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REPLY: LETTER TO THE EDITOR

We thank Dr David Berry, the Editor-in-Chief of the *Athletic Training Education Journal* for providing us the opportunity to respond to the editorial penned by Breitbach et al[1,2] concerning 2 manuscripts we authored in volume 12, issue 2, of this journal. For clarity and simplicity, the Geisler et al paper[1] will be referred to as the evidence-based athletic training (*EBAT) paper*, whereas the McKeon et al paper[2] will be indicated as the *knowledge paper*. As the opening editorial[3] in that issue noted, the purpose of the journal's first special issue was to hear more voices and to spark greater insights from the professional body in hopes of initiating critical conversations concerning various professional and educational issues in the new master's transition era. Toward that goal, we also thank Drs Breitbach, Reeves, and Eliot for taking the initiative to continue critical conversations prompted by our call for an evidence-based athletic training and our largely discursive paper[2] regarding the nature and definition of athletic training's professional knowledge. We are excited and honored to have this opportunity to provide further clarification in order to continue this important academic debate regarding the future of our educational and professional identities.

The focus of these papers was on athletic training's identity and legitimacy as a health care profession. Although interprofessional education (IPE) and interprofessional collaborative practice (IPCP) are essential emerging components of health care, we believe we need to first center our strategic efforts on more strongly defining athletic training as a profession. Our narrative and rhetorical positions pertaining to IPE in the EBAT paper were directed toward the critical issues we need to address in order to be considered a viable health care profession, in the eyes of both the public and our sister health care professions. Our readings of the literature and evidence on IPE[4] have coalesced with our collective professional and academic experiences across many professional settings and years to result in a bit of caution toward a full-throttle and widely implemented IPE movement in athletic training. In constructing the EBAT article in particular, we felt that the existing literature from the athletic training profession concerning IPE had not *yet* been fully represented or dissected, at least not to the point where it was capable of informing an effective, explicit, or practical strategy or specific professional-educational outcomes for programs transitioning to the master's degree.

We agree with Breitbach et al that more controversial proposals are included in the new Commission on Accreditation of Athletic Training Education standards for accreditation. To that end, our knowledge paper was intended to open and reshape much-needed conversations concerning the expanded skills, knowledge, and practice domain implications included in the Content section of the newly proposed standards. We sought to spark deeper thoughts and reflections about who we are as a profession, how we define knowledge that can be legitimately claimed by athletic training as ours, and how we go about positioning ourselves in the larger medical and health care worlds as experts who are viable players in IPE and IPCP. We feel that overzealously joining the IPE and IPCP movement before we answer these questions is akin to putting the cart before the horse. Given the intersecting theses in the 2 papers, we see this ontological-epistemological concurrence as somewhat of an ironic juxtaposition for our profession: one calling for pause, reflection, and strategic planning by the professional body.

Absence of Evidence is not Evidence of Absence, But...

To be clear, we are not anti-IPE, nor do we argue for professional isolationism to define and constrain our current or future work. Our primary message in the EBAT paper was to express concern about the *manner* and *speed* with which IPE is being proposed for immediate and potentially overburdening standardization in athletic training education by the Commission on Accreditation of Athletic Training Education. Although new literature is emerging daily, there remains a paucity of compelling and long-lasting evidence in athletic training and many other health care fields attempting to define their IPE so that IPCP is indeed enhanced and patient outcomes optimized.[1] As Breitbach et al pointed out in their response, objective evidence concerning the effectiveness of IPE and IPCP from athletic training specific settings or contexts is lacking. Overall, IPE and IPCP may be beneficial for health care professions, but perhaps we need to focus on defining our profession more completely before we seek to be *interprofessional* as defined by the World Health Organization and the Institute of Medicine. Without a legitimate claim to our own knowledge and sound evidence and outcomes for that knowledge, how can we come to the table saying we should play an integral role in IPCP?

In the athletic training literature, the appeals by the Institute of Medicine and the World Health Organization for expanded and extensive IPE and IPCP initiatives for all health care providers have already been reported and given due coverage by Dr Breitbach and others.[5,6] Not only did we not feel the need to rehash those widely available reports and associated findings in our recent papers, we continue to be of the opinion that literature sources in athletic training have spent inadequate time or space addressing the "other side" of the issue—the substantial challenges, lack of compelling and applicable evidence, and the hopeful nature of some claims made by IPE proponents and scholars, alike. Our evidence-based athletic training paper was *not* intended to provide a comprehensive review of the issue, but rather to present the other side of the equation in an attempt to provide the depth and balance required for an academic conversation with our peers on this important and timely matter.

