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Organizational Infrastructure in the Collegiate Athletic Training Setting, Part III: Benefits of and Barriers in the Medical and Academic Models

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Context: Academic and medical models are emerging as alternatives to the athletics model, which is the more predominant model in the collegiate athletic training setting. Little is known about athletic trainers' (ATs') perceptions of these models.

Objective: To investigate the perceived benefits of and barriers in the medical and academic models.

Design: Qualitative study.

Setting: National Collegiate Athletic Association Divisions I, II, and III.

Patients or Other Participants: A total of 16 full-time ATs (10 men, 6 women; age = 32 ± 6 years, experience = 10 ± 6 years) working in the medical (n = 8) or academic (n = 8) models.

Data Collection and Analysis: We conducted semistructured telephone interviews and evaluated the qualitative data using a general inductive approach. Multiple-analyst triangulation and peer review were completed to satisfy data credibility.

Results: In the medical model, role congruency and work-life balance emerged as benefits, whereas role conflict, specifically intersender conflict with coaches, was a barrier. In the academic model, role congruency emerged as a benefit, and barriers were role strain and work-life conflict. Subscales of role strain included role conflict and role ambiguity for new employees. Role conflict stemmed from intersender conflict with coaches and athletics administrative personnel and interrole conflict with fulfilling multiple overlapping roles (academic, clinical, administrative).

Conclusions: The infrastructure in which ATs provide medical care needs to be evaluated. We found that the medical model can support better alignment for both patient care and the wellbeing of ATs. Whereas the academic model has perceived benefits, role incongruence exists, mostly because of the role complexity associated with balancing teaching, patient-care, and administrative duties.

Key Words: hierarchy, role conflict, patient care

Key Points

- Role congruency and work-life balance emerged as the benefits of the medical model; role conflict, as the barrier.
- Role congruency emerged as a benefit of the academic model; role strain and work-life conflict as the barriers. The medical model supports better alignment for both patient care and the wellbeing of athletic trainers.
- Role incongruence exists in the academic model because of supervisor incompatibility.

Organizational infrastructure is the collection of policies and procedures of an organization that are based on the defined duties, roles, and responsibilities of its employees.[1] The overall performance of an organization and its departments depends on the organizational infrastructure because the policies and procedures are designed to ensure that business activities are performed consistently and efficiently.[1] Therefore, the organizational infrastructure, specifically the lines of leadership, can greatly affect the day-to-day and overall efficiency of an organization and its departments. In athletic training, organizational infrastructure has been suggested as a caveat to the creation of a workplace environment that is "family friendly" and "collegial."[2,3] That is, some workplace settings have been viewed as more conducive to finding work-life balance and promoting equity in balancing work, parenting, and life goals. Commonplace among these workplace settings is supervisor support and understanding of work-life balance, family needs and values, and professional autonomy in the workplace.[4] In fact, these aspects seem to help trump some of the challenges athletic trainers (ATs) face within the collegiate setting, which has often been described as demanding and adversarial to work-life balance.[5,6]

From an organizational standpoint, the supervisor's management style is suggested as necessary to create a work environment that is successful and augments satisfaction, fit, balance, and retention.[4] Organizational support can manifest formally through policies and procedures and informally via climate and culture, which is founded on shared values and camaraderie.[4,7] Opinions differ about how culture is created within an organization, but researchers[1,8] have agreed that the organizations' leaders substantially influence the establishment of culture.

Table. Participant Demographics

Pseudonym	Sex	Organizational Infrastructure	Age, y	Experience, y	National Collegiate Athletic Association Division
Alex	Male	Medical	34	10	I
Bret	Male	Medical	31	10	I
Callie	Female	Medical	25	3	I
Christopher	Male	Academic	28	3	I
David	Male	Academic	29	7	II
Janet	Female	Medical	26	5	I
Jordan	Male	Academic	32	10	I
Kimberly	Female	Academic	34	12	II
Kristen	Female	Medical	25	8	I
Lindsay	Female	Academic	29	6	I
Mary	Female	Medical	39	16	I
Michael	Male	Academic	47	25	I
Nathan	Male	Academic	27	3	I
Sam	Male	Medical	42	20	III
Tristan	Male	Medical	33	9	I
Zeke	Male	Academic	35	11	I

Slack and Parent[1] noted that leaders influence the organizational culture by setting a clear vision for employees and by paying attention to detail. A clear vision is important to establishing values and underlying assumptions, whereas paying attention to detail allows a leader to instill the organization's values through deeds. Supervisor support has surfaced as necessary to an employee achieving a relative degree of work-life balance,[7,9] which has been identified as a primary factor in job satisfaction and career intentions.[10] Supervisors have been identified as informal gatekeepers of work-life balance, as they can help their employees seek, use, and capitalize on work-life initiatives available within the workplace.[7] Whereas globally, supervisor support is critical,[7] having supervisor and administrator support is of utmost importance for work-life balance in athletic training.[5,11] Recently, researchers[9,12] in athletic training have shown that head ATs serve as the gatekeepers to work-life balance.

