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Exploring Cultural Humility Prevalence and Barriers in Masters of Science in Athletic Training Education Programs

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EXPLORING CULTURAL HUMILITY PREVALENCE AND BARRIERS IN MASTERS OF SCIENCE IN ATHLETIC TRAINING EDUCATION PROGRAMS

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ABSTRACT

EXPLORING CULTURAL HUMILITY PREVALENCE AND BARRIERS IN MASTERS OF SCIENCE IN ATHLETIC TRAINING EDUCATION PROGRAMS

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The purpose of this study is to understand the prevalence of faculty members' abilities to incorporate cultural humility into their Masters of Science in Athletic Training (MSAT) program curriculum and barriers they feel they face in implementing this into regular practice. There is a severe lack of focus on issues pertaining to social justice within the athletic training profession, and implementation of cultural humility skills into MSAT programs can help address the systemic injustices within athletic training healthcare delivery. While there has been a focus on cultural competency in athletic training education, there is little to no current research on cultural humility and how it is used in programs currently, nor how comfortable faculty members are with teaching their students cultural humility in intentional and effective ways. A qualitative method was utilized to explore the research question, and to understand perceived barriers to implementation of culturally humble training within the current curriculum. Faculty members at accredited institutions were interviewed virtually, and it was determined that cultural humility is taught to various degrees within differing programs. Student identity, faculty identity, social determinants of health, open-mindedness, and commitments to action are some themes identified within the work. Identified barriers include time, identity, and legislative restrictions. This study looks to provide a foundation so future research can shift the focus to patient-centered care techniques that will serve people of all identities and backgrounds. Athletic training needs to

become a pioneer profession of equitable and compassionate healthcare, setting the standard for other professions to overcome systemic inequities that decrease the quality of care delivered to diverse and historically marginalized patient populations. This dissertation is available in open access at AURA (https://aura.antioch.edu) and OhioLINK ETD Center (https://etd.ohiolink.edu).

Keywords: cultural humility, cultural competency, athletic training, education, social justice, social determinants of health, patient centered care, implicit bias, qualitative research, qualitative interview, diversity, equity, and inclusion

Dedication

This dissertation is dedicated to my mother, Beth Dubyak, whose endless love and support brought me to this epic end of my academic journey. From her tireless efforts early on to instill in me a thirst for knowledge, to constant cheers and excitement through each step of my 20+ years in school, there are many moments in which I recognize I would never have gotten to this point without her. Though she did not live long enough to see me complete this work, her love persists and has been felt every step of the way. Without her, in very many ways, this work would have never occurred. I love you, mama.

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Dad, you know I quite literally could not have made it this far without you. I love you, and thank you for loving me so deeply. And finally, to my friends and family. Thank you for your emotional, financial, mental, and physical support throughout every moment of this journey. I know I was a wreck for the majority of the past few years, but it never seemed to bother you. To everyone who gave warm hugs, sent encouraging texts, or bought me a bottle of wine, I appreciate you. I genuinely do not believe I could have made it here without you loving me unconditionally. We are nothing without our communities, and I am no exception.

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CHAPTER I: INTRODUCTION

Athletic Training and the Need for Cultural Humility

Athletic training is an allied healthcare profession that encompasses the prevention, examination, diagnosis, treatment, and rehabilitation of emergent, acute, or chronic injuries and medical conditions in a wide variety of active populations (National Athletic Training Association Organization [NATA], 2021). Athletic trainers are traditionally found in secondary schools, collegiate athletics, and professional sports across the United States, but they are also becoming integral parts of nontraditional settings such as dance companies, musical theater groups, industrial factories, physical therapy clinics, orthopedic doctors' offices, and other emerging healthcare areas. Due to the specific skill set of athletic trainers, they are often the first healthcare provider many active individuals see for care, and in some communities, athletic trainers are the only accessible healthcare professionals for patients to see (Wetherington & Pecha, 2020).

As frontline healthcare providers, the athletic training profession needs to be not only well-versed in physical and mental health care techniques, but they also need to be prepared to provide treatment for a variety of socially, politically, physically, and economically diverse patients. Athletic training happens to be a racially homogenous workforce, 81.4% identify as white (Board of Certification [BOC], 2021), and there can be large disparities in the quality of care provided to diverse patient populations. Because of this divergence in identities between the clinician and patient, there is a need for athletic training educators to better incorporate diversity, equity, and inclusion (DEI) teachings into the curriculum for athletic training students.

While athletic training continues to grow and evolve, attention must be paid to the demographic differences between athletic trainers and their most common patient populations.

According to the National Collegiate Athletic Association (NCAA), 44% of student-athletes identify as female, and 38% identify as Black, Indigenous, Latinx, two or more races, and Asian (NCAA, 2023). In high school athletics across the United States, more than 3.2 million young girls played a sport in their high schools, making up about 43% of high school athletes (Black et al., 2022). There is minimal reliable data available to explore other identity demographics between athletic trainers and their patients outside of race and cisgender statistics. No known widespread research to date has reported on sexual orientations, transgender or non-binary identities, religious background, socioeconomic status, or other significant factors that influence the ways in which individuals experience the world. However, despite a lack of data points, it is reasonable to assume there are many unique identities interacting with athletic training patient care settings, and that athletic trainers need to be prepared to understand how to listen to their patients' individual and intersectional experiences and incorporate additional considerations and concerns into their care plans.

Historically, the majority of DEI work in healthcare comes from professions outside of athletic training. Medical schools, nursing programs, social work, and psychology organizations generally show a longer-running commitment to social justice work in the healthcare landscape. Athletic training, compared to these other professional fields of practice, is a newer form of healthcare available in the United States. The profession of athletic training is only a few decades old, and continues to change, grow, and evolve constantly (NATA, 2021). Because of the youth of the profession, athletic trainers are behind the curve on learning about and implementing cultural humility practices into their educational programs. In the past few years, there has been a noticeable increase in the number of athletic trainers researching and discussing social justice

practices, but there is still a significant lack of action plans for the profession to utilize in delivering high quality, patient-centered care.

Cultural Humility Introduction

Cultural humility is a dynamic and lifelong process focusing on self-reflection and personal critique, acknowledging one's own biases (Tervalon & Murray- García, 1998) particularly as it relates to people who identify differently than oneself. Drs. Tervalon and Murray- García coined the term in 1998 when they recognized patterns of insufficient medical care delivery. Nurses and physicians who considered themselves "culturally competent" from information they learned in courses or sessions they attended continuously fell short of proper, equitable care for patients of differing cultural identities (Tervalon & Murray- García, 1998). This lack of commitment from hospital staff to continuously learn and improve patient care experiences led them to develop the term "cultural humility" and work towards teaching and implementing it into patient-care settings.

While similar to cultural competency, cultural humility is focused on lifelong learning and acknowledging we will never know "everything," but insisting we continue to do the work of understanding other peoples' complex identities with each interaction. Because of the continuous nature of cultural humility, implementation of this trait throughout Master of Science in Athletic Training (MSAT) programs could help encourage future athletic trainers to be mindful of the ways in which their patients' identities and experiences shape their ability to heal and respond to treatment. It also creates space for athletic training students to remain constantly aware of their own harmful implicit biases and how these conditioned views might alter their interactions with patients and peers. The root of cultural humility work is empathy, and empathy

is a learned skill (Wang et al., 2003), which means all MSAT students have the ability and opportunity to learn how to be better providers for their diverse patient populations.

Relationship to the Problem

As a certified and licensed athletic trainer for nearly a decade, I have seen first-hand how harmful bias towards certain patient populations can decrease the quality of care received. While I have been able to step in and protect the patients in my clinical workplace, there are thousands of other locations where patients might not be receiving the care they deserve or the same quality of care their peers receive. Athletic trainers are not free of harmful unconscious bias, myself included, and it is the responsibility of each individual to work towards unlearning any biases preventing them from providing high-quality, patient-centered care. Athletic training programs can help encourage this work through the incorporation of cultural humility into the curriculum.

My full-time position as a faculty member in an accredited MSAT program, as well as a career in a diverse secondary school setting, offers a unique lens through which this research is perceived. As a new member of the very population I am researching, I am able to examine the ways each program has the flexibility to include, and exclude, certain content based on vague guidelines pertaining to diversity, equity, and inclusion provided by the Commission on Accreditation for Athletic Training Education (CAATE, 2022). This perspective is uniquely situated between my history of clinical practice and journey in academia, allowing me to observe the complicated ways in which this content is currently taught in MSAT programs.

Role of the Researcher

In discussing a topic such as cultural humility, it is important to emphasize my own intersections of identity and how it influences my perception of this research. I am a white, queer, able-bodied, English-speaking, cisgender woman, from a middle-class Christian family in

a mid-sized city. From many perspectives, I am an extremely privileged individual. I have benefitted often from my whiteness and generational wealth within my family, and my sexual orientation has very rarely affected the way I am treated by others. My gender identity has caused the most stress for me as I have spent years as a woman working in athletics and experienced rampant misogyny and presumptions about my ability to care for my patients. There are many life experiences I take for granted, but my empathy for others with different identities has grown and developed over time. I will never fully understand the complicated and dynamic experiences of those from historically marginalized groups, and therefore recognize there will often be moments when I misunderstand or fail to consider the potentially negative experiences of people with whom I am interacting. Despite this challenge, my commitment to remain a humble and self-aware individual fighting for social justice is unwavering, and I will always pause to consider the ways in which my experiences inform my understanding of this research.

Purpose of the Research

The purpose of this exploratory, qualitative research is to answer the questions, "What is the prevalence of cultural humility in MSAT programs, and what perceived barriers do faculty members face when trying to implement this concept into their curriculum?" The goal is to understand where many MSAT programs in the United States currently stand with the concept of cultural humility, and the ways in which different programs work this form of empathy into their classes regularly. In understanding the barriers facing current faculty members, there is the potential for this study to serve as a foundation for curriculum development and better incorporation of cultural humility work into the standards of practice established by the Commission on Accreditation for Athletic Training Education (CAATE). If common barriers are able to be identified, then action plans can more easily be developed to confront those perceived

barriers. A consistent commitment to cultural humility and patient-centered care serving as a foundation for MSAT educational practice will send highly skilled and highly empathetic athletic trainers into the workforce upon graduation. This work has the potential to allow MSAT programs to standardize the ways in which they discuss the value of DEI and cultural significance for patient care, therefore raising the standard of care for the athletic training profession nationally, and ensuring each patient is receiving the level of care they deserve.

Research Intention

This research looks to serve as a foundation for future exploration in similar areas. Without an understanding of the current situation regarding cultural humility work in MSAT programs, there is no clear starting point to begin evaluating and implementing policies and procedures to update current practice. With this research, the hope is things like procedural changes through CAATE could be explored, or professional developments and curricula might be created. For these changes to have a chance of happening in the future, there needs to first be the initial investigation into how programs are already implementing cultural humility and the barriers faculty members believe they face so they can then be addressed in future work.

Limitations and Delimitations

Study limitations include, but are not limited to, bias on the part of the researcher and participants influencing the perception of questions and answers. There is a chance the sample size may be insufficient to apply to the general population. While the maximum number of participants was able to be reached at 15, it still may not have been enough to truly encapsulate and generalize the state of athletic training education. Research reached and superseded a saturation point, which speaks to the strength of the data, although again, with a sample size of 15, it is unknown if these results can truly be considered generalizable. There is also the

limitation of respondent bias, meaning there is a likelihood those who are already more inclined towards social justice work are the people most likely to respond to the recruitment letter. This is difficult to avoid, as those disinterested in cultural humility work may ignore attempts to contact faculty members. While diverse perspectives were able to be explored in this research, there is still no way to control who responded and was interviewed.

The study delimitations are an exclusion of the workplace of the researcher and a dissertation committee member. All MSAT programs who have voluntarily withdrawn their accreditation status, or who are not accredited at all, were excluded from the research. Any program that is a Bachelors or Doctorate in Athletic Training was excluded as they are rare and have a different curriculum and approach to education than the majority of Masters programs. All willing faculty members were welcome for interviewing, including multiple participants from the same program as perceptions will likely vary by person. This did occur with two participants from the same program responding, but both had their own unique contributions to the work and were included in the results.

Research Assumptions

The following assumptions were made about the research being conducted. All participants participated voluntarily and answered the reflection prompts and assessment tool questions, presumably in a truthful and honest manner. All participants were core faculty members in an accredited Masters of Science in Athletic Training. Finally, to teach at this level, all participants have postgraduate doctoral degrees and a basic understanding of providing empathetic and compassionate healthcare in accordance with Board of Certification and National Athletic Training Association standards of ethics. These assumptions were met and signed

consent forms (Appendix A) were collected and stored safely before any questions were asked of participants.

Definitions of Key Terms

Below are some useful definitions to allow readers to better understand the content of this paper and ensure readers understand the author's use of these relevant terms:

Athletic training is an allied healthcare profession that encompasses the prevention, examination, diagnosis, treatment and rehabilitation of emergent, acute or chronic injuries and medical conditions, traditionally for athletic and active populations such as high school, collegiate, and professional athletics, dance companies, industrial workers, and military (NATA, 2021).

Cultural competency is a range of cognitive, affective, and behavioral, linguistic, skills that lead to effective and appropriate communication with people of other cultures (CAATE, 2022). While important, cultural competency can imply an "end goal" of competence, negating the complexity of individuals' identities.

Cultural humility is a dynamic and lifelong process focusing on self-reflection and personal critique, acknowledging one's own biases particularly as it relates to people who identify differently than oneself. While similar to cultural competency, cultural humility is focused on lifelong learning, and acknowledging that we will never know "everything," but insisting we continue to do the work of understanding other peoples' complex identities with each interaction (Tervalon & Murray- García, 1998).

Social determinants of health (SDH) are defined as the conditions into which people are born, live, learn, work, play, and age that influence their health outcomes which typically include

their economic stability, education, social context, health and healthcare access, and the built environment of their neighborhood (Winkelmann et al., 2022).

Implicit bias refers to stereotypes that affect our attitudes, behaviors, decisions, and beliefs subconsciously which can be related to race, gender identity, sexual orientation, age, class, religion, ability, etc. Also known as *unconscious bias*, these stereotypes require personal responsibility to acknowledge and unlearn them so as to better respect individuals of differing identities (Mieres et al., 2022).

CHAPTER II: THE NEED FOR CULTURAL HUMILITY EDUCATION IN ATHLETIC TRAINING AND ALLIED HEALTHCARE PROFESSIONAL PRACTICES—A LITERATURE REVIEW

Introduction

This literature review will address diversity, equity, and inclusion (DEI) in American medicine, health equity, DEI work in athletic training specifically, culturally relevant teaching in athletic training education programs, and the need to implement cultural humility into athletic training program curriculums. It is vital to understand the current state of bias in medicine so we may better understand the value of implementing cultural humility pedagogy into Masters of Science in Athletic Training (MSAT) programs. There has been a shift in the past few years to center social justice work in medicine, and the athletic training community is finally beginning to address these disparities. The goal of this work is to begin to create opportunities to ensure future generations of clinicians are better equipped to deliver high quality, patient-centered healthcare when they enter the athletic training profession after graduation.

Diversity, Equity, and Inclusion in Healthcare

Before exploring the ways in which we need cultural humility implemented into athletic training curricula, there first needs to be an understanding of the relationship between disparities in healthcare and the ways it affects patient populations across the United States. Cultural humility is a lifelong process focusing on self-reflection and personal critique, acknowledging one's own biases (CAATE, 2022) particularly as it relates to people who identify differently than oneself. Cultural humility is focused on lifelong learning, and acknowledging we will never know "everything," but insisting we must continue to do the work of understanding other peoples' complex identities with each integration.

With that said, there is no shortage of research and reports on a lack of equitable healthcare provided to Black, Indigenous, and other people of color (BIPOC) in this country (Acosta & Ackerman-Barger, 2017; Adams et al., 2021; Almond, 2019; Braveman, 2003; Copeland, 2005; Hamed et al., 2022; Havens et al., 2011; Marya & Patel, 2021; Mieres et al., 2022). There are a plethora of books, articles, podcasts, documentaries, and magazines documenting this lack of inclusive healthcare offered to people of different identities in America. While all intersections of a person's life are important when building an understanding of cultural humility, the role racism plays in the healthcare system cannot be overlooked, underplayed, or ignored. Race is one of the main indicators of inequitable healthcare delivery, meaning a white American patient is far more likely to receive high quality care compared to a BIPOC American (Copeland, 2005; Deliz et al., 2020; Dennis, 2020; Dykes & White, 2011; Hamed et al., 2022; Havens et al., 2011). Systemic racism adversely affects healthcare delivery on multiple levels, and it is important to understand these influences so clinicians can best care for all patients. A proponent of cultural humility would argue to avoid these inequities in healthcare disparities and address the systemic racism, self-reflection on how "others" are treated needs to be addressed.

