Recommendations for Cultural Competence Education by Practicing Athletic Trainers: A Phenomenological Case Study

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Abstract: Athletic trainers are allied health professionals providing healthcare to individuals from diverse personal and ethnic backgrounds in various practice settings. The purpose of this phenomenological case study was to explore cultural competence of practicing athletic trainers, credentialed to practice between one and three years, having graduated from one accredited athletic training program in Texas. The guided protocol included five research questions to assess knowledge and skills of participants in provision of culturally competent strategies during clinical practice. Eleven athletic trainers were interviewed to assess the ability to define cultural competence and enumerate experiences of implementation of effective patient care. The findings revealed participants of this study provided culturally competent care to diverse patient groups. Additional findings included the ability to recognize the importance of effective communication, sociocultural considerations, and expanded needs for educational content for professional preparation. Findings in the study suggested the following implications: athletic trainers must be aware of patient diversity, the relationships between athletic trainer and patient are important for assisting patient outcomes, effective use of appropriate communication techniques is paramount to patient outcomes, and athletic training curricula need to provide a foundation of cultural competence. Enhanced curricular preparations for future athletic training professions needs to address details of patient diversity and effective culturally competent treatment methods. Enhanced awareness of diversity within society strengthens the need for athletic training educators and preceptors to be cognizant of these implications to ensure development of knowledge, skills, and abilities of future athletic trainers to provide culturally competent patient care.

Keywords: Athletic trainers, cultural competence, diversity, education, professional preparation

Expectations of Athletic Trainers

Athletic trainers provide healthcare in a variety of practice settings that are increasingly more diverse (Cartwright & Shingles, 2011; Grantham, 2015; Marra et al, 2010; Nynas, 2015; Volberding, 2013, 2014, 2015). Diversity in sport and society (National Collegiate Athletic Association, 2020a, 2020b; United States Census Bureau, 2020) supports the need for athletic trainers to have knowledge of cultural diversity to provide effective interactions with individuals of different ethnic and cultural backgrounds (Cartwright & Shingles, 2011; Marra et al, 2010; Nynas, 2015; Volberding, 2013, 2014, 2015). Cultural competence is a required expectation in

the athletic training educational standards and professional practices (Board of Certification for the Athletic Trainer, 2017; Commission on Accreditation of Athletic Training Education, 2018; National Athletic Trainers Association, 2020b). However, criteria for educational content related to cultural competency are not specifically enumerated in professional documents. The purpose of this phenomenological case study was to evaluate the evidence of cultural competence in recent athletic training graduates from one Texas academic program involved in clinical practice. The second purpose is to investigate specific recommendations for educating future athletic trainers based on the experiences of the participants.

Athletic trainers are credentialed allied health professionals as defined by the American Medical Association. They possess a diverse skill set including injury/illness prevention, emergency care, injury/illness evaluation, therapeutic intervention, rehabilitation, and healthcare administration (National Athletic Trainers' Association, 2020a). Athletic trainers are employed across the United States and in select foreign countries. With the enhanced awareness of and interaction with diverse patients and related stakeholders, the need for clinicians to know and implement culturally competent care is extremely relevant for current society. With the limited literature specific to the study of athletic trainers (Cartwright & Shingles, 2011; Marra et al, 2010; Nynas, 2015; Volberding, 2013, 2014, 2015), the need for a study of new graduates is germane to assist educators and preceptors to prepare future professionals for employment.

Therefore, this study investigated these research questions:

RQ1: How do practicing athletic trainers define cultural competence in athletic training care delivery?

RQ2: What culturally competent strategies do practicing athletic trainers implement?

RQ3: How proficient do practicing athletic trainers consider their ability to deliver culturally competent athletic training care?

RQ4: How has patient care been influenced by knowledge of cultural needs of patients?

RQ5: What challenges exist in delivering culturally competent athletic training care within the patient population?

