Working Toward Cultural Competence in Athletic Training

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Cultural competence refers to academic, clinical, and interpersonal skills that allow allied health professionals to remove barriers between themselves and their patients.[1] Uncovering biases based on an ethnic, religious, political, sexual-preference, or social prejudice requires time, knowledge, and experiences with individuals from diverse cultural backgrounds, as well as reflection on the clinician's own experiences. Culturally competent allied health professionals increase their understanding and appreciation of the cultural differences and similarities, including behaviors, communication style, language, belief systems, and attitudes.[1,2]

Rapidly changing demographics demand that health-care practitioners acquire heightened awareness, sensitivity, and skill in meeting the needs of culturally diverse groups.[3,4] Since 1995, many medical schools and residency programs have included cultural competency in their curricula.[1,4,5] The surgeon general of the United States has devoted significant attention to culturally competent care in relation to delivery of mental health services.[6] The National Athletic Trainers' Association (NATA) has included cultural awareness on the list of knowledge and skills to be mastered in entry-level athletic training programs.[7] The factors of cultural competence presented in this article are not intended to be all inclusive, nor is this review intended to advocate broad application of any concept to any group on the basis of cultural affiliation.

KEY POINTS

- The willingness of certified athletic trainers and therapists to increase awareness and to confront biases and stereotypes will lay the groundwork for a culturally sensitive environment.
- A culturally sensitive environment is influenced by physical factors, as well as style of communication, values, behaviors, and attitudes.
- Certified athletic trainers and therapists should recognize that an individual's choices, behaviors, and responses are affected by culture.
- Optimal outcomes in clinical settings are achieved when health-care practitioners possess more knowledge and respond with sensitivity to cultural issues.
- Key Words: cross-cultural, multicultural health care, diversity

Operational Definitions

Culture refers to patterns of language, thoughts, actions, customs, beliefs, courtesies, rituals, manners, interactions, roles, expected behaviors, and values of race, ethnicity, religion, sexual orientation, and disabilities.[2,8] Culture is not a static entity; it changes as awareness, beliefs, and environment change. *Ethnic* refers to similarities in ancestry, language, rituals, religion, music, and food preferences.[2] *Minority,* in a sociological sense, describes a group that faces limitations related to social resources, access to opportunity, status, and political power. In this context, the term *minority* is not intended to denote small demographic numbers.

Effect of Cultural Competence on Athletic Health Care

Patients' cultures influence their perception of care, compliance, communication, and the injury or illness assessment and management process.[6,9] Research findings suggest that when health-care professionals act only on what *they*

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feel is correct, the risk of patient insult and suboptimal treatment increases.[9] Research findings also suggest that there are some cultural variations in symptom presentation and expression, as well as subtle differences in the metabolism of certain medications. Furthermore, athletic trainers who provide culturally competent care have a unique opportunity to educate physically active individuals concerning general health issues endemic to specific sectors of the population. The athletic training profession can benefit from the strides made in medical and nursing education with respect to the manner in which cultural competence fits into clinical practice. Specifically, athletic trainers and therapists can better understand the dynamics of what happens in the clinical setting by appreciating external behavioral influences. Cultural competence emphasizes recognizing patients' cultures, developing professional skill and policies to deliver treatments, and developing effective management plans.[10]

Resisting Stereotyping

Stereotyping—making assumptions without gathering sufficient information—is associated with oversimplification of cultural facts. Culturally competent health-care practitioners will determine whether any particular assumptions they make apply to an individual patient.[9] Not all individuals who share the same culture, or individuals who are placed in particular census ethnic categories, identify with everyone else in that culture. Age, education, or individual personality can determine how culture is expressed as one identifies with groups of a certain religion, profession, sexual orientation, or age. In fact, an individual might identify with multiple cultures.

