

Time's Up! Needed Cultural Changes in Athletic Training Education and Clinical Practice

Destinee Grove, MS*; Jamie Mansell, PhD, LAT, ATC†; Dani Moffit, PhD‡

*Athletico Physical Therapy, Oak Brook, IL; †Department of Health and Rehabilitation Sciences, Temple University, Philadelphia, PA; ‡Department of Sport Science and Physical Education, Idaho State University, Pocatello

Context: Culturally competent care has been on the radar of peer health care professions for many years. The unique patient populations that athletic trainers work with lend us to be at the forefront of delivering truly patient-centered care. However, we have not yet appropriately incorporated this tenet of evidence-based practice.

Objective: To convey the importance of culturally inclusive care and education to athletic training clinical practice and educational programs. We also present a novel way to intertwine inclusivity in the classroom and the clinic in a way that is accessible at any point in one's cultural competence journey.

Background: Historically, cultural competence in athletic training education has focused on ethnicity and race. The students we teach and the patients we treat share a variety of cultures that are often forgotten yet need to be included for a more holistic approach.

Recommendation(s): Athletic trainers and athletic training educators need to continue the journey toward delivering culturally inclusive care. This journey also needs to extend to the classroom, from the delivery methods of teaching to the way we interact with our students. Teaching priorities should include a focus on the cultures around and within our profession.

Key Words: Inclusive, cultural competence, patient-centered care

Dr Mansell is currently Associate Professor and Program Director in the Department of Health and Rehabilitation Sciences at Temple University. Please address correspondence to Jamie Mansell, PhD, LAT, ATC, Department of Health and Rehabilitation Sciences, Temple University, 1800 N Broad Street, Pearson Hall 261, Philadelphia, PA 19121. jmansell@temple.edu.

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KEY POINTS

- Culturally inclusive health care is necessary to provide holistic, patient-centered care.
- By making education more culturally inclusive, educators ensure students are given (1) the best chances at academic success and (2) the tools needed to provide culturally inclusive care as they transition to practice.
- Paths toward culturally inclusive health care and education include self-reflection and intentionally seeking professional development and resources in these areas.
- Athletic training education, specifically, can be made more inclusive with thoughtful course planning, evaluation of the educational climate, insurance that clinical experiences incorporate culturally inclusive care, and mentorship.

The United States has struggled with the constitutional perception of equal protection and general welfare to its citizens. Lawmakers and advocates have played a tug-of-war of who fits into *equal protection*, often negatively affecting those who have historically been marginalized and underserved, including racial and ethnic minorities, women, children, veterans, rural individuals, and the LGBTQ+ community.¹ Culturally competent health care has become a driving force in health professions, both in the education of future clinicians and in meeting the needs of underserved populations, but there has been little evidence demonstrating its effectiveness in improving health care outcomes.² However, a lack of or inconsistent definition of *culture* and *cultural competency* and related terms may cause difficulty in implementation of care.²

When considering cultural competency, there needs to be some consideration as to what all is included. It is often thought to only be related to race or ethnicity; however, there are many other aspects. In the United States, there is a makeup of white (72.4%), black (12.6%), Asian (4.8%), American Indian and Alaska native (0.9%), native Hawaiian and other Pacific islander (0.2%), other (6.2%), or 2 or more races (2.9%) based on the 2010 census.³ The US Census Bureau considers Hispanic a separate listing due to the number of origins that constitute the Hispanic ethnic group (16.3%).³ However, understanding the color of skin does not constitute cultural competency. In a 2019 estimate, existing religious cultures include but are not limited to Protestant (46.5%), Roman Catholic (20.8%), Jewish (1.9%), Mormon (1.6%), other Christian (0.9%), Muslim (0.9%), Jehovah's Witness (0.8%), Buddhist (0.7%), Hindu (0.7%), other (1.8%), unaffiliated (22.8%), and don't know or refused (0.6%).⁴ There are language differences: English only (78.2%), Spanish (13.4%), Chinese (1.1%), or other (7.3%), based on 2017 estimates.⁵ Further, the United States has just under 20 million veterans, 9.4% of which are female.⁶ The LGBTQ+ populations range from 2.7% of the total adult population in North Dakota to 9.8% of the total adult population in the District of Columbia, as of March 3, 2020.⁷ And let us not

forget, as of 2018 estimates, 12.94% of the population is age 55 to 64, and 16.03% is aged 65 years and over.⁸ Which culture do our patients identify with, or our students? This term needs to be broadened in the minds of educators to include all cultures and cultural identities.