Currently, ATs can be employed in 3 main infrastructures within collegiate athletics. The most common is the athletics model,[13] in which an athletics director is the head of the organizational infrastructure. Less widespread are the medical and academic models. In these models, athletic training services are housed outside of the athletics department and conjointly with either an academic system or student health services (medical). Athletic trainers working in an academic model report either directly to an academic dean or to a department chair who subsequently reports to the dean. Often, clinical and academic ATs are employed together under the same organizational hierarchy and yet provide services to different populations (students versus patients). Athletic trainers working in a medical model are supervised by a physician within the university's health care center. Whereas many ATs employed in the athletics model are supervised by a physician, the athletics director is the leader of the organization and the individual who makes hiring and termination decisions. In the medical model, a physician is the head of the organization, and an athletics director is not responsible for hiring or terminating ATs. The medical model gained some attention after its possible benefits were presented in a recent editorial.[14]

Disagreements between ATs and coaches or athletics directors about patient care have resulted in termination of ATs.[15] Although most colleges and universities use the athletics model, the potential for conflict and incongruity regarding return-to-participation decisions appears to be greater anecdotally in the athletics model than in the medical model. Therefore, the purpose of our study was to explore the experiences of ATs working in 2 emerging organizational infrastructures, medical and academic. Despite continuing research about collegiate ATs' experiences of role strain, work-life balance, and satisfaction, few researchers have focused their investigations on organizational structure or hierarchy. We were guided by the following questions: (1) What were ATs' opinions of the academic and medical models? and (2) What were ATs' perceptions of their role in the academic or medical model and the relationships with those with whom they worked?

METHODS

Participants

We specifically recruited our participants from the medical and academic organizational infrastructures. We identified the organizational infrastructure through our knowledge of schools with each type of infrastructure and professional networking. Inclusion criteria for our study were full-time employment as an AT in the collegiate setting and receiving a salary from a university's academic or student health services. Through a previously described process,[13] we identified 12 universities (medical model = 8, academic model = 4) and obtained e-mail addresses from Web-based searches of these schools' athletics Web pages. Participants also confirmed our classification of organizational infrastructure during their interviews.

With data saturation as our participant guide and a snowball-sampling technique[16] from the initial pool of potential applicants meeting the inclusion criteria, 16 ATs (10 men, 6 women; age = 32 ± 6 years, experience = 10 ± 6 years), 8 from each model, completed the interviews. Participant pseudonyms can be found in the Table.

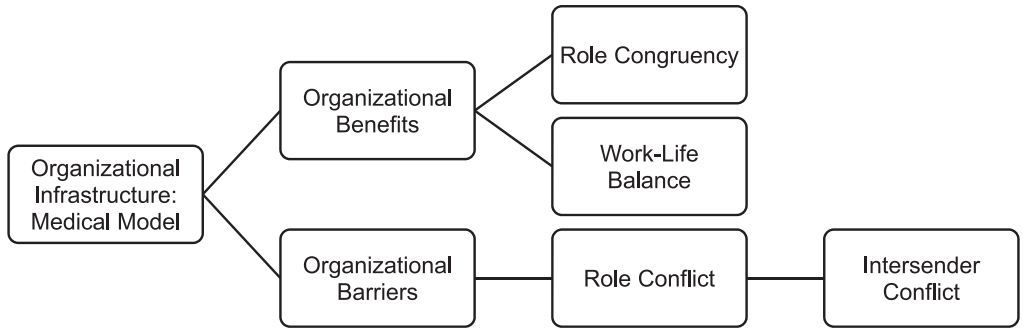

Figure 1. Benefits and barriers of the medical model.

Survey completion implied informed consent, and the study was approved by the University of Connecticut–Storrs Institutional Review Board.

Data-Collection Procedures

Data-collection procedures are described in part II of our study.[17]

Data Analysis

Data analysis followed the principles of general inductive analysis[18] and is described in part II of our study. The entire interview guide is provided as the Appendix of part I of this study,[13] and the specific questions on which we focused are provided in Table 2 of part II.

Trustworthiness of the Data

We used the same strategies to secure trustworthiness of our data as described in part II of our study.[17]

RESULTS

Organizational benefits and barriers emerged from our analysis of the medical and academic models. We present the emerging themes for each model separately with supporting quotations.