Literature Review

The importance of cultural competence in healthcare is widely accepted. Cultural competence is the capacity of the clinician to recognize and support differences between self and patient while delivering quality health care (Campinha-Bacote, 2001, 2003; Cartwright & Shingles, 2011). Without appropriate knowledge of patient ethnic norms, care may be limited or lack essential components that lead to desired positive outcomes (Campinha-Bacote, 2003; Cartwright & Shingles, 2011). Culturally competent healthcare has been documented to benefit patients with enhanced communication, reduced health disparities, and decreased healthcare barriers (Dunagan et al 2014; Hawala-Druy & Hill, 2012; Horevitz et al, 2013; Long, 2012; Loue et al, 2015; May & Potia, 2013; Mayo et al, 2014; Reyes et al, 2013; Sobel, & Metzler Sawin, 2016; Volberding, 2014). Many athletic trainers apply a positive attitude of cultural competence with patients through recognition and adaptation of care to the needs of the patient instead of personal preferences (Cartwright & Shingles, 2011).

Diversity in Demographic Data

Demographic data support the diversity of society and sport. Diversity is the heterogeneity of characteristics within a group or population (Leavitt, 2010). Table 1 provides a summary of data from the United States Census Bureau (2020) and the National Collegiate Athletic Association, (2020a). The comparative data reinforce the diversity of the United States population and athletes involved in all competitive divisions with collegiate sports of the National Collegiate Athletic Association (NCAA). Additional NCAA (2020b) data on the country of origin for international athletes further delineated the presence of diversity at Division I and Division II levels. Between 2014 and 2019, athletes from 200 countries participated in sanctioned sports. A review of Division I and Division II data showed international athlete participation in 19 female sports, 17 male sports, and one co-ed sport. This information further supports the evidence of diversity in collegiate sport participants. The demonstrated diversity of athletes supports the need for healthcare providers with knowledge of and willingness to meet cultural needs and medical preferences.

Table 1

United States Population and NCAA Athletic Demographic Percent Summary

Self-reported Demographic Characteristics	**US Population Data July 2019**	**NCAA Athlete Data 2018- 2019**
Female/Male	50.8% / 49.2%	44.0% / 56.0%
White/Non-Hispanic or Latino	60.1 %	63.8 %
Hispanic or Latino	18.5. %	5.9 %
African American	13.4 %	16.3 %
Asian, Native Hawaiian, Pacific Islander	6.1 %	2.2 %
American Indian, Alaskan Native	1.3 %	0.4 %
Multiracial	2.8 %	4.2 %
Non-US Resident	Not Reported	4.2%
Unknown	Not Reported	3.1%
Speaks another language at home beside English	21.6%	Not Reported

Self-reported information from the United States Census Bureau (2020) and National Collegiate Athletic Association (2020a).

The demographic data on athletic trainers provide evidence of less diversity than potential patient groups. The 2019 year-end member data from the National Athletic Trainers' Association (2020c) reported that females comprised 56% of the organization's membership and males 44%. However, only 18.5% of the total membership self-identified as ethnic minorities. Data substantiated that 21.2% of athletic trainers are employed in the college or university setting. The diversity of data of potential patients and the limited diversity of practicing athletic trainers support the need for the inclusion of cultural competency education in academic preparations.

Benefits of Culturally Competent Healthcare

Healthcare professionals with knowledge and willingness to respect patients' cultural needs and medical preferences provide healthcare with enhanced cultural competence (Meydanlioglu et al, 2015; Sobel & Metzler Sawin, 2016; Waite et al, 2013). Patients who received personalized care reported less perceived alienation and positively evaluated the level of care received from the clinician (May & Potia, 2013). Areas for specific consideration include appropriate communication, knowledge of health disparities, and recognition of cultural norms that could affect care.

Effective patient communication is essential in healthcare. Ensuring that the patient and the patient's family understand the injury/illness, the expected care sequence, and anticipated outcomes is paramount to achieving treatment goals (Sobel & Metzler Sawin, 2016; Volberding, 2014). Patient perceptions are enhanced when guided by medical professionals who employ communication methods that meet language needs and provide understanding (Sobel & Metzler Sawin, 2016; Vasiliou et al, 2013). Clinicians need to recognize that communication extends beyond oral interactions and is inclusive of knowledge of non-verbal cues (Cartwright & Shingles, 2011; Ingram, 2012). Clinicians with a basic understanding of the patient's ethnic background may avoid insulting a patient with physical movement that is considered offensive in the patient's culture. Additionally, clinician knowledge may recognize patient silence or lack of direct eye contact as a cultural expectation, not an indication of disengagement or disconnectedness from the care process.