Racism in Healthcare

This country's wealth and prosperity was built upon the unpaid labor of African slaves in the deep south, and upon stolen Indigenous land hundreds of years ago when it was claimed by European colonizers (Marya & Patel, 2021; Mieres et al., 2022). From the start, there was a clear disparity between the treatment of individuals with different skin tones and ethnicities, which was never undone as the nation developed, leaving us with a modern healthcare system that continues to disproportionately underserve and neglect BIPOC individuals (Mieres et al., 2022).

The buildup of hundreds of years of discrimination has continuously influenced the ways in which people interact with one another throughout society, and healthcare is no different. Historically, Black women are consistently undertreated by professionals due to a disbelief in their pain levels (Mosely et al., 2021). The myth of Black women, and Black individuals in general, having a higher pain tolerance perpetuates the belief that when they are complaining about pain, it is somehow less valid than the complaints of their White counterparts. Harmful bias in medicine is one of the largest personal factors influencing health outcomes (Almond, 2019; Mieres et al., 2022; Ufomata et al., 2021) and while understanding harmful biases is important when addressing social injustice, it fails to recognize the systemic ways in which racism affects the delivery of healthcare to historically marginalized individuals. There is an unequal power structure naturally built between patient and provider, placing the provider on a pedestal because of their specialized training in the field of medicine. Patient-provider communication is frequently influenced by the ways in which physicians interact with their patients, establishing and asserting a dominance over them as the "professional" provider (Almond, 2019). Addressing the communication styles and encouraging higher levels of empathy and consideration from clinicians may be the first step in individuals dismantling barriers to equitable care.

Harmful Bias in Medical Education

Problems with implementing DEI in medical facilities begin in the educational system. There is a unique way in which medical educators, textbooks, and classrooms default to stereotypes, and particularly center Whiteness in their curriculum and automatically assuming particular stigmatized ailments are primarily pertaining to Black patients:

> Other examples of this hidden curriculum show up in the classroom: we often assume a default (white) race by omitting race identifiers for white patients,

> associate other racial identifiers with specific diseases, and perpetuate knowledge gaps and stigma by showing medication-related rashes on patients with white skin while showing manifestations of syphilis on patients with black skin for example. (Ufomata et al., 2021, p. 1078)

This default assumption within the classroom creates a harmful bias for the students, who then move on to become the medical professionals treating a diverse population with unfair, unsubstantiated, or simply untrue assumptions influencing decision making. Students are not typically acutely aware of these malicious examples which perpetuate stereotypes and are in danger of developing harmful bias without realizing the way it affects their interactions with patients. Pictures of certain skin conditions on differing skin colors is one of the most obvious ways textbooks, and the system in general, perpetuate these harmful racial stereotypes.

The issues begin in the classroom, as medical schools, nursing programs, and other healthcare professional programs are negatively influenced by the harmful biases presented in the classroom (Almond, 2019; Ufomata et al., 2021). In addition to these default assumptions made in classrooms, there is an aversion to discussing disparities in healthcare for fear of initiating hard conversations. Avoiding discussing ways in which systems are set up to disadvantage particular cultural groups simply perpetuates the divides between groups. Acosta and Ackerman-Barger (2017) recommends healthcare professors initiate these hard conversations so their students learn it is acceptable, and in fact necessary, to discuss the ways in which prejudice, bias, and racism influence their delivery of patient-centered care. By speaking clearly and concisely on these issues, students will be better able to identify harmful practices, and it provides an opportunity for the individuals to influence the negative ways in which the healthcare system around them is working.

Health Equity

In theory, equality sounds like an ideal approach; giving everyone the same exact treatment regardless of their identity. However, the reality of our systems requires much more than equal distribution of goods and services. Instead, due to historical marginalization and systems already in place to continue to uplift certain groups and oppress others, the true goal needs to be equitable distribution of goods and services, including healthcare (Mieres et al., 2022). For example, due to historically racist practices, such as redlining, a large portion of the Black American population has been forced to live in areas which have become food deserts, places where reasonable access to good, healthy, high-quality food is restricted. This means young Black Americans are growing up with poor quality foods that then increase their risk of developing chronic conditions such as heart disease or diabetes (Marya & Patel, 2021). This increase in chronic disease for a traditionally marginalized group was manufactured through inequitable housing practices, but now influences the healthcare of several generations. Pursuing social justice within the healthcare system means finding a way to deliver equitable healthcare despite structural injustices which make this goal nearly impossible to achieve. Health equity is "striving to eliminate disparities in health between more and less-advantaged social groups" (Braveman, 2003, p. 182).

While one person cannot fight against these injustices alone, with a united front, individuals have the power to influence and dismantle the systems that unfairly oppress certain identity groups. Through collaborative action and advocacy, individuals have the power to make tangible changes to the systems that continue to oppress and harm others. Advocacy is one of the most powerful tools at the disposal of healthcare educators and professionals in the journey towards health equity and antiracism work (Breny, 2020). While racism against Black

individuals in the United States offers the most obvious examples of these inequities, there are many other historically marginalized groups who experience oppression in their access to healthcare as well (Alsharif, 2012; Cook et al., 2022; Mieres et al., 2022; Schulman et al., 2022; Stanton et al., 2022).

People with disabilities, women and gender non-binary individuals, those with various sexual orientations, many religious groups, individuals whose first language is not English, and those with lower socioeconomic status all face various forms of healthcare discrimination which requires constant advocacy work from their providers. Advocating for equitable access to healthcare for all historically marginalized groups can help the healthcare system begin to work for everyone, and receiving necessary care can no longer be a cause of stress, anxiety, and mistreatment in the United States. Cultural humility education and training will help prepare healthcare providers to work with the various communities and better serve their patients' needs.

Diversity, Equity, and Inclusion in Athletic Training

The profession of athletic training is much younger compared to other healthcare professions, such as nursing or physical therapy. Athletic training began to emerge in the 1950s when the National Athletic Training Association was founded in the United States (NATA, 2021) and has continued to grow and develop into a robust and necessary role for active populations across the country. The conversation surrounding social justice in athletic training has recently gained traction in the literature, although some athletic trainers began discussing cultural competency, harmful bias, and other social justice topics in the early 2000s (Cartwright & Shingles, 2011; Marra, 2008; Nynas, 2015; Volberding, 2013). Before then, however, there was not much work done to ensure equitable access to athletic training services, and many athletic trainers were never exposed to ideas such as cultural humility, social determinants of

health, and understanding harmful bias's influence in healthcare systems. There is a severe lack of literature surrounding these concepts before the early 2000s, and there are many athletic trainers in the workforce who may have never heard of this terminology and understood its importance in their clinical practices.

In 2008, athletic trainer Jeremy Marra wrote a master's thesis, published in 2010 alongside his professors, on understanding cultural competency in the delivery of healthcare, and it is a piece of literature widely referenced within the past few years by athletic training researchers covering similar topics surrounding cultural competency (Claiborne et al., 2022; Grove & Mansell, 2020; Kochanek, 2020, Liesener, 2017), safe space ally training (Aronson et al., 2021), and culturally responsive pedagogy (Denmark, 2019; Grove et al., 2021). Marra's research appears to be a catalyst for other conversations surrounding social justice work for certified athletic trainers (AT), and he found ATs overestimate their competency when it comes to being culturally sensitive (Marra, 2008). This work was important in highlighting the ways in which athletic trainers lack self-awareness when it comes to implementing cultural competency into their work, and the unintentional harm they could be causing their patients. The implicit biases athletic trainers have, a majority European-American population (BOC, 2021), negatively influences their ability to fairly care for their patients who come from a variety of backgrounds. In 2011, Cartwright and Shingle published a textbook called *Cultural Competence in Sports Medicine*, which some academics utilized to learn about cultural competency and how it might influence the delivery of high-quality healthcare in the field of sports medicine. This book, now more than 12 years old, was a good starting point for these conversations, but is now outdated and contains some questionable guidance for those looking to serve as more culturally competent providers.

While athletic training has historically lacked not only research, but the curricular inclusion of subjects related to diversity, equity, and inclusion, the past few years have shown a sharp increase in researchers investigating and discussing DEI in athletic training. There is research focused on increasing ethnocultural empathy (Moffit et al., 2022), cultural competency (Denmark, 2019; Grove & Mansell, 2020), implicit bias (Adams et al., 2021), social determinants of health (Freiburger et al., 2020; Winkelmann et al., 2022), gender equity (Schulman et al., 2022; Shaughnessy et al., 2021), and religious inclusion (Cook et al., 2022). This work is vital to helping the profession of athletic training move forward into a more equitable and just future, and the work must continue to push athletic trainers into a future where they can fight the social justice issues within the system so all patients can receive the care they deserve and need.

Cultural Competency in Athletic Training

In 2020, the Commission for Accreditation in Athletic Training Education (CAATE) updated the standards for athletic training education to remove the term “cultural competence” under the assumption it was a term which was already broadly understood (Grove et al., 2021). However, as the authors point out, if there is still a need to define “athletic trainer” in the Standards and Procedures, then the term “cultural competence” must also be clearly defined so as to omit any opportunity to claim it has been implemented in athletic training programs (Grove et al., 2021). The updated 2022 CAATE Standards and Procedures for Accreditation does contain a definition for “cultural competency” and added definitions for “cultural humility” as well. This change is a step in the right direction for the profession as there continues to be a push for increased social justice awareness within athletic training education.

This terminology update to the educational standards meant all accredited athletic training programs must prove they teach "cultural competency, cultural humility, and demonstrate respect in client/patient care" (CAATE, 2022, p. 67). However, it comes with little-to-no guidance on how to actually understand and implement these best practices for the faculty members who are expected to teach students and hold them accountable when they fall short of maintaining these standards. It is also important to note cultural competency and cultural humility are not the same thing, although they share similarities, as defined previously. Cultural competency naturally implies there is an "end point" where someone considers themselves competent in understanding and working with people within particular cultures. Cultural humility is an ongoing process of realizing one will never know everything about other cultures and identities, but committing to doing their best, apologizing when they cause harm, and an openness to realizing they will never know everything about a culture or identity (CAATE, 2022, p. 70). This distinction is important in understanding the ways in which one can be prepared to adapt to culturally sensitive needs of patients, but there will always be more to learn which is important to remember as well.

Grove and Mansell (2020) performed research on how competent and prepared athletic training educators felt with implementing cultural competency work into their curricula. They found the majority of current athletic training educators lacked formal training and education in regards to cultural competency. Those formally trained received generalized education in healthcare, but nothing specific to the field of athletic training. This research is important in highlighting the lack of resources to support educators who are now expected to implement these teachings into their programs. They find while there is insufficient research on the barriers to cultural competency in athletic training, nursing education provides a framework from which we

can understand the influences of this deficit. The lack of knowledge and preparation, harmful climates in the workplace and school, as well as limited experiences with diverse populations all contribute to the harmful ways in which patients are not receiving equitable care from healthcare professionals (Grove & Mansell, 2020). It is reasonable to assume similar barriers will affect the implementation of cultural humility in athletic training education.

While Grove and Mansell's research is recent, it was conducted before the major societal shifts which occurred in the past three years, such as the Black Lives Matter protests in the summer of 2020, the recent attack on transgender rights in the United States, and the mass-disabling event of the COVID-19 pandemic. This research also occurred just before the required transition to a Master's of Science which all athletic training programs were forced to undergo. It would be interesting to see how these major cultural moments have shaped and influenced athletic training educators' abilities to teach cultural competency now. These factors produce a gap in the relevant knowledge needed to accurately identify shortcomings in athletic training educational research related to cultural competency.

The current research regarding social justice work within the athletic training curriculum is almost entirely focused on cultural competency as its primary framework. This is important work to do and to understand, as cultural competency is a vital component of delivering patient-centered care. Without an understanding of the basics of cultural competency, clinicians will lack the ability to assess, appreciate, and respect the identities of their patients, and therefore fail to minimize harmful inequities in their delivery of healthcare (Kochanek, 2020). The research regarding the practice of cultural competency in athletic training programs is much more vast compared to research related to cultural humility.

Early Cultural Competency Research within Athletic Training

Nynas (2015) was one of the first authors to research the presence of cultural competency work in athletic training programs. Although their study was small, it showed a large population of athletic training students were mostly homogenous, typically white individuals, many of whom identified as female, and many from middle class backgrounds. This coincides with current data on the identity of most athletic trainers across the United States (BOC, 2021; NATA, 2021). Nynas (2015) found homogenous subjects and the lack of a truly diverse athletic training population could be one of the largest barriers to the athletic training profession implementing culturally competent skills into regular practice. It is important to acknowledge and affirm a lack of diversity within the profession exacerbates the social justice imbalances already present within the healthcare system.

The work of Liesener (2017) found there was a serious lack of formal education for the faculty members of athletic training programs who were severely underprepared to educate their students on culturally competent care. This work emphasizes the need for faculty members to be better prepared to teach cultural competency in the classroom setting. Many faculty members lack formal training and therefore do not know how to appropriately and confidently use theory to inform their teaching, adapt to difficult conversations, or incorporate interprofessional education into their curriculum (Liesener, 2017). They also suggest athletic trainers have the option to utilize existing cultural competency frameworks from other healthcare professional programs, such as physical therapy, nursing, and medical schools, to help teach this curriculum in their programs. The work of Volberding (2013) echoes this sentiment, where athletic training programs have fallen behind other medical professions when discussing and teaching cultural competence. In the past decade since these studies were published, the profession has begun to

move in the right direction, however athletic training as a whole is still too far behind the curve in regards to social justice topics in clinical practice.

Improving Patient-Centered Outcomes

Grove et al. (2021) also found athletic trainers and athletic training students alike tend to believe they are more culturally competent than they truly are in practice. This could be a dangerous pattern within the profession because an unearned trust in one's ability to be socially aware and thoughtful with patients could lead to many breakdowns in patient-centered care. This over-confidence in skill sets will lead to fewer athletic trainers acknowledging when they fall short in their care for others, and can set a dangerous precedent as new athletic training students learn from preceptors and professors who are ill-prepared to share their knowledge in this capacity. Grove et al. (2021) found many healthcare providers have implicit and explicit biases against patients of color, and those with lower socioeconomic status which tends to negatively influence their decision making when caring for these patients. While athletic populations generally tend to mimic the racial and gender makeup of the United States (Black et al., 2022; National Collegiate Athletic Association, 2022), the athletic training profession has a disproportionate number of white providers from high socioeconomic status working with these diverse patient populations (BOC, 2021). These differences in life experiences can pair providers with harmful implicit biases alongside patients who are different from them, which has the potential to affect the quality of care provided to current athletic training patients.

In recent years, the term "ethnocultural empathy" has begun to gain traction in the healthcare education field of research (Fleming et al., 2015; Karafantis, 2011; Lu et al., 2020; Moffit et al., 2022; Rasoal et al., 2009). This term, similar to cultural humility, focuses on an ongoing process of learning how to be more culturally aware and inclusive when caring for

diverse patient populations. While ethnocultural empathy naturally focuses just on race and ethnicity as identifying factors, the focus on empathy aligns very closely to the ideals of practicing cultural humility. Where the research lacks in cultural humility specifically, there are a number of researchers in healthcare looking to understand the importance of ethnocultural empathy within the social justice realm of healthcare. For athletic training education in particular, awareness and intentional education focused on empathy and continuous learning must be implemented so as to improve the students' understanding of important identities that make patients unique (Moffit et al., 2022). They conclude athletic training students in particular would benefit greatly from emphasis on diverse clinical experiences outside of the classroom to improve their ability to empathize and relate to individual patients.