Medical Model

Two organizational benefits and 1 organizational barrier themes emerged from the medical model data (Figure 1). The benefits of this model were role congruency and work-life balance, and the barrier was role conflict. Intersender conflict emerged as a lower-order theme of role conflict.

Role Congruency. This theory stipulates that a group will be positively evaluated when its characteristics are recognized as aligning with its typical social roles.[19] As health care providers, ATs believed they were most aligned when medical decisions were the priority. Kristen stated:

> I think that it [medical model] works really well from a medical decision-making standpoint, where the decisions that we make are evaluated by a medical professional, someone who understands the other options in the decision process, who really isn't biased in the decision to play or not to play … ultimately the person that I answer to is most interested in that person's health.

Our participants described the importance of working for a physician who would help limit potential conflicts of interest. Callie mentioned "knowing that there's no conflict of interest, if a coach has a question about my clinical decision making, they're going to come to me … rather than going up to the athletics director and making a complaint." Bret discussed the importance of employee evaluations being completed by individuals who have a strong understanding of the athletic training profession and the demands of health care:

> [I prefer] for [our supervisors] to be athletic trainers, and/or physicians at the highest levels. When you're talking about … things, such as staff development, … tenure and promotion … merit raises and actual job evaluations, I think that for the setting of athletic training this should be done by someone who understands health care and can actually make decisions that would affect patients, or understand decisions that were made about patients.

Role congruency is feasible when the values of supervisors closely align, such as ATs to the team physician. Kristen reflected on a setting in which the wellbeing of the patient is primary and the demands associated with collegiate athletics are secondary:

> I think in the college setting … I think that we need to be in the medical model, that there needs to be a scenario in which your ultimate boss is a medical professional, and someone truly just looking out for the student … I think in any other setting, even if there's a physician being involved, if the ultimate boss is still the athletic director, there's still a component of wins and losses that matter to that person's career.

Janet, like Kristen, believed that winning and losing and other aspects of collegiate athletics can become trivial in an organizational infrastructure that bypasses an athletic director or nonmedical personnel:

> My team physician is also an assistant athletic director, but the only thing he oversees are sports medicine and strength and conditioning. There's never any pressure from him to take care of an injury differently than we would if it was just a common person. It's always medically in the best interest of the student-athlete versus win/loss record and how that's going to affect our

team. . . . With the team physician being somebody that you report to, I think that we're all very aware . . . he's always going to do what he thinks is going to be the best option for that student-athlete.

Athletic trainers had role congruency because they could perform their jobs without the pressures associated with meeting the expectations of a nonmedical supervisor, which allowed them to focus on the wellbeing of the student-athlete. It was also a benefit for the patient care provided by the AT. Callie saw the value that the medical model provided in congruency:

> I think [our model] allows for better patient care in that same regard in that we truly care, you know, about not only their health as a student-athlete, but their health following their career as a student-athlete, whereas I think in a lot of schools where you're in that athletic model, your primary concern is their health as a student-athlete, not following it. Just because of the reporting structure and the external pressures put onto you due to that reporting structure.

Role congruency was also developed by having the team physician employed by the university and not directly through the athletics department. Several participants referenced the benefit of having their supervisor be an employee of their institution and how that provided stability and security. Bret discussed how changing who employs the team physician could benefit patient care and ATs:

> That person at the top, specifically if it is a physician, [should] actually [be] an employee of the institution . . . Because I think that there's some institutional security that comes within that department if that person is actually an employee of the college and university.

Tristan praised the medical model because of the supervisor role and the advocacy it can allow among the physician, staff, and ATs. He noted: "It's the first time I've worked under the system of having the physician actually on staff within the athletics department instead of through the hospital or whatever." He was quick to state, "Honestly it's great . . ." Having the team physician on the same staff as the ATs was a positive aspect for him.

The notion of role congruency that participants expressed stemmed from their relationships with their supervisors and their perceptions of advocacy by their supervisors.

Work-Life Balance. Participants discussed how structured schedules, valuing a balanced lifestyle, and contract length facilitated the attainment of work-life balance in the medical model. Kristen said: "I think in my current job I work at. . . a place where they really value my personal time as well . . . That's definitely the biggest thing that helps me here."

Callie recognized that athletic training does not have a typical schedule or consistency in time off, but in her current structure, balancing was possible when schedules were known ahead of time. She stated:

> I started to find that balance . . . I know that when I come to work, I'll work for 6 days, I'll work my butt off, but I'm going to get my seventh day off . . . My boss really does a great job of . . . tracking our staff as far as the hours worked of all the athletic trainers, and . . . it allows for us to get more staffing if needed.

