

Educational Perceptions vs. Reality; Classroom and Clinical Education

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As a college student, I spent two summers working as a tour guide and an archeological excavator (the professional archeologists didn't like us calling ourselves diggers) at a historic preservation site in the Midwest. Our duties included attending a class three mornings a week on American History of the period and of our particular site. Our professor, a prominent university historian, began the first class with a statement that has stuck with me over the years; "History is not what happened. Rather it is what people think happened." He then admonished us to study original documents of the period to discover what people of the day were saying, and by extension, thinking.

There are two issues relating to athletic training education for which perception may be overshadowing reality. They are "educators vs. clinicians" and "the relative value of clinical vs. class room instruction." My desire is to convince every athletic trainer to use language that does not perpetuate philosophies that I feel are detrimental to the profession. Knowing this is impossible, my hope is that I bolster the arguments of those who agree with me, and sway some who either are on the fence or have an opposing view to my way of thinking.

The phrase "educators versus clinicians" has developed over the years to differentiate between those who hold academic positions as athletic training educators from those who hold staff positions as athletic training clinicians. Clearly these two groups of professionals have different roles and responsibilities; one group is mainly responsible for classroom and laboratory instruction while the other is mainly responsible for patient care. Innocent enough.

The problem with these perceptions, however, is that they imply that clinicians are not educators. Some clinicians are not educators, but the vast majority are, especially those who function as approved clinical instructors in our accredited educational programs. Clinical education is a necessary part of our student's education, and to state, or even imply, that those to impart this education are not educators is not only demeaning to them, but is absolutely false. They are educators and should be recognized as such.

So if there is a need to differentiate between these two groups. I suggest we use the terms "academics" and "clinicians" Academics are those who hold academic positions at a college or university and

clinicians are those who hold clinical or staff positions. But regardless of how Human Resources classifies an athletic trainer, if he/she is teaching students, he/she is an educator.

There is much discussion about the relative value of clinical and class room instruction. Studies have been performed and opinion/editorials written. In a recent article in the NATA News¹, a student concluded that class room education was more valuable in passing the BOC certification exam, but that clinical education was more important in preparing one for real life as an athletic trainer. A point that appears to have been lost in this debate is that neither of these functions exists in a vacuum. They are interrelated, they exist together, they feed off each other (in a properly designed curriculum).

Athletic training involves the application of knowledge. Clinical decision making involves surveying a situation, establishing needs, and then determining a course of action that will meet those needs. An adequate knowledge base is necessary to establish needs and determine appropriate action. The greater the knowledge base, the greater the possibility that the clinical decision will lead to quicker or more complete resolution of the problem. So other things being the same, the more effective the classroom instruction is, the better the clinical decision making will be and the better the health care for the patient. However . . .

All the knowledge in the world is of no value if it cannot be applied. As stated earlier, athletic training is the application of knowledge. So without good clinical education, much of the value of the classroom education is wasted.

So let's turn our attention (and energy) away from exclusive language and debating the relative merits of clinical and classroom education. Rather we should work to strengthen and build both types of education, and those who impart both types of education. It is not a matter of whether the chicken or egg came first; it is a matter of a partnership. Both are indispensable to the partnership. Strengthening one will strengthen the other.

References

1. Huggins, R. Student Corner: Classroom vs. Clinic: Where Should Students Focus Their Learning? *NATA News*, Sept. 2006.

Commentary

After writing this editorial I asked the Education Council Executive Committee (ECEC) to review it. Their responses were outstanding. They extended the two themes of the editorial: refrain from using language that can be interpreted as excluding clinical instructors as educators and the relationship between classroom and clinical education. Their responses included some super ideas that should not be restricted to the ECEC. With their permissions, I have included them below. I also invite additional ideas from readers.

We Are All Athletic Trainers; We Must Be Inclusive

I agree completely with your intention to create a more inclusive environment; especially if we can bridge the divide between academics and clinicians. I think anything we can do to reinforce the concept that all athletic trainers are educators is a worthy effort. In that respect, I concur with your suggestions.

But let's not forget that we are all athletic trainers. Some teach students, some treat patients, some administer programs, some conduct research, and some do a combination of these things. But they are all still athletic trainers (at least that's what one of their credentials says). Another way of looking at this is to compare doctors who treat patients and doctors who teach in medical schools; they are all still referred to as doctors. Yes, HR personnel may classify different athletic trainers at an institution in different ways depending on their roles, but I go back to my original position - they are all athletic trainers. One last comment to "muck up" this discussion is the increasingly popular clinical faculty designation; this could be confusing when compared to clinicians defined as holding clinical or staff positions.

Maybe one of the ways we can restore some pride in the profession is for all athletic trainers, regardless of their roles and responsibilities, to proudly call themselves athletic trainers first, and what their specific duties are second.

-Dan Sedory

Suggestions for Bridging the Gap

Important subject. Excellent advice. My only suggestion might be to offer a few concrete suggestions to lower the barriers between academics and clinicians and/or better integrate didactic and clinical education. For example:

1. Creating accountability and reward systems for clinical educators for the educational portion of their jobs.
2. Developing authentic and ongoing professional development for clinicians involved in AT education.
3. Emphasizing the teaching AND practice of evidence-based medicine both in the classroom and in clinical settings. There is a significant gap here that cries out for remediation.
4. Creating partnerships between academics and clinicians by, for example, encouraging academics to reach out to clinicians in conducting research and involving academics, where possible and practical, in some aspects of the clinical services program.

