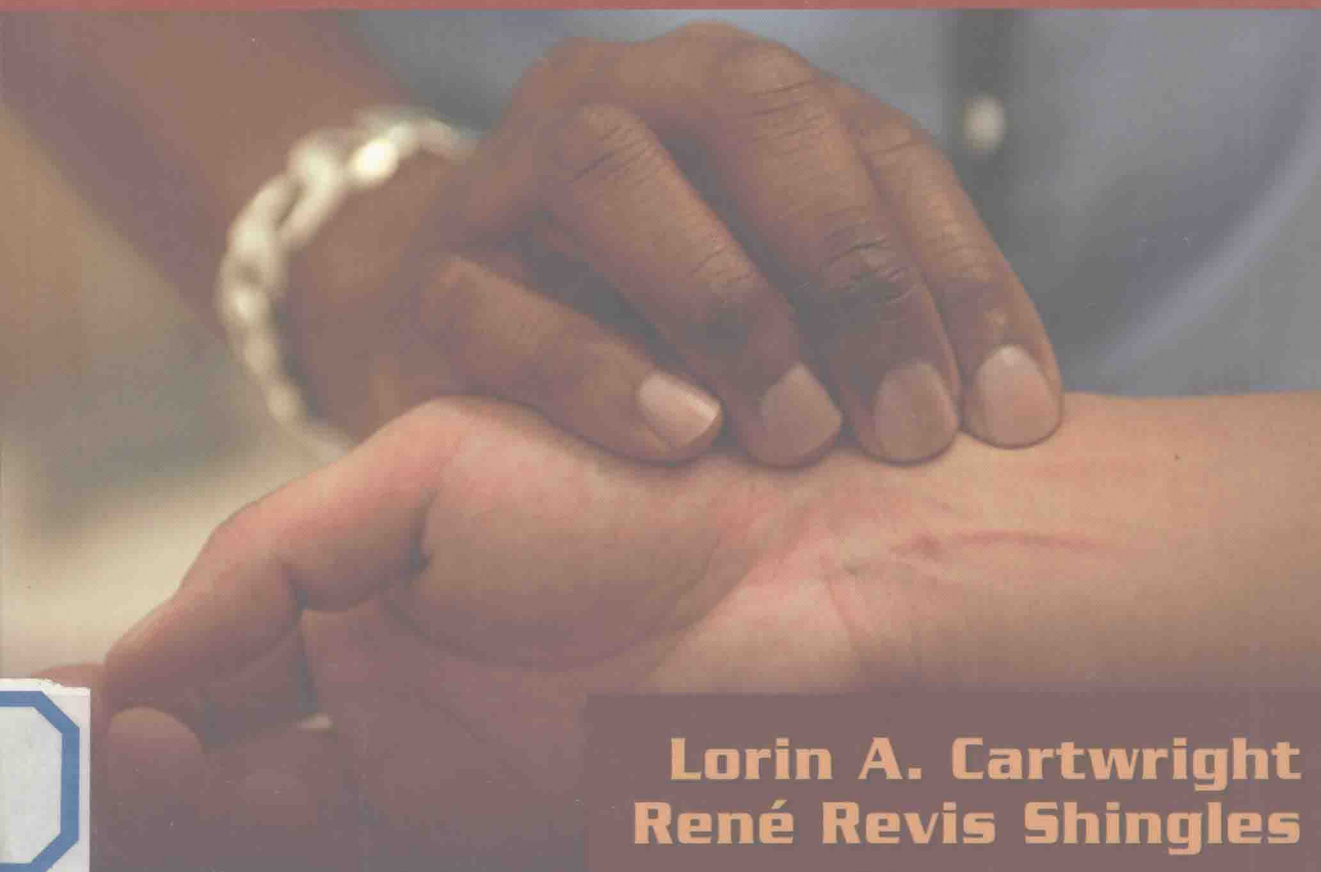
Cultural Competence in Sports Medicine



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Cultural Competence in Sports Medicine

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This book is dedicated to Robert Galardi and Bryan Westfield, two people who have taught me what diversity really means.