There is also diversity within racial and ethnic groups. Biological and genetic similarities among all races suggest that it is no longer appropriate to divide people into traditional anthropometric racial groupings of Caucasoid, Negroid, or Mongoloid.[6] Race has been transformed into a social category, whereas cultures are delineated according to socially significant criteria that relate to access to power.[11,12] Hispanics/Latinos are ethnically diverse. They might be Mexican, Cuban, Puerto Rican, South American, Central American, or European. Indigenous North Americans might be Hispanic/Latino if they are from Mexico or American Indian if they are from the United States. Many people from the Dominican Republic self-identify racially as Black (physically) but ethnically as Hispanic or Latino. Native Hawaiians and Korean Americans have limited similarities in heritage but are classified together as Asian. A Black Caribbean person might be very culturally different from a Black American. Children of Asian families raised in suburbia might identify more with American culture than with the culture of their ancestry. Southern Black and White Americans might be more homogeneous in some beliefs and behaviors than are southern and northern Black Americans.

Willingness to Confront Personal Biases and Stereotypes

There is a tendency to discount the importance of cultural differences with statements reflecting attitudes such as "We are all just human beings," "Color/culture doesn't matter," and "I am color-blind." Color blindness, culture blindness, cultural insensitivity, and cultural incompetence are in themselves impediments that do not permit clinicians to see the facets that make up an individual, contribute to the injury manifestations or illness, and affect the management of the condition. Clinicians who are willing to acknowledge cultural differences and who appreciate the influence of culture in a patient's decisions and responses approach people differently, and care is not compromised.[1]

Culturally Competent Clinical Environment

The U.S. Department of Human Services' Office of Minority Health[20] has proposed standards to make health-care services more responsive to the individual needs of patients. Although many of the suggested standards are intended for health-care organizations, several are appropriate for clinical facilities that are committed to promoting culturally competent athletic health care. The standards are also intended for use by educators of health-care professionals to raise awareness in their curricula regarding the significance of culture and language in the delivery of health-care services. The standards acknowledge practical difficulties in achieving these goals and focus on commitment and good-faith

effort rather than specific quotas and outcomes (see Table 1).

Elements of a culturally competent environment include physical surroundings, materials, resources, values and attitudes, and styles of communication. Music, posters, and educational materials in the clinical facility should reflect respect for cultural and ethnic diversity. For example, stereotypical representation of the American Indian people through the depiction of school mascots might compromise effective communication. The American Indian Mental Health Association of Minnesota and the Society of Indian Psychologists of the Americas, in 1992 and 1999, respectively, drafted similar statements regarding their view of the effect of this issue on American Indian children. The former source states that American Indian mascots, symbols, caricatures, and similar images used for non-Indian athletic teams, are "damaging to the self-identity, self-concept, and self-esteem of our people."[15,p1]

A power differential might be created or perceived in the clinical environment that causes a patient to feel inferior. Equity in care (access to equipment, supplies, or coverage) for physically active female students in American secondary schools and colleges is legally mandated by Title IX, sport-governing bodies (e.g., the NCAA), and professional-conduct codes (e.g., NATA's code of ethics). Correction of inequities has been an important step in the equalization of opportunity. Power equilibration is more challenging when a clinician and patient are of different ethnicities. The history and attitudes of the dominant culture have had a lasting impact on ethnic power relationships. In the United States, for example, the attitudes of Black and Native Americans toward the government of the dominant culture have been influenced by historical persecution and daily challenges associated with racism and discrimination.[6,16,17] The Tuskegee Experiment still affects the attitude of some Black Americans toward the health-care system and even influences the beliefs of some concerning the origin of HIV.[16]

The importance of cultural self-identification is a consequence of power and control issues that exist when communication of ideas and information, orally or in writing, by the dominant culture tells minority groups how they are perceived by its members. Many

