s critical that you get an understanding of what the problems are because if you miscommunicate or things are not followed because there was a communication issue whether it was language or culture language, that’s come back on you, you’re gonna bear the brunt of that legal decision even if we don’t talk about outcome”.

One participant, Cathy, was once again able to add a unique challenge that she is facing at a HBCU institution that was not seen in the challenges indicated by others.

“I’m really struggling to change the language, because students speak their own slang or whatever and they take that with them to the clinic and so we’ve really been working to try and get them to speak proper English and use the correct terminology and to them it’s a fine line because they identify so much with the way they speak and you’re trying to get themselves to present differently... We’re really struggling because you don’t want to stifle them, we’re trying to be sensitive to them and yet we know how that medical presentation comes across. For us, on this side, it’s how much do you insist on this and how much do you change behavior when really we’re talking about cultural issue on their side? It’s been an interesting dynamic that I haven’t faced before”.

The third and final barrier identified was a lack of focus on cultural competence education as a goal within the clinical setting. This was indicated to be both on the part of the program disseminating information to the preceptors and on the part of the preceptors taking the initiative to do so themselves.

Sara offered:

“What are their perceptions of the level of cultural competence of their preceptors? Much of the responses that I received was that they felt that they were fairly culturally competent and I said, based on what? How often do you know they do XYZ? Oh, I don’t know that. I agree, there needs to be more that’s done as far as education, so what does that mean?”

Jessica commented:

“I think from a professional scale, I think we’re trying to get there but I would say professionally I think there are a lot of things that people are like what does that actually mean and I could say that probably the EBP [evidence- based practice] people think that seems silly and say Ok, what do you want me to do about it? But I would also feel like cultural competence from a professional level we are at that point. Ok, I know it’s an important thing, I know I should be worried about it but I don’t really understand what it is, how to do it, how to incorporate it, how does it fit into my practice. I think if you were to ask a lot of clinicians, they would say well, I treat everyone the same, I treat everyone medically how they need to be treated. I think they would feel that they feel they were culturally competent”.

From an academic faculty perspective, many participants also addressed the lack of focus on cultural competence education on behalf of the program to the preceptors.

Tim commented:

“I can’t necessarily say, even as the clinical coordinator, that I spend time talking with my preceptors about how to incorporating that into their student education”.

Jessica responded:

“I think there are ways to incorporate it into our clinical but again right now if you ask me how to do it I would say I don’t know. I think the first step is me taking an active role in how

to figure that out and then educating our preceptors and our other instructors on how to incorporate it as well, not necessarily dictate on that they do that in their classroom but encourage it...and give them tools to use on how to incorporate it”.

Theresa offered:

“I would definitely need help and guidance on how to do that [cultural competence education in clinical setting], especially in a low diversity type of environment. I don’t know how to achieve that, but I would embrace putting into our clinical settings if given examples on how to do it”.

3.4 Clinical Implementation Strategies

Various implementation strategies were suggested by the participants as ways to increase the amount of cultural competence education in the clinical experiences of their students. The most common recurring suggestion assumes an ideal situation where it would be possible to vary the clinical rotation location to include different cultural areas and patients of differing backgrounds. While previously indicated as a specific limitation based on the location of each institution, comments from our participants did speak to the effectiveness that the small amounts of exposure that programs were able to offer even within their given limitation.

Mary commented:

“We do have some sites where, as I mentioned before, we have high populations of different groups of kids and I’m sure that the students are getting some of that from the preceptor. I’m the clinical coordinator and one of the things that I try to do is to make sure they are getting a spattering of a lot of different things”.

Tim said:

“One big advantage is that we do have a Japanese athletic trainer and she has done a tremendous amount to help our students with understanding athletic trainers from other cultures”.

Another implementation strategy suggested by participants is to encourage students and preceptors to have open and respectful discussions with patients from differing backgrounds. One participant, Ryan, spoke to the idea of open communication being important in interactions between patients and practitioners. “Five different athletes heard me say five different things, even though the words I said were the exact same”.

He adds:

“When we talk about preceptors in the rehabilitation clinic and orthopedic center, I think they [preceptors] probably do [address cultural competence education]. I don’t think they use the terminology, but I think they model it because they work with all different types of patients in different situation”.