-Lorin

To my husband and partner Stan, our son Lamar, and in loving memory of my parents, Anthony and Betty G. Revis. This one is for you.

-René

Foreword

In its report, Missing Persons: Minorities in the Health Professions, the Sullivan Commission on Diversity in the Health Workforce stated that while African Americans, Hispanic Americans, and American Indians constitute nearly 25 percent of the U.S. population, these three groups account for less than 9 percent of nurses, 6 percent of physicians, and only 5 percent of dentists. The Commission's report explained that "diversity in the health workforce will strengthen cultural competence throughout the health system," and that "cultural competence profoundly influences how health professionals deliver health care." Among the report's many recommendations was "key stakeholders in the health system should promote training in diversity and cultural competence for health professions students, faculty, and providers."

The challenges we face in the athletic training profession are the same as the health professions cited in the Sullivan Commission's report. The National Athletic Trainers' Association reports that 81 percent of the certified membership is Caucasian, 2.6 percent Black, 3 percent Hispanic, 3.6 percent Asian American and Pacific Islander, and less than 1 percent American Indian. The changing demographics of the U.S. population make it increasingly likely that certified athletic trainers will encounter a diverse patient population regardless of clinical practice setting. Indeed, the NCAA reports approximately 35 percent of all athletes in all divisions are of color, and essentially half of division I football and men's and women's basketball players are African American.

A culturally competent health care workforce that includes certified athletic trainers is also essential to addressing the challenge of health care disparities among African Americans, Hispanics, and low-income children and adults. The Center for Disease Controls' Office of Minority Health and Health Disparities has offered this guiding principle for improving minority health:

> *"The future health of the nation will be determined to a large extent by how effectively we work with communities to reduce and eliminate health disparities between non-minority and minority populations experiencing disproportionate burdens of disease, disability, and premature death."*

The concept of cultural competence also transcends one's ability to understand and communicate with a patient of a different racial or ethnic background. To be a culturally competent and aware athletic trainer requires an understanding of delivery of health care to all individuals, regardless of race, ethnicity, sexual identity, sexual orientation, religion, class, and ability—both physical and cognitive.

Cultural competence mandates that each and every one of us do all we can to help diversify the athletic training profession. The ethnic diversity of the health care professions is inextricably linked to the delivery of more effective health care and the reduction of health care disparities. We know that racial and ethnic health care providers are more likely to serve minority and medically underserved

communities, thereby increasing access to care. Also, racial and ethnic minority patients report greater levels of satisfaction with care provided by minority health care professionals. We can promote diversity within our health care profession by embracing the many initiatives promoted by the Ethnic Diversity Advisory Committee and becoming more literate about diversity and inclusiveness in athletic training education and clinical practice.

Cultural Competence in Sports Medicine is a welcome and overdue contribution to the athletic training literature. The book will guide athletic training faculty, clinicians, and students through an exploration of cultural competence that includes definitions, information on various culture-related illnesses, and how the changing demographics of our country will influence delivery of health care. The book also facilitates a self-examination and exploration of one's own background, which is necessary to help recognize and addresses one's own biases. Ultimately, readers of *Cultural Competence in Sports Medicine* will develop the skills necessary for the effective delivery of culturally-based and competent health care delivery.

David H. Perrin, PhD, ATC
University of North Carolina, Greensboro

Preface

In 2001, the Office of Minority Health in the U.S. Department of Health and Human Services issued a report titled *National Standards for Culturally and Linguistically Appropriate Services* [CLAS] *in Health Care.* One intended use was for educators "to incorporate cultural and linguistic competence into their curricula and to raise awareness about the impact of culture and language on health care delivery. This audience would include educators from health care professions" (p. 4). In response, the National Athletic Trainers' Association revised its educational competencies for entry-level athletic trainers by including cultural competence—an area that had lacked strong teaching—as a professional behavior. In turn, our intent for this textbook is to help educators, particularly those in athletic training, expand their teaching into the area of cultural competence.

