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Incorporating Interfaith Concepts in Education on Patient-Centered Care

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Context: Many topics related to diversity, equity, and inclusion are receiving attention in the popular media and in literature. However, religious, spiritual, and secular identities and how these relate to culturally competent patient-centered care have received considerably less attention.

Objective: Encourage athletic training educators to enhance their curriculum related to providing culturally competent patient-centered care by including content on interfaith patient care and offer guidance on foundational concepts and practical strategies. This paper provides a framework for providing education on quality patient care with respect to patients' religious, spiritual, and secular identities: (1) create a foundation of understanding, (2) establish a rationale for content inclusion, and (3) provide practical strategies for teaching and the provision of quality patient-centered care with respect to religious, spiritual, and secular identities.

Background: Religious, spiritual, and secular identities are often an important part of a patient's self-concept, and thus need to be considered when providing culturally competent patient-centered care. The Board of Certification Standards of Professional Practice and the Commission on the Accreditation of Athletic Training Education standards for professional athletic training programs both address patient care with specific language related to cultural competence. Although athletic trainers recognize the importance of considering religious, spiritual, and secular identities of patients, many athletic trainers may not feel equipped to address these identities when providing culturally competent patient-centered care.

Description: Students should be better prepared to provide a more complete holistic approach to culturally competent patient-centered care.

Educational Advantage: A framework for addressing this content in an athletic training curriculum includes providing foundational concepts and a rationale for the inclusion of this content and then offering practical strategies for considering religious, spiritual, and secular identities in patient-centered care.

Conclusion(s): Athletic training educational programs should include education on religious, spiritual, and secular identities for culturally competent patient-centered care.

Key Words: Cultural competence, religion, spirituality, diversity, inclusion

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KEY POINTS

- Religious, spiritual, and secular identities are often an important part of a patient's self-concept; however, athletic trainers may not feel equipped to address these identities when providing culturally competent patient-centered care.
- Athletic training students should be better prepared to provide a more complete holistic approach to culturally competent patient-centered care.
- Athletic training educational programs should include education on religious, spiritual, and secular identities for culturally competent patient-centered care.

INTRODUCTION

Many areas related to diversity, equity, and inclusion are receiving an increased amount of visibility in both the research literature and popular media. Yet, even with the increased attention to diversity, equity, and inclusion, religious, spiritual, and secular identities, along with how these identities influence the provision of culturally competent patient care, have received considerably less attention. This lack of attention could be related to the potential specialized nature of the content or to a lack of recognition that this is an important aspect of providing culturally competent patient care. With the lack of research and literature on providing interfaith patient care, this is likely an area that is missing from the curriculum of many athletic training education programs. We recognize that athletic trainers (ATs) are very likely to work with patients who place a high value on their religious, spiritual, or secular beliefs, and that ATs should address these patient beliefs because they may improve patient outcomes; however, many ATs may not feel equipped to actually address patients' interfaith needs in clinical practice.

Additionally, the predominant term used to describe education in this area, *cultural competence*, may not be the best goal when we consider development of students in this area. The term *competence* carries a connotation of expertise or of checking a box indicating that once an AT has completed a course or specific education, they can call themselves culturally competent.[1] However, the likelihood of any AT becoming an expert on every possible iteration of religious, spiritual, or secular identities is virtually zero, and viewing cultural competence as a destination, rather than a continual process, can be detrimental. As Lekas et al[1] indicate, focusing only on competence may enhance stereotypes and implicit discrimination, discount the importance of intersectionality, and limit the potential for lifelong learning. Additionally, confidence in ability to provide culturally competent care does not necessarily equate to proficiency in cultural competence.[1] Thus, we want to encourage educators to move towards developing and teaching *cultural humility*, which "refers to an orientation towards caring for one's patients that is based on: self-reflexivity and assessment, appreciation of patients' expertise on the social and cultural context of their lives, openness to establishing power-balanced relationships with patients, and a lifelong dedication to learning" in both themselves and their students.[1] Therefore, in an attempt to move forward the need for further education on this topic of quality patient-centered care, this paper is intended to serve as a call to action for athletic training educators to enhance their students' development in cultural humility[1] specifically related to providing quality patient-centered care with respect for patients' religious, spiritual, and secular identities. This paper will provide a framework for including educational content on quality patient care with respect to religious, spiritual, or secular identities: (1) create a foundation of understanding, (2) establish a rationale for content inclusion, and (3) provide practical strategies for teaching and for the provision of quality patient care with respect to religious, spiritual, and secular identities.