The 2020 Commission on Accreditation of Athletic Training Education (CAATE) standards removed cultural competency from the standards. When asked why it was removed, it was noted that cultural competence is part of patient-centered care; it should be understood.⁹ With all due respect, it should be understood, but often is not. If the term athletic trainer is defined in the 2020 CAATE standards, perhaps a term that is often misunderstood, such as cultural competence, should as well. As such, providing patient-centered care is synonymous with culturally competent care, and this should be emphasized.

The first discussion of cultural competence or multiculturalism in athletic training and athletic training education emerged in 2003.^{10,11} Defining associated terms and the need for pedagogic understanding was introduced, but it was demonstrated that the implementation may still be lacking.¹⁰ Moreover, in a profession that has essentially existed since the ancient Olympic games,¹⁰ how much has really evolved? On a small scale, Nynas¹² revealed that athletic training students demonstrated good cultural awareness and sensitivity; however, they were less likely to practice culturally competent care. This was consistent with a previous study that found that athletic training students were found to be aware of cultural issues, but demonstrated limited competence and proficiency in their ability to provide care.¹³ Both studies included small samples, but are indicative of a larger problem in athletic training education: the routine exclusion or low priority of cultural competence in athletic training education curricula, which may explain the similar findings of these studies. Looking at this from a broader perspective, the questions that we as educators must answer are, "Why isn't my program doing enough to value cultural competence?" and, "How do we fix this?"

In examining our peer health care professions, culturally competent care has been on the radar for some time; however, this is a continuous journey. Nursing has had a journal dedicated to this issue *The Journal of Transcultural Nursing* since 1989. Specific to physicians, there is currently legislation in some states requiring cultural competency courses to maintain licensure, including New Jersey, Arizona, and New York.^{14,15} In California and Illinois, legislators are considering cultural and linguistic competency acts, which will require not only cultural competency courses, but foreign language courses as well.^{14,15} Both the physical and occupational therapy professions are moving forward with the need for culturally competent education; the American Physical Therapy Association (APTA) even names cultural competence as a foundational skill required of entry-level physical therapists.¹⁶ Health care professions, including athletic

training, have begun to examine their own cultural competence. However, findings of insufficient cultural competence and the continuous evolution of what cultural competence means as a construct suggests that no one has it completely figured out yet.^{10–13,15,17,18} It is time for athletic training to step up and be leaders in an area of health care that is vitally important in a country that is becoming more diverse every year. In this article, the importance of culturally inclusive health care will be examined, and practical solutions will be offered for implementation into athletic training educational programs. It is important to note that being culturally inclusive, both in the classroom and in the field, are not a means to an end, but are rather a continuous journey and solid examples of inclusivity today will need expansion in the future.

Why Is Culturally Inclusive Health Care Necessary?

There is a paucity of athletic training research about the importance of providing culturally inclusive and holistic patient care. However, this has been heavily studied in nursing and physician practice, and the research that exists clearly demonstrates the importance of providing such care. As early as 1988, nurses began to acknowledge the rapid diversification of the United States and a growing necessity to meet the cultural needs of a changing population.¹⁹ Additionally, a 2000 literature review by Brach and Fraser²⁰ describes how providing culturally inclusive services, such as language interpreters, clinician training, and inclusive health promotion materials, can reduce health disparities by increasing access to and compliance with care.²⁰ Moreover, a recent critically appraised topic paper published in 2018 concluded that having a culturally competent health care provider improves patient satisfaction and increases patient participation in treatment.²¹ Also of note is that, as athletic training continues to embrace evidence-based practice (EBP), it must be understood that providing culturally inclusive care falls under the EBP tenet of patient-centered values (Figure). Despite this, current research has found that certified athletic trainers and athletic training students are not as culturally inclusive as expected and that this may be limiting the quality of care we provide to our patients.^{12,17}

Additional evidence demonstrates some health care providers may possess implicit and explicit biases against patients of color, low socioeconomic status, or both and that these biases negatively influence care provision and outcomes.^{22,23} Further, ignorance of some cultural and religious norms may cause athletic trainers to create unwelcoming or even hostile clinical environments that discourage patient reporting.¹⁷ For example, if clinicians fail to account for patients who primarily speak a language other than English, communication barriers may lead to noncompliance and discontinuity in care. Also, just as with students who may be experiencing homelessness or food insecurity, patients may not prioritize their health and treatment compliance if they cannot afford and secure basic living necessities.