Indeed, the volume before you is a pioneering textbook that introduces the world of culturally competent health care. We present detailed information for all students who will be working with diverse populations. The book is divided into four main parts:

In part I, we help you better understand cultural competence and why it is important. Specifically, chapter 1 presents models and theories of cultural competence, including the process of cultural competence as applied to the delivery of health care services, which serves as the book's foundation and basis of organization. Chapter 2 presents a detailed description of cultural-bound syndromes and of complementary and alternative medicine, and chapter 3 discusses the influence of demographics and health disparities in health care.

In part II, we discuss cultural awareness. Chapter 4 helps you learn about factors affecting cultural competence, including race, ethnicity, class, gender, sexuality, religion, and spirituality. Chapter 5, in turn, helps you become aware of your own cultural health care issues, barriers, and biases, as well as ways in which you may tend to stereotype. Thus the book teaches you how to assess your cultural attitudes and behaviors.

In part III, we help you develop cultural knowledge. These chapters discuss various areas of the world in terms of two, or often three, cultures from each given area. For each culture, the discussion addresses demographic and cultural background information, a brief history of country of origin and immigration, primary languages and communication styles, family structure, daily living and food practices, spiritual or religious orientations, health care information, biocultural assessment, common sensitivities and conditions, beliefs about illness, preventive healing practices, symptom management, and treatments. This rich discussion allows athletic training students to glean key information for use in providing assessment, rehabilitation, and education based on each culture. Readers should also understand that first-, second-, and third-generation immigrants may have different expectations from one another. For example, first-generation

immigrants may be more inclined to believe in supernatural cures, whereas individuals who have been acculturated to the United States will likely not adhere to first-generation culture. Additionally, readers should remember that the information provided in this part may not apply to *all* people in a culture. Thus, we've included an icon near a clarifying statement to help readers be aware of this mindset before reading more about a particular culture.

In part IV, we provide you with strategies, tools, and models for developing culture-specific skills. You will learn various ways to conduct cultural physical assessments, including strategies for eliciting information from your patients. Part IV also teaches you about cultural encounters in the health care environment—providing culturally competent care to your patients is not enough; you must also learn to practice your craft in a diverse work setting.

As an athletic training student, it is critical for you to develop understanding of the role you play when working with patients. You must become familiar with the cultures of the populations with whom you will work—and learn how best to work with each person within each culture. You will also have to address your own personal biases and privileges in order to ensure that you can give the best care possible and be respected for your work.

You will see several recurring features to help you throughout the book.

- **Professionals in their own words:** Each chapter opens with a feature about a noted professional in a health field. These features present a variety of professionals discussing their experiences in varied settings.
- **Chapter objectives:** We explicitly state the objectives for each chapter to help you focus your learning.
- **What would you do if . . . ?** This segment gives students the opportunity to reflect on a cultural encounter and discuss it in the classroom setting.
- **Activities:** This feature allows students to practice what they have learned about cultural competence in terms of knowledge, skills, and attitudes.
- **Questions for review:** Important questions are asked at the end of each chapter in order to help students summarize the chapter's content.
- **Key terms:** These terms appear in boldface in the chapters and are defined in the glossary at the end of the book.
- **Appendix:** This material supports athletic training students by providing additional information about illnesses and conditions.

Acknowledgments

Everything happens for a reason. This book started five years ago with a chance meeting in a hallway at the NATA convention. God put René and I together to write this book based on that chance meeting. It started with a dream we both had, and it finishes with the involvement of so many people.

Thank you to Barb Hansen, for tedious hours of reading, rewriting, editing, encouragement, interest, and pride. I could not ask for a better person in my life.

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To Cindy Nordlinger for her artistic impression of the original maps. May God bless you with good health. I love you. Thanks to Jan Lauer for being a great friend and believing in my ability to educate. I'm truly blessed by your friendship.

-Lorin

Were it not for the grace of God, a strong faith, the many prayers that were always answered, and the contributions of many, the writing journey would not have been completed successfully. I thank you . . .

My family, mentors, and friends, particularly, Mr. Stan L. Shingles, Mr. Lamar Shingles, Mrs. Betty G. Revis (in memory), Mrs. Sheila R. Smallwood, Mr. Ricky Revis, and Dr. Yevonne Smith for your unwavering love, support, and encouragement.