TABLE 1. ASSESSING CULTURAL COMPETENCE IN ATHLETIC TRAINING CLINICAL FACILITIES

Goal	Implementation
Have all patients experience culturally and linguistically competent encounters with clinical staff	Overcoming communication barriers, environment in which the physically active are comfortable discussing cultural beliefs and practices, encouraging such discussion, familiarity and respect for traditional healing systems and beliefs, integrating these systems and beliefs into the management plan.
Achievement of diversity in clinical staff	Using proactive strategies to build a workforce that is representative of the diverse demographic population to include its leadership, governing boards, clinicians, and administrators; staff includes all subcontracted and affiliated personnel.
Ongoing education and training for staff in the delivery of culturally competent care (A diverse staff does not guarantee culturally competent care.)	Establishing training objectives that are relevant to the specific needs of the physically active population.
Accurate and effective bridging of linguistic barriers	Ensuring that individuals responsible for delivering language services demonstrate bilingual medical proficiency.
Availability of easily understood written materials	Making parental written communication and injury-education materials available in languages encountered by a significant percentage of the population in the service area. Other groups have the right to receive oral translation of these materials.

Note. Table referenced from Office of Minority Health.[8]

clinicians are aware that using oral or written ethnic-identification labels is always challenging. For example, cultural differences within the Black community have resulted in a variety of identification preferences including *Black, African American,* and *Afro-American*. Ethnic and cultural minorities often capitalize to denote proper nouns rather than adjectives. In the Hispanic culture, identifiers vary as well, including *Hispanic, Latino, Chicano,* or by specific country of origin. Clinicians might find the results of a recent survey helpful in establishing a dialogue with ethnically diverse individuals. Forty-four percent of Black Americans prefer to be referred to as *Black,* and 28% prefer *African American*. In the Hispanic population, 58% prefer to be referred to as *Hispanic*. Fifty percent of the people indigenous to North American prefer *American Indian,* and 37% prefer *Native American*.[18] The self-identifying label used by indigenous people in North America appears to be undergoing an etymological evolution, however. The contemporary use of *Indigenous Peoples* or *First Nations Peoples* has profound social, political, and cultural meaning for this ethnic group.[14]

People with physical and mental disabilities face similar challenges with identification labels that denote very different meanings. The Americans with Disabilities Act suggests that the reference should be to a *person* who is blind, for example, rather than a blind person. People with visual impairment are typically referred to as people who are visually challenged, people with visual impairment, and people who are blind. Individuals with hearing impairments are referred to as people who are deaf and people who are hearing impaired. Within the culture of people with disabilities, however, values are not always shared with either general American culture or other people with disabilities. There are some who deplore the use of the terms that are called euphemisms. They explain that just as one probably would not object to being referred to as an intelligent person, they do not object to the use of words that reflect the fact that they are simply unable to see; they are blind people. Activist deaf communities might embrace the use of *Deaf*, as in " I am Deaf." The capitalization usually denotes an identity and cultural pride.

Nonetheless, *disability,* to some born with congenital conditions, implies that an ability was lost. Because this is not their circumstance, they prefer to be referred to as *handicapped*. Other individuals with disabilities refer to themselves as *differently abled* because they are offended by the derivation of the word *handicapped,* which emanated from the stereotypical image of an individual begging with cap in hand (S. Steinberg, personal communication, February 2002). Health-care practitioners have a responsibility to respect all cultural groups and to ask individuals how they refer to themselves. Clinicians should also be aware that not all physical, medical, and cognitive "disabilities" are visually apparent.

Certified Athletic Trainers' Socialization in the Medical Culture

Because culturally competent care cannot exist without self-awareness, certified athletic trainers need to recognize their own values, belief systems, and styles of communication.[2] In addition to their personal ethnic, religious, and cultural biases, allied health-care professionals tend to adhere to a set of rituals, beliefs, and practices that have evolved in Western medical culture,[1,2,6] which is reflected in the jargon, attitude, and manner in which health-care professionals view the world. Most medical conclusions are derived from objective scientific and empirical methodology; those not meeting these criteria are not recognized.[1,2]