Why Is Culturally Inclusive Education Necessary?

As educators, it is imperative to acknowledge and address our weaknesses around establishing culturally inclusive learning environments and teaching practices. We must recognize and admit our ignorance and commit ourselves to creating

inclusive, accessible, and equitable classroom and health care spaces. If we fail, we risk alienating those closest to us: our students and our patients.

Though the topic of culturally inclusive education is new to athletic training, other professions, like nursing and physician practice, have begun to address the need for culturally inclusive learning environments. For example, in a 2013 study of interviews with nursing students, Morton-Miller found that students who immigrated to the United States within the last 20 years and whose first language was not English were reluctant to ask questions for fear of being judged by both educators and peers.²⁴ The interviews also revealed students perceived faculty as assuming all students having comparable backgrounds and prior preparation for postsecondary education; this assumption included expecting students to have a certain level of prior knowledge about both nursing and higher education systems. The assumptions faculty placed on these students, who may not fit the traditional student profile of that educational institution, place those students at risk for failure and attrition.

Similarly, a 2015 survey of undergraduate athletic training students found that students of color were highly influenced by classroom climate and program subculture and highlighted the need from program directors to create environments where all students, but especially students from historically underrepresented and marginalized backgrounds, feel comfortable discussing their personal experiences and values.²⁵ Therefore, educators, not just program directors, must be able to objectively assess the climate they are creating and determine if that climate is welcoming and promoting success for all students or just some students. However, we cannot adequately and appropriately assess our classrooms and programs for inclusivity if we do not know what that means. We cannot ensure we are meeting the cultural needs of all our students if we do not know what those needs are, and we cannot ensure our students are assessing for and meeting the cultural needs of patients if we do not first model it as educators in our programs.

As educators, we must ask ourselves, are we holding assumptions? Are we expecting and operating as if all students arrive to our classrooms on equal footing and with homogenous backgrounds? If we do operate under these assumptions and students who do not meet these expectations exhibit poor grades and socialization, we may label these students as lazy or unfit for our program or for the profession. However, in reality, they may be the first-generation student who has no idea how to navigate the complex higher education system. They may be an ethnic minority student who feels alienated from their culture and is having trouble adjusting socially. They may be the housing-insecure, food-insecure, or both student whose grades are dropping because so much of their time is focused on simply surviving. These students are worthy of being seen and having their cultural needs acknowledged. They are worthy of success, and we must be prepared to help them achieve it.

We must also consider inclusivity on a larger scale. Our students are diverse in ways beyond skin color, including age, level of ability, veteran status, religion, family status, and language. Having a veteran in class may mean that 8-week courses are problematic because the GI Bill will not support

Figure. Cultural education.

CULTURAL EDUCATION

What is culture?

Unique information systems based on the customs, arts, social tendencies, and historical experiences of a group of people.

DIVERSITY

Having multiple cultural identities represented in a group, though everyone may not be represented equally (or at all) and those from underrepresented identities may not feel fully included.



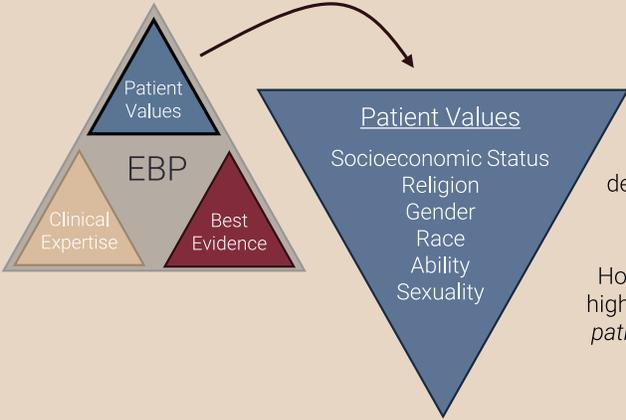
INCLUSIVITY

When multiple cultural identities are appropriately represented in a group and all members are made to feel welcome and included.