The Influence of Clinical Experience in Delivering Culturally Humble Care

While changes need to be made to assist educators with delivering cultural humility teachings in the classroom, there must also be an acknowledgement of the value and importance of clinical experiences for these students as they develop into professional athletic trainers. Clinical experiences are a mandatory part of athletic training education. Students are assigned, usually each semester, although occasionally for a few weeks at a time within a single semester, to clinical sites where they get hands-on experience working with full-time athletic trainers and real patients. Clinical sites often include, but are not limited to, local high schools, collegiate teams, professional sports teams, dance and theater companies, industrial settings, military bases, and outpatient rehabilitation clinics (NATA, 2021). Athletic trainers are found in very diverse settings, which allows athletic training students the opportunity to learn in a variety of settings before they are certified and on their own in the field.

The new educational requirements from CAATE related to social determinants of health and cultural humility are beneficial for current students, but certified athletic trainers who are acting as preceptors and already in the field likely lack this kind of education. Therefore, athletic training students are in clinical rotations with preceptors who likely lack the knowledge and understanding of the influences of social determinants of health on healing and how to maintain patient-centered care practices to benefit all patients (Winkelmann et al., 2022). This gap in educational knowledge versus clinical practice could be detrimental to the development and growth of current and future athletic training students. The historical lack of cultural humility education for athletic trainers plays a large role in the poor clinical experience practices current students may witness with their preceptors at these sites.

There are generations of practicing athletic trainers who may not have the skillset to provide equitable care to their patients, and this is something athletic training students will witness and absorb through their clinical experiences. Current certified athletic trainers acting as preceptors might have no understanding of social determinants of health and the role identity plays in the healing process or their ability to deliver patient-centered care. Therefore, it is vital to ensure preceptors for these programs are also working on continuing education to learn cultural humility skills and educators are not only focused on teaching their students, but ensuring preceptor training and evaluations also address the unjust ways in which patients are able to receive care.

Developing Cultural Humility within Athletic Training Education

It is important for educators to understand the value of implementing culturally relevant teaching into their courses throughout the Masters of Science in Athletic Training program. By incorporating concepts of diversity, equity, and inclusion with cultural humility education,

MSAT programs have an opportunity and a duty to promote more culturally aware workplaces with practitioners who are able and willing to learn about patients whose identities differ from their own (Brown et al., 2021). While cultural competency work is important and helpful, an emphasis on cultural humility would elevate the level of care athletic trainers are able to provide. It would teach necessary skill sets for them to remain empathetic, humble, and compassionate throughout their years in the profession as societal expectations continue to shift and evolve. Cultural humility can be incorporated into regular practice throughout all athletic training courses as case studies, workshops, group discussions, and a variety of creative ways to ensure students are constantly aware of the ways in which they can be more empathic and equitable in their approach to delivering care. Creating good habits of consistent empathy and awareness can prepare the next generation of athletic trainers for a career of patient-centered care. Madden and Tupper (2022) share there are numerous resources available to help train healthcare providers in cultural humility practices, including sites with infographics and tips on common cultural traditions to serve as easy reminders.

Cultural Humility as a Framework

As previously mentioned, cultural humility was first defined in 1998 by Drs. Tervalon and Murray- García, who saw a gap in practitioners who claimed to have achieved "cultural competence," but still lacked the ability to learn about individual patient's needs. Cultural humility de-emphasizes cultural knowledge and competency, and instead places greater emphasis on lifelong nurturing of self-evaluation, promotion of interpersonal sensitivity, addressing power imbalances, and advancing an appreciation of intercultural individuality to avoid stereotyping (Murray- García et al., 2014; Stubbe, 2020). When healthcare workers are

responsive to the individualized experiences of each patient they encounter, they are better able to combat the inequities that have persisted in the United States healthcare system for decades.

Components of Cultural Humility

As Drs. Tervalon and Murray- García (1998) developed the framework of cultural humility they focused on three core components. The first component is lifelong learning and critical self-reflection. This places the pressure on the individual to commit to learning about others throughout their lives. People are dynamic, complex individuals with unique life experiences. It is vital for healthcare providers to commit themselves to remaining open to learning about each patient they encounter. One cannot understand other identities if they do not understand their own first. Cultural humility is a process-oriented approach to care, involving a dynamic understanding of personal identity and lived experiences (Mosley, 2017). Through critical self-reflection, individuals are challenged to not only understand the role their intersectional identities play in the delivery of care, but also understand when they make mistakes, they must apologize and find a way forward. This is where humility becomes an important component of cultural humility. Providers are challenged to reflect on where they might have gone wrong and genuinely apologize for errors, regardless of intentions.

The second major component of cultural humility is recognizing and challenging power imbalances. This aspect of the skill of cultural humility relates to the ability of the individual to view complex systems. Understanding complex systems allows providers to understand the complicated dynamics of healthcare delivery. This component can be better understood through lessons on social determinants of health (Freiburger et al., 2020; Mieres et al., 2022; Winkelmann et al., 2022) and disablement models, like the International Classification of

Function (Kirschneck et al., 2011), both of which consider how environmental and social factors might influence health.

The third and final critical component of cultural humility as defined by its founders, Drs. Tervalon and Murray- García (1998), is institutional accountability. Culturally humble healthcare providers must call upon their institutions to model the principles of cultural humility. If social justice work only falls onto providers, and allows institutions to continue to disadvantage patients, the individuals will be more likely to burn out and no structural changes can occur. Drs. Tervalon and Murray- García recommend a commitment from clinicians to advocate for their patients on an institutional level. If clinicians are truly practicing cultural humility, there is a necessary component of advocacy for change within an imbalanced system. While this component is obviously outside of individual providers' control, the clinicians can still call upon their institutions to make necessary changes to help patients.

Additional Skills Required for Cultural Humility

Scholars within various healthcare fields have explored cultural humility as a skill. Foronda and Belknap (2012) studied nurses in a foreign country and found in their work that a variety of barriers stopped these nurses from fully developing as culturally humble providers. When overwhelmed by the environment, they experienced barriers such as egocentrism, perceived powerlessness, and an emotional disconnect from patients with whom communication was challenging. This shows how the circumstances of healthcare providers must support their ability to continue to grow as culturally humble clinicians. Without institutional and social support, the barriers to providing high quality, equitable care may overwhelm providers.

Drs. Tervalon and Murray- García (1998) provided suggestions on teaching cultural humility to future clinicians. Student or trainee success in cultural humility requires an

examination of their patterns of implicit and explicit biases in regard to racism, classism, homophobia, and other forms of prejudice. This kind of self-assessment can be difficult, but utilization of small-group discussions, journaling, videotape and feedback, and professional role models leading discussions has been recommended to help encourage learning. These pedagogical approaches can guide educators towards better development in their educational settings and encourage the utilization of a variety of tools to assist students with critical self-assessment.

Cultural Humility and Athletic Training Education

The research pertaining to cultural humility within the athletic training profession and education is significantly lacking. While some authors incorporate it into their discussions of cultural competence (Grove et al., 2021; Stanton et al., 2022), there is not yet published work specifically analyzing the presence and use of cultural humility as a framework for athletic training education. One scholar, Dr. Natalya Denmark, is actively speaking about cultural humility in athletic training, but she is the only person currently discussing this specific topic. Her dissertation, *Teaching Towards Culturally Responsive Pedagogy in the CAATE Accredited Athletic Training Classroom* (Denmark, 2019), speaks specifically to the importance of cultural humility in athletic training education, and serves as her foundation for presenting on the topic as a continuing education provider. Other conversations surrounding cultural humility in healthcare (Chang et al., 2012; Hughes et al., 2020; Isaacson, 2014; Kibakaya & Oyeku, 2022; Stubbe, 2020) as a whole are more prevalent than sports medicine specifically, however it is clear cultural humility in healthcare is still an emerging topic requiring further exploration.

Cultural humility is the theoretical framework through which this research is viewed. It is the focal point of this work, and all aspects of this research focuses on understanding its use in

athletic training education. Therefore, the current lack of cultural humility research in the field of athletic training shows a great need for this work to help guide future generations of athletic trainers towards higher quality delivery of care.

Conclusion

While the research is still lacking in the ways cultural humility is implemented in the field of athletic training, there is plenty of information available to help build a case for the need for more equitable and humble practice in healthcare. Athletic training and other healthcare professions have been discussing the concepts of cultural competency, patient-centered care, social determinants of health, and cultural humility for several years. All of this research can act as a guide and framework for establishing the importance of social justice work within healthcare, and it can help establish a need to continue this work through learning about cultural humility in particular. The athletic training profession will benefit greatly from a deeper understanding and more intentional pedagogy focused on cultural humility. It is vital all athletic trainers go into the workforce understanding they will never know everything about each cultural identity, but they are self-aware and empathetic enough to put in the work to ensure their patients receive the best quality care available.

CHAPTER III: METHODOLOGY

Introduction

The athletic training profession is young when compared to other healthcare professions spending decades studying and understanding ways to implement social justice practices into their fields. At this time, there is little published evidence of faculty members' perceptions of new Commission for Accreditation in Athletic Training Education (CAATE) guidelines surrounding diversity, equity, and inclusion (DEI), and the research done focuses only on cultural competency for athletic training educators (Grove & Mansell, 2020). The only prior research done pertaining to cultural humility in athletic training was a dissertation finished in 2019 by Dr. Natalya Denmark. Otherwise, no other sports medicine scholars have conducted research particularly pertaining to cultural humility. There is also a severe lack of research trying to understand the barriers MSAT faculty members face when attempting to implement social justice teachings like cultural humility into their current curriculum. The hope is the athletic training field can find ways to incorporate cultural humility work into their accredited programs so as to create more social justice and equity in the emerging workforce of athletic trainers.

Rationale

The purpose of this research is to understand the current state of cultural humility implementation in MSAT programs, as well as the barriers faculty members feel they face when trying to implement cultural humility pedagogy. There is a severe lack of cultural humility-related research and teachings in the field of athletic training compared to other healthcare professions. However, in the past few years, there has been a large increase in the number of athletic training professionals talking about and researching topics related to DEI (Cook et al., 2022; Freiburger et al., 2020; Grove & Mansell, 2020; Grove et al., 2021). This

newfound focus on DEI initiatives shows the need to implement social justice conversations into regular educational practice.

The goal of this study was to establish a foundational understanding of where MSAT faculty members are with their ability to implement cultural humility into their classes at this time. The study aims to focus on understanding how much empathy and humility is intentionally taught to athletic training students at this time, so as to better understand the ways in which athletic training programs accomplish the established standards for implementation of cultural humility (CAATE, 2022). The study explored the perceived barriers to teaching cultural humility in a variety of university and collegiate programs across the country with the intention of serving as a foundation for addressing those barriers in future work.

Research Design

A qualitative, exploratory design (Creswell & Creswell, 2018) was utilized in order to best evaluate the way faculty members perceive cultural humility and the barriers they face when implementing these practices into their programs. Qualitative research is a means of exploring and understanding the meaning individuals ascribe to a particular social human problem (Creswell & Creswell, 2018). Qualitative interviewing was an appropriate approach to the research question because it provided the space for participants to answer in their own words how they perceive and address a complicated issue. This method was utilized for semi-structured interviews (Seidman, 2019) with faculty members from a variety of MSAT programs across the United States with the goal of answering the established research question. Interviewing allowed faculty members to express, in their own words, how they view their ability to incorporate cultural humility into their programs, and provided space for the research question to be more fully understood and explained. Qualitative interviewing research is very naturally aligned with

the constructivist research paradigm, as interviewing is a way for researchers to understand how participants find meaning in their experiences. This method of exploration offered an opportunity to delve deeper into the rationale behind the current situation within MSAT programs nationally, as well as better understand what barriers could be negatively influencing faculty members from better incorporating cultural humility in their teachings.

Research Paradigm

This research was conducted using the constructivist paradigm, emphasizing meaning-making to understand the viewpoints of the participants (Gonzalez & Faubert, 2020; Ignelzi, 2000). Meaning-making is a process meant to help understand how individuals interpret different situations or events based on their prior experiences and knowledge. It helps encourage the incorporation of one's own context and apply it to their current situations. Meaning-making exists within a constructivist research paradigm, in which each participant in the research is considered an individual with knowledge that has important consequences for how they interpret the behavior or actions of others (Magoon, 1977). In this case, this research was conducted as a means of applying understanding to the ways in which faculty members perceive their utilization of cultural humility in their classrooms, as well as their personal barriers to incorporating cultural humility more regularly into education. Each individual faculty member experiences cultural humility differently, and this qualitative interviewing research aims to apply meaning-making and constructivist understanding to these experiences to analyze how we can more effectively utilize cultural humility work in athletic training education.

Study Setting and Population

This study was conducted virtually by using the contact list on CAATE's website of current program directors of accredited MSAT programs in the country. The video conferencing

platform Zoom was used to conduct this research as respondents were from various areas around the country and there was no need to be physically present with them. The CAATE has a list of all accredited athletic training programs, at all levels, in the United States and Canada. The list includes program directors' names and links to program websites where phone numbers and email addresses are publicly available. An expansion on this information is found in the Recruitment section below. The research population was full-time faculty members in United States MSAT programs. Inclusion and exclusion criteria for the research population are listed below.

Inclusion/Exclusion Criteria

Eligible participants were any core faculty members at an accredited MSAT program in the United States. Adjunct faculty members were excluded from assessment. Anyone who is a full-time faculty member within an accredited program may be interviewed. Multiple faculty members from the same program were able to participate, as perceptions and meaning-making varies between individuals. Excluded from the list of accredited programs being explored was the department of the researcher and a member of the dissertation committee. Unaccredited programs or doctoral athletic training programs were excluded from the study.

Recruitment

Program directors' names for accredited MSAT programs were found on the CAATE website with ease. All 230 eligible programs are listed there with links to program web pages where faculty contact information can be found. Some word-of-mouth was utilized as well for researcher name recognition, through an already-established network of colleagues of the researcher within some programs across the Midwest and East coast. This approach greatly

improved the number of respondents and a maximum number of participants were interviewed due to the power of word-of-mouth.

The recruitment email (Appendix C) contained an introduction from the researcher pertaining to who they are and what they are studying, as well as an informed consent copy (Appendix A), and a link to schedule a time for an interview based on their availability. It also included descriptions of how long the interviews would likely take, and confirmation their schools and identities will be hidden in the research results, so as to help encourage honest and deep responses. Anonymity was maintained with coded numbers for respondents in the order in which they were interviewed. Program directors were contacted more than once since initial response rates were low, and there was a need for more interviews to reach a saturation point. The researcher anticipated needing fewer than 15 interviews for a well-rounded understanding of perceptions, but was willing to continue gathering information and interviewed 15 respondents. All eligible programs were contacted via program directors in an effort to get a geographically diverse group of respondents from all 11 districts identified by the National Athletic Training Association, or at least all geographic regions of the United States.

The Google Form was only viewed by the researcher as a means of collecting basic information, like gender, race, age, geographical region, and common schedule availability. This was an effective way for the researcher to confirm interest, understand general information about the intended participant, and schedule a call with minimal interruption to the participants' lives and duties.

Informed Consent

The informed consent process was completed prior to the interview to ensure the participants understood their identities and any additional identifying factors will be hidden from

the results. Each participant was provided with the informed consent form (Appendix A), allowed time to review it and ask questions, and return it with a virtual or physical signature and date. There was no direct risk of harm as a result of this research, however, the researcher had an ethical responsibility to ensure each participant understood their rights before participation. The nature of social justice topics might be uncomfortable for some participants to discuss, and they were made aware of their right to withdraw from participation at any time without penalty. No one withdrew once they signed the consent form and scheduled the interview. One respondent who expressed interest via Google Forms never responded to follow up emails.

Collection and Analysis

The researcher utilized a semi-structured one-on-one interview protocol (Seidman, 2019). Appendix B provides the list of questions, but if a participant's answer required deeper insight or further explanation, it was appropriate for the researcher to ask additional questions. This did occur in some circumstances where follow up questions enhanced the researcher's understanding of the participants' answers and details about their experience within their programs. Each question in Appendix B was asked in each interview. All interviews had sound recorded and stored on a cloud-based network only the researcher has access to, Otter AI. No interviews were accessible to others outside of the researcher out of respect for anonymity. Anonymized transcriptions were provided to external individuals as part of the validation process, but all transcripts had only numbers identifying participants and any mention of their school or state was removed from the transcript before it was shared for validation. Once the video-conferencing interviews were completed, all interviews were transcribed using the program Otter AI. These transcriptions were then coded to group them into coordinating and recurring themes (Creswell & Creswell, 2018). Each theme was explored in depth to ensure all

commonalities were identified and understood. Common themes were explored to the point of saturation, and the most commonly recurring themes have been noted and explored in the findings.