-Rich Ray

Symbiotic Relationship Between Classroom and Clinical Education

I think that there will continue to be a disconnect in the education of our athletic training students until we can begin to bridge this "great divide." As Rich stated, I think we need to try and lower the barriers between academics and clinicians. Yes, the roles need to be defined . . . in a mutually respectful way.

Yes, there is a symbiotic relationship between classroom and clinical education. This is what we need to be yelling from our roof tops! We need to somehow make people understand that both academic education and clinical education are equally important. To achieve a successful outcome for our students, the academic educator and the clinical educator must have the best interest of the student at heart. We must find a balance between theory and application. Theory is the foundation for which we base our decisions. It is the backbone of our clinical reasoning process. Clinical education provides us that "real world" experience and a mechanism in which to apply, test and question that theory. From these experiences, theories will be refined or discarded and new theories and best practices will evolve. There must be a strong collaboration between academicians and clinicians. We must communicate, compromise and develop a mutual respect and understanding of each others roles. We must work together to enhance the overall educational process for the best interest of our patient/athletes, our students and for the profession.

-Kris Boyle-Walker

All Athletic Trainers Are Educators

I think that it is important to understand (and I give this to my students and others) is that not only are we all athletic trainers, all athletic trainers are educators. Regardless of the setting, whether we educate our students, our peers, the public, our patients, whoever, we are all athletic training educators.

-Ray Castle

Educate the Whole Student

Reading these comments got me thinking about another point. While I can't disagree with what Dan said, there is an element in his response I feel compelled to comment upon. If we all (athletic trainers working in university settings, regardless of role) simply call ourselves athletic trainers and leave it at that (which is not what Dan suggested, but which some could imply from his comments), I believe we do a serious injustice to the students we serve and the academy of which we are a part. And here's why:

There is far too much fragmentation, specialization of roles, and "silo-ing" taking place on our campuses already. The result is that biology professors won't help students improve their writing skills ("I'm no English professor"), English professors who won't help students improve their numeracy ("I'm no mathematics professor"), and communications professors who think they are the only ones who can teach students to speak ("I'm the professional, after all").

While athletic training educators, whether "academics" or

"clinicians," certainly have special knowledge, skills, and abilities they are responsible for transmitting, they (we!) are also responsible for the total development of each student. The failure to recognize this, is what is largely to blame for the underachievement of our colleges and universities. I guess what I'm arguing for, and perhaps it's not realistic but I think it's darn important, is that from now on when someone asks you (or me!) what you do for a living, tell them you're a college professor. Once we agree to take on the role of teacher, our specialization, while important, takes a back seat to student achievement broadly defined. People who are narrowly confined to roles as athletic trainers, biologists, historians, or nurses can't realize this goal. College professors can.

-Rich Ray

Economics contributes to the Great Divide

I believe that there is a great need for members of our profession to contextualize their roles for a better understanding of the entire educational process. Financial structures in many cases mandate divisions that no one wants or desires, but for accountability reasons people have to be codified to make all the FTE and Budget criteria match. I have witnessed this in a few places where full time Athletic Department ATs were removed from classroom teaching because they were not on the academic unit's payroll and therefore other faculty within the academic unit (often new academic AT faculty) picked up didactic courses. The sadness/bitterness created by this reality has been very obvious by the AD staff and ultimately helped to create the "Great Divide" of academics vs. clinicians.

I think the more that AT's in total can comprehend the economic realities of most programs, where faculty are paid out on one unit and clinical staff in many cases are paid out of another, there would be less of a tendency to categorize. Yes, we are all athletic trainers, we are all educators, but our roles are very different but our goal is the same, a competent qualified student at graduation.

-John Schrader

Reduce Insecurity; AT Ahead of the Education Curve

Yesterday I asked my students (post-professional) 'where were you taught athletic training knowledge and skills?'. They agreed that over 90% of what they perceived as formal teaching came from the classroom or lab setting. I followed up by asking 'In what environment did you learn - and by definition I mean what environment is responsible for what you now know and apply?'.

The group consensus was that around 65-75% of what they 'learned' is attributed to the clinical setting. What we teased out, which was no great surprise, was that most of their formal education came in the classroom and the clinical setting was the glue that made it stick. They acknowledged, as we all would, that much of their formal learning that wasn't reinforced with application and modeling has been lost.

To put things in perspective, consider a little of what is going on in medical education right now. First, they are moving toward more competency-based education and think they are leaders in healthcare education for doing it. Obviously, lots of other health professions have been doing this for some time now. Second, they are realizing that the first two years of the basic science curriculum (academic) are largely useless and students can't apply what is learned there because they have no construct (patient care) from which to internalize it and build upon (learning). So, some medical schools are radically reforming their curricula to integrate basic science (academic - didactic) with patient care (clinical education). Sound familiar? Again, they think they are leaders in healthcare education for having figured out something radical in how people learn. But, athletic training and other health professions have been integrating didactic and clinical education for decades. I point this out because it is important we recognize sometimes when we have got it right. Our model of integrated didactic and clinical education is right and we should take great pride in it. Furthermore, we should work to formalize our arguments for why it is the appropriate model, thereby validating both parties involved in teaching (academics and clinicians).

-Eric Sauers

Knowledge Transfer Between the Laboratory and Field

Yes. And another need for, and benefit of, a symbiotic relationship is that it will facilitate knowledge transfer between the field and laboratory. Much like medicine, it is imperative that we increase our ability to move knowledge from the field to the laboratory, and vice versa as we advance our research and educational/clinical missions.

-Carl Mattacola