Diversity is superficial and can be thought of as structural representation. Inclusivity is intentional and is aimed at moving beyond visual representation to ensure all persons feel respected and meaningfully valued.

WHY DOES IT MATTER TO PATIENT CARE?



Patient values are a tenet of evidence-based practice.

...

A patient's culture(s) will inform their values.

...

These values must be considered when making clinical decisions to appropriately provide evidence-based care and ensure a high standard of care is being delivered.

...

However, to appropriately consider patient values and provide high-quality care, *students must understand how culture informs patient values and be comfortable inquiring about and adjusting care based on patient values and needs.*

Educators must ensure they are prioritizing cultural education and teaching students the information needed to care for patients from various cultural backgrounds.

WHAT CAN YOU DO?

Self-reflect on your own cultures and values and how they inform your clinical decisions.

Take an *inventory of your biases* and how they may influence how you treat patients from different cultural groups.

Learn more about culture, diversity, inclusivity, and equity and their relation to athletic training and healthcare.



FURTHER GUIDANCE

- <https://www.nata.org/sites/default/files/patient-values-clinical-decision-making.pdf>
- <https://implicit.harvard.edu/implicit/takeatest.html>
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5333436/pdf/12910_2017_Article_179.pdf

them. With the move to the master's level, there may be more students who are married with children, juggling the expectations of the program and a job to support their family. Gender nonbinary and nonconforming students may

lead the requirement for safe spaces. The list will grow longer as the profession continues to grow. Hopefully, the more inclusive our athletic training programs, the more representative of the population our profession will become.

How Do We Make Teaching More Inclusive and Equal?

Self-Reflection. The first step is to self-reflect on our own experiences and commit to a clinical practice that is both inclusive and respectful. To do this, we need to face some tough realities about ourselves, including confronting our explicit biases and stereotypes and trying to determine what our implicit biases are. It is not enough to acknowledge cultural differences; we must intentionally confront biases and make both our clinical and educational practices more inclusive and representative of the population of patients and students that we serve. To do this, we need to question our assumptions, both at the level of course and the program. The question should not be, “Are there areas where I can improve?” but rather, “What are the areas that I can improve?” Cultural competency should be thought of as a journey and not a destination. We should all be constantly learning, acknowledging our biases, and actively working to improve ourselves. We recognize that this may be a difficult task for many, but multiple resources exist for those who may not know where to start, including Harvard University’s Project Implicit.²⁶ Using Project Implicit, people can use free implicit association tests (IATs) to assess their implicit biases related to a number of social categories (age, weight, ability, race, etc). People may then choose to begin their self-reflection journey based on their IAT results, eventually exploring and reflecting on other biases and their relationship to teaching and mentorship decisions.

Training and Professional Development. From a programmatic standpoint, one way that we can improve is to actively seek out training and opportunities on-campus and at national or regional conferences. Most universities will have an Office of Diversity or Inclusion, where faculty and program directors can seek help when designing courses or when problem-solving. Some other areas to consider: Are there offices or departments on-campus to conduct safe space training? Do you display safe space stickers or include your pronouns in your email? Is there a food pantry or emergency assistance for students who are food or home insecure? Are these supports listed in your syllabus or in your handbook for students to access when needed?

Additionally, professional membership organizations may offer valuable training and professional development resources. For example, National Athletic Trainers’ Association’s (NATA’s) LGBTQ+ Advisory Committee has compiled numerous resources available online and conducts Safe Space Ally Training (a focused safe space training designed specifically for athletic trainers) at many state, district, and national meetings.²⁷ Moreover, both the LGBTQ+ and Ethnic Diversity Advisory Committees hold town halls at NATA’s annual Clinical Symposia and AT Expo as well as specifically curated educational sessions. These town halls and educational sessions serve many purposes, including sharing and receiving information related to minority health, fostering a network of professionals who care and want to learn more about minority health, and creating visibility for oft-ignored aspects of athletic training and health care.

Course Planning. To promote an inclusive environment in the classroom, we must plan for diversity when designing courses and syllabi. Scenarios, simulated patients, exam questions, and presentations should have representation from

individuals of different backgrounds. If you look at your presentations or videos, do you include photos of patients and clinicians who are of different cultural backgrounds? It is important for students to not only see people who look like them delivering the care that they will be delivering but also that there is no standard patient, and they must be prepared to care for patients who do not look like them or the majority of the people they know. Additionally, a 2015 study of undergraduate athletic training students found that students of color in particular were more influenced by the environmental climate of the classroom and subculture of the overall athletic training program than students not of color.²⁵ Therefore, it is imperative that you reflect on what you are doing to promote a positive classroom environment. How do you encourage participation while fostering a sense of community with students from various backgrounds? How do you encourage students to partner with people that they would not normally partner with for an authentic and safe conversation?