Sam comments:

“It’s important for my students to see from a clinical perspective, when we do have African Americans or even Caucasians that aren’t responding in a cultural norm way in regards to pain or treatment, that I talk to them about it’s more than just looking at this person as they’re not ‘sucking it up’ like other people do, there is cultural influences going on in here”.

Perhaps the most profound commentary on the importance of communication and having respectful conversations revealed in the data came from one participant in particular.

Sara commented:

“Relationship is important, that’s an ingredient and it’s important to have good relationships. That takes an appreciation of the other person, the individual. In order to appreciate that person, I have to appreciate their culture and their perspective on things”.

4. Discussion

The findings of this study are similar to those in other healthcare professional programs, in that there is very little consistency in the implementation of cultural competence education among athletic training programs for various reasons. Most state that time for implementation and lack of strategies or ideas on how to implement are the biggest barriers to providing quality cultural competency education for their students. This has been followed by reports of lack of diversity within both the staff and the reported patient populations at various institutions.

The subjects interviewed for this study possess an average of 13.6 ± 7.41 years of teaching experience within athletic training, though when asked on a scale of 1-5 how they perceive their abilities to incorporate cultural competence into their education programs, the average response was 3.15 ± 75 . This has shown us that most educators that are required to implement cultural competence education into athletic training programs do not feel confident in their abilities to do so. Certain participants in this study have called for more prescriptive means of implementing cultural competence education, though it seems unlikely that this will occur in the near future given the higher need for institutional autonomy.

Strategies for implementation of cultural competence education were given, mostly from those with higher self-reported perceived abilities, but all included the major subtheme of implementation over time. This idea accounted for 13 of the 38 implementation strategy suggestions given by participants, and the majority of the participants interviewed in this study indicated that they are currently working to weave cultural competence education into the overall curriculum at their respective institutions and not attempting to address the topic all at once. This strategy is already being used within athletic training education to demonstrate integration of material at multiple points in the curriculum for almost all other required skill content areas. Strategies given by participants include diverse examples used in class settings to provide a visual consideration of diverse patient populations, reflections on personal biases related toward different cultures, and open discussion on the subject of diversity and how it

might impact injury and performance outcomes.

In both medical education programs and nursing education programs, we are able to see an approach to cultural competence education that is more similar to our findings within athletic training (Long, 2012; Betancourt & Cervantes, 2009). In an article done by Betancourt and Cervantes (2009), implementation strategies show integration throughout the existing medical curriculum at many different points. Their focus was three pronged; first by introducing concepts to change the attitudes of their students, second by giving more information to increase the knowledge of the student in relation to culture, and third to integrate that knowledge into applicable scenarios and critical thinking skills (Betancourt & Cervantes, 2009). The approach for nursing is similar, focusing on communication and scenario based knowledge application (Long, 2012). The implementation strategies given by the majority of the athletic training participants indicate that they follow a similar approach, first by introducing the topic and allowing the examination of biases, second by imparting knowledge that would help to increase understanding of cultural norms, and third by the use of varying case studies or in class examples to include cultural aspects, as well as the use of cultural aspects within clinical skills assessments. However, also similar to our field, Betancourt and Cervantes (2009) give no measurable assessment to their implementation strategies.

Within the research in the field of health care education, there is an ever-growing viewpoint that a clinical immersion experience within another culture as the best way to increase cultural competence in health care education (Long, 2012; Lipson & Desantis, 2007). It would stand to reason that greater exposure to a culture other than your own would increase cultural awareness and allow for adoption of cultural norms that would allow an individual to be fully functioning within that society. Within nursing programs across the country, a clinical immersion experience in a different cultural setting is becoming more and more common, though there is limited ability in measuring the impact this experience has on professional practice (Long, 2012; Lipson & Desantis, 2007). Certain athletic training programs are attempting to offer a similar experience to a small number of students, though the increasing difficulty of finding a supervising clinician outside the United States has been reported to greatly hinder the process.