Health conditions and illness occurrences have varying rates of prevalence across people groups (Cartwright & Shingles, 2011). Clinicians should understand the pervasiveness of conditions within the ethnicities of their patient group. While the number of conditions is extensive, understanding the signs and symptoms for patient groups may be beneficial for care and prevention. One example, clinical knowledge of signs, symptoms, and effects of high blood pressure or diabetes when working with patients with Hispanic, Latino, or African ethnic background benefits provision of quality holistic care. The value of the athletic trainer's role in providing patient education of medical conditions to decrease health disparities as a preventative measure was initially described by Ford (2003) and continues as a role in athletic training patient care (Board of Certification for the Athletic Trainer, 2017; Cartwright & Shingles, 2011; Commission on Accreditation of Athletic Training Education, 2022).

In the United States, traditional medical care is delivered through a Western medicine model (Campinha-Bacote, 2003). A patient may prefer an alternate treatment method based on cultural background and worldview (Cartwright & Shingles, 2011; Steinke et al, 2015). A clinician who is willing to integrate the appropriate patient preferences with traditional care regimes may boost the patient's confidence in received care. Common alternate treatment practices include herbal supplementation, manual therapy, energy medicine, complementary therapy, and alternative medicine. Culturally competent healthcare improves accessibility and effectiveness in patient care (Cartwright & Shingles, 2011; May & Potia, 2013).

Benefits of Cultural Competence Education

Various methods of educational intervention have enhanced cultural competence of healthcare professionals (Long, 2012). Successful educational formats included formal didactic

instruction, professional workshops, seminars, and clinical placements (May & Potia, 2013; Nynas, 2015; Palombaro et al, 2015; Reyes et al, 2013). Cultural competence education development should include best practices that are inclusive of considerations of diverse patient backgrounds, awareness of prevalent health concerns by people groups, appreciation of cultural values different from self, and recognition of cultural stereotypes based on unsubstantiated thoughts rather than on particulars of the culture (Steed, 2014). For example, a clinician who has appropriate cultural competence education on interacting with a Hispanic patient may be more understanding of the patient's attempt at home care prior to seeking professional intervention as a cultural norm rather than thinking the patient disregarded the need for advanced intercession (Sobel & Metzler Sawin, 2016). Another example is after an initial elevated blood pressure screening, a clinician can conduct subsequent blood pressure assessments on a patient of African descent due to the prevalence of high blood pressure and the known complications for an untreated patient (Sobel & Metzler Sawin, 2016).

Clinicians develop higher cultural competence in patient interactions (Long, 2012). Additionally, clinician cultural competence may be expanded by personal experiences (Esterhuizen & Kirkpatrick, 2015; Mayo et al, 2014; Nynas, 2015). Documented interventions included travel, employment opportunities, and educational experiences that focused on cultural competence. One specific example is how clinicians enhanced patient care with knowledge related to effective treatment of Hispanic individuals, particularly those who spoke Spanish and had experience with Spanish/Latino culture and/or individuals (Mayo et al, 2014). Clinicians with a personal background to alternate cultures through residency, travel, or lifelong learning enhanced mindfulness for patients' viewpoint and culturally competent care (Esterhuizen & Kirkpatrick, 2015; Nynas, 2015).

Methodology

The purpose of this phenomenological case study was to evaluate the evidence of cultural competence in recent athletic training graduates, from one Texas academic program. Participants active in clinical practice offered specific recommendations for educating future athletic trainers based on the post-graduation experiences of the subjects. The phenomenological case study methodology was selected to allow the experiences of a group to be supported by a common educational experience (Creswell, 2013). Concepts for the study were developed from research related to cultural competence strategies of patient care, experience with meeting cultural needs, and assessment of cultural competence education (Campinha-Bacote, 1998, 1999, 2001, 2002, 2003; Campinha-Bacote et al, 1996; Cartwright & Shingles, 2011; Dunagan et al, 2014; Ford, 2003; Hawala-Druy & Hill, 2012; Horevitz et al, 2013; Lie et al, 2012; Long, 2012; Loue et al, 2015; Mayo et al, 2014; Meydanlioglu et al, 2015; Reyes et al, 2013; Sobel & Metzler Sawin, 2016; Steinke et al, 2015; Truong et al, 2017; Vasiliou et al, 2013; Volberding, 2014; Waite et al, 2013). A guided protocol with open-ended questions was developed to allow participants to share reflections and experiences within their employment setting when working with diverse patients. This study methodology allowed the athletic trainers to discuss personal experiences based on common educational involvement from a single athletic training undergraduate curriculum.