Although validation can be tricky to achieve in qualitative research (Creswell & Creswell, 2018), attempting to provide the most reliable and valid data possible was still the goal of this research. Validity has come from reaching a saturation point in the data, where interviews were no longer producing new information from participants. This implies a large enough sample has been taken to accurately reflect the opinions of the population being studied. Respondent validation has also been utilized to reinforce the data collected. Once interviews were completed and data had been summarized, initial findings were sent to participants for review and certification the responses they shared have been accurately interpreted and represented. Of the 15 participants sent the initial findings, nine responded and all confirmed they felt the themes identified accurately portrayed their responses.

In an attempt to improve internal validity within this research, transcripts were read through multiple times over the course of the analysis process. The first read-through was for general understanding and overall comprehension of answers provided during the interview. This also involved cross checking the AI-generated transcriptions and correcting any misheard words, or poor punctuation produced by the AI software. The second read-through of the transcripts looked for common concepts and ideas which arose within the interviews. The third read-through focused on contradictions within the responses, as there was the possibility of conflicting answers and ideas. This only occurred once and did not influence the generation of themes for the question. Each opportunity to revisit the transcripts was a chance to ensure comprehension and interpretation was as accurate as it can be for qualitative research.

Thirdly, validity was confirmed through the sharing of information with outside individuals with experience in research. Three colleagues were sent the anonymized transcripts separated by question. They all took time to identify themes, and those themes were compared between all three colleagues and the main researcher's initial findings. All themes were consistent with each other, implying the researcher's thematic analysis was an accurate portrayal of the information shared in interviews.

CHAPTER IV: ANALYSIS

Interviews were conducted via Zoom from late December 2023 through the end of January 2024. There were 17 voluntary participants who expressed interest in the study. Ultimately, 15 were interviewed. One potential participant was omitted due to no response after two attempts to contact them, and another was omitted because all 15 target interviews had been conducted and a saturation point had been reached. All interviews were recorded and transcribed by Otter AI and transcriptions were confirmed by the primary researcher. On average, interviews took about 15 minutes to complete. None exceeded 30 minutes at the most. Initial themes were developed by the primary researcher through multiple readings of the data. It was read initially for clarity, a second time to explore commonalities, and a third for any additional information which may have been missed. The researcher was able to identify three to five common themes for each of the five interview questions, and subsections within some themes were determined based on two or more similar answers from participants. Anonymized data was then shared with a research review panel to triangulate and identify themes from their perspectives. The four analyses were then compared, and all themes established by all four individuals were in alignment. The agreed upon themes are discussed in this chapter.

Participant Demographics

Participants were all full-time faculty members at accredited Masters of Science in Athletic Training programs within the United States. All interviews were voluntary and aligned with IRB approval. Participants were anonymized and assigned a number in chronological order in which interviews occurred. After the interview was conducted, all identifying information was removed from transcripts, including state and school references. Within the 15 participants interviewed, nine of 11 NATA districts were represented. A majority of participants came from

the East Coast and Midwest regions of the United States. There was a mixture of private and public institutions represented in the data as well, which came up naturally as participants discussed barriers and resources. There was also a mixture of urban and rural campuses, as well as religious and non-denominational institutions. Two participants were from the same school, but offered diverse and unique perspectives in their answers. Participants were largely between the ages of 30—45 (Figure 1), most have fewer than 10 years of experience specifically within AT education (Figure 2), and a majority identify as cisgender female (Figure 3). All participants identified as cisgender, and sexual orientation was not asked. The majority of participants identify as racially white (13), with one identifying as Black/African American, and one identifying as mixed race (Figure 4). These demographics align with the general makeup of athletic training educators, and athletic training demographics as a whole (NATA, 2021).

Figure 1

Self-Reported Age of Participants

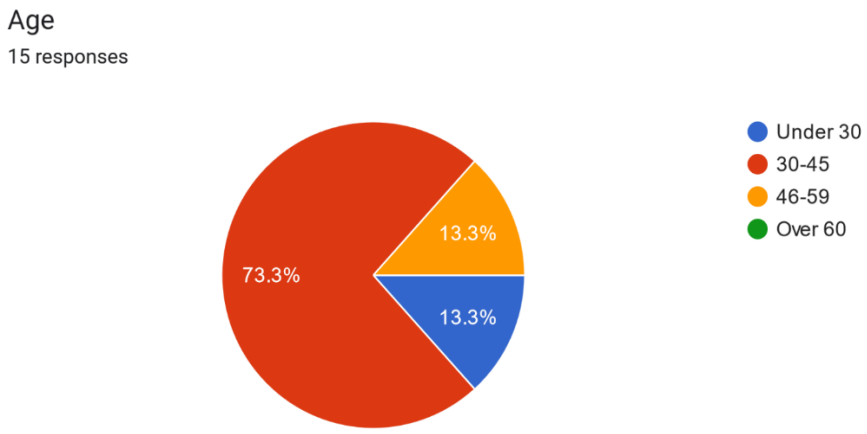


Figure 2

Self-Reported Years of Experience of Participants

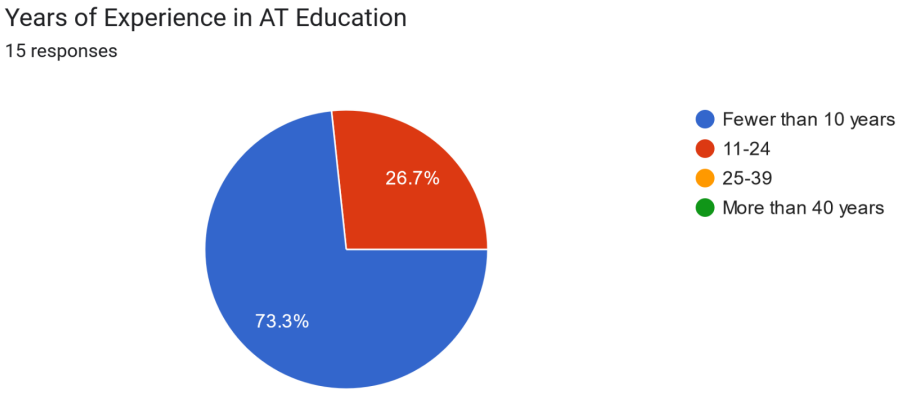


Figure 3

Self-Reported Gender Identity of Participants

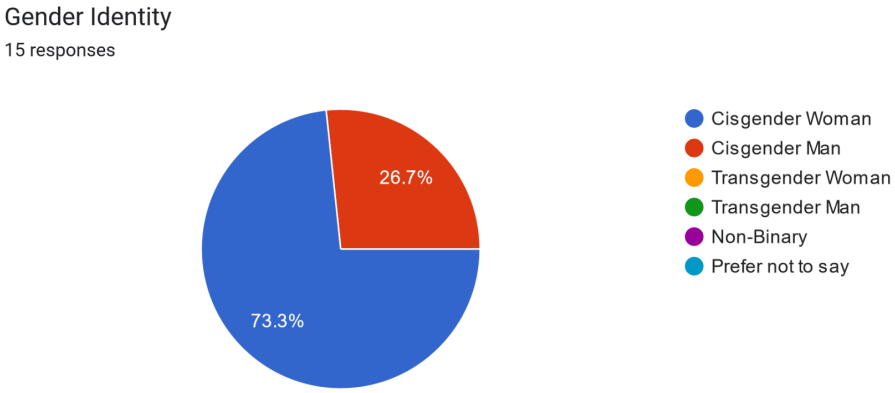
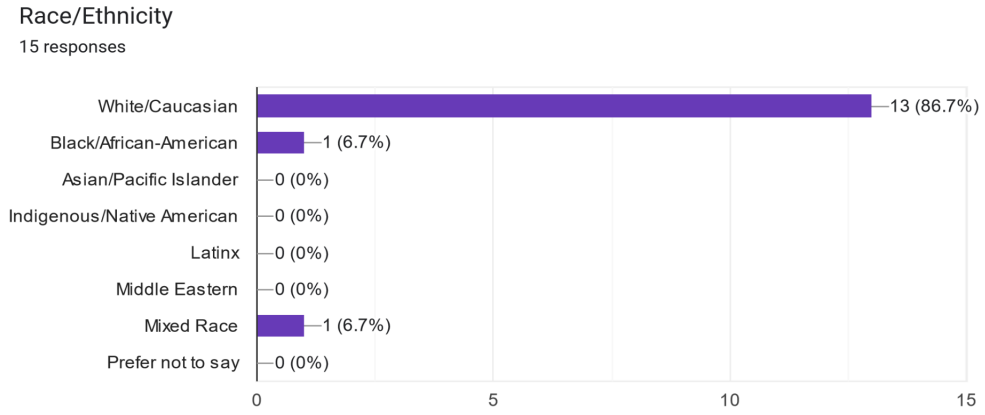


Figure 4

Self-Reported Racial or Ethnic Identity of Participants



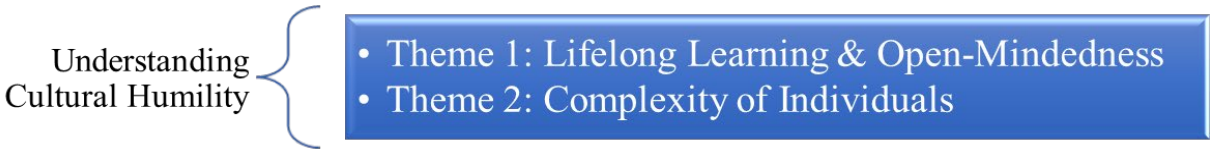
Results

Identifying Cultural Humility

The first question asked of all participants (Appendix A) was, "In your own words, what is your understanding of cultural humility?" This ensured the participant and interviewer were discussing the same term without confusion, and also allowed the participant to reflect upon their interpretation of a CAATE accreditation standard (CAATE, 2022). All participants were familiar with the term, and all provided definitions of varying detail that summarized the term well. Some neglected to include the commitment to lifelong learning, but everyone was able to differentiate between cultural humility and cultural competency. Two common themes emerged in the answers to this initial prompt.

Figure 5

Visual Summary of Themes for Question 1



Theme 1: Lifelong Learning and Open-Mindedness

The first theme identified in the responses involve cultural humility's commitment to lifelong learning. Many participants identified this term as a value which will never stop being important for athletic training students to understand and commit to developing. Common responses surrounded recognizing one's own limitations in cultural knowledge, where cultural competency tends to fall short (Grove et al., 2021), and cultural humility focuses on a need to foster constant self-awareness. Participant 4 summarizes one of the key points within the cultural humility framework, "cultural humility is more of the commitment to the lifelong journey of, you know, appreciation of all people and I think it's our ability to realize that we don't know everything. That's okay, keep learning." There is a natural need for open-mindedness in the effective practice of healthcare. Participant 1 shared healthcare is a social transaction, and while the science and evidence-based practice is important, one cannot separate the social, human aspect of care from athletic training. Participant 10 stated;

> So who they are, and what they've experienced, and how they live, and where they come from plays a big part in how they interact with other people, and how they interact with care and how we have to do that and that it's kind of constantly changing. All of our new experiences and all of the places that we go and people that we interact with and all those identities we take on, keep changing and keep growing. So it's a continuous process.

While lifelong learning was shared multiple times, it was also forgotten or omitted in some participants' own definition of cultural humility. This difference in definitions highlights the

importance of ensuring educators understand the nature of cultural humility, and cultural humility is differentiated from cultural competency because of the commitment to lifelong learning.

The importance of remaining open-minded emerged often in definitions of cultural humility. Many participants, in sharing their personal definition, shared their own life experiences as a means of defining what cultural humility means to them and how they approach it. Oftentimes, in the first two interview questions, participants shared with me their own perception of cultural humility and how it showed up in their personal and professional experiences. This common occurrence often resulted in stories related to the need to remain open-minded to other people's unique lived experiences, as well as a focus on how vulnerability can improve patient care experiences. One participant (6) shared how listening to patients' experiences is an important component of being a culturally humble practitioner, and then a part of the required openness is admitting when you have done something wrong, and caused harm to a patient.

Theme 2: Complexity of Individuals

It is well understood that humans are unique, dynamic, and highly individualized people with their own lived experiences shaping their perspectives. This concept was also highlighted amongst participants in response to the prompt defining cultural humility. One participant (13) discussed how even those within the same cultures are different, and see the world in various ways. They shared that cultural humility requires awareness of how each interaction will be unique and will require an understanding you will not have the same thoughts, feelings, and opinions as everyone you come into contact with as a clinician. Many participants shared the belief that part of the definition and core of cultural humility is the importance of individualized,

patient-centered care. This concept first appeared as part of participant's definitions of cultural humility and was later emphasized when discussing how they teach this concept in their programs.

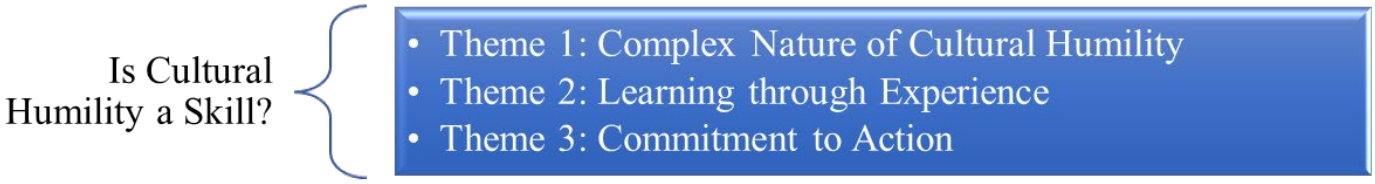
Personal identity is a factor brought up many times throughout interviews, and many participants highlighted the need for practitioners to understand their own cultural identity in addition to others'. Participant number 7 shared, "I think of cultural humility as the stepping stones to better understand one's own culture. And then to be able to, once you've identified and understand your own culture, to be able to best understand your patients' culture and how it might impact health outcomes," emphasizing how one's own identity is just as important as that of the patient.

Cultural Humility as a Skill

The second question asked in interviews (Appendix B) was, "Do you think cultural humility is a learned skill? Why or why not?" Emerging from this question were multiple interpretations and viewpoints showing the wide breadth of knowledge and understanding of participants. Some respondents agreed or disagreed outright, while others felt like the answer was more complex. In every response, as participants explained their viewpoint, almost all settled on the idea that yes, it can be learned, but only if the desire is present. From this question, four overarching themes were identified and explored.

Figure 6

Visual Summary of Themes for Question 2



Theme 1: Complex Nature of Cultural Humility

Cultural humility is seen as a multifaceted, dynamic concept encompassing a myriad of unique skillsets. Participants identified dynamic skills such as metacognition, critical self-reflection, and commitments to lifelong learning as critical components of cultural humility. Some believe cultural humility in and of itself cannot be learned without understanding these other approaches and skillsets first. Emotional intelligence was also shared as a necessary skill on the way to becoming culturally humble in clinical practice. Participants also commonly mentioned they believe while cultural humility can be taught, there are aspects of it which cannot be taught and are experiential in nature. Participant 15 summarized this well when they said:

> When it comes to cultural humility for me … I can teach you about cultures, and backgrounds, and beliefs, and ways of life, and how people may view things differently, but it's your process of actually having to put it together. I think self-reflection can be taught and can be guided and encouraged. But a person's got to want to choose to engage with that.

The belief in cultural humility as a complex, teachable skill was echoed by several participants, as well as the need for students to want to invest in developing the skills needed to be culturally humble providers.

Theme 2: Learning Through Experience

Lived experiences arose as one of the main components of many answers to this second question. Many respondents shared they believe cultural humility is often learned from a young age and developed as one grows up in particular circumstances. Participant 2 shared,

> It is something you're not born with, we'll just put it that way. It is going to be learned, in that your environment has a lot to do with it. It has to do with, unfortunately, what you see media-wise, and it's going to be learned either positively or negatively.

Life experience was a major component of most answers to this question, and participants often identified family background as a key aspect of one's ability to more easily learn cultural

humility. Geographical region, political views, information previously taught in schools growing up, cultural background, and family dynamics are all identified at some point as components of this perspective worth noting.

