INVITED COMMENTARY

Paula Sammarone Turocy, EdD, ATC
Duquesne University

The authors have taken on an age-old discussion in athletic training, one that has occurred in many other allied and medical health disciplines: What is the best way to provide the education needed to train our health care professionals? During World War I, Mary McMillan developed the War Emergency Training Program for Reconstruction Aides using graduate nurses and physical education persons. This program was the first formalized didactic and clinical education program to educate the "medical gymnasts" who were the predecessors to today's physical therapist. Integral to the development of the physician assistant profession, Dr. Henry McIntosh trained local fireman in emergency procedures for the community in exchange for their agreement to staff cardiac catherization laboratories at Duke, while former Navy hospital corpsmen also were hired at Duke for similar roles as physician assistants. In 1959 when the Professional Education Committee's recommendation to develop a model curriculum related to the employment of athletic trainers was approved by the NATA Board of Directors, the course work was designed to prepare students not only as athletic trainers but also as high school teachers, primarily in health and physical education. The three objectives of this program were to 1) give the individual the broadest teaching certificate possible, 2) provide pre-physical therapy courses that would be acceptable to AMA-approved physical therapy school, and 3) provide a curriculum that would prepare men in the management and prevent of athletic injuries. The commonality between athletic training and these other disciplines is that we all began providing formal education based upon the needs of the time and the available opportunity. Inherent in this comparison is the fact that the scopes of practice, education, and recognition of all of these disciplines, including athletic training, have evolved, and I would suggest that while the education of athletic training continues to evolve to match the expanding scope of practice of athletic trainers, the location of the educational programs has failed to follow suit.

To be fully transparent in my response and to disclose any possible bias, I should inform the readers that I have been a department chair and faculty member in the Duquesne University John G. Rangos, Sr. School of Health Sciences for over 17 years, and I have found this position not only beneficial to my students, but also to me and my colleagues who are senior faculty members in that school.

Athletic trainers were recognized as allied health professionals by the American Medical Association in early 1990. According to the Association of Schools of Allied Health Professions, "allied health professionals are involved with the delivery of health or related services pertaining to the identification, evaluation, and prevention of diseases and disorders; dietary and nutrition services; rehabilitation and health systems management, among others." This definition closely mirrors the NATA's definition of athletic trainers who are "health care professionals who collaborate with physicians to optimize activity and participation of patients and clients. Athletic training encompasses the prevention, diagnosis, and intervention of emergency, acute, and chronic medical conditions involving impairment, functional limitations, and disabilities." Conversely, if we accept the authors' suggestion to keep undergraduate ATEPs in schools of physical education (PE) and kinesiology, it would appear that we would not be positioned to meet the description and educational content required by the profession. According to a commonly-used information site for perspective college freshmen, kinesiology is "less (of) a career than a conceptual framework with applications in athletic competition, health maintenance, rehabilitation or any work with a physiological basis." It then could be surmised that even if a degree is awarded in athletic training, the perception of the public and potential payors will be that AT is part of the study of kinesiology which would not adequately describe the level of professional education and clinical expertise required of the Athletic Training health care professional.

The authors conclude that undergraduate programs should be housed in departments of PE/kinesiology because this will allow students to receive well-rounded, multi-disciplinary educational opportunities. They further conclude that entry-level master Athletic Training Education Programs (ATEPs) should be in schools of health sciences. I would suggest that this line of logic is inconsistent on several levels. First, both undergraduate and entry-level master ATEPs are required by the Commission on Accreditation of Athletic Training Education to contain the same professional content and skills. The author states that beyond the pre-requisite courses (eg, anatomy and physiology), there is no longer curricular connection between AT and Kinesiology/PE. The authors also suggest that courses in philosophy and sociology of sport, sport psychology, and motor learning courses will provide undergraduate AT students with a well-rounded education. I would suggest that a more well-rounded education would include not only the basic and applied sciences, but also a comprehensive liberal arts education that is often required in other allied health professional education programs. This more generalized curriculum would include courses in philosophy, speech, sociology, history, English, and general psychology as opposed to the more sport-specific versions suggested by the author.