The scripted qualitative research protocol and study details were approved through the Institutional Review Board of the affiliated academic institution. The guided protocol interview investigated participant experiences related to common topics within contemporary literature: components of cultural competence, employed strategies of patient care, experience with meeting cultural needs, and assessment of cultural competence education (Cartwright & Shingles, 2011; Dunagan et al, 2014; Loue et al, 2015; May & Potia, 2013; Mayo et al, 2014; Meydanlioglu et al, 2015; Sobel & Metzler Sawin, 2016; Schwarz et al, 2015; Steinke et al, 2015; Truong et al, 2017; Volberding, 2014). Analysis of the data provided summary evidence of clinician practices, care interventions, and reflections on educational requirements.

Participants

The participants were recruited from the pool of students graduating with a Bachelor of Science in Athletic Training from one regional institution in Texas with an accredited athletic training program. The participants completed the three-year professional program inclusive of didactic and clinical education courses to gain the expected knowledge and skills for credentialing at the state and national levels. The participants for this study were recruited from the 2015, 2016, and 2017 graduation cohorts, ensuring the similarity of program education and being new to professional practice.

As a component of the comprehensive curricula, a senior didactic course included an introductory class lecture on cultural competence and provided ideas for best practices in the provision of diverse patient care. The students then participated in a class activity where they developed a simulated patient with diversity in ethnicity, religion, preferred medical model, family characteristics, type of medical insurance, and medical condition. Each student researched the details of the case study and delivered an oral presentation to the cohort about the cultural and medical needs of the simulated patient. Each athletic trainer in this study participated in the educational intervention the fall semester prior to graduation.

Potential participants from each cohort were contacted and provided with an overview of the study to request self-verification of alignment to inclusion criteria. Eleven of the 15 eligible individuals agreed to participate in the study. The 11 participants included seven male and four female practicing athletic trainers. Eight of the participants self-identified as white/Caucasian, two as Hispanic, and one as Biracial (Caucasian and Hispanic). Nine of the participants identified as working with a patient population that was ethnically different from their self-identification. All participants reported interactions with patients of various cultural backgrounds with three of the athletic trainers identifying specific experiences with international patients in their clinical practice. The years credentialed were between one to three years with an average of 2.64 years. Additionally, each participant was credentialed and employed as an athletic trainer when the interview was conducted.

Data Collection and Treatment

Individuals who confirmed their willingness to participate were verified for meeting inclusion criteria and then scheduled for individualized interviews. The interviews were conducted in person or by synchronous video conference. A digital recording of the interview

was completed along with the researcher taking field notes (Creswell, 2015). The guided protocol was reviewed as a method of trustworthiness by two allied health professionals who were knowledgeable in cultural competence and qualitative research (Creswell, 2015). Additionally, the researcher developed detailed instructions prior to the start of the interviews to ensure the protection of shared information. Interviews were conducted through direct contact or video computer conference. Appendix A provides questions used in the interview. Each guided protocol interview was delivered in the same order for participants to share unique experiences they implemented in clinical practice.

Digital recordings of the interviews were transcribed and provided to the subject for review and approval (Creswell, 2015). Approved transcripts were reviewed again by the researcher and content from the transcripts was categorized into a matrix aligning with the guided protocol questions and allowing for analysis to determine themes. Specific experiences, particular illustrations, and robust quotations were noted in the analysis coding. Responses by each participant were uniquely coded to assist with anonymity. Any personally identifiable information for names, locations, or employers was assigned a pseudonym for use in review, analysis, and data reporting.

Results/Findings

The results of this study demonstrated that athletic trainers used culturally competent care knowledge in the provision of patient care. Participants identified patients with ethnic diversity. Hispanic/Latino patient contacts were most frequently reported. Additional personal interactions included individuals from various countries from regions of Africa, Asia, Europe, and South America. The interactions that the athletic trainers shared were specific to instances of meeting the cultural needs of the patient. The emerging themes of the participants were *methods for effective patient communication* and *flexibility in treatment plans based on knowledge of multiple sociocultural issues*.

