The Elephant in the Room: Adequate Supervision, Not Direct Supervision

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lephant in the room, you say? What elephant?

- Graduate program directors and potential employers calling for reference checks on prospective hires, asking, “How does so and so function on their own?” and “How is so and so in independent situations?”
- Dedicated and insightful colleagues bringing the issue up for “discussion” at virtually every professional meeting and conference I’ve attended in the past several years.
- Undergraduate athletic training students describing how “stripped away” their current clinical education feels since their well-designed and legal “first aider” experiences have been taken away from them.
- Graduate educators and supervisors reporting that newly certified graduate assistants need considerably more time, experience, and mentorship to improve their decision-making skills and autonomic performance.¹

Enter the sound of an elephant trumpeting—at this point, loudly. We all hear the trumpet call and fully see the elephant in our midst, yet we often find it easier to pretend we don’t, and we typically resign ourselves to water cooler talk, private exchanges, and tepid whispers in the hope that the elephant will quietly go away with minimal suffering or collateral damage. But if left alone in a room to its natural curiosities and needs, an elephant can—and will—do considerable damage. Ignore the elephant just enough, and it is sure to do some unforeseen yet significant destruction to the environment and its occupants. It is time to pay stern attention to the large pachyderm in our midst making considerable noise in our collective rooms; it’s time we stop skirtsing the difficult conversation that this contentious issue deserves.

My friends, it is time to address the elephant known as the “direct supervision standard” in athletic training education before it makes an untenable mark on our educational process and thus, by extension, on our profession.

Regardless of the professional position you currently hold, you undoubtedly know by now that according to the most recent accreditation standards of the Commission on Accreditation of Athletic Training Education (CAATE),² athletic training students must be “directly supervised” at all times during their clinical education. However, you may be surprised to know that a definitive follow-up edict was passed down in spring 2012 that effectively outlawed any variation of “first aider” policies that many athletic training education programs had developed in good faith to satisfy the needs of their insti-
tutions, compliance with the standard, and, to be honest, a degree of independent experience for upper-level students needing to develop their professional competence and confidence. The arguments about the rightness or wrongness of the policy have been lively and consistent since the policy’s implementation a few years ago, and, to be frank, most of the comments have supported the sentiment that the one-size-fits-all, black-and-white standard requiring such direct and proximal supervision of all clinical experience is not in the best interest of our educational mission, nor our profession. There, I said it.

To be clear, I also do not know of anyone who longs for a return to the way it was, whereby athletic training students were doing the jobs of professionals and getting little to no direct supervision or meaningful direct mentorship. I don’t know of anyone who’s calling for a complete abandonment of the direct supervision policy, but I do know countless educators who are making rational and credible calls for a change to “something in the middle.” After all, just how many things in life fall into simple dichotomies of choice—right versus wrong, good versus bad, effective versus ineffective? In my experiences, not too many.

Thus, it is time for the CAATE to reconsider the all-or-nothing direct supervision policy that currently dictates much of what athletic training educators and clinical preceptors can and cannot do in the process of the professional and clinical competence development in tomorrow’s practitioners. Why can’t there be numerous models that ensure patient safety and outcomes, student learning, and the development of professional responsibility, all with different flow, specifics, and logistics relative to the institutions that operate them? What’s wrong with having a middle ground?

Looking at it another way, I find it just a bit ironic, weirdly paradoxical even, that in today’s evidence-based culture, we have no evidence available to us that infers that our current direct supervision policy is the “best” way to educate and develop autonomous, critical, and well-thinking clinicians. In athletic training education, there is no evidence (that I’m aware of) that supports the pedagogical superiority of our current direct supervision. Obviously, this raises the question of the inquiring mind, “just where did this policy come from?” Yet, this policy is mandated to us by the current standards of accreditation. In contrast, the passionate water cooler talk engaged in by many athletic training educators, employers, or supervisors seems to suggest that anecdotally, at least, the current direct supervision standard is actually having a concertedly negative effect on professional development, particularly as it pertains to confidence, decision making, autonomy, and critical thinking.

Even more bothersome than this evidence-based pedagogical paradox is the following quagmire: because all accredited athletic training education programs have to follow the same standard regarding clinical education to be compliant, it is now impossible to conduct any type of comparison-based outcomes project that might examine the potential effectiveness of other supervisory models in clinical education. Think about that for a moment—in effect, it is essentially illegal to conduct pedagogical research on any type of other supervisory model that doesn’t completely fall into line with the current standard of direct supervision. The end result is that an accreditation-induced monopoly has been instituted, precluding creative and effective initiatives from being developed by talented and energetic educator–scholars in athletic training education. Aside from unethical or potentially dangerous designs or theories, I can think of no other example in clinical practice or education in which such an off-limits research reality exists.

With all due respect to the current “supervised autonomy” program being put forth by the Executive Committee for Education’s Professional Education Council (PEC), I do not think that simply rebranding or repackaging a pedagogical strategy or technique is the answer to the negative consequences that direct supervision may already be producing. I applaud the effort to provide effective and creative ways to promote clinical competence in developing entry-level practitioners, but, to be frank, there really is nothing inherently new in the idea of supervised autonomy for clinical educators to get excited about. In my mind and experience, supervised autonomy is what excellent clinical educators already do every day—they contextually decide what each individual student is capable of doing safely and effectively, not only when, but where as well. But they don’t have to be in “visual and physical proximity” at all times to do what they’ve already been doing well for a long time, likely with dozens or even hundreds of students and novice clinicians in their careers. For example, Scriber and Trowbridge made a fantastic argument for “guided autonomy”
in their 2009 critique on direct supervision by pointing out that the direct supervision policy precludes athletic training students (who aren’t being directly supervised) from (1) doing things on, to, or with athletes that they have already been graded on as “proficient” because of the learning over time and other existing clinical education standards, and (2) doing things like stretching, taping, bandaging, and applying ice bags that any citizen can already do legally, including coaches and parents.