Before educational content on interfaith patient care can be created, educators need a foundational understanding of the topic. Prior to diving into the concepts related to interfaith patient care, we need to address a few initial key principles. Athletic trainers need to recognize that all patients an AT works with have a right to form their own religious, spiritual, or secular identities. Patients have a right to be believers or nonbelievers, Christians, Muslims, Taoists, atheists, or any other version of religious, spiritual, and secular identities that may be present. Patients also have the right to express their identity. It is not simply that a patient may identify as a Buddhist; the patient also has the right to decide how and when that identity is expressed. And, to take this one step further, patients also have the right for their religious, spiritual, and secular identities to be reasonably accommodated. Reasonable accommodations could include adequate facilities for observance of various religious practices, a variety of meal offerings to accommodate different food practices, and an almost infinite number of other options.

While we are exploring the rights each individual has around religious, spiritual, and secular identities, we also need to recognize that "to respect someone else's identity does not require you to agree with it, or accept it."[2] Respecting other's religious, spiritual, and secular identities is closely related to the first 2 points: everyone has a right to have a religious, spiritual, or secular identity and to have that identity be reasonably accommodated. As educators and students continue through the journey of building their background and understanding of providing interfaith patient care, it is important to keep these notions in mind. Each patient encountered has these rights, and, as a health care provider, it is the role of the AT to respect patients' identity, to provide the reasonable accommodations, and to provide patient-centered care from a holistic perspective that considers these identities.

CREATE A FOUNDATION OF UNDERSTANDING

As we consider how to create educational content on interfaith patient care, first we need to define the basic concepts to make sure educators are using similar language.

There are many different definitions of spirituality, which can make it challenging to standardize content. A reasonable place to start is to consider the concept of a worldview. *Worldview* refers to "a commitment to a religious, spiritual or secular tradition that informs an individual's tenets, values, and meaning making."[3] Often when we think of the term *spirituality*, we focus on specific religions; however, the concept of spirituality is much broader. Therefore, rather than focusing simply on religion or just the term *spirituality*, we use the more inclusive terms of "religious, spiritual, and secular identities," as referenced by Baxter's[3] definition of worldview. In this context, *religious identity* refers to individuals who consider themselves to be a part of a specific religion, such as Judaism, Christianity, Hinduism, or any other organized religion[4]; this can include individuals who actively practice a religion and individuals who more loosely subscribe to ideals related to a particular religion. *Spiritual identity* refers to individuals who may or may not align with a specific organized religion; individuals may identify as spiritual and not religious.[4] *Secular identity* refers to individuals who do not align with an organized religion and can include individuals who identify as atheist or agnostic or individuals who still subscribe to a moral code and may use terms like "the universe."[4] It is important to keep in mind that although these are individual terms, in practice, it is likely that many individuals fall on a continuum and may identify with multiple terms. There may be a patient who considers themself to be a combination of a particular religion and a spiritual or secular identity. An individual who grew up ascribing to a specific religious group may be in the process of evolving and changing their views. And there is no singular way to practice any particular religious, spiritual, or secular identity, so even if an AT is working with 2 patients who both consider themselves to have the same worldview identity, their beliefs, values, and behaviors could still be markedly different.

Recognizing diversity in the ways that religious, spiritual, and secular identities manifest in individual patients is an important starting place in working towards developing cultural humility and providing quality patient-centered care from an interfaith perspective. However, when we are teaching cultural humility and quality patient-centered care from an interfaith perspective, we need to encourage students to go beyond simply noting that there is diversity in religious, spiritual, and secular identities and move toward the concept of religious pluralism. Religious pluralism is an active engagement of individuals with diverse identities aimed toward a positive result.[2] Rather than simply identifying the existence of various identities, practicing religious pluralism involves individuals with various identities, such as an AT and patient who have different identities, finding ways to work together to encourage understanding and empathy and to work towards a common goal, for example a particular return-to-participation outcome.

Another concept to consider as we discuss religious pluralism is the concept of interfaith cooperation. Interfaith cooperation is a process in which people who orient around religion differently come together in a way that respects different identities, builds mutually inspiring relationships, and engages in common action around issues of shared social concern.[5] It is important to recognize that interfaith cooperation is not dependent on shared perspectives among individuals of different identities, and thus there is room for disagreement on important concepts.