Theme 3: Learning Through Commitment to Action

The question of nature versus nurture arose several times in answers to this question. It is not just important to note how lived experiences influence cultural humility, but also wanting to learn and challenge oneself is equally as important. The term "innate" showed up multiple times in answer to this question, and the focus was on the fact some people will want to learn how to be culturally humble because they are naturally empathetic or compassionate. Participant 9 shared this concept through stating,

> I think it's both. I believe we are creatures of emotional capacity that we can be born with that patience and understanding from the nature approach, but I think there is a nurture piece to it ... And you have to take the time to teach them those things.

A commitment to learning about cultural humility and developing the skillset was highlighted multiple times in responses. The desire to be a more culturally humble provider seems to be an important aspect to faculty members in their opinion of this skill. Participant 4 summarized this well when they shared;

> I think that the pieces to becoming culturally humble can be learned but I think there has to be something innate almost that makes it burn inside somebody to be like, this is something I'm committed to. I think you can get better at it if you continue to be pushed.

Committing to this work is a vital piece of learning cultural humility.

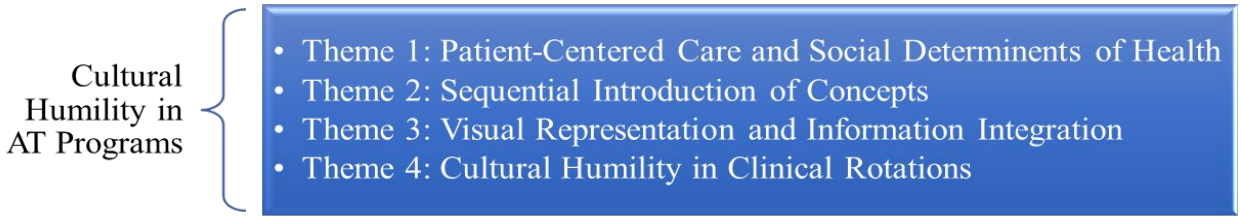
Cultural Humility within Athletic Training Education

The third question asked in this research involves the ways in which cultural humility is taught by these faculty members. They were asked, "In what ways do you teach your MSAT

students cultural humility?" These responses were the longest and varied the most of all five interview questions. Despite variation, there were some common themes which emerged throughout the exploration of this question. It is important to remember there are CAATE standards requiring the incorporation of cultural humility into athletic training education programs, so all participants do touch on it in some way. However, the requirements are extremely vague and each participant had varying levels of cultural humility incorporated into their curriculum. The following themes are what surfaced from the ways in which it is incorporated in their programs.

Figure 7

Visual Summary of Themes for Question 3



Theme 1: Patient-Centered Care and Social Determinants of Health

The majority of participants mentioned they utilize frameworks of patient-centered care and social determinants of health. They often noted how these frameworks are a natural introduction to more complex concepts like cultural humility and offer easy ways for students to connect the concept of treating the whole person with the scientific information they are learning. By utilizing these frameworks as a starting point, many educators feel they can more easily transition into cultural competency, and then cultural humility from there.

Some also incorporated the biopsychosocial model and psychosocial strategies in athletic training as a foundation upon which they can build cultural humility skills in patients. One respondent mentioned they are able to utilize patient centered care as a way to show students

how healthcare interactions are inherently culturally charged, as is any interaction with another person, and they need to understand the science of healthcare can therefore not be separated from the social aspects.

Theme 2: Sequential Introduction of Concepts

Alongside this approach, a natural connection to the timeline of teaching cultural humility emerged in participant's responses. Participants expressed a need to begin early and with fundamentals, before building up to cultural humility itself. Many participants expressed they will begin with social determinants of health, patient centered care, and inclusivity discussions in the early stages of their programs. From there, as students progress through the two-year master's degree, the faculty members will then become more specific and identify cultural humility as a framework from which the students have been unknowingly applying through their education. Several participants expressed they like to introduce the concept of cultural humility without naming it, so students get a chance to practice this skill set without realizing it is an established framework for healthcare professionals. Participant 13 specifically stated;

> The easiest way for me to start talking about cultural humility, and it is directly addressed in my curriculum, but I don't explicitly say, 'today I'm teaching you cultural humility', because that's the thing that is addressed throughout the whole curriculum, and it's just part of my philosophy as an educator. But the first thing that we do to address it is teaching through the [International Classification of Function] model. Because if we're not teaching through disablement models and looking at social determinants of health, we're not providing complete patient care. So we start with that week one, day one, and we address it in multiple classes.

This approach seems to be common amongst many educators and they spoke positively about the positive responses from students when introducing cultural humility in this way.

Theme 3: Visual Representation and Information Integration

Several participants mentioned their intentional integration of visual diverse populations included in the resources they provide students throughout their coursework. For some, this includes intentionally choosing to place pictures of individuals on PowerPoint slides, such as Black athletes, those using mobility aids, or wearing religion-specific garments as a more subtle way to get students to think about those with various identities. Many professors share they are intentional about building cultural humility skills into courses which otherwise do not allow space to explicitly discuss this topic. Participant 4 dove into this concept quite thoroughly when they shared;

> When people ask, 'how do you accomplish this standard?', I'm like, it's literally baked into everything that we do. You know, from the faces on the PowerPoints, to the examples that we give, everything has a diverse body in it. When we do our simulated patients, we always make sure that there's diversity within that so whether it be sex, or gender, or even job type, religion… we try to make sure that they're kind of getting all of that so that it's just something that they automatically think about, right? So if you're not thinking about the whole patient, and you're not going to be able to get them better.

This sentiment was echoed often, and the "baked-in" approach to cultural humility appeared in multiple responses. Most faculty members affirmed they intentionally share cultural humility ideas and lessons in all of their classes despite the topic. For some, it comes more easily within particular courses, but others struggle more to seamlessly transition from course content to mindful consideration of diversity, equity, inclusion, and access. It seems as though courses involving therapeutic interventions or rehabilitation techniques allow for smoother integration of cultural humility into the patient care scenarios that naturally occur in courses like that. However, in administrative courses, or kinesiology class, it is more difficult for faculty members to weave cultural humility into the conversation as effortlessly.

Theme 4: Cultural Humility in Clinical Rotations

Athletic training students are required to complete clinical rotations as part of their master's degree, which involves time spent each semester at various sites with preceptors and in direct patient care. Clinical rotations are a vital part of the learning process in athletic training education and emerged as a key influence in students' responsiveness to cultural humility. While clinicals happen outside of the classroom, most respondents commented on the influence clinical rotations and preceptor relationships have over students. Partially due to contact hours in class versus at clinical, and partially because of the one-on-one relationships students build with preceptors and patients, faculty members note clinical sites have a great deal of influence over students' responsiveness to cultural humility education in the classroom.

Participants who teach in more urban and ethnically diverse areas commented on how often clinical rotations have a positive impact on students. Due to student exposure to diverse patient populations, there is a great understanding of cultural humility and its importance. Some participants commented on Emergency Medical Service ride-alongs, free clinic hours, and proximity to Indigenous American reservations as learning enhancements for students and their journeys developing cultural humility. Others mentioned students working at public high schools in low socioeconomic areas, or regions with dense Mormon populations as a great opportunity to enhance learning. One participant told me;

> I think the clinical piece helps tremendously. The diversity of clinical sites and working in low socio economic, and then in rural areas, and then working on campus here at [school name]. They have a lot of resources, and then they turn around and go to a HBCU that's right down the street. And it's like, you see the disparities, and the differences, and way of life, and I think that's when the self-reflection starts to kick in more from the clinical education side when they're like, 'I've learned about it in class, but it doesn't make sense until I see it.'

This is a good summation of some common experiences faculty members have when integrating learning from clinicals and classes together so students leave with a greater understanding of providing culturally humble care.

Within the classroom, these clinical rotation experiences seem to play an important role in student responsiveness to cultural humility, or lack thereof. Often in interviews, faculty members lamented the ability to find an ideal balance between prioritizing the scientific educational needs and the social justice educational needs of students. They find unique and diverse clinical rotations help them bridge the gap between hands-on learning and implementing DEI concepts in patient practice. Participants share that students who are assigned to clinical rotations with inclusive preceptors, or rotations at diverse settings, tend to have an easier time working in class with standardized patient encounters or fake patient care scenarios centered around diverse identities.

Clarifying Questions

In the first several interviews, a follow-up question emerged as a means of improving understanding for the researcher and ensuring clarity. The first several interviews required a follow up question regarding the frequency of cultural humility incorporated into the curricula. It was not immediately apparent in the original responses how often faculty members discussed it with students, and the semi-structured interview style left space for clarifying questions. Not all participants were asked to clarify the frequency dependent on how succinctly it was shared in their initial response. When it was not apparent, for about four interviews, it was then asked of participants to share how often their classrooms discussed cultural humility. This allowed for more thorough understanding of the current prevalence and a more accurate identification of the themes described above.

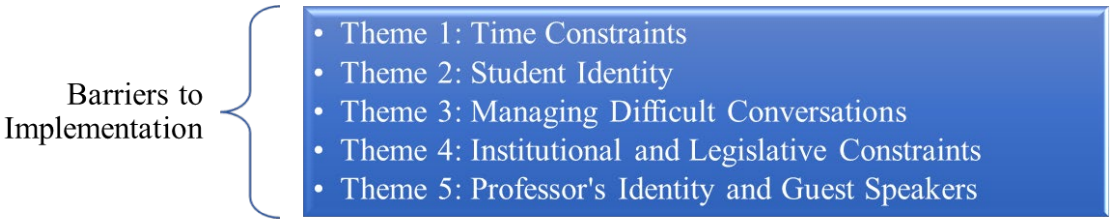
Additionally, in some interviews, participants were asked to share information with the researcher about their program demographics and university system. This information was not directly utilized in the analysis, but did contextualize some of the answers from participants when the makeup of their students' identities was explored. This clarity allowed the researcher to have a better understanding of the emerging themes at times.

Barriers to Implementation

Question four of the interview process transitioned to addressing the second portion of the research question. "What barriers do you face when trying to implement cultural humility more regularly into your curriculum?" This question aimed to understand what might be holding some faculty members back from more fully integrating cultural humility into their curriculum. While several themes emerged and will be shared subsequently, it is also important to note three participants shared they do not feel as though they face any barriers. Through internet resources, the DEI support at their schools, and their own work in this subject matter, they no longer feel as though anything is holding them back from achieving their culturally humility goals in the classroom. This was not separated into its own theme as it does not inform any need for change, but does feel significant enough to mention and celebrate.

Figure 8

Visual Summary of Themes for Question 4



Theme 1: Time Constraints

Time was one of the largest barriers and most commonly mentioned issues with faculty hoping to more regularly implement cultural humility into their curriculum. This was brought up in various ways, but a lack of time itself was always the root of the barrier. For some participants, the number of credit hours their programs offer was a part of this constraint. They feel because there is a push to decrease credit hours, and therefore decrease tuition costs at their institution, they lack the proper time to focus on cultural humility alongside the rest of the vital content they are delivering to students.

Others found this barrier arises due to contact time with students in the classroom conflicting with clinical rotation contact hours. This was briefly mentioned previously, but due to clinical rotations requiring several hours in direct patient care under the supervision of a preceptor, students spend significantly more time with their preceptors than they do with their professors. This can sometimes be great when preceptors are also culturally humble providers, but it can also become an issue if the opposite is true.

Participants also found time becomes a barrier when they are attempting to maintain course integrity and ensuring the 70+ other CAATE standards are met. While all standards are necessary and important components of athletic training education, participants find making time to integrate these concepts more seamlessly into their classroom can be a challenge. Because students are trying to practice and perfect their clinical evaluation skills or other hands-on skill work, participants expressed that it leaves little room for cultural humility to also be explored and considered in the classroom.

Theme 2: Student Identity

Due to the cultural makeup of athletic training, participants find student's personal identities, which are largely homogenous, tends to be a barrier to learning cultural humility more fully. The lack of representation of diverse life experiences in the classroom tends to be a barrier many faculty members face. They acknowledge that to be a graduate student in athletic training typically requires the financial resources to be in a specialized program, which adds to the lack of representation in the classroom. Participant 5 expressed this idea;

> I think another challenge is if you're talking to a student who's in a graduate level health care profession program, by the nature of the fact that they're in that seat, they may not have ever really thought about this before because they've had advantage, and they've had privilege, and like they've never considered that people don't have the same opportunities and advantages as them so I think it's sometimes a little bit awkward to bring it up.

Students' privilege and life experiences can make them less receptive to culturally humble care approaches, and often prevents them from genuinely understanding the importance of DEI work in the classroom. Student identity also makes it difficult to discuss complicated topics encompassed within cultural humility because of a lack of personal experience upon which to draw. They do not understand empathy and privilege as easily because they have largely benefitted from their own privilege. Participant 7 stated;

> The students that are really getting it and connecting the material from class to their patients are our non-privileged students. They're our students who are not from this country, they're our students who are on scholarship, they're our students who see it and who have experienced it themselves. It's our LGBTQ students, it's our non-binary students. So I have struggled to connect with students and see that light bulb go off of why this is important with our white, male, cisgender students who are privileged and well off. So that's my biggest barrier is trying to get some of our more privileged students to see they are privileged in other areas, and maybe marginalized in other areas that they haven't even considered yet.

Theme 3: Managing Difficult Conversations

A tangential theme which arose through interviews was the difficulty of managing uncomfortable conversations and triggered reactions in the classroom. I find this is related to student identity in a way, because it was often expressed in responses pertaining to students who come from privileged backgrounds struggling the most with these difficult conversations. Multiple participants expressed discomfort or a lack of confidence in elegantly navigating conversations surrounding cultural humility in the classroom. This is a barrier for instructors who need to have these conversations with students, but feel unprepared or unsure how to navigate that space. Participant 13 summed it up well when sharing;

> When you have conversations about cultural humility, there are people, especially when you have diverse populations in the room, there are people in that room that will be triggered and have gone through traumas. And so … it just took some extra work on my hands to say … to not tiptoe but to directly state the inequities that are present, that some people experience. And some people in the room are really triggered by that because they've experienced those inequities and so making the space for them to be angry … making that space and also trying to like bring everyone into the conversation at the same time. So like developing other people's social skills, making sure that I'm presenting things correctly and allowing space for people that are feeling triggered in the same dynamic. It's a lot of things to manage. But I think it is massively important that we manage it and that I have the skills to be able to do that.

Faculty members are often managing dynamic classroom relationships, and this challenge can be intimidating to approach without proper preparation or skill.

Theme 4: Institutional and Legislative Constraints

For several participants who teach in public schools, the recent legislative restrictions around DEI topics allowed in public institutions presents a barrier to their integration of cultural humility into their curriculum. This topic is challenging because per state legislature there are restrictions on these topics, but from the accreditation standards set by CAATE and necessary for continued accreditation, cultural humility is required. This puts educators in a difficult position

with two opposing regulations both requiring compliance. Understandably, this is a barrier for those in states with conservative governments and those in public institutions primarily. Some specific topics shared were caring for transgender athletes and how to care for athletes with unwanted pregnancies. For some of those not directly affected by legislative restrictions at the time interviews were conducted, there was still mention of elections for governor influencing their ability to teach necessary content, and fear of future laws may be passed depending on who is in office. This barrier is significant, and it underscores the impact political elections may have on programs trying to teach holistic, patient centered care models.

Theme 5: Professors' Identities and Guest Speakers

The final common theme which emerged from this question revolves around the identity of the educator. This came about in a few various ways and perspectives. One common barrier shared was that of the educator themselves. Many identify as white, all are cisgender, and particularly the men shared they often feel as though they doubt their ability to educate students on a topic like cultural humility. They are aware their own identity places them in a privileged position, and they may not be the best person to share stories of diverse perspectives and considerations. Participant 9 stated, "This is my biggest challenge that I face as a heterosexual white male and I'm talking about a full spectrum of diversity, equity, inclusion and cultural humility. How do I teach something that—there's a perception of my privilege that overshadows the ability to overcome those things?" The other side of this, is an expression of uncertainty surrounding students' reception to this information particularly from guest speakers who are from more diverse backgrounds. Some participants shared their students question the qualifications of guest speakers to have these conversations, and they feel confused by students' aversion to guest speakers. Participants believe they are doing the right thing by allowing

individuals from culturally diverse backgrounds speak on topics pertaining to their identities, but student feedback does not share the same belief. Some of this likely comes back to student identity and readiness to receive this information.