More irksome to me still is the operational definition of and rationale for supervised autonomy, which is largely anecdotal and exaggerated, that is wrought with paradoxes and lacks strong empirical evidence, and contains many theoretical inconsistencies that, in the end, fails to offer concrete support for supervised autonomy as “the best evidence method” for clinical supervision in athletic training. Furthermore, this mostly theoretical model does not change or challenge the rigid and overly constraining CAATE direct supervision standard in any meaningful way—it doesn’t allow for clinical context (time and space); student level, ability, or maturity; preceptor responsibility or expertise; or program or institutional differences to factor into the equation in any way that says, “I’m different.” Highlighting my concerns with the rationale and justification of the supervised autonomy model, one of the seminary pieces from medical education cited in the PEC’s presentation explicitly states that “current supervisory practice in medicine has very little empirical or theoretical basis” and specifically calls for more structured and methodologically sound research projects to be performed on various models of effective supervision. This is a great call to action for medical education research, but remember, such an exciting research agenda is now impossible in athletic training education due to the tone, text, and spirit of the direct supervision standard.

Was our old way of doing things before direct supervision perfect or proper, even? Of course not—it was wrong in many ways and, in retrospect, disturbing to consider the then-standard practice of students putting in more than 1000 clinical hours in the name of clinical education, freely doing the job that paid professionals should be doing, and far too compromising the safety of our patients—those points I do not argue, nor do I call for a return to those practices. Students do need to be supervised, mentored, and challenged in appropriate and contextually relevant manners, but they also need to learn in real time and develop genuine autonomy and confidence to make decisions and mistakes and to reflect and build on their collective experiences to develop into competent entry-level clinicians.

An ancient Kashmiri proverb says, “Until a physician has killed one or two, he is not a physician.” That sentiment suggests that students need to make mistakes in order to grow and mature as clinicians, and they need to have pressure put upon them without knowing their decisions are always, in reality, virtual or simulacra because they have someone in proximity who can and will trump those decisions. Students require the full context of clinical practice to appreciate the totality of the responsibilities and servitude they will face when they are on their own, a month or 2 after they graduate and start working as a certified athletic trainer in some facility. Programs and educators need to be given the responsibility and autonomy to develop, implement, and track graded and diverse supervisory models that prove to produce favorable student-learning outcomes and competent clinicians while also ensuring patient safety and outcomes and minimizing institutional liability. In short, those involved in the education of athletic trainers should “ensure that trainees work within their competencies and that they are adequately supervised when acquiring new skills.” We have to appreciate and honor the notion that one size does not fit all when it comes to learning and growth—not in K through 12 pedagogy and not in medical or allied health education. All things considered, adequate supervision may just be a better, newer standard of educational practice.

You may ask, do we have outcomes for the way it used to be? Do we have outcomes from the old days, which may offer some empirical support for doing things differently? In a way, we do—in the thousands of outstanding clinicians that matriculated before the direct supervision policy went into effect. Although I don’t know the specifics of their relative educations, I’m pretty sure that practicing athletic trainers and experts in the field such as Kevin Guskiewicz, Marjorie King, Douglas Casa, and Julie Max, among thousands of others, have turned out fine without direct supervision governing their undergraduate education—these athletic trainers are competent, confident, caring, fallible, and yet supremely professional. Most assuredly, all of them made their share of mistakes, or “killed a patient or two,” along the way toward their current po-
positions as extremely accomplished professionals.

As our current epoch finds us increasingly pondering a move toward a master’s degree as the entry-level requirement for the profession, let us first directly pay heed to the elephant that’s currently in our rooms, wreaking havoc and commotion. Before we consider moving to a degree change that will require considerable revisions in policy and curriculum for the majority of programs, let’s have a thoughtful and critical conversation about rewiring the CAATE’s direct supervision policy; let’s seriously consider a supervisory policy that contains the sentiments, latitude, and values inherent in a model of adequate supervision.

For clarity, I’m in favor of an entry-level master’s requirement for many reasons, but not if we don’t first alter or amend the direct supervision policy with one that has more potential for meaningful and constructive growth than the supervised autonomy model being touted as the answer. Requiring 21- to 22-year-old students who have a minimum of 2 to 3 years of formal athletic training education in hand—an impressive dossier containing myriad didactic and theoretical lines of knowledge from the various sciences that inform our profession; hundreds of hours of graduated, highly structured, and supervised clinical experiences; and documented proficiency in literally hundreds of skills—to return for a fifth, or even a sixth year of formal education with the same obstructive and restraining direct supervision policies in effect as in their first 3 years seems to be nothing short of irrational and ill informed. Certainly, there are times, places, and instances whereby fifth- or sixth-year athletic training majors can be trusted and empowered to activate an emergency action plan and provide acute care, stretch an athlete’s hamstrings, tape and brace, apply ice or heat, or do an initial evaluation without being directly supervised. Certainly, uncertified athletic training graduate students who were deemed proficient to select and apply ultrasound and electrostimulation in their prior 3 years of study and have since safely used these techniques hundreds of times under direct supervision can be trusted to safely apply those modalities to a patient–athlete while their preceptor is beyond the distance deemed appropriate for visual observation and physical intervention.2

Like anything that’s deemed worthwhile, it won’t be easy, but let’s tackle the elephant that’s in our rooms now before we make another monumental change in our educational procedures by inviting another elephant into the room with us. Three’s a crowd.

REFERENCES