4.1 Limitations and Suggestions for Future Research

Though the researchers attempted to be as varied as possible and capture the perspectives of educators from many different areas, backgrounds, and institutional types, this research does not encompass the entirety of approaches to cultural competence education within the field of athletic training. Though there are many similarities in barriers and implementation strategies from the participants included in this study, the possibility exists that unique and personal experiences within cultural competence education are not addressed within the content of this article. Further expansion on the research topic with a larger number of participants might yield different results.

In a similar need for additional research, the effectiveness of implementation strategies has also not been explored to this date. While many helpful examples are given, measurements and assessments are in the infancy of development within athletic training and similar health care fields (Betancourt & Cervantes, 2009; Lipson & Desantis, 2007). Assessment tools tend to focus on the perceptions of cultural competence or cultural awareness within students as measures of perceived levels of cultural competence (Maurer-Starks et al., 2008; Volberding, 2014, 2015). Further research is also necessary to measure not only the effectiveness of the implementation strategies given, but also to develop a measure for integration of cultural competence education concepts into clinical practice.

5. Conclusions

As the population of the United States continues to diversify, the AT profession must be prepared to encounter and effectively communicate with a patient population that could be much different than our own. As educators, particular emphasis has been placed on the need to incorporate cultural competence education into existing curricula, regardless of our comfort level in doing so. Limitations and barriers have been shown to exist in all areas of the country, with certain institutions hosting unique circumstances that might further complicate the ability for educators to increase cultural competence to the level they feel appropriate. Suggested implementation strategies have been given to help those in the field navigate and possibly incorporate a greater level of cultural competence education into an existing curriculum, though further research is needed to show the effectiveness of such strategies. As we continue to make cultural competence education a priority in our education programs, we as a profession can continue to strive to provide a high quality patient care experience to every individual, regardless of cultural background.

References

- Barnes, E., Bullock, A. D., Bailey, S. E. R., Cowpe, J. G., & Karaharju-Suvanto, T. (2013). A review of continuing professional development for dentists in Europe. *European Journal of Dental Education*, 17, 5-17. <https://doi.org/10.1111/eje.12045>
- Betancourt, J. R., & Cervantes, M. C. (2009). Cross-cultural medical education in the United States: key principles and experiences. *The Kaohsiung Journal of Medical Sciences*, 25(9), 471-478. [https://doi.org/10.1016/S1607-551X\(09\)70553-4](https://doi.org/10.1016/S1607-551X(09)70553-4)
- Brown, T. C., Volberding, J. L., Baghurst, T., & Sellers, J. (2014). Faculty/staff perceptions of a free campus fitness facility. *International Journal of Workplace Health Management*, 7(3), 156-170. <https://doi.org/10.1108/IJWHM-05-2013-0020>
- CAATE. (2012). *Standards for the accreditation of professional athletic training programs*. Austin, TX: Commission on Accreditation of Athletic Training Education.