The faculty and students in the Athletic Training Education Program at Central Michigan University, who when faced with the challenge of finding resources on cultural competence said, "you just need to write a book," so I did. Thanks for being the impetus. Special thanks to Ms. Adero Allen, Mr. Matt Branceleone, Ms. Mollie Coe, Ms. Ali Jeske, Mr. Alex Lundy, Ms. Ashley Reed, and Ms. Kelly Reid, who served as research assistants.

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-René

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-Lorin and René

Contents

PART I

Exploring Cultural Competence

Part I helps you gain a broader perspective on culture, cultural competence, and factors (e.g., demographics) that may affect the provision of culturally competent care. Chapter 1 establishes the importance of cultural competence and presents definitions from scholarly sources and leading organizations. It also addresses the theoretical underpinnings of cultural competence and highlights several models of cultural competence, including the process of cultural competence in the delivery of health care services developed by Dr. Josepha Campinha-Bacote. Her model—which includes cultural desire, cultural awareness, cultural knowledge, cultural skill, and cultural encounters—serves as the foundation and organizing principle of this text, and it is discussed in detail. The chapter also presents terminology and language commonly used to describe specific ethnic and racial groups.

Chapter 2 addresses various culture-related illnesses, beliefs, and health care practices that athletic trainers may encounter. Specifically, the chapter defines a number of culture-bound syndromes, which are presented by geographic region, then by country of origin or culture, in order to show their relationship to each other. Not all patients from a given culture will be familiar with or believe in the culture-bound syndromes, but athletic trainers should be aware of such practices in the event that a patient presents with symptoms. The chapter also includes a discussion of complementary and alternative medicine (CAM) practices and lays out four domains of such practices: mind–body medicine, biological-based practices, manipulative and body-based practices, and energy medicine.

Chapter 3 discusses changes in U.S. demographics associated with race and ethnicity, language, income and poverty, and insurance. It also addresses how these changes could affect health disparities—particularly, access to health care. The last part of the chapter focuses on several cultural competence techniques that may help alleviate health disparities.

CHAPTER

1

Defining Cultural Competence

Learning Objectives

Upon completing this chapter, students will be able to do the following:

1. Define cultural competence
2. Explain the importance of developing cultural competence
3. Identify the models and theories of cultural competence
4. Describe the model of cultural competence used in this text
5. Define language and terminology commonly used to describe racial and ethnic groups

Frank E. Walters, PhD, ATC

Photographer: Broward Health

I am currently the director of sports medicine for Broward Health and the director of the Wellness Center at Broward General Medical Center in Fort Lauderdale, Florida. I direct a sports medicine program designed to care for secondary athletes affiliated with contracted secondary schools in Broward County. I supervise, evaluate, and coordinate the work of 27 athletic trainers.

Prior to my present position, I was the first coordinator of the athletic health care services for the Department of Athletics, District of Columbia Public Schools. Before working in the DC Public Schools, I was an assistant professor in the Department of Kinesiology at Texas A&M University. I also worked as the head athletic trainer at Prairie View A&M. In 1977, I started my career as a teacher and athletic trainer at Pharr San Juan Alamo High School and then moved to a similar position at MB Smiley High School in Houston, Texas.

I was born in Munich, Germany and grew up in Brooklyn, New York. I obtained a BS degree in physical education at Brooklyn College in 1977 and an MS degree in

physical education with a concentration in athletic training in 1978 from Indiana State University. I received a PhD in physical education from Texas A&M.

I have been a certified athletic trainer since 1977. I am a member of the National Athletic Trainers' Association, the Southeast Athletic Trainers' Association, Athletic Trainers' Association of Florida, and the National Society of Black Athletic Trainers. I am a board member of the Board of Certification (BOC). I was also the first president of the National Society of Black Athletic Trainers. I have served as a member of several National Athletic Trainers' Association (NATA) committees.