Provision of Patient Care

Each of the participants identified language as an obstacle to the provision of care. Many of the participants recalled multiple instances where challenges in communication affected exchanges with patients. The participants recognized the need for accuracy in communication and provided example techniques used within clinical practice. Common methods highlighted the use of translators, anatomical models, images, internet sites, video, and translated program documents.

Participants provided evidence of employing culturally competent care with their knowledge of patient-specific sociocultural factors. One summarized the response conveyed by multiple participants this way:

> [For the] student athletes that I work with, the care that I'm able to provide them is probably the best care that they've had thus far in their life. For me, I think that's the most important, and helping [them] understand that when you think about your future, your health is really important.

The athletic trainers valued their role in the provision of quality healthcare. Moreover, they recognized for many of their patients, they were the primary resource for care and therefore wanted to assist their patients in both short- and long-term quality of life.

Developing positive relationships with patients and getting to know motivating factors benefits care delivery. Athletic trainers who work with patients from other cultural backgrounds may grow in their cultural competence through the actions of patients. One participant recounted a specific conversation with an international college athlete where he learned how to assist the patient through surgical rehabilitation protocol:

> I [the athletic trainer] was like, "You know, I was really impressed with you, because a lot of people don't take that initiative or the information to get better themselves. They wait. They want someone to sort of be there and walk them through it." She goes, "Where I'm from, that's what you do. That's just what you do." So, we talked about that, and I was like, "Explain that to me further, please? It's a foreign idea to me, I guess." She was just like, "I could either lay in bed all day and feel bad for myself, or I could do my straight leg raises or sit on the edge of my bed and do long-arc quads."

The athletic trainer also shared the patient's reflection on her mother later in the interview, further reinforcing the patient's actions.

> "If she's [the patient's mother] ever sick, it didn't matter. She got up. She made us breakfast. She took us to the bus stop for school, and then she went to work. Being a woman in my country is celebrated, and it's exciting."

It is important for clinicians to have knowledge of differences in gender roles and expectations within patient groups. As with the patient highlighted here, her country celebrates women while in another patient's culture, it would be the father as the primary figure.

Participants who had awareness of religious considerations were able to assist the patient and provide education to the team to further support the individual. One participant shared a specific reflection based on religious preferences. His athletes desired to uphold religious practices during Lent while meeting the demands of the sport and team travel. The athletic trainer recounted the situation this way:

> When some of my Catholic students or athletes weren't able to eat meat, I had to explain to [other] students who didn't know what was going on, and I just explained why they weren't able to eat meat, why they were fasting at that time.

While this experience highlighted one example of dietary considerations, it would not be the only example. Religious practices can vary from abstention from certain foods to fasting periodically. Individuals who work with competing athletes or recovering patients need to be aware of religious practices to ensure nutritional needs are met appropriately.

A second participant shared that her willingness to show empathy assisted her in making the appropriate provider referral to ensure the patient's religious convictions were upheld. The athletic trainer recalled the experience:

> We were doing echocardiograms on some kids and there was one young lady, she couldn't lift her top up while there was a male in the room… He [the physician] was turned the other way but, she's like 'It's my religion, I can't have my skin exposed around him.', so we … [referred] her to a different place and… [did the test] there.

Other participants expressed awareness of patient religious practices; however, they did not have a specific example of adjusting patient care decisions based on religious practices.

Participants expressed an understanding of how to incorporate their patients' desires for alternate treatments in conjunction with traditional athletic training healthcare. One shared the importance of advocating patient desires with collaborating medical specialties. While many are comfortable with engagement in the typical Western Medical Model, some patients will be more familiar with and have a desire for alternative treatments. One participant shared an experience in advocating for a patient's desire for more holistic medical options by saying, "I know … [the physician was] going to want to prescribe an anti-inflammatory, but she [the patient] doesn't want them. She won't take them." This type of intervention can assist in the development of a care plan that meets the goals of the patient and medical provider.

Additional Educational Preparation Ideas

While the knowledge of diversity within location varies, only one participant received employer-provided professional development on stakeholder ethnic and socioeconomic demographics. Participants relied on pre-employment knowledge to assist in the provision of patient care. One athletic trainer provided this reflection:

> I wouldn't say I was unprepared, but I could've been better prepared … I think, for me, it would've helped to know there's a very good chance that you will be in a situation where the culture is vastly different, because we learned about in class. I was like, 'I'm never gonna be in a situation where I'm going to have to deal with someone from India or even Ethiopia.' I would never have thought that. Just knowing how prevalent that [diversity] is in our area even, I think would've … set me up a little better.