In her reflections, Callie recognized the need for supervisor support and time off, as did Tristan, who acknowledged his supervisor:

> [Our supervisor] lets us have some time off especially in the summer. He wants us to be away. He wants us to be away when we're out of season. Doesn't demand us in the summer for all of us to be here from 8:00 to 5:00 nor does the administration, so that helps too. But he's really been a big proponent of trying to protect us, as well as help us . . . I think here it's been easy because it's something that's a priority for the administration and Dr [X] and just our staff, as well. Just to maintain balance to be able to not burn out; to be able to kind of do things outside of work.

Two participants noted that the medical model provided structure to their work schedules, mostly because of policy development and the support of their supervisors. Callie reflected on her love for her current position:

> We have a policy in place, that the coaches need to give us 30 days' notice if they want to change a practice time . . . And you know, we make exceptions to that policy if we're able to accommodate them, but the coaches know that the policy is there, and they have to give 30 days, and if we're not able to accommodate them, they can't have a contact practice, or they can't have practice at all, depending on what the sport is . . . When you've got 40 sports that you're juggling 11 athletic trainers for, it's a necessity . . . And I really think that's the beauty of our model, like if our athletic trainer was reporting to the [athletic director], there's no way that policy would be enforced.

Role Conflict: Intersender Conflict. Within an organization, an employee may face multiple kinds of conflict, including intersender conflict. In *intersender conflict*, the expectations of one individual may be in conflict with those of other individuals employed in the organization.[20] Our participants specifically described how the expectations of their coaches did not often match their expectations of their job and roles. Alex discussed how coaches wanted faster turnaround for medical care: "[The] other thing that causes stress is just sometimes when the injury case load is really heavy, I get a lot of pressure from coaches to try to be faster with things."

Bret explained that the greatest challenge he faced in his position was the expectations of coaches, particularly related to coverage and care: "One of the largest challenges has been preconceived expectations of anyone that I interact with about what may be available, or what may be offered . . . that may be coaches' expectations for coverage versus care." He also said, "People already seem to have preconceived notions of what will be done or what should be done before understanding what the actual role of our department may be." Janet expanded on the conflicting expectations of the coaches with whom she works:

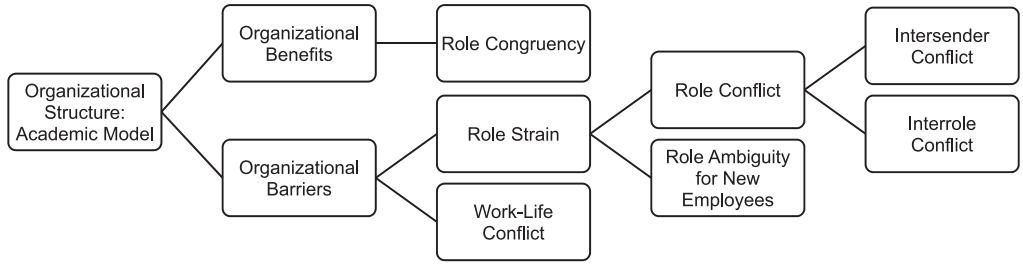

Figure 2. Benefits and barriers of the academic model.

> I definitely think coaches have a little bit different expectations still. A lot of that is I have a very young coaching staff, but they've all come from very different backgrounds. So I have some coaches that are here from the Division III or the NAIA [National Association of Intercollegiate Athletics] level and so they're surprised that I'm at every practice and at every trip. Whereas some of my other coaches are all from very elite Division I schools, and so they expect me to buy the kids tissues and bring them soup when they have a cold. So we're working on setting those expectations at a more realistic level for each of the coaches.

These conflicting expectations seemed to stem from a lack of understanding of how the sports medicine department worked. The intersender conflict observed in our participants was directly influenced by the coaches with whom they worked. Mary said: "I think our coaches just want more of us."

Academic Model

One organizational benefit and 2 organizational barriers emerged as higher-order themes from the academic model data (Figure 2). The benefit of this model was role congruency, and the barriers were role strain and work-life conflict. Role strain comprised 2 lower-order themes: role conflict and role ambiguity for new employees. Intersender and interrole conflict were subthemes of role conflict.

Role Congruency. Many participants discussed the agreement and alignment they perceived between their role as an instructor and AT and their supervisor and the department in which their program was housed. Jordan shared his level of satisfaction with his current position and organizational infrastructure:

> . . . it's a good situation in the end . . . it's good to be separate from the athletic department because . . . sometimes there's less pressure, I guess, in reporting to coaches or the athletic director . . . if that's who my boss was, I think it would be a different environment.