Full Citation:
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To buttress our brief analysis of IPE, we cited 10 peer-reviewed articles, including numerous systematic reviews that more fully dissected and elaborated upon some of the known educational outcomes and considerable challenges associated with IPE in various health care fields. In our minds, these important aspects of the conversation were not adequately addressed or brought to light in recent IPE-focused papers[5,6] from within the athletic training profession. In light of our central thesis in the evidence-based athletic training manuscript, given the considerable level of "unknowingness" associated with IPE outcomes and their effect on IPCP and knowing that IPE implementation is widely reported to be costly in curricular, clinical, human, and financial resources, we continue to feel that stronger and more contextually relevant evidence concerning IPE should first be secured, assessed, and consulted before we put regulations into place for all academic programs (the evidence-based regulation component of evidence-based athletic training).[1]

Our commentary on IPE also brings to the table questions concerning exactly what is needed in our profession as it regards this issue. We wonder too "what is missing" or "where is the void" when it comes to athletic training's place in and within interprofessional collaboration or practice? Athletic trainers do not work in chaotic and stressful emergency room situations where they are required to collaborate with radiologists, nurses, physician assistants, and physicians in acute and potentially fatal and comprehensive situations. Athletic trainers do not work with chronically ill patients presenting with comorbidities and multiple system conditions such as cancer, autoimmune, or metabolic disorders requiring intricate and competent collaboration with pharmacists, psychologists, sociologists, nutritionists, physicians, nurses, and others in order to optimize patient care in such complex situations. However, athletic trainers have long been critical participants in IPCP in athletic training contexts—practicing, teaching, and mentoring interprofessional practice since "day one" [7(p5)] as vital members of the sports medicine team many of us learned in our first athletic training class and clinical education experiences. Further, athletic trainers have long been working under the supervision or in collaboration with physicians and other health care providers in almost all contexts for decades. Athletic trainers regularly communicate and collaborate with team physicians, radiologists, nutritionists, physical therapists, physician assistants, strength and conditioning coaches, and others in various clinical contexts while caring for their active patients and athletes. Where is the evidence that we are bad at this type of work or education? Athletic training students have been learning how, when, and why to do this kind of comprehensive and collaborative care for a long time. We point out these examples not to minimize the importance or relevance of IPCP, but rather to provide professional context to the topic and to elucidate the connections among knowledge, evidence, and practice.

In our collective opinions, IPE is just one critical topic presented in both papers that requires more meaningful and widespread debate, investigation, and consideration across the spectrum of our profession before full-fledged implementation. In an effort to construct our model for an evidence-based athletic training, we also spent considerable (but not complete) time and space deconstructing the role that basic sciences play in health care and athletic training education in order to challenge the rationale for adding more basic sciences to our pre-education phase. To extend our discourse, we also highlighted 8 other pertinent aspects in critical need of evidence, dialogue, and reflection, as they all promise to have significant and longstanding influences on how the new master's curricula will look and operate, and accordingly, upon future generations of practicing athletic trainers.[1(p85)]

Our knowledge paper was envisioned to stoke serious conversation about who we are as athletic trainers based upon a rhetorical and sociological inquiry about what we know and, by extension, what we do. In trying to close the loop between our 2 papers with IPE and IPCP, we feel strongly that a deeper and more informed analysis of our professional knowledge has a direct effect on any initiatives and energies regarding IPE or IPCP moving forward. Given the extensive expansion of knowledge and skill levels being proposed for the new master's degree standards, we see the inherent challenge of brazenly stepping into the murky waters of IPE and IPCP when we apparently do not yet have a firm, authoritative, and credible articulation of what athletic training knowledge is. If we keep changing the landscape of our professional knowledge, how do we navigate those interprofessional waters with other professionals who have "owned" that knowledge for a considerable time period already? What exactly will those conversations look or sound like?

We are thankful for Dr Breitbach and colleagues' editorial response to our 2 papers and that their reading of both critical pieces inspired this conversation, for that was the intent of our papers and the entire special issue. With sincere appreciation, we commend the academic work both completed and planned in the arenas of IPE and IPCP from all health care fields to date, and we look forward to being a part of such critical conversations in the coming months and years as athletic training scholars and administrators look to address these complex issues in manners that move our profession forward.

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