Direct Supervision and Independent Learning Can Coexist: Not a New Concept

Over 20 years ago, I was an athletic training student at a state institution with an accredited athletic training education program. That NCAA Division II football school had a long-standing athletic training tradition. One particular clinical semester, I was selected to be the football senior athletic training student with 2 junior subordinates, which is quite a bit of responsibility for a student. Many athletic trainers of my generation boast because we, as athletic training students, had tremendous independence and enormous responsibility for all aspects of an athlete’s health care. We learned by doing, and we learned the hard way. Can students still get that kind of experience?

As students then, we performed all of the prepractice preparation—from taping to wound care. We were in charge of organizing all supplies for practice and games, as well as preparing the locker room and sideline, with little to no help from our mentors. In addition, we had to ensure we had all the necessary supplies for travel. When we arrived at an away event, we needed to be resourceful. Our tasks and questions included: unload the van and find the ice source and the water. Get everything in order before the players arrive. Where’s the field entrance? Where’s the locker room? Where do we tape?

As students, we were evaluated, criticized, praised—and sometimes berated—but we learned. My instructor considered it his duty to ensure we left his institution prepared. And we were! He was a former Division I-AA football player, former President of the National Athletic Trainers’ Association (NATA), and an NATA Hall of Famer. He knew if we could work for him, we could work for anyone. He was absolutely correct! This was vintage clinical education, the old way.

Current athletic training students could never receive this type of quality clinical education; yet, they still meet the direct supervision guidelines as defined by the Strategic Alliance Statement on Athletic Training Student Supervision. Impossible! Not impossible! Perhaps unlike many athletic trainers from my undergraduate era, I was consistently and directly supervised. We were accountable, stimulated, challenged, stressed, and, most importantly, supervised. In retrospect, I cannot recall a situation where the athletes were at risk had I made a poor decision. I did all of the evaluations first, prescribed treatments, and performed rehabilitation protocols. I performed all of the on-field evaluations during practice. The difference was that
my instructor double-checked my decisions, and I prayed they were right. You see, the consequences (he called it feedback, I called it consequences) of being wrong were not pleasurable but were immediate, as all feedback should be for optimal learning. Practicing bad habits was not an option. Rarely did a mistake go unnoticed, and if it did, I actually felt as if I had dodged a bullet. I felt pressure, isolation, and stress, which further developed my critical thinking skills and ability to be independent. But the athletes were protected from my inexperience because I was directly supervised.

The point of my story is that direct supervision and the creation of an independent, entry-level athletic trainer can coexist. The critics of direct supervision in athletic training clinical education may argue that the degree of supervision I received should have detracted from my learning. On the contrary, Seegmiller,1 in his 2003 publication, “A Model for Clinical Education in Athletic Training,” provided ample evidence of such learning and concluded, “Structured clinical experience leading to supervised field experiences will help students transition into their professional roles as allied health care providers.”

My undergraduate athletic training experience exemplifies what Sexton et al2 described as “supervised autonomy,” and his philosophy is what I strive for in the preparation of our athletic training education program’s preceptors. This perfect phrase for optimal clinical instruction is not a new or difficult concept: “Supervised autonomy allows for direct supervision of the student while mentoring the student to foster the independent, but guided, application of clinical proficiencies and critical thinking skills to match the individual student’s level of clinical competency.” Students do not need to be isolated while at practice or travel alone to learn autonomy or clinical independence. What students do need is a clinical instructor who has learned and is willing to put into practice the philosophies of supervised autonomy, while maintaining the safety of the athletes.

As educators, we need to embrace the concept of direct supervision with supervised autonomy. Knight,3 in his article “Progressive Skill Development and Progressive Clinical Experience Responsibility,” perfectly stated, “Autonomy is a matter of attitude—not proximity.”

Knight3 continued:
There are many great clinical instructors who have mastered the art of evaluating injuries through the hands of a student. They stand back physically, but are fully invested mentally, in the evaluation process. They watch the evaluation carefully, noting the patient’s response to the intervention of the student. They may suggest at times that the student perform this or that in addition to what the student has already done. Allowing such autonomy does not compromise patient care, if the student has been properly prepared for the situation, and if the instructor is attentive in spite of being silent.

For educators to implement these simplistic techniques, we must renounce the antiquated notion that students must be alone to be autonomous. In addition, educators who understand the theories of Knight,3 Sexton et al,2 and others agree that in terms of athletic training student development, unsupervised clinical experience simply does not maximize learning. As stated in the Strategic Alliance Statement on Athletic Training Student Supervision,4 “Clinical instructors and supervisors should provide students the appropriate freedom to engage in critical thinking and decision-making in a suitable environment.” Above all, supervision by an instructor or supervisor must be sufficient to ensure that each patient receives competent and quality care. I have yet to encounter a legitimate argument for undirected supervision. Such independence must provide educational and athletic health care benefits greater than or equal to the CAATE’s recommendation. The rationale of “staffing” is unacceptable and stifles the advancement of the profession.

If we create an environment of supervised autonomy, all stakeholders will profit, and we will prepare students to perform as apt entry-level athletic trainers. In addition, students will not be abused or used as a work force. Good employers will increase staffing, and if they don’t, we must be prepared to seek alternate employment, as progress can be painful.

The solution is not difficult; the words of Sexton et al2 and Knight3 provide most of the answers. If you believe that your students need more independence, give it to them. Stay in your office and supervise through the window, sit in the stands behind the bench, or simply stand back and “be attentive in spite of being silent.” When you travel, bring a student but relinquish control. Intervene on behalf of the athlete and student only as needed. Remember that “Autonomy is a matter of attitude—not proximity.”

The principles of supervised autonomy are not perfect, but they can satisfy many of the issues described by the Commission on Accreditation of Athletic Training Education (CAATE) and mollify the complaints of those reluctant to change. We focus all too often
on how to allow a student to function alone and independently, while bending the rules just enough to be compliant with the CAATE. We call students “First Responders” and “First Aiders.” We have students sign contracts and create job descriptions to protect the program so that students can travel without supervision. Perhaps we need more direct focus on what we, the clinical educators, can do to improve the most valuable part of an athletic training student’s education.

I believe mastery of the concept of supervised autonomy is the solution for and the evolution of clinical athletic training education.

REFERENCES