He continued: "I think that's a great way to operate because we can worry more about the health care side of things and not have to worry as much about making everybody happy."

Participants discussed the ability to focus on health care decisions and patient care within the academic model and how that aided in the job security of ATs. Having an AT serve as the dean in the academic model places a leader who understands the complexity of the athletic training profession atop the organization. Lindsay explained: "I think [it] helps having an athletic trainer in that position because [they] can try and advocate for the profession itself and advocate for us working in the profession."

In addition, our participants discussed the benefits of teaching while simultaneously working clinically as an AT. Kimberly said: "It's awesome for our students [to see us both in the academic and clinical worlds]." She explained how the multiple roles made her a stronger AT:

> I think that I'm a better clinician because I'm an educator, and I'm a better educator because I'm a clinician. And having the undergraduate ATP [athletic training] program puts [the students] at such an advantage having us in the classroom and then clinically.

Christopher echoed these thoughts:

> I really like being in the educational side of things . . . I think it really gives us an opportunity to stay on top of cutting-edge stuff . . . I think it really pushes us as clinicians, to stay on top of things and to pose questions to [the students so] that we may [help them] develop clinically . . . it's really a good 2-way street.

Participants also discussed how they developed role congruency with their coaches over time. Christopher noted:

> We're all trying to do the same thing. And we're fortunate with the situation that we have right now at [our university] where we don't really have any problems with the coaches at this point in time.

David described how his relationship with coaches had changed over time:

> When I first got here, I was with basketball, and the coach and myself didn't see eye to eye on a lot of things . . . we're not under athletics, and some of the coaches have expectations of us . . . that they aren't in a position to have since we don't work for them or anybody in athletics . . . But we got over everything, and worked through it, and it was all fine at the end . . . So I think initially it's a hurdle with the coaches, but once you win them over, then I think it's smooth sailing from there.

Jordan commented on how the patience and commitment to strengthening the relationship with the coaches equated to a mutual respect:

> I think there's a lot of mutual respect . . . We've worked really hard to kind of nurture that relationship with the coaches and have open lines of communication, which I think has been very effective . . . Since there's typically 1 athletic trainer assigned to a specific sport or a couple of sports, you definitely foster a relationship with the coaching staff. And I know, in my experience personally, I've worked really well with the coaches and there's been a mutual respect there. And then the same thing would be true for the other athletic training faculty members and graduate assistants.

Role Strain. Participants experienced role strain with role conflict and role ambiguity for new employees.

Role Conflict. *Role conflict* is the existence of clear but competing or incompatible expectations. Two subthemes emerged (Figure 2).

Intersender Conflict. Intersender conflict, a subscale of role conflict, describes the conflict or incompatibility of the demands of one person in the role set with the demands of another person in that role set.[20] Whereas some participants discussed role congruency over time with coaches, others struggled with athletics conflicts. Intersender conflict stemmed mainly from coaches and athletics department administration and often their lack of understanding of the AT's job demands. Jordan observed that the conflict frequently stemmed from working in multiple departments:

> We kind of live in both worlds [academic and athletic]. And that's sometimes difficult for athletics to understand that athletic training isn't our only job. It might be 25%, it might be 50%, it might be 75% of our total workload depending on the semester and depending on the person. But it's not the only gig. So there's a lot more work that goes into it because we're also teaching college courses.

Nathan remarked that this conflict originated from coaches not having a good understanding of what his role and responsibilities were:

> It's tough when coaches have the perception that you are supposed to be there 24/7 on call. And that is something [where] I have tried to break that cycle of being on call 24/7 because that is not my job.

Zeke noted that many of his coaches seemed to forget that he also had academic responsibilities:

> A lot of times when those coaches see you on the bus preparing a lecture, and you have your laptop out . . . they say they are reminded that: "Oh, you also teach class." I would have one of my coaches make a comment: "When is the athletic director [going to] get y'all out of the classroom." And I will . . . [say]: "We're hired by academics." And they're like: "Oh yeah, that's right." . . . Sometimes I think they forget . . . some of them have no clue.

Lindsay summed up how her intersender conflict came about because coaches and employees in the athletics department lacked general knowledge of her role and the athletic training profession as a whole. When asked if athletics personnel understood her role, she replied:

> Definitely not. I think the athletics [personnel] here feel like we should be for athletics 24/7, on call, everything like that. And I think it's mostly because they don't really understand the profession itself. And then they don't understand the extent of our roles and how many responsibilities we have. So we're continuously trying to educate them and try to teach them about the profession and then teach them that we do have all these other expectation[s] and roles.