Six of the participants advocated for enhanced educational preparation in culturally competent healthcare needs, cultures, and religious practices. One participant recognized that athletic trainers do not need to know everything about all cultures. However, he stated, "I think they should have the awareness to ask in a job interview, what the typical student population is and what different obstacles are they to expect." Clinicians need to have a basic understanding of the typical patient demographic under their care that includes specific cultural norms and common healthcare considerations.

Participants expressed how clinical practice could be enhanced with greater cultural knowledge. As one participant stated, care would be strengthened through knowledge of "culture of sport and different countries and different backgrounds of cultures…very basic background of what … healthcare is in varying regions and countries." Another identified their desire in "learning about different ethnic backgrounds and religion." Additionally, expanded knowledge of alternate healthcare models would be beneficial. He supported the statement with:

> If they prefer holistic health and they have strep throat, then they need [may want] to boil some kind of tea and put ginger in it…. Use some turmeric. There's ways that you can naturally get the same benefit. It's just not as easy, and it is frustrating, because it's like I could give you a pill right now and you would feel better.

It is important for clinicians to recognize that patient care preferences may differ from the treatment choices they would make for themself. Showing support for the patient's choices validates the patient and may enhance the working relationship.

Participants recognized that culturally competent care differs based on patient needs and personal background. Therefore, more specificity in education was suggested. One stated, "Break it [cultural competence] up into different [people] groups." Another proposed providing "knowledge of what their patients are able to do, what they can't do," elaborating the need to understand the "times when different [religious practices]… pray … [to avoid] conflicting with what they need to be doing [athletically]." Participants recognized the need for regional or patient-specific instructions based on the demographic in the employment location. This was sustained with the suggestion "If you have a specific culture in your setting, then it helps to know ahead of time what they do and don't approve of [for care]." Clinicians in multicultural areas should have some knowledge of each ethnic group to assist in appropriate care and communication during patient interactions.

Participants recognized the value of accurate communication and information to patients. For effective communication, multiple participants advocated for language learning to be included in athletic training curricula. Participants supported learning basic conversation in at least a second language, along with limited medical terminology to assist in patient communication. One participant suggested that educational programs should provide "more on language; where to find resources on translators, [and] how to effectively get your word across yourself." Effective communication is essential during patient interactions. Clinicians need knowledge of appropriate resources to employ when interacting with non-native-speaking individuals.

Limitations

The limitations of this study are related to the athletic training participants and the phenomenological case study methodology employed. Three specific limitations influence this study. First, the sample of graduates willing to participate and their patient interaction experiences are significant to the outcomes of this study. Second, while all participants had an educational intervention in cultural competence as a component of their athletic training curriculum, the potential influence of additional cultural competence education or enhanced patient interaction was not evaluated in this study. Lastly, the results of this study may not be generalized to all graduates of athletic training curriculum programs.

Discussion and Implications

This study demonstrated that participants from one program in Texas had the knowledge and skills to provide culturally competent care. Athletic trainers provided their recognition of the various needs of patients, the desire to meet patient needs, and the willingness to adapt patient care for positive outcomes (Cartwright & Shingles, 2011, Grantham, 2015; Horevitz et al, 2013; Lie et al, 2012; May & Potia, 2013; Mayo et al, 2014; Nynas 2015; Palombaro et al, 2015; Steed; 2014; Volberding, 2014, 2015; Waite et al, 2013). Participant responses supported the notion that athletic trainers value patient individuality and diversity. Relationships between the athletic trainer and patient enhanced trust in patient outcomes (Campinha-Bacote 2003; Meydanlioglu et al, 2015; Truong et al, 2017). Moreover, participants supported evidence of patient diversity in care considerations (Campinha-Bacote, 2003; Cartwright & Shingles, 2011; May & Potia, 2013).

Additionally, participants supported the need for effective communication, which was universally identified as essential for effective patient care (Campinha-Bacote, 2003; Cartwright & Shingles, 2011).

