Politics or Progression?

In the editorial published in the March/April 2014 issue of *Athletic Training & Sports Health Care*, Kaminski correctly pointed out that change is coming. In fact, it is already here. Several online and conference sessions have been dedicated to the work of the National Athletic Trainers’ Association’s (NATA) Executive Committee for Education, which led to the white paper titled *Professional Education in Athletic Training: An Examination of the Professional Degree Level*. At the Eastern Athletic Trainer’s Association’s regional meeting I attended this year in Mashantucket, Connecticut, the speakers indicated that the white paper was only a position paper and that no decision had been made about the minimum degree level. As indicated in the white paper, the NATA is reported to have investigated the question of the entry-level master’s degree (ELM) three times previously. I can imagine a child asking his or her parent to stay up late again and again, but if the circumstances change, for example after the child’s birthday, perhaps the answer will be different. This time, the Commission on Accreditation of Athletic Training Education, the NATA, and the Board of Certification (BOC), which all have different levels of influence and responsibility, will accept the professional degree at the master’s level (ie, ELM).

Athletic trainers in the United States have fully subscribed to profession-based education since 2004, which marked the end of the internship route. Many other professions subscribe to an accreditation process to determine eligibility for entry to the profession, association, or certifying examination. The question explored over the years is at what degree level the minimum standard should be set.

In Canada, athletic training education is established at the bachelor’s degree level. I do not anticipate that this will change in the near future. Physiotherapy education in Canada is accredited and delivered at the master’s level. Of note, the vision statement of the American Physical Therapy Association (APTA) indicates that “by 2020, physical therapy will be provided by physical therapists who are doctors of physical therapy.” Revised in early 2014, the *Evaluative Criteria PT Programs*, published by the Commission on Accreditation of Physical Therapy Education, indicates that the deadline for programs to upgrade to the Doctor of Physical Therapy degree level is December 31, 2015. Furthermore, it indicates that the
ultimate deadline before programs would lose an accredited status is 2017.4 The relatively new clinical doctorate seems to be an effort to compete with other health care providers. Therapists calling themselves doctors and doctors calling themselves physicians5 may confuse people. In an effort to protect professions and titles and prevent patient confusion, some legislative efforts exist that limit or ban the use of doctor, unless the individual clearly indicates what kind of doctor he or she is. Most of us can probably remember squabbles or competition between doctor of chiropractic versus medical doctor, physical therapist versus doctor of chiropractic, athletic trainer versus physical therapist, kinesiologist versus athletic trainer, and registered massage therapist versus athletic trainer/physical therapist. I have probably left some permutations off this list; however, some interesting history on some of these competitions exists.6

APTA provides no justification for the move to the Doctor of Physical Therapy degree—it is just a vision. I was unable to view any data to support APTA’s position. However, programs are buying in, and most programs have already transitioned to the entry-level doctorate. In this vision, other good news exists for health care and patients, as APTA lists the following as one of its principles:

Collaboration. The physical therapy profession will demonstrate the value of collaboration with other [health care providers], consumers, community organizations, and other disciplines to solve the health-related challenges that society faces.7

This statement, as well as the NATA and APTA agreement in 2009 on the recognition of the educational quality of athletic training, bodes well for these organizations to not only be less antagonistic, but also for each to limit its criticism of the other’s skill, knowledge, and work environments.

The bottom line is that all health care professions require profession-based education. Each profession has some level of accreditation or certification examinations based on competency established through role delineation analysis. However, different degree levels exist among the professions. The white paper states that “peer healthcare professions” are trained at the graduate level and that “graduate level education in healthcare professions was predictable and has reached an irreversible critical mass.”2 Regardless, a justification to come to some determination on the degree level for professional education is needed. The white paper lists 4 reasons for the basis of the examination on the issue:

(1) the increasing complexity of the current and future healthcare system;
(2) the growing need for athletic training-specific patient outcomes research; (3) an expanding scope of requisite knowledge, skills, and abilities while continuing to strive for depth in athletic training-specific knowledge, and; (4) the need to ensure proper professional alignment with other peer healthcare professions.2

I cannot determine the benefit of the professional degree to tackle the increasing complexity of the health care system, nor can I see how the professional degree leads to an improvement in research associated with athletic training-specific patient outcomes. In fact, none of the 11 key findings indicate improvement on this area of research or any research involving athletic training.

The contribution of research to the methods of athletic training are important. We need more research than just outcome-based projects, although that would go a long way to add to the justification of our presence in the health care community. Other research is also crucial, such as knowing how to decrease pain or increase range of motion, or knowing who gets more anterior cruciate ligament injuries so we can target our prevention programs. The realization that research and understanding data are crucial has led to the implementation by the BOC of evidence-based practice to our continuing education requirements.5

A question arises around how this evidence will be developed. We can look to other likeminded health care professionals, but we also need to develop this information ourselves. What is the best educational model to do so? What then becomes the implication of the ELM? Certainly, we will have a higher trained professional, but the effects on research production may not have been given due consideration. Will ELM students be aids to researchers completing their projects? Will ELM students complete a thesis, thus adding to the research base? Will ELM students generate an interest in research, and if they do, will a non-thesis-based ELM degree contribute to PhD eligibility for the ELM graduate? A capstone project has been suggested,9 but these projects are usually not of
high enough quality to progress the profession with regard to research. These are important questions that the athletic training community needs to consider as it speaks for or against the educational direction.

Of course, the ELM could improve some aspects of athletic training. For example, those certified athletic trainers who usually pay for their master’s degrees through assistantships may be out of an opportunity, but this shortfall could be made up from certified athletic trainers seeking employment. The question of whether institutions will be willing to pay for this employment or if the salary level is above that of a frontline worker (i.e., $40,000) remains to be seen. A residency program may not be a good answer. Reasonable potential exists that some athletic directors and coaches will under-appreciate or undervalue athletic trainers. Considering the likely cost increase for the student, an analysis of the return on investment from the employer/employee perspective needs to exist.

Another point to be considered is the improvement of the athletic training practitioner. Most would agree that the ELM student will be more mature. In the white paper, higher scores on the BOC examination are reported in the ELM group; with 27 master’s and more than 360 undergraduate programs in the United States, more examination of this point is necessary. However, it remains to be determined whether these components lead to better practitioners or better jobs and pay.10

The athletic training constituent in the United States might also consider the international perspective. Legislation in most or all states indicates the requirement of a bachelor’s degree or equivalent or higher. Although no immediate need to open these practice acts seems to exist, will there be pressure to consider the expanded knowledge that a master’s degree brings or pressures to remain competitive with other peer health care professions? In turn, what does this mean for the long-term growth of athletic training within and beyond the North American borders?

In the white paper overview, the project work group wrote that they gave consideration to aspects that will “best place our profession in a competitive advantage 5, 10, or 20 years in the future.”2 Rightly so! It now falls to the athletic training community at large to determine whether what they propose will in fact do this. Looking back at the 4 criteria, it seems that the last one (i.e., to align with other health care providers) is of paramount importance. This is not a bad thing, but let’s understand all the implications. Read, talk, think, and then talk some more. The decision might have been made, or perhaps it is as stated and still a discussion? If so, discuss it. The decision might be the best thing since the end of the internship route.

REFERENCES