Interrole Conflict. Another form of role conflict in organizations is *interrole conflict*. It occurs when an individual's position involves multiple roles that are divergent and accompanied by different expectations.[21] Many participants working in the academic model struggled with the multiple overlapping roles they tried to fill as instructors, preceptors, scholars, administrators, and ATs to the patients they served. Jordan stated:

> I feel like . . . I am pulled in a lot of directions . . . because from a faculty standpoint, there's expectation of service and scholarship, which obviously takes a lot of time. And there's not . . . a whole lot of time to dedicate to things [beyond patient care].

This interrole conflict seemed to stem from the responsibility of teaching in conjunction with participants' responsibilities as clinical ATs. Lindsay, who taught 3 days each week and devoted afternoons to her clinical work, said:

> I originally was interested in teaching, and now that I've kind of been through it, I'm [starting] to think that just being an athletic trainer and just having 1 role is a better fit for me . . . it's hard not having the time or energy or resources to do what I would like to do in the athletic training side because I have my academic responsibilities. In my position now, I just feel like I'm kind of getting pulled in so many different directions. It's hard to kind of do it all because you have so many different roles. You can't really focus on one specific role. You're just kind of spread out over numerous things, and it can kind of get overwhelming more times than not.

Our participants also highlighted the stresses placed on higher educators. Kimberly, who taught 4 classes, addressed the demands on her as a faculty member:

> I think there's been a lot more demand placed on faculty members as far as publications, as far as service that you have to provide to the university. So I think that has made it extremely difficult to wear all the hats. I think that there's definitely some times [that] expectations [are higher] than can be attained. So I think I have a good grasp on what the expectations are. And I'm also aware that at times I'm having difficulty meeting them, which makes it difficult. I think our department chair delegates

our responsibilities and tells us what we need to do and how we need to perform. And sometimes that's overwhelming.

Role Ambiguity for New Employees. Role ambiguity is the degree to which clear information is lacking with respect to the expectations associated with a person's role, methods for fulfilling known role expectations, or the consequences of their role performance.[22] Participants expressed role ambiguity especially when they were newly hired for their current positions. They perceived this ambiguity more in terms of their academic role than their patient care or administrative duties. Whereas Nathan knew clearly what was expected of him as an AT, he believed, overall, that his role expectations were

> a gray area . . . It's gray in the fact that I know what I'm expected to as an athletic trainer because of the . . . guidelines code and ethics have clearly defined . . . and are entrusted to know . . . those are pretty black and white. The academia side, I'm not sure exactly [as far as my classes] . . . [one class] is an entry-level class . . . the expectations . . . are not clearly defined as far as goals set forth by the people who have hierarchy.

He also reflected on when he was initially employed during an emergency 2 weeks before the semester started:

> I wasn't given a lot of briefing or maybe I wasn't given the proper introduction of how things are run. So the first month and a half has been flying [by] the seat of my pants . . . and trying to get my bearings straight on that. There were no expectations other than we expect you to keep the class and be a full-time athletic trainer.

A few participants recognized the ambiguity facing new colleagues, which stimulated reflections on their own uncertainty. Zeke was aware of the limited understanding that can accompany the initial role transition. He shared how he had initial uncertainty but became clear because of his "learning over time":

> I want to say now [my expectations are clear] because I've been here for awhile. But I think that when we hire the new athletic trainers, new clinical instructors, do they struggle with it, yes. They're trying to find their way, . . . they have to find out how to prioritize all those things . . . I think as a new hire, you have to ask a lot of questions . . . I think you do learn by trial and error, but you try to limit those errors.

Work-Life Conflict. Most participants expressed perceptions of work-life conflict in the academic model. For instance, when asked about work-life balance, Jordan replied: "I think it's really important. It's just not always the easiest thing to do, especially when you wear a lot of hats and you have a lot of different responsibilities . . . trying to keep balance is a challenge." Athletic trainers working in the academic model assumed many roles in the workplace, and that created difficulty with work-life balance as they were being pulled in different directions. When asked about her greatest challenge as an AT, Lindsay answered:

> Probably the position that I'm in now, being able to kind of juggle all the different responsibilities and finding time for myself, meeting friends or relaxing or anything like that. It's hard to find the time because you're just pulled in so many different directions and you have so many different responsibilities. So finding that balance between personal life and professional life, I think, has been the hardest battle that I've faced so far in my career.

Zeke also believed work-life balance was difficult because he was always trying to complete tasks simultaneously:

> . . . you're doing work at home. You carry a lot of work home. You get to work early. You're working on the weekends . . . you try to put in that time and make sure that you're prepared . . . [and] a lot of athletic trainers are out of shape, have health problems, overweight . . . we're so busy taking care of everybody else that we neglect ourselves.