Participants in this study addressed knowledge and application of cultural competence that aligned with the five research questions. Participants defined *culturally competent care* as knowing and meeting the specific needs of the patient. Factors that influence patient care in defining cultural competence include ethnic identification, socioeconomic status, language needs, and religious practices (Campinha-Bacote, 2003; Cartwright & Shingles, 2011). Participants advocated for developing a personal connection with mutual respect as a key to the development of clinician-to-patient trust (Campinha-Bacote 2003; Meydanlioglu et al, 2015; Truong et al, 2017).

Participants provided examples of methods they used to deliver culturally competent patient care. The need to connect and build positive relationships with patients was significant in the successful provision of care. This was achieved through learning cultural dynamics, expanding methods for communication, and providing patient education on general health along with injury care information. Athletic trainers considered it important to learn about one's patients and indicated that even small efforts to respect culture were beneficial to patient outcomes (Sobel & Metzler Sawin, 2014). Participants enumerated how they assisted patients with the implementation of personalized and compassionate care (Cartwright & Shingles, 2011).

Effective communication was identified as essential for proficient care delivery. Participants shared the value of how technology enhanced communication with diverse patients and their family members. Participants shared innovative uses of translator applications, textbooks, posters, online images, and videos to assist in explaining the injury and care plan. Implementation of quality and effective communication strategies is essential for all athletic trainers who seek to elevate cultural competence (Cartwright & Shingles, 2021; Volberding, 2014).

Participants of this study recognized the influence of cultural needs on patient care. Each person shared experiences with patients who had different cultural backgrounds under their care. Therefore, the value of educating themselves on the need of patients and the diversity of alternate worldviews was significant in meeting patient needs (Cartwright & Shingles, 2011). Communication was significant in influencing care. Additional influences included religious practices, expressions of pain, and family or cultural influences. Athletic trainers who understand these and have the ability to effectively integrate care are potentially perceived as more effective by the patient (May & Potia, 2013).

Participants identified challenges in the delivery of culturally competent care. The need for additional education and training in cultural considerations was a significant theme. Only one participant received additional professional development from the employer about the demographic composition of the patient group. Participants supported the inclusion of educational content in didactic academic courses in preparation for future employment (Boggis, 2012; Haack & Phillips, 2012, Hawala-Druy & Hill, 2012; Long, 2012; Loue et al, 2015; Palombaro et al, 2015; Reyes et al, 2013). Additionally, the participants recognized the

clinician's responsibility to learn about their specific patient needs (Cartwright & Shingles, 2011; Steinke et al, 2015). Participants enumerated the value of continued professional development related to cultural competence, religious practices, healthcare models, and languages (Campinha-Bacote, 2003; Cartwright & Shingles, 2011; Dunagan et al, 2014; Lie et al, 2012; Mayo et al, 2014). Multiple participants advocated for athletic trainers to learn a second language as a formal course or self-study. Athletic trainers who are willing to recognize challenges and seek innovation in individualized patient care will be valued by patients.

Future Research

This study investigated the ability of athletic trainers to identify and enumerate culturally competent healthcare in clinical practice. The origin of cultural competence research in allied health professions started nearly 30 years ago (Campinha-Bacote, 1997, 1998, 1999, 2001, 2002, 2003; Campinha-Bacote et al, 1996; Cartwright & Shingles, 2011). Today, the topic remains significantly relevant based on current societal and sport demographics (Grantham, 2015; National Athletic Trainers' Association, 2020b, 2020c, National Collegiate Athletic Association, 2020a, 2020b; Nynas, 2015; Truong et al, 2017; Volberding, 2013, 2014, 2015). Based on the outcomes of this study, future research initiatives on this topic in collegiate athletics should include studies related to athletic training education, athlete perception of received athletic training care, and athlete evaluation of coach's knowledge of cultural diversity.

With changes in athletic training education, future studies should investigate individuals who graduated from accredited master's in athletic training degree programs (Commission on Accreditation of Athletic Training Education, 2022). Researchers could conduct a phenomenological case study of credentialled trainers from a unique accredited master's degree in Athletic Training Program on their knowledge and understanding of culturally competent care. A broader study would be a comparison of athletic trainers graduating from multiple accredited athletic training programs to investigate similarities and differences in educational intervention and the development of culturally competent skills. Additionally, the scope of cultural competence could be expanded beyond ethnicity and race to ideas related to diversity, equity, and inclusion for patients based on sexuality or disability. Moreover, future studies should investigate athletic trainers' cultural competency in all facets of patient care using a valid assessment instrument.

