

# Current Literature Summary

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*Our charge is to monitor education-related journals (e.g. Journal of Nursing Education, Journal of Higher Education) and identify articles which are the most applicable to our readers. We will provide brief synopses of the articles plus potential applications to AT education.*

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**Oermann MH. Clinical evaluation and grading practices in schools of nursing. *Nur Educ Persp.* 2009;30(6):352-367.**

Reviewed by Michele Monaco, Lehigh Carbon Community College.

Accountability has dramatically increased in higher education. An obligation to progress the student through a well defined program is necessary in developing competent nurses. Clinical practice has always been an integral part of the education process, yet the method of clinical evaluation is not consistent in programs throughout the country.

Evaluation is a process of systematic collection and interpretation of data gathering by multiple sources to evaluate clinical competence. Typical strategies for evaluating learning and performance can include: observations and the use of anecdotal notes, check lists, and rating scales, as well as written assignments, case studies, care plans, concepts maps and clinical reasoning webs. One of the challenges of clinical evaluation is the development and use of valid and reliable clinical evaluation tools.

As athletic training education progresses, clinical competence is a key factor in developing the athletic training student. Educators must continually assess their clinical evaluation strategies. Clear articulation of performance expectations and outcomes are necessary. There also may be variability in the role of the evaluator and the teacher, as well as changes in clinical environment.

Educators should continually evaluate their assessment plan to ensure both formative and summative evaluations in the clinical experience and the clinical course. Faculty and clinical educators should be evaluating on a continual basis, providing feedback for the learner.

**Bainbridge L, Nasmith L, Orchard C, Wood V. Competencies for interprofessional collaboration. *J Phys Ther Educ.* 2010;24(1):6-11.**

Reviewed by David Diers, Governors State University.

Collaboration among health professions is an integral part of care. The athletic trainers, physicians and physical therapists, along with many others, need to work together to provide optimal care for the athlete. This collaboration should begin immediately upon entering the profession. To accomplish this goal, a health professional must have learned it in the course of their education. This can be a difficult concept to teach. This article outlines a few competencies which can assist in fostering the idea of collaboration in the curriculum.

The article describes a framework for collaboration which utilizes both previous frameworks and current literature to develop competencies for collaboration with other health professionals. There are six domains contained in the competency framework: collaborative leadership, interprofessional conflict, teamwork functioning, role functioning, patient-centered care and communication. Collaborative leadership is one domain which includes interprofessional conflict, teamwork functioning and role functioning. Each of these domains intersects with all of the other domains, and all are important concepts in all parts of interprofessional collaboration. Patient-centered care and communication are the other domains which are also integrated throughout the framework. There are also three themes which

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support the competencies: context of practice, level of complexity and quality improvement.

The framework is flexible and will evolve over time with input from the stakeholders based on its construction. It will be a practical tool for all health professions which are included as its stakeholders. This framework gives the educator a firm foundation in which to teach collaboration among all health professions.

**Williams R, Klamen D, Hoffman R. Medical student acquisition of clinical working knowledge. *Teach and Learn in Med.* 2008;20(1):5-10.**

Reviewed by Courtney Burken, University of Mary Harden-Baylor.

The authors evaluated the acquisition of diagnostic pattern recognition (DPR), defined as an intuitive recognition of a clinical pattern representing/relating to an injury or condition, and clinical data interpretation (CDI) or analytic fact checking during

diagnosis. These two categories were compared for data scores and learning curves between students in each year of medical training and a selection of family practice physicians. Both DPR and CDI increased throughout medical school, but the growth pattern leveled off in year 3. CDI rates were lower than DPR at all times and CDI growth rate was slower than the DPR growth rate. The results were discussed and compared to evidence of learning in medical education. This research is an interesting, clinical-based approach to elucidate where and how learning occurs throughout medical school.

Athletic trainers use similar reasoning and data interpretation strategies during assessment processes. The education process is designed to provide students with the reasoning and critical thinking skills to perform job duties. Education processes are regularly redesigned to enhance the education process with little outcome data on the effectiveness of those processes. This study attempts to begin to solve that issue.