Clinical Education. Beyond classroom materials, it is also important for students to have authentic interactions between the material and real-life. “I don’t see differences,” or, “I treat all patients the same,” is not representative of patient-centered care. To treat the whole patient, it is imperative that we include the patient’s preferences and cultural norms in an authentic way. It is important for students to participate in various clinical experiences and to spend time with patients and clinicians of different cultural backgrounds so that they can begin to see health care through the eyes of the patients. The inclusion of culture in our educational and clinical experiences must extend beyond the stereotypical discussions of fasting during Ramadan and risk of sickle cell crisis. For these experiences to be a learning experience and a place of growth for students, programs need to include preceptors in the conversation and may need to provide professional development opportunities.

One way to create real-life examples and foster student inclusion in classroom decisions is to ask students what experiences they have witnessed in clinical education. This gives students the chance to (1) practice understanding the direct impact of cultural values on care and (2) process and reflect on their own missed opportunities to build patient rapport and incorporate cultural values into evaluation and clinical decision-making. Everyone benefits in this scenario because students meaningfully contribute to classroom decision-making, and educators learn what students are seeing in clinical experiences and can better incorporate that material into didactic education. However, this can only happen if students are taught to prioritize cultural and patient values during nonclinical learning, students feel comfortable sharing this information with their educators and peers, and educators are receptive to the students’ suggestions.

Mentorship. There is little research that investigates the role of cross-cultural mentorship in athletic training, with most being focused on black women.^{28,29} Cross-cultural mentoring involves an ongoing, intentional, and mutually enriching relationship with someone of a different race, gender, ethnicity, religion, cultural background, socioeconomic background, sexual orientation, or nationality.³⁰ In athletic training education, there will be students who fit every trait listed, but they may find that they do not have anyone who they can look toward who has the same background.

That is not always possible; and in reality, that may not always be the best fit for the student. Therefore, as an educational program, being understanding of those situations becomes important for that student. The role of a cross-cultural mentor is to provide personal and intellectual development for the mentee during the difficult time of transition to practice.³⁰ Understanding how this can create a more inclusive program is paramount; this includes not only the administrators, but also the instructors and preceptors students come in contact with. Being willing to be that mentor will make excellence inclusive. Seasoned cross-cultural mentors know there are challenges, but also know the satisfaction that they can provide. Areas where cross-cultural mentors develop successful bonds include (a) becoming adept at navigating cultural boundaries: personal, gendered, racial, ethnic, and geographic; (b) understanding the need to possess certain attributes or virtues, including active listening skills, honesty, a nonjudgmental attitude, persistence, patience, and an appreciation for diversity; (c) maintaining a dual perspective, seeing the mentee as an individual as well as part of a larger social context; and (d) understanding the importance that the mentor avoid becoming overly prescriptive or invested in the mentee's choices.³⁰

Continuous Growth

Finally, it is important for us to realize that culture is constantly evolving. In looking at the literature in nursing, it is obvious that there have been shifts in thought throughout the years, including a shift from cultural competence to cultural humility and now, to cultural *competimility* (a portmanteau of competence and humility). If athletic trainers and athletic training students both score themselves as more culturally competent than they are in actuality, as evidenced by existing research, it is essential that educators make culturally inclusive care a priority in curriculum programs. We also need to acknowledge that we will have missteps or moments when we do not know or do not do the right thing. This is part of the process, and when those things happen, we should acknowledge it and use it as an opportunity for growth. If you hurt someone with your words or actions, the first thing to do is apologize and do better next time.

As the profession is moving rapidly toward the 2022 deadline for the move to the professional master's level, now is the time for the athletic training profession to join the nursing and other rehabilitation professions to prioritize culturally inclusive care as part of clinical practice and education. While the 2020 CAATE standards include standards on patient-centered care, it is incumbent upon us as educators to address these topics in a multifaceted and integrated way. To get by with the bare minimum is truly a disservice to our students as well as the patients that we serve.

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