While the literature provides many different studies related to cultural competence, researchers have not investigated athlete perception of care. Therefore, a future study could investigate international and ethnic minority athletes' perceptions of the athletic care received, along with characteristics of athletic trainers related to best practices in culturally competent care. A follow-up study to this would be to evaluate athletes' perception of coaches' knowledge of cultural diversity, the characteristics that support athlete diversity for enhanced sport performance, and the effect of culturally competent care on patient mental health.

Conclusions

This phenomenological case study considered the cultural competence of recent graduates from one academic program. The collective knowledge and experiences recalled by

the participants offered evidence of culturally competent concepts implemented in the educational intervention within their curricula. The participants expressed empathy and commitment to their patients, which supported the need for professionalism in the provision of culturally competent care. Additionally, the data provided support for initial academic preparation along with ongoing professional development to benefit professionals for the diversity within the employment setting.

With the expectation of inclusion of cultural competence instruction in athletic training education (Board of Certification for the Athletic Trainer, 2017; Commission on Accreditation of Athletic Training Education, 2022; Grantham, 2015), along with the knowledge of potential diversity between an athletic trainer and patient group (Grantham, 2015; National Athletic Trainers' Association, 2020c), it is essential that athletic trainers be knowledgeable in cultural competence. As with the goal of innovation in treatment or rehabilitation techniques, athletic trainers should have that same drive to learn about patient groups and implement strategic care. While athletic trainers should possess the ability to define cultural competence, enumerate strategies for implementing culturally competent care, and identify challenges to delivering culturally competent care, it is essential for theory to be implemented into professional practice. The techniques for successful implementation are limited by an unwillingness to assimilate and go beyond the status quo. Athletic trainers who implement culturally competent care should have greater patient trust and elevated outcomes.

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Appendix A

Guided Protocol Interview Questions

Interview Questions

1. Tell me about your community.
2. Tell me about your specific patient population.
3. How do practicing athletic trainers define cultural competence in athletic training care delivery?
    a. Beyond ethnic identification, what other factors should be considered in cultural competence?
    b. Which of these is/are most important to consider/incorporate when providing athletic training care? Any why?
    c. Is there one that you believe places barriers to your ability to provide athletic training care? Which one and why?
4. What culturally competent strategies do practicing athletic trainers implement?
    a. What avenues of continuing education have you had on cultural differences and the relevance to health conditions?
    b. How has your employer provided training to equip you with information about your school/clinic's demographics?
    c. Have you attended any professional conferences, meetings, or workshop with cultural diversity as a focus?
    d. Why have you attended or why have you not attended?
    e. What have you learned by talking with a patient or a patient's family member to gain more insight on the ethnic/cultural background?
5. How proficient do practicing athletic trainers rate their ability to deliver culturally competent athletic training care?
    a. What types of communication strategies do you use with patients and their families for non-injury care communication?
    b. How do you communicate with patients about injuries and healthcare needs?
    c. How do you communicate with a patient's family members about injuries and healthcare needs of their athlete/patient?
    d. How often do you use an interpreter? How confident are you that the interpreter is accurately translating what is being said?
    e. Share about a time where you tried some innovative communication technique with a patient or family member, and it was successful.

6. How has patient care been influenced by knowledge of cultural needs of patients?
    a. What sociocultural factors affect the delivery of quality athletic training healthcare?
    b. What are your greatest cultural challenges that affect your provision of athletic training care?
    c. What are the psychosocial characteristics of your patients that affect how pain is expressed by your different groups?
    d. What strategies do you use to find out patient's true evidence of pain?
    e. Can you share about experience/experiences where your cultural knowledge was effective in meeting the patient's need for athletic training care?
7. What challenges exist in delivering culturally competent athletic training care within the patient population?
    a. What cultural competence education components should be included to prepare new athletic trainers for clinical practice?
    a. What elements of a cultural competence education program should be retained to prepare future athletic training professionals for athletic training healthcare?
    b. What considerations of cultural competence were not including in your preparation that you would recommend being added into a cultural competence education program to prepare future professionals for culturally competent athletic training care.