Editorial

# Reforming Athletic Training Education

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Developing the minds and skills of athletic trainers does not fall under the auspices of any one organization or individual. Rather, effective education requires the interaction and cooperation of a wide range of entities, the Joint Review Committee-Athletic Training, the NATA Board of Certification, the NATA Foundation, and the Convention Committee. The *Journal of Athletic Training* plays an essential role in our professional growth by disseminating high-quality research not only within our profession but also, just as importantly, to other allied health professions. As a means to this end we should embrace Dr. Perrin's goal for the *Journal* to be included in *Index Medicus*.

Our profession has undergone an amazing amount of growth during a relatively short amount of time. In less than 50 years, we have progressed from the equipment room to the athletic training room, and we are now entering clinics, hospitals, and industrial settings. While the face of our client population base has changed rapidly, our educational methods and content have not evolved as swiftly.

Competition in the healthcare arena, disparities in the preparedness of entry-level athletic trainers, and the proliferation of new work environments all motivated the NATA's Board of Directors to establish the Education Task Force. Cochaired by Richard Ray and John Schrader, this committee was charged to evaluate all aspects of athletic training education and make recommendations on how they could be improved. The Education Task Force completed its mission by submitting 18 recommendations to the Board of Directors aimed at improving and standardizing entry-level, graduate, and continuing education of athletic trainers. In March 1996 the Board of Directors formed the Education Council (EC) to oversee the implementation of these recommendations and provide ongoing vision and leadership for education. This agency will be, not an omnipotent agency, but rather a sounding board, advocate, and change agent for all other education-related agencies.

Athletic training education involves the incorporation of no fewer than five areas that could be considered the provinces of other professions. No other profession's clinicians are responsible for preventing injury and illness, for evaluation/management, for rehabilitation, for counseling, and for education of its clientele. We are the original multiskilled healthcare providers, although none of this knowledge or skill is unique to our profession.

Our marketability stems from our ability to combine these knowledge bases, apply them to a specialized population, and capitate the costs associated with injury. When dealing with the physically active population, athletic trainers must strive to be recognized as the experts, a label that comes only via education: not only education of athletic training students and continuing education of certified athletic trainers, but also education of the public, education of our potential employers, and, perhaps most importantly, education of legislators.

In light of the current healthcare reform movement, much emphasis has been placed on multiskilled practitioners. It is vital to understand, however, that multiskilled and multicredentialed are not equivalent terms. Dual credentialing is appropriate as a means for athletic trainers to expand their potential patient base. It is inappropriate when it is required for athletic trainers to practice our profession with our traditional patient base in nontraditional settings. Our educational foundation must be solidified to the point where athletic trainers are permitted to practice our profession in any setting without drawing criticism regarding the scope and breadth of our educational construct. Only by strengthening the quality, reputation, and educational requirements of the ATC credential will the status of the dual-credentialed athletic trainer be enhanced.

To compete in the healthcare arena, a term that includes the "traditional" high school, college, and professional settings, our educational model must begin to adapt to the expectations of the healthcare community. We must formally embrace the allied health care model of professional preparation. "Critical Challenges: Revitalizing the Health Professions for the Twenty-First Century," the Third Report of the PEW Health Professions Commission, describes the common set of competencies that all health care providers should possess by the year 2005 (www.futurehealth.ucsf.edu/pewcomm.html). As we plan our course into the next century, these recommendations should be a benchmark by which we measure educational excellence.

Among the most pressing issues to be addressed by the EC is clinical education. An initial question that must be posed is, "Are clinical hours an effective measure of a student's clinical learning?" The answer to this is most

probably "No." The use of hours places a quantitative measure on what should be a qualitative experience. Is a student who has completed 400 hours of clinical experience halfway to being professionally prepared? What skills has this individual mastered? What are the student's strengths and weaknesses?

Our students' clinical education model should be based on a set of measurable, standardized, and referenced learning objectives that describe the type and nature of the experience obtained. Achieving these goals is contingent upon a common response to the question, "What is entry level?"

This definition will also assist in the identification of entry level-specific skills, answers that will be based on the next Role Delineation Study of the Entry-Level Athletic Trainer and a revision of the Competencies in Education. Then we can begin to develop the areas to be targeted in advanced master's programs and continuing education programs.

The Education Task Force's recommendations have been described, not as the elimination of one route to certification, but as "taking the best elements from each route to form a single, better educational model." One of the internship route's greatest strengths was in the clinical education of its students, but this is not to imply that the 1500-hour requirement was its strength. Most likely, we can point to the student-clinical instructor mentorship that occurred as being its hallmark. The requirement for a Certificate of Added Qualification for clinical instructors mandates that we must examine the nature of clinical interaction between the student and the instructor, teach mentoring skills, and understand the wants and needs of students who are learning in the clinical setting.

"Educating the Educator" will be a common theme within our profession over the next four or five years. This will integrate the newly developed entry-level Competencies in Education, Clinical Education Objectives, and the requirements to sit for the NATABOC certification examination. We must reemphasize the "student" in student athletic trainer and the "instructor" in clinical instructor to build a healthy, reasonable, and financially tolerable clinical learning environment for our students. We must also be cognizant that, in some cases, the way we approach clinical education may send the wrong message to our employers and the public, a message that is counterproductive to professional growth, improved salaries, and increased job opportunities for certified athletic trainers.

The benefits of these reforms will not be immediate, and the necessary changes may, at times, be painful. During these times we must remain focused on the betterment of our profession and the promise of a bright future for our students. We must all work together in this spirit of cooperation to better our profession, our professional image, and ourselves. The Education Council invites input from all members of our profession on achieving these goals. Please feel free to E-mail your comments and suggestions to the Education Council at: nataec@nata.org.

Editor's note: Dr. Starkey is chair of the NATA's Education Council. For more information on the Education Task Force report, see the February 1997 issue of the *NATA News*, "NATA Board takes first step in reform" (pp. 4–6, 25) and "Recommendations to reform athletic training education" (pp. 16–24).