Preventing disease and injury; using medical jargon; regular hand washing; a systematic, objective approach to assessment; and adhering to hierarchal authorization are habits, preferences, beliefs, norms, and values of Western medical culture. They form part of the context for communication, comparison, and expectations of others, which are often underestimated as contributors to cross-cultural conflicts. Because most health-care professionals have been socialized into at least two cultures, a degree of cultural competence is required for most clinical encounters.[2]

Patient Cultures in Conflict With Western Medical Culture

Naturally, when a health-care practitioner and a patient are not from the same ethnic or cultural background, there is great potential for cultural differences to affect care and communication. For example, a practitioner who believes in technology and Western

definitions of health and illness might prescribe certain medications for an American Indian patient with a cold. [2] A traditional healer who appreciates this patient's worldview would emphasize the collaboration between the healer and the patient. In many areas of the country, American Indians' traditional views of wellness influence an approach to reestablishing harmony within one's life, the community, and the environment that might include certain ceremonies and prayer.[19] Unfortunately, many professionals regard American Indian traditions as primitive.

Health-care providers in many areas of the country will face the challenge of developing competence in Hispanic/Latino values and worldviews to effectively manage the care of the fastest growing ethnic minority group in the country.[2] For example, it is considered respectful to address individuals formally. Time orientation is more flexible than the Western-medical-culture view. The atmosphere surrounding interactions is generally enhanced after a verbal exchange regarding the family.[9] Traditional foods might be offered as a token of respect to health-care providers, and a visit to the home might commence with a hospitable refreshment offer. Gracious acceptance of both is expected. Perception of disease and illness is often affected by beliefs about body disharmonies.[1]

Increasing Awareness and Sensitivity With Broad Cultural Knowledge Base

Practitioners should accept responsibility for becoming knowledgeable about commonly encountered cultural or religious practices and observances. Religious observances of several cultures can affect injury and illness prevention. Periodic fasting is a part of religious observances of Mormons and individuals who practice Judaism. Prolonged fasting, as practiced by Muslim athletes during the Feast of Ramadan (daylight fasting for 30 days), could affect training and competition regimes. American Indians might participate in a spiritual-cleansing sweat-lodge ceremony frequently or occasionally, depending on local custom. Lack of knowledge of an individual's participation in such an activity might compromise hydration during athletic participation. Athletes might appreciate knowing that they can share this information and receive support from athletic training staff. Because the U.S. government attempted to extinguish American Indians' spiritual practices until 1978, practitioners working with these athletes should be especially sensitive regarding discussions about traditions involving religion.[6]

Some customs require that some adjustments be made to accommodate modesty or prohibitions regarding physical contact with the opposite sex. A defensive or emotional reaction might result if aspects of physical contact or close proximity to the opposite gender are not considered for several ethnic groups, including Chinese, Japanese, Vietnamese, Puerto Ricans, and many who practice Islam.[9] Touching during an injury assessment might be stressful and considered disrespectful. Practitioners must assess individual perceptions and act accordingly.

Many of American society's racial and ethnic minorities use alternative approaches to cope with illness and injury. Knowledge of complementary healing methods in use by patients is essential, because some of these therapies can interact with traditional medicine. In addition, some individuals might exhibit noncompliance with your management plan in deference to traditional treatments.

Medicinal herbal and natural remedies are used widely in the practice of Asian healing. In traditional Asian therapy, ginseng is widely used for a multitude of illnesses, and urea is still widely used to clean wounds.[2] Among the Chinese, nausea and fatigue are believed to result from too much yin and are treated with hot soups and ginseng. Diarrhea, resulting from too much yang, might be treated with yin foods such as fruits and vegetables.[9]

Within the Hmong population, cupping (to reduce lung congestion), coining (stroking the skin with the edge of a spoon or coin), and pinching (for headache) are used to release pain or illness-causing toxins from the body. The purpose is to create an ecchymosed area through which the illness or pain passes.[9] Lack of awareness of these practices can lead to misinterpretation as evidence of child abuse (Caroline Wong, personal communication, April 2000).