Interestingly, one participant who holds multiple diverse identities also expressed this as a barrier, but from an alternative perspective. They feel because of their racial and gender identities, which directly contrasts the general identities of their students, they feel as though when they do talk about cultural humility in their classroom, students are not receptive because they assume the professor is only speaking about it because of their personal identity. These students are not responsive to the diverse perspective from this professor because she does not look like them. The participant expressed the desire to find guest speakers whose identity aligns more closely with her students' so they might be more receptive to hearing about cultural humility from someone who looks like them and comes from a historically privileged background.

Finally, within faculty identity, there was often a reported disconnect between educators within a program and the integration of cultural humility into all classes. Some respondents acknowledge while their colleagues may talk about cultural humility every so often, they are doing so to meet the CAATE standard rather than fostering those conversations because they are personally committed to its importance. This leads to inconsistent integration of the concept, greater disparities between educators and students in the same program, and can add resistance to student reception. Participant 14 told me;

> They don't go into it—they skate over it. So for them, they sprinkle it on in their classes because they have to now because of the standard. I don't feel it is as important to them in teaching the students to have cultural humility. And it is because of their own beliefs.

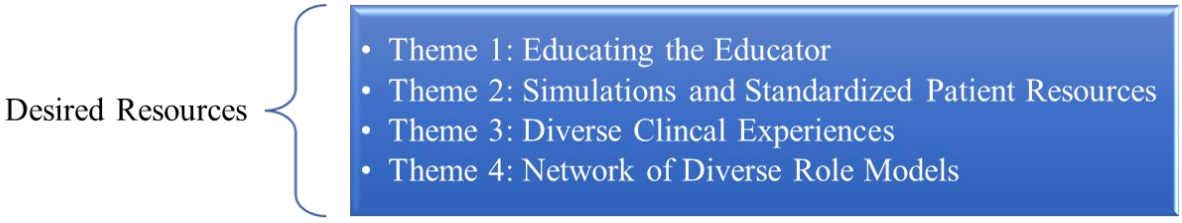
The identity of faculty members, while valuable in and of itself, should not influence their ability to share cultural humility lessons in their classrooms.

Resources Needed to Improve Delivery

The fifth and final question asked in interviews was, "What resources do you feel you would need to accurately and succinctly implement cultural humility skills into your programs?" This question aimed to help better understand the second part of the research question in navigating barriers, and establish some suggestions to help guide a plan of action. Hearing 15 diverse opinions on this front strengthens the recommendations emerging in this research. Four common themes emerged, with some subsections within them. Something worth noting is there were a few participants who said they could not think of any resources they needed. They said there is enough information on the internet for them to rely upon so they could not suggest any additional recommendations. This was not separated into its own theme because it does not have any action item potentially associated with it, but it is worth sharing.

Figure 9

Visual Summary of Themes for Question 5



Theme 1: Educating the Educator

The first and most robust theme involves providing resources to support educators in their own journeys trying to teach cultural humility. For some, this involved a desire for more continuing education opportunities and professional development programming. As certified and licensed athletic trainers, all educators are expected to get 50 continuing education units (CEUs)

every two years, however most CEU programs are intended for clinical athletic trainers, not necessarily athletic training educators. Participants would like opportunities to learn from professionals how to better foster understanding of cultural humility and other DEI-related skills. Workshops, webinars, or courses covering topics such as cultural humility, emotional intelligence, and inclusive teaching practices would be helpful for participants to rely on and improve their own skills.

Another similar answer involves improving educators' emotional intelligence and self-awareness. Participants would like to have opportunities for themselves and colleagues to understand their self-identity and how it relates to their delivery of cultural humility content. Some suggestions revolved around guided journaling prompts focused on cultural humility, patient-centered care, and navigating biases in healthcare interactions. While many participants are attempting to do this themselves, they also acknowledge their own work will only get them so far before expert opinion and guidance is needed to continue their journey of self-discovery.

Theme 2: Simulations and Standardized Patient Resources

Participants expressed a desire for structured simulations and standardized patient encounters involving cultural humility to help better challenge students. Standardized patient encounters, or just standardized patients (SPs), are commonly used in healthcare education programs to help students get more comfortable with simulated patients and better assess their clinical skills. Standardized patients can either be peers or external individuals coming in and acting as an "injured" fake patient for the student to evaluate and treat. This allows students to practice these skills in a safe environment and gives professors opportunities to provide feedback on the student's abilities. Participants shared their own efforts to accomplish this, but recognize their creativity in challenging students through these approaches are limited by personal

experience. They are able to share common culturally significant experiences to challenge the students, but it is difficult for them to include less familiar cultures and identities. Participant 11 said;

> I think our students learn a lot off of concrete experience. So if they don't get that experience, they would have to be simulated in some way or another. So that might be something that is helpful- having more simulations that are dealing with different cultural issues related to the patient and maybe their resistance to care or adherence.

When clinical practice might fall short due to preceptor buy-in, geographical location, or a variety of other factors, simulated patient care experiences in the classroom can help begin to bridge the gap between theory and practice. Standardized patient encounters or simulations which have been built for educators to better implement cultural humility practice in the classroom could provide students with opportunities to practice clinical skills, empathy, and communication in culturally sensitive ways without the risk of harming real patients.

Involving a standardized patient process in clinical and classroom settings could be a quantifiable way to teach students about cultural humility. Participant 12 suggested;

> I think in an ideal world having like a really great standardized patient process where we could actually make it an outcome and track patient centered care but also like cultural humility as an outcome or an assessment. Because I think that's one of the better ways to show students how well they're doing in something … we're going to grade you on how you interact with this patient based on these factors and then, obviously, building learning activities up to that point so that they feel prepared.

This approach would give educators and preceptors opportunities to provide graded, objective feedback about an often-subjective experience. For many students, this approach could be helpful when they need direct, graded information upon which to improve.

Theme 3: Diverse Clinical Experiences

Several participants share the desire to offer students more diverse clinical rotations, as well as find ways to ensure preceptor buy-in on modeling skills like cultural humility. Clinical rotations play a large part in students' learning outcomes, and therefore further commitment to diversifying the clinical experience could be a helpful resource to provide. Participant 7 shared;

> And then my second [resource] would probably be preceptor buy in. So as you know, a lot of times we'll teach something in the classroom, and then they'll go out in clinical, and they'll come back into the classroom and say 'my preceptor has never done that'. Or, 'my preceptor doesn't measure with a goniometer, why should I?' and it's the same thing with cultural humility. If we teach it in the classroom, but then the preceptor isn't considering some of those identity issues or demographic issues at their clinical sites, there's a big disconnect between what the faculty is saying and what they're seeing in clinical practice.

This quote does a good job in summarizing the disconnect sometimes found between the classroom and clinical sites. Increasing certified athletic trainer's awareness and commitment to cultural humility could then bridge the gap sometimes experienced by students in the classroom and clinicals. Exploration of challenges pertaining to this concept are explored further in Chapter V.

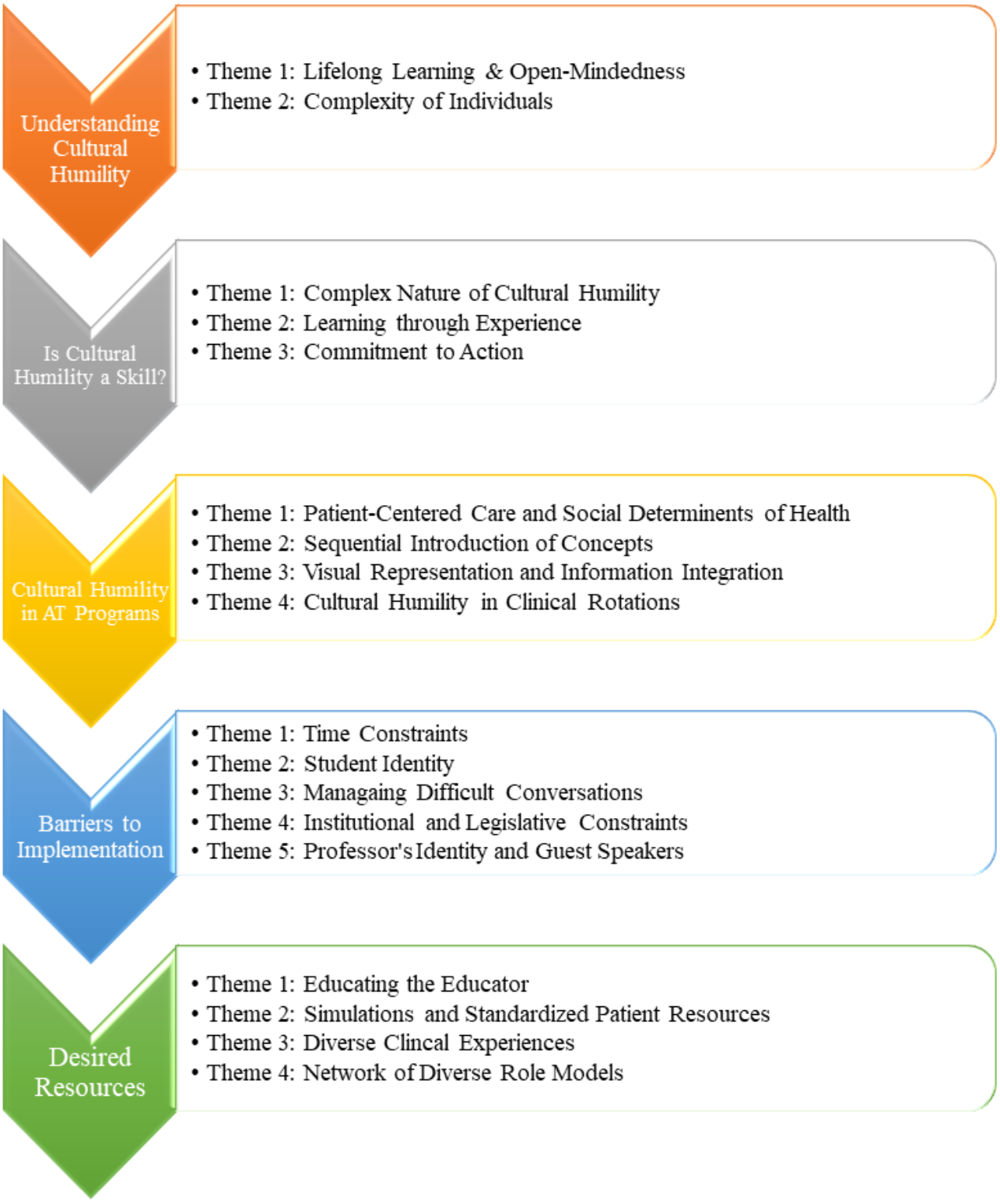
Theme 4: Network of Diverse Role Models

Finally, a common resource conceptualized by several participants is a network of some kind with diverse role models who are willing to share their experiences with students. This idea was presented often, although many participants are not sure what it would even look like, the need for greater access to storytelling as a means of encouraging cultural humility in students was often mentioned. There is a desire for some centralized network of athletic training-related professionals with diverse backgrounds for educators to contact and rely upon for guest speaking and storytelling within programs. This closely relates to the barrier of faculty and student identities influencing cultural humility delivery in the classroom. A centralized network of

human resources could provide many educators with opportunities to have real people with unique experiences involved in teaching students more effectively.

Figure 10

Visual Summary of the Emergent Themes



In summary, the research question pertaining to the prevalence of cultural humility in athletic training education programs was sufficiently explored in this research. It was established participants understand cultural humility, most believe it is a skill which means it can be taught and learned, and they shared a variety of methods for implementing cultural humility in their master's program curriculum. The questions asked to participants also allowed space to explore the ways in which they are not as successful in their implementation of cultural humility as they could be, and ideas for a variety of resources that could enhance their ability to teach about cultural humility. The implications of these results are further explored and expanded upon in Chapter V.

CHAPTER V: DISCUSSION

Interpretation

The findings of this research parallel with much of the previously discussed research and established need for further exploration of cultural humility in athletic training education. This chapter explores the context and interpretation of the themes that emerged from interviews with the participants. Some of the participants' answers aligned with expectations of the current state of athletic training education's use of cultural humility, and some answers offered unexpected, but important, insight into the ways in which we are still falling short as a profession. These findings are developed from the participants' answers, and linked back to the pertinent research and literature previously established to offer a unique and new perspective on DEI work in athletic training education.

My interpretation of these results does come from the lens of a white person, but I have relied upon my extensive knowledge and exploration of diverse identities, including the experiences of those who participated in the research, to attempt to minimize the influence of my own unconscious bias in this analysis. While I recognize there will likely be ways in which I still fall short, my experiences as a woman and queer person, as well as my continuous work of listening to diverse individuals and unlearning harmful biases, have helped inform my understanding of these findings and explore them with deeper understanding and perspective.

Understanding Cultural Humility

Faculty members participating in this research seem to generally understand cultural humility. As defined earlier in chapters one and two, it does differ from cultural competency, a framework that has been around for longer in healthcare fields (Grove et al., 2021). An important aspect of this research was to establish first and foremost that participants understand how

cultural humility differs from cultural competency. One of the most important aspects of cultural humility is the commitment to lifelong learning and recognizing you will never know everything you need to interact with diverse individuals. Despite the limitations in knowledge of diverse identities and their intersections, healthcare providers should be humble enough to admit when they were wrong, take ownership of their actions, and be willing to move forward from areas where they may have caused harm.

Critical Self-Reflection

In the first prompt of the interviews involving personal definitions of cultural humility, participants often expressed a nuanced understanding of the term. In various ways, they discussed the complexity of individual identities and how it necessitates development of cultural humility as a skillset for athletic trainers to provide the highest quality of care possible. These responses fit well within the critical self-reflection piece of cultural humility's complex definition (Murray-García & García, 2008). Acknowledgement of one's own identity appeared often in answers, which is a vital part of the cultural humility framework previously explored. For athletic trainers to provide the highest quality care possible, there naturally exists a need to understand their own identity and how it influences their ability to provide care.

In the same way social determinants of health influence patients' abilities to receive care, SDH also change how clinicians provide care based on their own life experiences and situations (Freiburger et al., 2020; Mieres et al., 2022; Winkelmann et al., 2022). Those who understand the complex systems within which we function as a society are better able to respond to patients' needs, and it is often easier for those who come from historically marginalized communities to maintain awareness. This thought emerged frequently throughout interviews and highlights the importance of those from historically privileged communities to learn about diverse identities to

positively influence their interactions. Participant 1 phrased it perfectly when they stated, “healthcare is inherently culturally charged, you can't separate the science of health care from the social aspect of it.” There is no better summary of the importance of this topic. The inherently social nature of healthcare is vital for students to understand before they are in patient care settings, and it is clear that most participants understand and teach this in their MSAT programs.

Open Mindedness

Another common theme worth exploring is the need to remain open-minded. Participants frequently discussed the need for students to be responsive to cultural humility teachings in order to truly grasp the concept and then apply it to patient care settings. Open mindedness is also significant as it relates to cultural humility as a framework. Many participants shared their own experiences as a means of talking about how they were not always this way, but did the work to open up. They spoke to the role vulnerability plays in this as well. The ability to apologize, which is a necessary component in cultural humility, requires vulnerability and a release of pride or ego. As explored earlier, egocentrism and emotional disconnect can become barriers to students fully embracing culturally humble approaches in medicine (Foronda & Belknap, 2012). It is a good sign that faculty members are aware of this and will be better able to intervene when students fall short of this skill throughout their learning.

Complexity of Cultural Humility

Multiple participants view cultural humility as a complex skill encompassing additional skills that can and are already taught. They identify metacognition, critical self-reflection, and constant self-awareness as necessary parts of cultural humility, which aligns with skills mentioned by cultural humility’s founders Drs. Tervalon and Murray- García. These acknowledgements are important as it highlights the complex nature of cultural humility as a

framework. There is a need to understand diverse perspectives, have the self-awareness to uncover one's own biases, practice learning and developing empathy, remain humble enough to apologize when one is in the wrong, and commit to continuing the journey of cultural humility throughout one's professional and personal life. This framework is dynamic and interconnected with other skills, and this is important to note as students learn how to be more culturally humble without being too hard on themselves when they fall short.