I have received numerous awards, most notably the first Indiana State University Athletic Training Department's Outstanding Alumnus Award in 1994. In 2002, I was named the NATA's Ethnic Diversity Advisory Council's Bill Chisolm Professional Service Award honoree, and in 2003 and 2010 was presented with the NATA's Most Distinguished Athletic Trainer and Hall of Fame Awards, respectively.

I chose athletic training as a profession primarily because of my mentor, Bill Chisolm, who showed a genuine interest in me as a person and as a student. I am confident that part of Bill's interest had to do with my being an African-American student, considering there were very few Blacks in athletic training at that time. Bill was only the second African-American professor I had ever encountered and I was fascinated and impressed. While Bill mentored many other students, I am confident that he worked especially hard to encourage those who were ethnically diverse. I have made it a part of my personal and professional mission to continue in Bill Chisolm's footsteps by actively engaging ethnically diverse athletic training students and young professionals.

"No matter how people are packaged, they get up each day and go about the business of living" (Funderburg, 2006). While doing the business of living, people sometimes become ill or injured and may seek the services of a health care provider, such as an athletic trainer. What happens during the ensuing health care encounter may be mediated by culture, race, ethnicity, social class, gender, sexuality, and religion. The ways in which people are perceived, how they perceive others, and the ways in which they view the social world may also affect how they are treated, how they respond, and how they treat others in the health care environment. As athletic trainers, then, it is important that we be responsive to the needs of all patients, regardless of how they are packaged. One way to be responsive is to develop cultural competence.

WHAT IS CULTURAL COMPETENCE?

Developing **cultural competence** is a process in which an athletic trainer learns to appreciate and respect cultural differences and take them into consideration in order to care for patients in a culturally congruent manner (Purnell & Paulanka, 2008). Cultural competence also involves analyzing and criticizing systems of power and privilege (Andersen & Collins, 2007) that create inequities in health care and health care delivery. For example, if a provider establishes office or clinic hours of

9:00 a.m. to 4:30 p.m.—with time off for lunch from noon to 1:00 p.m.—one consequence is that people who work during those times (particularly hourly workers) thus face a systematic barrier to care. A person in this situation must decide if seeking health care is more important than receiving pay. Thus, if a large number of community members are hourly workers, then providing culturally competent care that meets the needs of the community may mean adjusting one's hours of operation to give patients better access to that care. Cultural competence can be developed, and doing so takes time, energy, and commitment; the process requires an active choice followed up with conscious effort.

Scholarly Definitions

Cultural competence has been defined by numerous scholars (Andrews & Boyle, 1995; Campinha-Bacote, 2002, 2007; Giger & Davidhizar, 2007; Leininger, 1978; Purnell & Paulanka, 2005, 2008; Spector, 2004) and organizations (Office of Minority Health, 2005). Although no universally accepted definition exists, many of the definitions address common themes. In terms of individual health care providers, two recurring themes are as follows: (a) recognizing one's own cultural attitudes, beliefs, and biases in order to better understand the patient's culture and health care practices, and (b) acquiring culturally based knowledge and skills in order to provide care in a culturally congruent manner. Other themes focus on the health care system (organizational cultural competence)—for example, being able to work effectively with colleagues from a diversity of cultures.

Here are two scholarly definitions of cultural competence:

- "[T]he ongoing process in which the health care professional continuously strives to achieve the ability and availability to work effectively within the cultural context of the patient (individual, family, community)" (Campinha-Bacote, 2007, p. 15).
- "[C]ulturally sensitive, culturally appropriate, [and] meeting the complex culture-bound health care needs of a given person, family and community" (Spector, 2009, p. 8).

Definitions from Professional Health Organizations

Various health care organizations have either defined cultural competence or identified it as a desirable value. Here are several examples.

- **Health Resources and Services Administration (Bureau of Primary Health Care):** Cultural competence is a set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations. It reflects the ability to acquire and use knowledge of the health-related beliefs, attitudes, practices, and communication patterns of clients and their families to improve services, strengthen programs, increase community participation, and close the gaps in health status between diverse population groups. Cultural competence also focuses on population-specific issues, including health-related beliefs