Communication Barriers

Professional interpreters are critical for understanding what athletes and their parents are saying in a cultural context and to properly interpret the subtleties of the language. Ensuring that one's intentions

and specific directions are understood and followed depends on bridging linguistic barriers with individuals who have limited proficiency in speaking, reading, or understanding the English language. This includes individuals who use American Sign Language (ASL) as a first language. ASL is not translated English but a language with a syntax and grammar of its own (Tevis Thompson, personal communication, May 2002). For example, the word *run* has many different meaning; *run* for the bus, *run* in my stocking, *run* for office, it makes my nose *run,* and *run* a race are all translated differently. Note writing is not an acceptable form of communication to a native ASL user any more than giving a note in English to a native French speaker is acceptable communication, because the written English word might not translate adequately.

When language barriers exist, clinicians should use professional interpreters rather than have an athlete translate for another athlete or for his or her parents. Research suggests that individuals who have been exposed to a second language or who have been raised in a bilingual home often overestimate their ability to communicate.[20] Ideally, the communication skills of bilingual staff or interpreters should be verified by formal testing to ensure that knowledge of terms and concepts relative to athletic medicine will facilitate complete and accurate comprehension and communication.[20] The National Council on Interpretation in Health Care recommends at least 40 hr of formal training for medical interpreters.[20] When using an interpreter, look at and speak directly to the athlete or parent, not the interpreter. Avoid exaggerating lip movements or shouting.[9]

Be conscious of behaviors and gestures that are taken for granted in American culture. The gesture used to indicate "come here" with the fingers extended upward is considered offensive in Asian culture. In American culture, not to look one in the eye when speaking is considered disrespectful. Culturally appropriate behavior for many Asian children is to avoid eye contact and to look down as a sign of respect. Chinese Americans might view asking questions as a sign of disrespect. Nonverbal communication is valued among Native Americans, and during conversation they tend to use a low tone of voice.[2,9]

Resources for Culturally Competent Health Care

American Medical Association Cultural Competence Compendium. ISBN 1-5794-7050-5. Available from the Division of Medical Education Products 312-464-5333 or www.ama-assn.org/catalog. Includes resources for communication, books, publications, virtual resources, assessment tools, and course offerings in several states.

Lipson J, Dibble S, Minarik P. *Culture and Nursing Care: A Pocket Guide*. San Francisco, Calif: UCSF Nursing Press; 1996. ISBN 0-9436-7115-9.

Rosenstein J, dir. *In Whose Honor?* [video]. 1996. New Day Films, 22-D Hollywood Avenue, Ho-ho-kus, NJ 07423. Ph 201-652-6590. Documentary providing insight into the Native American mascot issue for clinicians in secondary and college athletic settings.

Spector R. *Cultural Diversity in Health and Illness*. Upper Saddle River, NJ: Prentice Hall. ISBN 0-8385-1536-3.

Cultural Competence in the Educational Setting

In addition to recruiting and retaining ethnically diverse or culturally competent athletic training clinicians and educators (currently underrepresented in the athletic training profession), preparing competent professionals should include emphasizing cultural knowledge and cultural-competence training in didactic and clinical curricula. Visual aids and textbooks should reflect cultural and ethnic diversity. Guidelines should be established to help educators and speakers address cultural issues in presentations. Speakers and writers who use case studies might consider how culture relates to injury management. Assessment tools are available that can be applied to educational and clinical settings. Resources are available, primarily in nursing and medical education, that identify appropriate changes and their implementation. It is also suggested that faculty-development lectures and workshops be conducted so that students' role models are "cognitively astute, clinically competent, and *culturally sensitive* [emphasis added]."[1,p118] Finally, students and clinicians learn to apply cultural-competence principles by working in varied culturally diverse settings.[1]

Summary

Building cultural competence is a lifelong process that is worthy of clinicians' most serious consideration for personal growth and the welfare of the physically active population that we serve. One can find Internet resources by searching using key words *culturally competent health care* and *cross-cultural health care*. Resources that are commonly used in nursing curricula are also available (see the sidebar). ▮

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