The concept of "the work is never done" was discussed by Kimberly. She believed that balancing academic roles, patient care, and other work-related duties was challenging and an impediment to completing other responsibilities:

> I think the other hard part about that balance is also when you work in academia, it's never really done. Your day is never really done when you leave. There's always things that you need to be working on. There's always things that you could be preparing. And I think that's hard because you go home and then you see all the other things you have to do like the laundry and dinner and whatever. So I feel like that . . . because your work is never finished, I think that's hard.

Work-life conflict was a concern for this group of ATs working in the academic model and mostly resulted from competing work-related responsibilities that were time intensive.

DISCUSSION

Debates have increased about whether moving from an institution's athletics department can help improve not only the quality of life for ATs but also the care provided to patients. Our study represents the first examination of those models that employ ATs independently from the institution's athletics department. Determining the effect of the organizational reporting structure on collegiate ATs is critical to better understanding the role of organizational factors on professional concerns, such as job satisfaction, work-life balance, and career intentions. We found support for claims that a medical model can increase the coordination of care provided to student-athletes while simultaneously increasing work-life balance.[14] We also observed that role conflict can manifest in the workplace when an AT's various roles are demanding and require similar time commitments. The medical and academic models provided ATs an opportunity to achieve congruency in their roles. That is, employment outside the athletics department reduced the conflicts that can arise between coaches and ATs. Whereas the reduced conflict was

partially mediated by organizational infrastructure, communicating and developing a mutually respectful relationship over time was also helpful. Our findings are unique to these 2 organizational infrastructures, as researchers[15,23] continue to report problems in the athletics model between coaches and ATs regarding medical care and return-to-participation policies and procedures. That is, ATs should be cognizant of the benefits and challenges of each model so they can manage them.

Benefits of the Models

Kroshus et al[23] recently highlighted the pressure that ATs working in the athletics model experienced from coaches and administrators to return concussed athletes to competition sooner than ATs believed was appropriate. Anecdotally, the medical model appears to focus on a more patient-centered approach to health care.[14] That is, ATs report directly to a physician who has working knowledge of medical topics rather than to an athletics director who may not have the same medical knowledge. Role congruency was noted in participants' responses, as they continually discussed the importance of reporting to a physician who had medical knowledge and seemed to make athletes' health their top priority. This congruency between ATs and team physicians can potentially lead to interpersonal trust between employee and leader. Interpersonal trust is fundamental to team effectiveness.[24] Employees' trust in their leaders has been positively correlated with multiple productivity-related processes and outcomes, including organizational citizenship behavior, organizational commitment, communication, and problem solving, whereas it has been negatively correlated with employee turnover.[25] Gillespie and Mann[24] found that 3 factors predicted 67% of the trust employees have in their leaders: (1) consulting team members when making decisions, (2) communicating a collective vision, and (3) sharing common values with the leader. This potential for increased trust between ATs and their team physicians likely creates an environment that allows for the anecdotally reported patient-centered care and treatment approach.

In the academic model, participants also described a role congruency that existed within their organizations. Again, these ATs discussed their ability to work for an individual who could put the medical needs of an athlete first. The statements from participants in both models seem to suggest a strong leader-member exchange (LMX). The LMX theory tells us that leaders develop high-quality social exchanges with some members of the organization that are based on trust and liking.[26] The social-exchange relationships create a perceived obligation in employees to respond to their leader's trust and liking through "citizenship behaviors" and good performance.[26] These LMX relationships create a type of social capital for organizations that may influence overall organizational performance. High-quality relationships between leaders and members of the organization may give organizations a competitive advantage in retaining and motivating talented employees.

Participants working in the medical model also discussed how their reporting structure enabled them to maintain balance between their work and personal lives. This observation was consistent with the comments of Laursen,[14] who suggested that transitioning away from the traditional organizational hierarchy of a sport model to a more patient-centered model can greatly improve the work-life balance of ATs. Athletic trainers working in the academic model did not describe their work-life balance as positively as those employed in the medical model. However, both AT groups discussed role conflict; perhaps the notion of wearing "2 hats," as described by many in the academic model, provided a greater challenge to attaining balance between work and personal responsibilities.