With the goals of cultural humility and quality patient-centered care and with pluralism and interfaith cooperation in mind, the Interfaith Triangle is one framework that can be used to help educators frame their discussions.[6] The Interfaith Triangle provides a structure of 3 areas of understanding, where gaining additional insight in one area can facilitate development in the other 2 areas. The first area in the Interfaith Triangle is *relationships*, which refers to creating relationships with individuals of different religious, spiritual, and secular identities from one's own.[6] As humans, we often have a more positive view of an identity if we personally know someone who has that identity. The second area in the Interfaith Triangle is *knowledge*, which is framed as the concept of appreciative understanding.[6] Appreciative understanding is an intentional process of working to acquire accurate and positive knowledge about a religious, spiritual, or secular worldview and to discount any inaccurate or selective knowledge. The third and final area in the Interfaith Triangle is *attitudes*, which includes the thoughts, feelings, and perceptions individuals hold about different religious, spiritual, or secular worldviews.[6]

The premise of the Interfaith Triangle is that improvement in any one of the 3 areas will naturally encourage growth and development in the other 2 areas.[6] If we personally know someone who holds a different identity from our own (relationships), we tend to learn more about that identity through conversation (knowledge) and we often have more positive perceptions about that identity (attitudes). Similarly, if we learn accurate and positive information about a different identity (knowledge), we are more likely to create a relationship with an individual who holds that identity (relationships) and to perceive that identity in a more positive light (attitudes). As we consider how an educator might frame their curriculum around teaching cultural humility and quality patient-centered care, encouraging growth in each of 3 areas of the Interfaith Triangle would be a reasonable goal.

Providing consistent language and a solid foundational understanding of the concepts related to religious, spiritual, and secular identities is an important place to start, both for educators who are going to teach the content and when delivering the content to students. Educators can consider using the content provided in this section to encourage their own growth and understanding and to provide students with this foundational knowledge. The ideal goal of any education related to providing quality patient-centered care with respect to religious, spiritual, and secular identities would be to go past diversity and into pluralism and to help students develop all 3 areas of the Interfaith Triangle.

RATIONALE FOR CONTENT INCLUSION

Now that we are working from a similar base level of knowledge regarding religious, spiritual, and secular identities, the next step is to help educators understand the importance of including this content in their curriculum. To establish that relevance, we can examine current standards within the profession of athletic training; current epidemiologic research regarding the importance of religious, spiritual,

and secular identities in society; and current research on the perceptions of practicing ATs' comfort with this topic.

Beginning with the current standards within the profession of athletic training, we can examine both the Board of Certification Standards of Professional Practice[7] and the 2020 Commission on the Accreditation of Athletic Training Education standards.[8] Within Code 1, Patient Care Responsibilities, the Board of Certification Standards of Professional Practice states,

> *The athletic trainer. . .:*
>
> *1.1 Renders quality patient care regardless of the patient's age, gender, race, religion. . . or any other characteristic protected by law. . .*
>
> *1.4 Communicates effectively and truthfully with patients and other persons involved in the patient's program, while maintaining privacy and confidentiality of patient information in accordance with applicable law.*
>
> *1.4.1 Demonstrates respect for cultural diversity and understanding of the impact of cultural and religious values.*[7]

The need for education in this area is further reinforced within the 2020 Commission on the Accreditation of Athletic Training Education standards[8] for professional athletic training programs in the Core Competencies—Patient-Centered Care Standards:

> *Standard 56: Advocate for the health needs of clients, patients, communities, and populations.*
>
> *Standard 57: Identify health care delivery strategies that account for health literacy and a variety of social determinants of health.*

Clearly, education in providing quality patient-centered care with respect to religious, spiritual, and secular identities is written into the documents that help define the profession of athletic training, and thus needs to be incorporated into the education delivered to students.