Faculty Identity

It is easy to understand why some faculty members might be intimidated by the complex nature of cultural humility. There could be a disconnect between the identity of athletic training faculty members and their commitment to learning about such a complex theoretical framework. Faculty are already juggling multiple course loads pertaining to healthcare and the human body, as well as furthering their own professional development, and supporting students. It is natural to assume because of the workload associated with teaching full-time in a postgraduate program, as well as the need for personal and professional growth, that some faculty members may feel overwhelmed and intimidated by this work. This research shows there are professors who are confident and committed to implementing cultural humility in their curriculum as often as possible, which is a positive sign of growth within the profession. However, the research also proves faculty members are able to interpret the CAATE standards for cultural humility in a variety of ways. Some participants are intentionally spreading cultural humility through every facet of their program and curriculum, while others do talk about it, but it is confined to a single course or semester. This variety in implementation shows the need for more standardized expectations and consistency between athletic training programs. Without specific guidance, there is room for professionals to incorporate cultural humility in whatever way they wish.

However, this also leaves room for faculty members to simply meet the bare minimum of mentioning it in passing, without creating deeper understanding and continuous commitment to cultural humility.

Life Experience

An often-discussed theme in interviews involved life experience influencing the students' abilities to respond positively to cultural humility in the classroom and in their clinical settings. This is a significant part of this research and worthy of discussion. Responsiveness to cultural humility taught in the classroom appears to commonly rely on student identity and the ways in which students were brought up within their own communities. Many participants shared that students who come from historically privileged backgrounds seemed to struggle most with this concept. Because of their background, some students are less inclined to commit to changing or developing skills related to cultural humility. These students seem to commonly be brought up in communities which lack diverse perspectives in at least some ways, and therefore these students often lack the ability to appreciate the role an individual's identity plays in the delivery of healthcare. Participants often brought up the need for students to have an innate sense of justice, and desire to commit to action when integrating cultural humility into athletic training patient settings. When discussing whether or not cultural humility is a skill, many participants expressed cultural humility can be learned but can only be learned by those open to receiving it.

Commitment to Learning

Commitment to learning cultural humility may rely upon the idea of nature versus nurture influencing student interest in the framework. This concept was conveyed in a variety of ways through interviews, and participants shared how their own upbringing, and subsequent change of opinion, allowed them to better develop their own commitments to cultural humility. These

participants often shared they were raised in conservative-minded households, and in largely homogenous communities. However, their upbringing in these communities did not stop them from exploring issues surrounding diversity, equity, and inclusion. Participants often shared this experience as a way of utilizing storytelling to prove their own social justice journey could be aligned with the journey of students as well. There is an opportunity to improve regardless of background, as long as the commitment to learning is present. They were using their own life experiences, and their own commitment to learning about cultural humility, as a way of showing improvements in their interactions with diverse individuals.

Participants inadvertently became testament to what can happen if one is willing to learn, remain open-minded, and commit themselves to better developing their own humility. If faculty members were able to improve despite their upbringing, then students will be able to as well, as long as they have the innate desire to work for that change. Participants' personal stories modeled the ways in which nature and nurture might both be critical components of growth. Their environments and upbringing forced them to nurture skills like cultural humility throughout their lives, but their ability to do so came from an innate sense of justice and care for others that perhaps cannot be taught.

Relevance

The first part of the research question pertaining to the prevalence of cultural humility in athletic training educational programs was powerfully answered through the methods of this research. While the depth and breadth of cultural humility utilized within individual programs in athletic training education varied widely, there is no doubt cultural humility is implemented at some point within these programs. As previously stated, the Commission for Accreditation in Athletic Training Education does require cultural humility be taught as part of Standard 72

(CAATE, 2022). However, the vague nature of the standard allows for a wide variety of interpretation and implementation of this concept in practice. The following sections will explore the relevant themes which arose from interviews in connection to answering the first part of the research question pertaining to the prevalence of cultural humility within MSAT programs.

Patient-Centered Care

One of the most common responses pertaining to teaching cultural humility in athletic training education surrounded the application of patient-centered care and social determinants of health as foundational theories for students to learn. A large portion of participants discussed their utilization of patient-centered care to introduce students to the importance of prioritizing the person over the pathology. Patient-centered care approaches are vital in every healthcare setting, and athletic training is no different. By prioritizing patient concerns and the patients' needs, every health care provider will be empowered to provide higher quality care. Similarly, understanding social determinants of health is an important part of introducing more complex frameworks like cultural humility to athletic training students. To understand how an individual's identity influences their ability to receive care, athletic trainers must first understand the ways in which cultural infrastructure impacts patients.

Disablement Models

Social determinants of health provide students with concrete examples of the ways in which the structure of the social systems and identity might influence one's ability to receive and respond positively to healthcare interventions. Social determinants of health allow athletic training students to view factual, interconnected, and complex systems as barriers to positive patient responses to care. Patient-centered care, disablement models like the ICF, and social determinants of health are commonly utilized, according to the research participants, and provide

a foundational understanding of the complexities of health in America. As explored in Chapter II, these frameworks can be utilized to help students develop an understanding of the second core component of cultural humility, recognizing power imbalances (Tervalon & Murray- García, 1998). The frequent mention of frameworks like social determinants of health in interviews shows a strong commitment to helping athletic training students better understand and recognize power imbalances and complicated systems.

Sequential Concept Introduction

Related to this implementation of patient-centered care and social determinants of health in athletic training education programs is the idea of sequential introduction of concepts to students. Participants often shared they feel it is important to begin early with educating students on topics related to social justice. This early integration of concepts includes beginning with fundamentals, and then building up to cultural humility. For some participants, foundational concepts include working with students to consider their own identity and then understanding how their identity might influence their patient interactions.

Subtle Integration of Visually Diverse Patients

Others find it is helpful for them to integrate cultural humility in more subtle ways early on. Subtle integration of these concepts often includes showing obviously diverse identities on visual aids in class, utilizing various experiences in standardized patient encounters, and challenging students to treat the whole person during classroom scenarios. Some participants make a conscious effort to include Paralympians, ethnically diverse, religiously distinct, and gender diverse people on PowerPoint slides in their courses. One participant shared they are always sure to show skin conditions on different colored skin in their general medical conditions classes so students get an opportunity to understand conditions which might appear differently

on various bodies. These are some of many examples of the ways in which participants are intentional in introducing diverse considerations early on in their program, and are then able to draw stronger connections to cultural humility later on in course work with students.

Clinical Rotations

Another important approach to cultural humility in athletic training programs involves the role of clinical rotations in influencing student perspectives. Clinical rotations are an important and vital piece of athletic training education involving direct patient care under supervision from certified athletic trainers. While clinical placements are not directly related to curriculum, participants often find clinical rotations as well as preceptors' identity are very powerful influences on students' responsiveness and receptiveness to topics pertaining to cultural humility. Students spend a minimum of 200 hours per semester at their clinical site working under the direct supervision of certified athletic trainers and their team, school, or patient population. Per CAATE standards, students must be sent to a variety of clinical sites including various collegiate teams, secondary school settings, and any unique professional or industrial clinical sites might be available to a program.

An interesting and unexpected part of this research pertained to the influence these clinical sites have over students. A majority of participants shared that placing students in particular locations or with particular preceptors plays an influential role in students' development. Some participants are fortunate to be in larger cities with various options to send students to diverse clinical placements. Sometimes this involves students working with their collegiate athletic teams at their predominantly white institution one semester, and then being sent to a nearby historically Black college or university with completely different patient populations and resources. Sometimes this involves students having an opportunity to work at

public inner city high schools and public suburban high schools with vastly different funding and student bodies, on average. This diversity in clinical placements gives students an opportunity to witness firsthand the disparities within communities, cultures, and identities in the United States. Participants who work at schools able to offer diversity in clinical sites share they have a much easier time teaching students cultural humility because students have the context through their clinical experiences to see the importance of cultural humility integration.

Conversely, participants who work at more rural universities sometimes struggle because of their geographical position. Participants at more rural universities often shared that because of a lack of diversity in their options for clinical placements, students then struggle to contextualize the importance of cultural humility when it is discussed in the classroom setting. These students often end up working with patient populations who share many commonalities with their own identity and therefore do not challenge their perspective. These clinical placements are still important and significant to the student experience, however participants from schools with this barrier shared holding space for positive and productive classroom discussions pertaining to cultural humility can present as more of a challenge because of the influence of these rotations.

Regardless of the geographical locations of athletic training programs, the importance of clinical rotations cannot be downplayed. Clinicals allow students to apply theoretical knowledge to real world scenarios and deepen their understanding of social justice frameworks like patient-centered care, social determinants of health, and cultural humility. Clinicals also allow students to have direct patient contact with supervision as they are learning about athletic training concepts. Many athletic training students learn best in a hands-on setting and their clinical rotations give them a valuable opportunity to practice these DEI approaches with real

patients. For many participants in this research, clinical practicals could not be ignored in the role they play in graduating high quality athletic trainers from these programs.

Implications

The information shared in this qualitative study helps contextualize the present state of athletic training education in regards to faculty members' abilities to integrate concepts such as cultural humility into their curriculum. It is important to understand not just the present state of cultural humility in athletic training education, but also discuss with faculty members the barriers they face and the resources they need to better apply cultural humility in their classrooms. This was part of the research question because after establishing an understanding of the current state of cultural humility, it is then important to develop a plan of action to improve upon the situation. As stated, athletic training educators appear well-informed when it comes to cultural humility ingrained in programs, based on the response from participants. However, it is important to remember these perspectives are only coming from 15 of hundreds of athletic training faculty members in the United States. Depending on the interest of those who responded to the call for participants, some of this information could still be skewed towards individuals who have a commitment to social justice topics and cultural humility. Because of this perspective, exploration of the barriers these professors face, as well as resources they believe could be helpful, could be distorted.

As shared in Chapter IV, there are some participants who do not feel as though they face barriers at this point in time. These people have been committed to exploring issues surrounding social justice in athletic training for several years, and therefore have already overcome their most obvious barriers. They feel as though they are able to access the resources needed to continue their journey without major interference. Regardless, several of them still shared advice

or stories pertaining to barriers they had to overcome previously. Many participants still face some obstacles and feel they could be better supported in this venture.

Time

Time emerged early on in the research as one of the most common hurdles to implementing cultural humility inside of the classroom. This barrier is perceived in different ways depending on the respondent, but ultimately time itself, or the lack thereof, was one of the biggest problems many educators feel they face. Some participants acknowledged they have limited contact time with students in the classroom. Depending on their course load, they may only work with students for six to nine hours per week. Often, this face-to-face time is spent learning about complicated anatomy, kinesiology, therapeutic interventions, general medical information, emergency care, or organizational and administrative concepts that are directly significant for students to understand before taking the certification exam and entering independent patient care. Because of the complexity of healthcare as a career, participants feel as though they are often forced to prioritize the more science-heavy information in face-to-face class time, as opposed to the more social information. Healthcare education can often be more rigid than other fields, requiring a large amount of information to be fit into four semesters of classes. Due to time constraints, these participants shared they often find ways to integrate cultural humility concepts in their delivery of athletic training content instead of spending a whole semester or class dedicated to the topic. This allows them to still prioritize the scientific information students need to know to pass their certification exam and care for active populations, while also ensuring issues surrounding social justice in healthcare delivery can be taught as well.

Time at Clinicals

Another approach to viewing time as a barrier includes, once again, the influence of preceptors and clinical rotations. Students only see professors for, at most, nine hours per week in face-to-face instruction. However, they are expected to spend roughly 15 hours per week at their clinical rotations. This imbalance in contact time can be a barrier to implementing cultural humility in athletic training programs depending on the clinical rotation site and the approach of the preceptor. If students are not seeing their preceptors provide care in culturally humble ways, participants then see students fail to consider cultural humility in their standardized patient scenarios as well. This imbalance could prove to be an issue and therefore requires attention on the ways in which current certified athletic trainers acting as preceptors may need additional continuing education in the area of cultural humility. Cultural humility as a framework is a more recent development in healthcare as a whole, and particularly within athletic training. There is likely an entire portion of current certified athletic trainers who have never been introduced to the concept before. This dichotomy between the educational goals for faculty members and the clinical goals for certified athletic trainers can become a barrier to providing a high-quality education to athletic training students.

Student Identity

The identity and culture of athletic training students also proves to be a barrier to several participants who are working hard to teach students about cultural humility. As previously stated, athletic training is a largely homogeneous profession. While diversity of identities in the United States continues to grow, athletic training is struggling to grow alongside these demographic shifts. Many athletic training students come from white, middle-class families and therefore maintain a historically privileged position in this country (CAATE, 2022). Lack of representation

is a barrier in and of itself because many students struggle to define their own culture, and therefore struggle to understand the way culture and identities may influence their patients. It is worth noting this is a generalization and there are plenty of athletic training students who either come from culturally diverse backgrounds, or who identify as historically privileged, but remain committed to learning about cultural humility.

While it is great to have students like this, there is still often a disconnect within athletic training programs for students who are not quite ready to have these difficult conversations. Students may sometimes lack the life experience needed to make them empathetic to the ways in which identity shifts someone's ability to positively respond to healthcare practices. If students are unable to acknowledge the role culture can play in the healing process for patients, they will likely struggle to connect with their patients and will not be able to provide the highest quality health care possible. It is important educators focus efforts on breaking through to these students and providing them with the knowledge, context, background, and storytelling needed to improve their commitment to acting as culturally humble providers. This approach aligns with the first pillar of the cultural humility framework, critical self-reflection (Tervalon & Murray-García, 1998).

Managing Difficult Conversations

Due to student identities in the classroom, many participants shared it can be difficult to manage uncomfortable conversations. This was identified as a common theme and barrier for faculty members who have experienced this difficulty in a variety of ways. For some, they recognize when the room is mostly filled with white, straight, cisgender, and those who speak English as a first language. Anyone who identifies differently can sometimes feel like they are unfairly alienated in spaces with this kind of identity imbalance. Some participants shared how

ethnically, socioeconomically, or culturally diverse students would approach them after classes in which cultural humility and similar concepts were discussed. These students would tell their professors they felt as though the professor needed to have a diverse body in the room to be able to compare the student's life experience to everyone else's. This is obviously not fair to students who should not feel obligated to teach their peers about having a diverse identity.

Negative Reactions

Other participants shared they sometimes feel unprepared to manage reactions from historically privileged students who feel as though their values or morals are being challenged through these conversations. Participants sometimes shared students who come from more commonly privileged backgrounds can react negatively to issues pertaining to diversity, equity, and inclusion brought up in the classroom. More than once, the comment was made that students feel they treat everyone equally and it is sufficient. However as previously established, there is a difference between equality and equity. These students fail to recognize the ways in which the healthcare system is designed to disadvantage certain portions of the American population, and because of the flawed system design, patients need to be treated equitably in order to achieve equality. This is an important part of the discussion because healthcare providers need to constantly be aware of the ways in which the system disproportionately disadvantages some patients and must acknowledge equality will never be enough on its own. This aligns with the second pillar of cultural humility, the ability to recognize power imbalances (Tervalon & Murray- García, 1998).

Faculty Identity

An interesting theme which emerged in interviews surrounding barriers to the delivery of cultural humility in athletic training classrooms involves the identity of the educator and guest

speakers brought in. The most interesting part of this theme pertains to the angles from which it is viewed as a barrier. Throughout interviews, three participants who identify themselves as white, cisgender, and male shared they feel as though they are not the most qualified individuals to speak on cultural humility because of their privileged position within society. An important note on this concept is all three of these participants have done extraordinary work professionally and personally to educate themselves on DEI issues. While their experience of the world may come from a place of privilege, they continue to work towards improving their empathy, and creating space for diverse individuals to share their stories. These participants talked about how bringing in guest speakers who identify differently from them helps improve the quality of their courses, however students do not always respond positively to this experience. One participant talked about how students doubt the quality of guest speakers, and would prefer he be the one to educate them on this topic. He shared his frustration with this because he does not believe he is more qualified than the guest speakers to share stories pertaining to the need for cultural humility. The other participants also share similar sentiments in regards to the restrictions they have in speaking from a position of authority on cultural humility.

Another angle of the role faculty identity plays in educating students on issues surrounding cultural humility was unexpected and seemingly contradicts the experience of the white, male faculty members. A participant who identifies as a Black American woman shared; she often feels students do not care to listen to her when discussing cultural humility. Students assume their professor's identity is the only reason she feels it is important to discuss DEI topics. This professor voiced that due to her involvement in diverse campus groups, her identity as a Black woman, and her passion for social justice issues, students are not as responsive to

classroom discussions surrounding identity and equity. She wishes she could bring in experts who look more like her students so the students are more likely to listen.