- CAATE. (2018). *2020 Standards for the accreditation of professional athletic training programs: Master's Programs*. Austin, TX: Commission on Accreditation of Athletic Training Education. Adoption Date: January 9, 2018.
- Calvillo, E., Clark, L., Ballantyne, J. E., Pacquiao, D., Purnell, L. D., & Villarruel, A. M. (2009). Cultural competency in baccalaureate nursing education. *Journal of Transcultural Nursing*, *20*(2), 137-145. <https://doi.org/10.1177/1043659608330354>
- Cooper, L. A., Roter, D. L., Carson, K. A., Beach, M. C., Sabin, J. A., Greenwald, A. G., & Inui, T. S. (2012). The associations of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care. *American Journal of Public Health*, *102*(5), 979-987. <https://doi.org/10.2105/AJPH.2011.300558>
- Crawford, T., Candlin, S., & Roger, P. (2017). New perspectives on understanding cultural diversity in nurse-patient communication. *Collegian*, *24*(1), 63-69. <https://doi.org/10.1016/j.colegn.2015.09.001>
- Kim, D. H., & Kim, S. E. (2013). Cultural competence and factors influencing cultural competence in nursing students. *Journal of Korean Academy of Psychiatric and Mental Health Nursing*, *22*(3), 159-168. <https://doi.org/10.12934/jkpmhn.2013.22.3.159>
- Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, *49*(2), 149-164. <https://doi.org/10.1177/1363461512444673>
- Lie, D. A., Lee-Rey, E., Gomez, A., Bereknyei, S., & Braddock III, C. H. (2011). Does cultural competency training of health professionals improve patient outcomes? A systematic review and proposed algorithm for future research. *Journal of General Internal Medicine*, *26*(3), 317-325. <https://doi.org/10.1007/s11606-010-1529-0>
- Like, R. C. (2011). Educating clinicians about cultural competence and disparities in health and health care. *Journal of Continuing Education in the Health Professions*, *31*(3), 196-206. <https://doi.org/10.1002/chp.20127>
- Lipson, J. G., & Desantis, L. A. (2007). Current approaches to integrating elements of cultural competence in nursing education. *Journal of Transcultural Nursing*, *18*(1 suppl), 10S-20S. <https://doi.org/10.1177/1043659606295498>
- Long, T. B. (2012). Overview of teaching strategies for cultural competence in nursing students. *Journal of Cultural Diversity*, *19*(3), 102-108.
- Marra, J., Covassin, T., Shingles, R. R., Canady, R. B., & Mackowiak, T. (2010). Assessment of certified athletic trainers' levels of cultural competence in the delivery of health care. *Journal of Athletic Training*, *45*(4), 380-385. <https://doi.org/10.4085/1062-6050-45.4.380>
- Maurer-Starks, S. S., Clemons, H. L., & Whalen, S. L. (2008). Managing heteronormativity and homonegativity in athletic training: In and beyond the classroom. *Journal of Athletic Training*, *43*(3), 326-336. <https://doi.org/10.4085/1062-6050-43.3.326>

- NATA. (2011). *Athletic Training Education Competencies* (5th ed.). Dallas, TX: National Athletic Trainers' Association.
- NATA. (2018). *Ethnicity Demographic Data: September 2018*. Dallas, TX: National Athletic Trainers' Association. Retrieved from <https://www.nata.org/sites/default/files/ethnicity-demographic-data-sept-2018.pdf>
- Nynas, S. M. (2015). The assessment of athletic training students' knowledge and behavior to provide culturally competent care. *Athletic Training Education Journal*, 10(1), 82-90. <https://doi.org/10.4085/100182>
- Pacquiao, D. (2007). The relationship between cultural competence education and increasing diversity in nursing schools and practice settings. *Journal of Transcultural Nursing*, 18(1 suppl), 28S-37S. <https://doi.org/10.1177/1043659606295679>
- Renzaho, A. M. N., Romios, P., Crock, C., & Sønderlund, A. L. (2013). The effectiveness of cultural competence programs in ethnic minority patient-centered health care—A systematic review of the literature. *International Journal for Quality in Health Care*, 25(3), 261-269. <https://doi.org/10.1093/intqhc/mzt006>
- Rowan, M. S., Rukholm, E., Bourque-Bearskin, L., Baker, C., Voyageur, E., & Robitaille, A. (2013). Cultural competence and cultural safety in Canadian schools of nursing: A mixed methods study. *International Journal of Nursing Education Scholarship*, 10(1), 1-10. <https://doi.org/10.1515/ijnes-2012-0043>
- Seeleman, C., Suurmond, J., & Stronks, K. (2009). Cultural competence: a conceptual framework for teaching and learning. *Medical Education*, 43(3), 229-237. <https://doi.org/10.1111/j.1365-2923.2008.03269.x>
- Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, 27(2), 237-246. <https://doi.org/10.1177/1098214005283748>
- US Census Bureau. (2014). *U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin: 2014-2060*. Washington, D.C.: US Census Bureau.
- Volberding, J. L. (2014). Relationship Between Cultural Competence and Athletic Training Students' Confidence in Providing Culturally Competent Care. *Athletic Training and Sports Health Care*, 6(1), 31-36. <https://doi.org/10.3928/19425864-20140103-02>
- Volberding, J. L. (2015). Individual, Programmatic, and Institutional Influences on Undergraduate Athletic Training Student' Cultural Competence. *Journal of Cultural Diversity*, 22(4), 134-141.