Continuing with the current epidemiologic research, in 2014 the Pew Research Center[9] conducted the Religious Landscape Study to better understand the trends in beliefs and behaviors around religious, spiritual, and secular identities in the United States. Researchers found only 22.8% of respondents were unaffiliated with a religion, which included those who described themselves as atheist, agnostic, or nothing in particular. The overwhelming majority of respondents identified their religion as Christian (70.6%), which included specific affiliations of evangelical Protestant (25.4%), Catholic (20.8%), mainline Protestant (14.7%), historically Black Protestant (6.5%), Mormon (1.6%), Orthodox Christian (0.5%), Jehovah's Witness (0.8%), and other Christian religions (0.4%). Other religious worldviews, such as Jewish, Muslim, Buddhist, Hindu, and other world religions, comprised 5.9% of the sample, and other faiths, including Unitarian and liberal faiths, New Age, and Native American religions made up the remaining 1.5%.[9] Taking this information as a whole, we can see that almost 80% of the respondents, who comprised a representative sample of adults in the United States, had a specific religious or spiritual identity. It is important to point out that the Pew Research Center identified Christianity as the majority religion and non-Christian faiths as minority faiths, and thus there is potential for some unintended bias in the language in the study and the presentation of the results.

The Religious Landscape Study also included questions about general beliefs and behaviors, providing further insight into the importance of religious, spiritual, and secular identities to patient populations.[9] When asked about the importance of religion, 53% of respondents considered religion to be *very important*, 24% said *somewhat important*, 11% indicated religion to be *not too important*, and another 11% noted that religion was *not at all important*. Summarizing these data, we see that religion is either somewhat or very important to almost 80% of the United States population.

The self-reported perceptions provide some insight into the importance of religious and spiritual identities, though examining behaviors is perhaps even more impactful. In the same study, when participants were asked to rate how often they attended religious services, 36% reported attending religious services at least once a week and 33% reported attending religious services once or twice a month/a few times a year.[9] When asked about prayer frequency, 55% of participants reported engaging in prayer at least once daily, 16% indicated engaging in prayer weekly, and 6% reported engaging in prayer monthly.[9] Although the total proportion of the sample who engaged in behaviors related to religion is lower when compared with the data on perceptions, we still see well over half of the sample self-reporting an influence of their religious, spiritual, or secular identities on their behavior.[9] When we look at perceptions and behaviors together, we see that it is extremely likely that over half of the patients with whom ATs interact on a daily basis place some importance on their religious, spiritual, and secular identities, providing a clear rationale for the importance of this content in an athletic training program.

Understanding the importance of religious, spiritual, and secular identities to patients is vital in establishing the relevance of including this topic into educational programs. It is also important to consider whether this is a topic practicing ATs are already comfortable with based on the education most ATs are currently receiving. There would not be a need to add this content to the curriculum if ATs already feel generally competent in providing quality patient-centered care with respect to religious, spiritual, and secular identities. McKnight and Juillerat[10] used survey research to provide insight into the perceptions of ATs on their comfort with including religious, spiritual, and secular identities in their practice. They found 82.4% of the sample of practicing ATs either agreed or strongly agreed with the statement "Addressing the spiritual concerns of an athlete could result in a more positive outcome when treating an athletic injury."[8] Additionally, 61.7% of the sample also strongly agreed or agreed that "ATs should have some basic skills and knowledge necessary to support the spiritual needs of the injured athlete."[10] Clearly, ATs recognize the importance of considering religious, spiritual, and secular identities in practice.

However, in contrast, McKnight and Juillerat also found that 66.6% of the ATs agreed or strongly agreed with the statement "Spiritual care is not in the athletic trainer's scope of practice."[10] Looking at this study in total, we can see some clear dissonance in that ATs believe in the importance of considering religious, spiritual, and secular identities in providing quality patient-centered care, but do not appear to feel it is their role to provide care with respect to religious, spiritual, and secular identities.

As we consider how to address this potential dissonance, we can refer to the Interfaith Triangle.[6] Providing education on religious, spiritual, and secular identities as a part of the athletic training curriculum can help encourage students to develop their appreciative understanding of worldviews that may be different from their own. Growth in the area of knowledge will likely also encourage growth in both attitudes and relationships; thus, including this content will likely encourage students to have more positive attitudes toward different worldviews, along with the likelihood of being able to build positive relationships with patients who may have different worldviews. Ideally, the growth in appreciative understanding, along with the development of cultural humility, would allow students to feel more positive about their ability to interact with diverse patient populations and more equipped to provide quality patient-centered care from an interfaith perspective.