The author also concludes that understanding PE/Kinesiology would allow students to integrate multi-disciplinary skills and information into their professional practice, but I would suggest that our undergraduate students would benefit more from sharing course work with other future allied health professionals. Not only would they have similar course content, but the students would also learn to work together and respect each others' knowledge and skills, establishing a framework that will transition more easily into actual clinical practice. Finally, the author also express concern that PE/Kinesiology departments will need to evaluate their financial resourses to determine the feasibility of maintaining accredited undergraduate programs. Working in a school of health professions for over 17 years, I can assure you that AT program costs, needs, and expectations are consistent with those shared by the other allied health disciplines in allied health schools across the country.

In conclusion, I encourage athletic trainers to continue to move their programs toward the education model recommended by the NATA's Task Force on Education more than a decade ago. I firmly believe that if we wish to provide our graduates with the best possible opportunities to meet the goals of the profession and afford them the respect and position that they have earned in health care, we must continue to allow our professional education to evolve just as other disciplines have done, and firmly establish our ATEPs in schools of allied health. This plan of action will not only benefit the students and the profession directly, but indirectly it will better position Athletic Training to achieve licensure in all states, be recognized by Medicare/Medicaid Services as an allied health profession eligible for reimbursement, and provide other payors with justification to reimburse athletic trainers for our services.

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AUTHOR'S RESPONSE

I would like to first say that I appreciate the ideas shared in this invited commentary. It is through these collegial dialogues that the discussion on the appropriate locations for ATEPs can be addressed and advanced.

There are several points against keeping ATEPs in Kinesiology/PE departments that are discussed in the commentary that I would like to respond to and clarify. First, the author suggested that housing athletic training programs in kinesiology departments would lead to the ATEP "not be[ing] positioned to meet the description and educational content required by the profession." Preparing students with the educational content to be successful and competent practitioners, and training them to meet and fulfill the NATA's definition of an athletic trainer is the responsibility of the ATEP and its faculty no matter where the program is housed. The departmental affiliation should not dictate or hinder the program's ability to produce qualified athletic trainers who are capable of meeting the NATA's definition for the profession.

The author also recommended that a comprehensive liberal arts based educational curriculum could be an adequate or even preferable alternative to the kinesiology curriculum if the ATEP were housed in an allied health department. Having graduated from a staunchly liberal arts university, I have a soft spot for this type of curriculum. While I agree that a liberal arts curriculum provides an excellent educational opportunity for students in the fields of philosophy, psychology, sociology, etc., it does not provide coursework in exercise physiology, biomechanics, motor learning, or other kinesiology courses that are essential educational pre-requisites for successful athletic trainers. Being housed in the kinesiology department offers access for ATEP students to these courses and the sport-specific versions of the liberal arts program. The kinesiology program presents ATEP students with the liberal arts and scientific courses that will help to make them well-rounded, multi-disciplinary scholars.

Finally, the author suggested that housing ATEP programs in allied health departments provides students with the opportunity to collaborate with other students in similar fields. While, in theory, developing a collaborative learning relationship with physical therapy, occupational therapy, and physician assistant students would be a positive situation for all involved and could lead to improved working relationships among the professions in the future, it is important to remember that most other allied health professions require graduate degrees to enter practice. Undergraduate ATEP students would therefore be attempting to collaborate with graduate students in the other fields. Theoretically, this collaboration would be wonderful, but in practice it may be difficult to successfully intermingle students at different academic levels without inherent feelings of discomfort or even disdain appearing on both sides. Entry-level graduate students working collaboratively with graduate students in other allied health fields could lead to strong relationships and alliances between the various fields. However, I am concerned that the same could not be found in a department that includes students at different academic levels.

One solution currently being considered by some colleges and universities that may provide the ultimate resolution to this dilemma is to take the entire kinesiology department, including the athletic training program, and house it in a school of allied health. If there is no teacher education component involved in the kinesiology department, this may indeed be the ideal answer. The ATEP would be included in the allied health department, but it would still have full access to the courses and involvement with the students in the undergraduate kinesiology program. This may or may not be the solution for the future, but it does provide another option to consider for the athletic training field and its education programs.