In the medical model, participants believed they could find work-life balance, which was not the case among those working in the academic or the athletics model.[13,17] Some participants working in the medical model discussed how their organizational infrastructure mandated advance notice for any schedule changes to practices or games. This notion of a better regulated schedule should be more closely examined and potentially developed into formal policies. Scheduling is often cited as a barrier to work-life balance,[4,5] and establishing formal policies would potentially alleviate the burdens on ATs employed in the collegiate setting.[11]

Challenges of the Models

Long work hours and limited time off in the summer emerged as catalysts to work-life balance concerns in the academic and athletics models. Interestingly, the established policies of the medical model helped reduce the spillover and effect of the long hours and need for increased medical care during the summer. That is, medical care policies and work schedules used in the medical model appeared to buffer ATs from becoming overworked. Our findings give credence to the discussions of Laursen[14] about how the medical model can positively affect ATs and also support the claims of Mazerolle et al,[11] who suggested that medical care policies and guidelines may help ATs and sports medicine staff create balance and satisfaction in the collegiate athletics setting. Struggles with work-life balance in the academic model illustrate the effect of role overload; that is, too many job responsibilities can severely affect the time available for outside interests and obligations. Moreover, those demands can exhaust ATs and potentially lead to burnout or thoughts of leaving their position.

Role strain, especially interrole conflict, emerged for ATs working in the academic model. This finding was not surprising, as role complexity and strain have been reported among ATs who had additional responsibilities, including teaching and clinical supervision.[27] The time demands necessary to succeed as an instructor (classroom or clinical) also stimulated challenges with work-life balance for this group. Again, this finding was not unanticipated, but it supports the need for ATs to have a full understanding of their roles and expectations in order to succeed. Some of our participants highlighted role ambiguity early in their careers, as they fully understood patient care but did not know how to allocate and distribute their time in the workplace. In fact, their duties often overflowed into their personal lives, as they needed more time at work to adequately fulfill those roles, which left less time for outside activities and interests.

Not surprisingly, participants from both organizational infrastructures discussed experiencing intersender conflict specifically related to their interactions with coaches. Many

participants noted that their own expectations and goals were sometimes in direct conflict with those of the coaches with whom they worked daily. A major component of any organization is goals,[8] which are the product or outcome of workplace action.[28] The difficulty in establishing organizational goals is that many individuals may have different opinions on what the outcome of workplace action should be. Individuals and departments within an organization may have goals that conflict with one another. Likely, a coach would have a goal of a winning season, whereas an AT's goal would be to ensure the safety and health of all athletes. These dichotomous goals probably explain the intersender conflict that our participants experienced and also the pressure that ATs working in the academic model experienced to return players with concussions to activity.[23]

The benefit for ATs working in the medical and academic models is that the leader of their organizational hierarchy is more likely to have goals that are closely related to their own. In this respect, for ATs working in the medical or academic model, potential conflict with coaches is unlikely to result in their jobs being in jeopardy over disagreement with return-to-participation decisions. The recent interassociation consensus statement detailing best practices for sport medicine management in secondary schools and colleges described the potential conflict of interest for ATs or team physicians employed by athletics departments.[29] Recently, researchers[14,30] have advocated for ATs and sports medicine departments to be structured within medical units rather than athletics departments. The authors suggested that this organizational infrastructure would potentially reduce conflicts of interest in athlete care. Whereas these articles were based on intuitive conjecture, Kroshus et al[23] provided empirical evidence highlighting the conflict that ATs working in the athletics model experience.

The interrole conflict that our participants working in the academic model described is probably explained by role-conflict theory. This interrole conflict could also explain why ATs working in the academic model did not view work-life balance as a benefit of their model.

LIMITATIONS AND FUTURE DIRECTIONS

Continued research is needed to better understand the medical and academic model infrastructures. As presented, we examined the 2 models by studying ATs working in each model. Future researchers could conduct focus-group sessions that include multiple members of the same athletic training staff to help triangulate the findings of this study. A case-study design could allow for a more in-depth investigation of the organizational infrastructure and its effects on workplace atmosphere, subculture, and other concerns, such as work-life balance. We also presented only the ATs' perspectives on employment within the 2 models. Future investigators should include supervisors and coaches in addition to ATs to understand the care provided to the student-athletes, the level of satisfaction, and the workplace atmosphere. Finally, we presented data gathered at 1 time point. As suggested, a longitudinal perspective may provide a more thorough understanding of professional commitment, satisfaction, and role continuance for ATs.

CONCLUSIONS

As best practices and ways to advance the athletic training profession continue to be examined, we must evaluate the infrastructures in which we provide medical care. The athletics model represents the most common infrastructure in collegiate athletics; however, medical and academic models exist. Our findings suggested that the medical model can support better alignment for patient care and the wellbeing of ATs. The academic model also has perceived benefits; however, as with the athletics model, role incongruence exists because of supervisor incompatibility. That is, an academic dean or athletics director may not understand the roles and responsibilities of ATs and, therefore, may not serve as an appropriate supervisor.

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