TIPS FOR TEACHING

We have provided an overview of foundational concepts and a rationale for interfaith content inclusion; now we will share some practical strategies for teaching and for the provision of quality patient care with respect to religious, spiritual, and secular identities. Before engaging in conversations with students about cultural humility and quality patient-centered care, self-reflection can be a helpful process. Educators should consider their own values regarding religious, spiritual, and secular beliefs, and should encourage students to do the same. The concept of cultural humility can provide a framework, and the self-reflection should include consideration of biases, assumptions, prejudices, or judgments regarding specific religious, spiritual, or secular practices, and how important religion and spirituality are in their own lives. Starting with an understanding and recognition of perceptions will help educators and students to work in withholding judgment, minimizing biases, and allowing more open conversations between educators and students, and ultimately with patients.

When starting to incorporate this content, educators and students may worry that they will misspeak or overgeneralize when discussing this topic. Educators should share with students, and be genuine in this, that they are making their best effort to stay informed of the latest terms and definitions, and that yes, they may misspeak and overgeneralize. We all do this at one time or another, and when this happens, we should apologize for our error and correct our language. In a safe learning environment, students should be encouraged to provide corrections if they are more informed in a particular area. Overgeneralization can occur when educators are providing examples, and they should make students aware that the examples may not be representative of all religious, spiritual, and secular identities.

A starting point for students to have conversations about interfaith topics is to present discussion prompts, such as:

1. A patient comes to you during practice and tells you they feel dizzy. You ask what they have eaten today, and they share they are fasting for the 19-Day Fast practiced in the Baha'i faith.
2. A patient has a B-12 deficiency and low iron levels due to their plant-based diet. The patient is Hindu (or Jain or Buddhist) and is committed to a plant-based diet as a spiritual practice of doing no harm.
3. A female AT greets a male patient by outstretching her hand to shake the patient's hand. The male patient is an observant Orthodox Jew who does not touch women who are outside of his family.
4. An athletic training student approaches their preceptor and says their patient is unwilling to remove their hijab during a shoulder evaluation. The student does not know how to complete their inspection and palpation over clothing.
5. A patient who is Sikh (or Mormon) and wears special undergarments is seeking treatment for a hamstring strain. The AT considers treatment options with respect to removing these undergarments.
6. A patient is refusing a medical treatment (or vaccine) because their spiritual practice is to rely on natural remedies, using crystals, essential oils, and supplements.
7. The AT notices that a patient is struggling in some way, and the AT learns that the patient practices Buddhist meditation as a self-care strategy. The AT builds this practice into a treatment plan as a way to support compliance and the healing process.

Another educational activity is to have students review preparticipation exam paperwork or intake paperwork: does the paperwork include an area for patients to indicate their religious, spiritual, and secular identities if they choose? If the patient does include this information, how might the student talk with the patient about their treatment preferences? This would be an opportunity for the students to practice role-playing by acting as patients and ATs. Role-playing this type of conversation about the influence of religious, spiritual, and secular identities on treatment preferences gives students practice with using terminology and having discussions about topics that may feel sensitive or emotionally charged. It is important to recognize that any conversation about religious, spiritual, and secular identities has the potential to evoke emotional responses, both positive and negative, in students. Practicing these conversations in class, and encouraging the students to work through their discomfort by relying on cultural humility, empathy, and the concept of interfaith cooperation, can help the students feel more comfortable with this content and more confident in their ability to work through difficult conversations in practice.

Cultural humility and interfaith patient-centered care should take into consideration, at minimum, attire, diet, fasting, and medical practices, though there certainly may be other situations that could be addressed as students are learning about specific worldviews and identities. Students should be taught how to respect patients' religious, spiritual, and secular identities in various situations. A learning experience may be to have students present different cases and discuss how

Table 1. Interfaith Calendars[a]

Calendar	Description	Web Link
Interfaith Calendar	Contains calendars from past, present, and future years, as well as for specific religious, spiritual, and secular traditions.	https://www.interfaith-calendar.org
Interfaith Action	Contains the present year's calendar with color-coded events, as well as a downloadable PDF.	https://interfaithaction.org/contact/calendar

[a] An awareness of interfaith events may assist athletic trainers with interfaith patient care.

patient care could be best conducted. A simple awareness of interfaith events may also assist in patient care; Table 1 contains internet links for interfaith calendars.

Attire Examples

Various religious, spiritual, and secular traditions may have special dress or undergarment requirements. Patients may also have specific modesty practices. Students should be taught to not make assumptions and to communicate with the patient about their preferences for care. Educators may have students brainstorm how standard treatments can be modified to accommodate attire and modesty. For example, have students consider how an evaluation would be done while the patient is wearing protective equipment—now consider how an evaluation would be done over clothing. Students can also brainstorm options for treatment, such as having the patient work with an AT of the same sex.