This response was unexpected, but highlights the challenges professors of any identity could face depending on the perception of their students and the commitment to patient-centered care concepts. The common thread between these responses from professors of differing identities is the apparent desire of students to hear about cultural humility from individuals who look like them. The implication here is students seem to respond more positively to these uncomfortable conversations when the facilitator shares similar cultural identities to them rather than hearing from individuals with first-hand experience regarding the need for cultural humility.

The Influence of Government

Another important implication of this research concerns the barriers around teaching social justice issues in public universities within conservative states. Everything in the United States is political, and athletic training education is no different. For faculty members who teach in public institutions within conservative states, the legislation passed by state government systems can be a barrier to teaching cultural humility. In recent years, there has been a push for restrictions on free speech within public institutions as a means of suppressing conversations around diversity, equity, and inclusion within the classroom. Unfortunately, this does take a toll on athletic training educators whose curriculum is directly influenced by state laws.

States with majority conservative lawmakers are most often experiencing these restrictions on topics surrounding transgender experiences, anti-racism, women's rights to healthcare, and other hot button talking points. When state legislatures restrict faculty members' abilities to discuss these topics, they therefore restrict faculty members' abilities to teach cultural

humility, holistic healthcare, and patient-centered care. Laws affecting conversations surrounding diversity, equity, and inclusion in the classroom directly conflict with CAATE standards required for maintaining accreditation. This dichotomy places faculty members in uncomfortable positions where they are forced to choose between following laws, or damaging the integrity of their patient-centered care approaches.

Luckily, participants in this research have found ways to still encourage holistic healthcare approaches for students, however they are concerned for the future of their program. Some participants at public institutions mentioned they are fortunate their recent state elections resulted in the election of a Democratic governor to office. They recognize their institution is at risk of the government interfering with their ability to provide high quality education depending on the outcome of future elections. This is a major issue for not just athletic training education, but all healthcare education, and public education as a whole. Suppression of social justice topics in college classrooms will lead to even greater divides in an already imbalanced healthcare system. This is an area of significant concern, and continued advocacy for freedom of speech in the classroom, and freedom from religious extremism, is important to maintain the integrity of public institutions' athletic training programs. This approach to breaking down this barrier aligns with the third pillar of cultural humility, institutional accountability (Tervalon & Murray- García, 1998). With continued advocacy at the institutional, local, state, and national levels, athletic trainers have the opportunity to push for systemic justice that would allow for improved patient outcomes.

Plan of Action

The final question of this research provided participants with an opportunity to share their own insights and desires for resources they believe could be helpful. It was important to also

receive input on ways to move forward when exploring obstacles to teaching cultural humility. It is great to understand barriers people face, however, it is equally important to develop an action plan for continued growth. While some participants feel well supported and do not feel the need for additional resources, they were an outlier in this data collection. The majority of participants shared ideas for resources they personally believe would be helpful as they try to improve their delivery of cultural humility education within their athletic training programs.

Diverse Clinical Sites and Preceptors

An important resource brought up by more than one participant is the desire to have access to more diverse preceptors and clinical sites. This was not divided into its own theme simply because diversity of clinical sites is dependent on geographical location. Due to the cultural makeup of the United States, more rural institutions will always struggle to have access to diverse clinical sites nearby, because there will be fewer schools, professional teams, and communities for them to draw upon. More diversity in preceptors will come with time as athletic training continues to diversify as a profession. An actionable item pertaining to increasing diversity of preceptors surrounds increasing opportunities for people who come from historically marginalized backgrounds to have access to athletic training education through financial support.

Scholarship Funds and Increased Salary Expectations

Investment in scholarship opportunities for historically marginalized students, support for the profession starting in high school, and advocating for an increase in base salary for athletic trainers nationally are all ways in which diverse individuals can be encouraged and enabled to join this career. Without investing in young people who are interested in healthcare and orthopedics, an entire profession will remain inaccessible for individuals who come from a lower socioeconomic status.

There is an imbalance between the cost of obtaining a master's degree in athletic training, and the average salary nationwide upon graduating (NATA, 2021). Included in the cost of the degree is the expectation of obtaining clinical hours, while needing to also complete homework, and have a job to afford rent and food. For many students, this is an extremely challenging degree to balance. Not only is the education itself hard, but then these students are passing the certification exam and obtaining a license for clinical practice in a career with low pay, furthering their financial troubles as student loan repayments begin quickly. Until this changes, athletic training education will most likely continue to be almost exclusively accessible to individuals who come from wealthier families, which tends to be white, middle class, Christian people, who speak English as a first language.

Continuing Education Opportunities

Another action item which requires discussion is the idea of educating the educator. All athletic training faculty members are required to maintain their certification and licensure. This requires 50 hours of continuing education units (CEUs) to be reported every two years. Continuing education units are offered by a variety of local, state, regional, and national athletic training bodies. The courses offered for credit are most commonly geared towards clinical athletic trainers and helping them improve their patient care practices. Several participants mentioned they would benefit from CEU opportunities geared towards educators and social justice concepts like cultural humility. Athletic training is already a smaller healthcare profession compared to nurses and physicians, and athletic training educators are an even smaller subset of the profession. Educators feel they would benefit from additional opportunities to learn about cultural humility, and opportunities to improve their skills when it comes to delivering culturally humble content to their students. The development of workshops, webinars, or courses covering

topics like cultural humility, emotional intelligence, or inclusive teaching practices would benefit educators and their students. If educators are given opportunities to improve their own emotional intelligence and self-awareness, they believe their growth would have a positive impact on their students.

Standardized Patient Database

Further resources which could be helpful for athletic training educators would be a database with structured simulations and standardized patient encounters to help improve cultural humility skills. A resource like this would allow educators to better incorporate cultural humility in their classroom and provide students with opportunities to learn how to improve care for patients without the risk of causing harm. While many participants try to accomplish this, they recognize there are limits to their own creativity and ability to represent a myriad of intersectional identities patients may hold.

Athletic training students seem to respond positively to hands-on learning, and a standardized patient resource would encourage the application of these skills in the classroom. Another benefit of a resource of this kind connects back to the lack of diverse clinical sites some programs struggle to procure. If educators could access a resource providing context for diverse patient experiences, they will better fill the gaps for students who do not have an opportunity to work with diverse patients under supervision. Another benefit of standardizing the patient simulation process would be providing educators with an opportunity to give students specific and quantifiable feedback. With many other athletic training skills there are opportunities to give students direct feedback on how to perform skills more efficiently or more accurately. With something like cultural humility however, it becomes much more subjective and can be more difficult for educators to provide guidance and for students to receive it. If we could find a way

to create a resource quantifying a student's ability to provide culturally humble care to patients, real or fake, it could greatly improve outcomes.

Athletic Training Diverse Identities Network

The final resource commonly suggested by participants involves creating a centralized network of diverse athletic training role models from which educators could access case studies, advice, multimedia material, and even guest speaking roles. Many educators shared they lack a network of professionals willing to discuss their own experiences pertaining to athletic training and cultural humility. If we were able to create a centralized resource to pull from, educators would more easily access unique stories and opportunities from which students could learn. This could be beneficial in a variety of ways. As previously shared there seems to be a desire for students to learn from individuals who look like them. A resource like this could allow educators to contact individuals students may identify with more easily. Conversely, an opportunity like this would provide educators who do not feel like they are authorities on topics surrounding DEI to contact individuals who may be better suited to speaking on the matter. This desire emerged early in interviews and continued to be brought up by many of the speakers who would love an opportunity to use the interconnected nature of our society to their advantage. While some professors do not live in culturally diverse areas, they would love the ability to connect with people outside of their local community who are able to share more interesting life experiences with students. A network of guest speakers who occupy unique spaces and therefore have unique perspectives could greatly improve the educational experience of athletic training students.

Implications for Future Research

Some interesting ideas emerged from this research. Early on, it became apparent clinical experiences have a huge influence over students. The influence may be positive or negative, but

is prominent either way. Athletic trainers need to have a greater understanding of the ways in which clinical rotations interact with the pedagogical approach in athletic training education. More research should be done on cultural humility in clinical athletic training settings. Since cultural humility is a newer framework within healthcare, it is very likely older, more experienced athletic trainers have never been introduced to the concept. This does not mean practicing athletic trainers who are not familiar with cultural humility are "bad" athletic trainers. However, this does mean there is an opportunity to continue educating practicing clinicians on ways to improve the patient care experience and understand how clinical athletic trainers utilize cultural humility skills in their facilities.

Shared Identity

Additional research should be done to investigate the reason behind students only interested in hearing about cultural humility and other conversations surrounding DEI from people who look like them. There are likely multiple sociological and psychological reasons for this apparent desire for students to feel represented by the individuals teaching them about cultural humility. It is interesting that students would rather hear from people who look like them than people who have first-hand knowledge and experience in this field of work. Further research could seek to understand the role identity plays in the delivery and reception of social justice topics within athletic training education.

Continued Exploration

There are opportunities for research to further explore many subsections within the themes that have emerged. There could be benefits from taking the results of this research and conducting a quantitative or mixed methods study synthesizing the information discovered here and allowing greater reach to a larger portion of athletic training educators. Continued

exploration of themes that emerged in this work could provide more clarity on the barriers educators face when trying to implement cultural humility into their curriculum.

Limitations

Future research should also focus on faculty members who were not able to be reached within the limitations of this study. While the maximum number of participants were successfully recruited and interviewed, there is still a very large subset of athletic training faculty members whose insights and opinions could not be gathered. Faculty members who work in athletic training programs on the western coast of the United States are not fully represented. There are two additional NATA regions not represented within this work whose members' insight could shed greater light on the state of cultural humility within athletic training education. This research was limited due to the capacity of a single researcher performing interviews as well as time constraints within a doctoral program.

Participant Demographics

This research also collected very basic demographic information about participants including age, racial or ethnic background, years of experience, and gender identity. Further exploration into sexual orientation, socioeconomic status, religious beliefs, and other facets of identity making people unique could shed more light on the perception of cultural humility, its importance, and its use in the classroom. People are complicated and occupy various intersections of identity that uniquely situate all of us in positions to experience the world differently. Further analysis of all of the ways in which we experience the world could offer greater insight and understanding into the depth and breadth of this topic.

Conclusion

It has been established athletic training is a young profession compared to other healthcare careers and continues to grow and evolve as the landscape of the United States proceeds to change. The delivery of equitable healthcare in the United States continues to be a problem for patients from historically marginalized groups. The healthcare system itself is fundamentally flawed and biased towards white, cisgender, English-speaking, heterosexual, and Christian Americans. Simultaneously, the country grows more diverse each day, and healthcare providers are tasked with the challenge of providing equitable care in an unequal system. This imbalance places significant pressure on providers, instead of compelling the healthcare system to work better for everyone. Despite the fundamental changes needed within healthcare in the United States, there is still a level of personal responsibility placed on clinicians to provide the most equitable care possible. Healthcare is an inherently social interaction, requiring clinicians' constant awareness of their personal harmful biases, and commitment to overcoming interpersonal conflicts. Providers are the ones face-to-face with diverse patient populations, and therefore it is the responsibility of providers to commit themselves to continuous learning and constant humility in their patient-centered care treatment plans.

Ultimately, this research seems to have established a foundational understanding of the current nature of cultural humility taught in a variety of athletic training programs. It has been demonstrated that athletic training professors are aware of cultural humility and find ways to address it within their curriculum through various approaches. There is a commitment to incorporate cultural humility whenever possible within athletic training education. It is also clear faculty members face some barriers outside of their control, negatively influencing their delivery of cultural humility within their classrooms. Despite the barriers shared in this research, there are

courses of action which may improve outcomes for these participants. Through the creation of centralized resources, standardized approaches, and increased advocacy for the profession, athletic training educators may be better equipped to accomplish their goals of incorporating cultural humility in everything they do. Athletic training education appears to be in a promising place, with opportunities for continued growth and improvement in the delivery of cultural humility to improve student learning. Through collective effort and continued commitment to improving the delivery of cultural humility in athletic training education, there is an opportunity for educators to send high quality, patient-centered, empathetic, and holistic athletic trainers into direct patient care upon graduation.

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APPENDIX A: INFORMED CONSENT

Project Title: Exploring Cultural Humility Perceptions and Barriers in Masters of Science in Athletic Training Education Programs
Project Investigator: Nathalie Towchik MS, AT, ATC
Dissertation Chair: Dr. Lesley Jackson

1. I understand that this study is of a research nature. It may offer no direct benefit to me.
2. Participation in this study is voluntary. I may refuse to enter it or may withdraw at any time without creating any harmful consequences to myself. I understand also that the investigator may drop me at any time from the study.
3. The purpose of this study is to understand MSAT faculty comfort levels and barriers to implementing cultural humility teachings into their program curriculum.
4. As a participant in the study, I will be asked to take part in the following procedures:
    a. A Zoom call with the investigator answering questions about my ability to teaching cultural humility in the classroom
    b. Recording of the call and understanding my answers will be later transcribed
5. The risks, discomforts and inconveniences of the above procedures might be:
    a. Participants may be uncomfortable discussing the subject matter
    b. There is no other potential harm as a result of these procedures
6. The possible benefits of the procedure might be:
    a. An opportunity to reflect on my teaching style
    b. Better understanding of cultural humility
    c. Reflection on the barriers my team faces in implementing cultural humility in our institution
7. Personal identifiers will be removed and the de-identified information may be used for future research without additional consent.
8. Information about the study was discussed with me by Nathalie Towchik. If I have further questions, I can call her at (xxx-xxx-xxxx).
9. Though the purpose of this study is primarily to fulfill my requirement to complete a formal research project as a dissertation at Antioch University, I also intend to include the data and results of the study in future scholarly publications and presentations. Our confidentiality agreement, as articulated above, will be effective in all cases of data sharing.

If you have any questions about the study, you may contact Nathalie Towchik, at telephone (xxx-xxx-xxxx) or via email at xxxxxxxx@antioch.edu.

If you have any questions about your rights as a research participant, you may contact Dr. Hays Moulton at xxxxxxxx@antioch.edu

Date:_____ Signed:_____

APPENDIX B: QUESTION BANK FOR SEMI-STRUCTURED INTERVIEWING

1. In your own words, what is your understanding of cultural humility?
2. Do you feel like cultural humility is a learned skill? Why or why not?
3. In what ways do you teach your MSAT students cultural humility?
4. What barriers do you face when trying to implement cultural humility more regularly into your curriculum?
5. What resources do you feel you would need to accurately and succinctly implement cultural humility skills into your programs?

APPENDIX C: RECRUITMENT LETTER

Dear prospective participant;

I am writing to let you know of an opportunity to participate in a research study about the perception of teaching cultural humility in Masters of Science in Athletic Training educational programs, and barriers faculty members face when trying to implement these teachings more regularly. This study is part of a dissertation for Nathalie Towchik MS, AT, ATC at Antioch University as part of her work in the EdD in Educational and Professional Practice program. This study will be conducted virtually through video conferencing and involves a brief interview with Nathalie lasting no more than 30 minutes.

Your contact information was obtained through your school website as you are listed as a program director for a CAATE accredited MSAT program. I ask that you disseminate this as you see fit to your staff, as you do not need to be a program director to participate in this research, but any full time MSAT faculty member is welcome to participate. You and/or any interested faculty member on your staff may fill out the brief Google Form link provided in this email to provide some very basic information, including preferred contact methods and preferred interview times. Also attached to this email is a consent form for all interested participants to review and sign, either physically or electronically.

All of your information will only be viewed by the researcher, Nathalie, and while interviews will be recorded for coding and transcription purposes, no answers given will be linked to you or your institution in the research results. There are minimal, if any, risks from participating. Your identity will be anonymous. No personally identifiable

information will be associated with your responses to any reports of these findings. Any interest expressed does not mean you have been enrolled automatically in the study. Your participation is voluntary and you may elect to discontinue your participation at any time. There is no compensation offered for participating in this study.

If you have any questions or clarifications about the research study, please contact me, Nathalie Towchik, at xxxxxxxx@antioch.edu or on my office phone at xxx-xxx-xxxx.

Thank you for your time and your consideration of this research opportunity. I hope to hear from you soon.