Diet and Fasting Examples

Students should be taught about various forms of vegetarian and vegan diets as they relate to Buddhist, Hindu, and Jain traditions and be aware of food restrictions such as the Jain practice of no root vegetables or the Jewish practice of not mixing meat and dairy in the same meal, and understand that certain traditions have food preparation standards, such as kosher or halal practices. Students should be made aware of how a patient's diet influences energy levels and nutritional balance. This should also include awareness of hydration and heat illness and should include recommendations for activity modification and temperature monitoring. Students should be educated on prominent fasting examples, such as for Muslims during Ramadan, Baha'is during the 19-Day Fast, Jews on Yom Kippur, and Catholics on Ash Wednesday and Good Friday.

To apply these concepts, educators can have students review their setting's dining options and food availability and create an advocacy plan for any areas that are lacking. As part of an assignment, students could be asked to create a travel plan for patients with religious, spiritual, and secular diet preferences. With an awareness of diet and fasting, students could review timing of patient medications as well as scheduling of treatments.

Medical Examples

Followers of certain traditions may not want certain medical treatments (eg, blood transfusions, vaccines, hormones), and followers of some spiritualities that are more nature based may not be interested in pharmaceuticals and may prefer to use natural remedies. As part of a role play, students can practice communication techniques to discuss with patients' treatment options that are consistent with the patient's religious, spiritual, and secular traditions. Students can also explore with patients whether certain modalities are acceptable as part of a prevention or treatment plan. Finally, students should be educated on supplement regulation and banned substances as they relate to pharmaceuticals and natural treatments.

ADVANTAGES

This framework provides educators with a starting point to include education on interfaith patient care in their athletic training education programs. The foundational content and rationale for inclusion can help create a common language and understanding and help both educators and students understand why this content is included in the athletic training program. The tips for teaching provide learners with practical strategies for delivering holistic patient care with consideration of patients' religious, spiritual, and secular identities. Providing quality patient-centered care from an interfaith perspective is clearly part of an AT's scope of practice.[5,6] We cannot reasonably expect students to be able to deliver quality patient-centered care from an interfaith perspective without providing foundational content and practical strategies in their curriculum. Using the content and strategies provided here will allow educators to better prepare their students to confidently provide quality patient-centered care from an interfaith perspective and improve the experiences of their future patients.

CONCLUSIONS

Teaching interfaith concepts within the athletic training curriculum is a start. Continued work must be done to provide quality patient-centered care with respect to religious, spiritual, and secular identities. Although interfaith resources specifically for ATs and patient care are limited, a myriad of online resources exist; examples of these are listed in Table 2. Additionally, when ATs have questions about providing care for a patient with a specific religious or spiritual belief system, they may seek guidance from (1) their institution's interfaith chaplain or institution/work-based resources, (2) counseling services, (3) patients themselves, or (4) individuals around patients (families, friends, etc). Research in the role of the AT in providing quality patient-centered care from an interfaith perspective is quite limited. The lack of research limits both the resources used to create this paper and the resources educators can use when providing this content in their curriculum. Thus, we relied on resources that were specific to the interfaith concepts and then adapted that to the provision of quality patient-centered care. Educators and future researchers should consider working to expand the

Table 2. Online Resources

Resource	Description	Web Link
Interfaith America	This site contains a vast offering, including resources for higher education and faith and health.	https://www.interfaithamerica.org/
The Learning Network (by the *New York Times*)	In addition to articles and videos, this site contains lesson plans.	https://learning.blogs.nytimes.com/2010/09/10/resources-world-religions/
Teaching Tolerance	This site contains classroom resources and professional development.	https://www.tolerance.org/
National Athletic Trainers' Association Cultural Competence	This site offers articles, blogs, continuing education links, and infographics.	https://www.nata.org/practice-patient-care/health-issues/cultural-competence

knowledge on this topic within the profession of athletic training by conducting research focused on the influence of religious, spiritual, and secular identities on the provision of quality patient-centered care by ATs.

Athletic trainers should continue to educate themselves in the areas of (1) world religions and traditions, (2) interfaith and intrafaith diversity and doctrinal differences, and (3) intersectional identities. Actively learning about various worldviews and identities and seeking out accurate information to better understand various religious, spiritual, or secular identities is essential for providing quality patient-centered care.

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