

Academic Medicine in Athletic Training

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One of the inevitabilities of reaching middle age is the need to visit the doctor more regularly. I'm lucky to live in a city with remarkable health care options, and I have a job that affords me quality health insurance with incredible access to care at an academic health center in my community. I see two elements that make this care so strong: (1) a R1 research university dedicated to staying on the cutting edge, and (2) a school of medicine and public health committed to teaching the health care providers of the future. These two elements are interwoven into the mission of the campus, the school of medicine and public health, and the health care facilities. The clinics and hospitals in our community are educational environments dedicated to learners in all phases of care. I entrust my own care and the care of those closest to me to providers practicing this special brand of medicine: academic medicine.

As a patient in this setting, I understand that being seen at an academic health center means that learners will participate in my care, and any visit will likely include either a learner or newly minted (eg, resident) health care professional. As a patient in a teaching clinic or hospital, my radiographs, laboratory work-ups, treatments, and even surgical interventions can be used

to further the education of those in training. In exchange, my health care is guided by faculty and staff attending professionals who are attracted to the academic setting by a love of teaching, a dedication to research, and a desire to employ this research in evidence-guided practice as soon as possible.

I recently asked a physician colleague if she ever tired of having learners in her clinical settings or grew weary of needing to help drive or participate in research. She told me: "Having learners is always harder and more work, but [that] is what it means to be in academic medicine." She added, "If I didn't want these duties and additional obligations, I would practice in a private setting without learners."

I found myself impressed with these lofty goals and felt good that, as a patient, I was part of a larger system of academic good. It also got me thinking about athletic training. Although learning has always been a stated goal, have we fully embraced the idea of our clinical settings as academic health centers? Does athletic training need a more concerted academic medicine approach?

As our profession completes the transition to master's degree level training, I believe that our mindset about the needs of learners and the clinical settings where they are trained must take a major step for-

ward. If we have learners in our athletic training facilities, we can no longer practice athletic training in the same way. We must practice academic athletic training. Embracing an academic learning approach similar to academic medicine will help further integrate athletic training into the broader health care landscape.

Academic athletic training is not a phrase that I hear tossed around much, and I only started using it in recent years. Historically, it seems that the only qualification to guide a student in clinical education was simply to be an athletic trainer. There are several historical reasons for this belief. Maybe the previous internship route to certification contributed to the expectation that students should be ubiquitous in all athletic training facilities, or the increase in educational programs that followed created a need for student placement, giving the impression of abundance. The reality is that athletic training programs (mine included) have placed students into settings primarily out of convenience, historical practice, and the presence of available preceptors. This availability, coupled with the recognition that athletic training students could help with certain tasks (eg, ice, water, and field set-up), often trumped the need to be a quality clinical teacher and, therefore, the needs of the learner.

Is our profession willing to break with traditional clinical placement models, move beyond the limitations of convenience and convention, and adopt a true academic learning model? An academic athletic training approach is essential to the new, immersive clinical experiences required in the 2020 Commission on Accreditation of Athletic Training Educa-

tion Standards.¹ First and foremost, athletic training students will need to be fully immersed in all aspects of patient care in clinical settings. These settings should fully embrace the core competencies² for health care professionals: provision of patient-centered care, working in interdisciplinary teams, use of evidence-guided practice, dedication to quality improvement, use of health care informatics, and professionalism.

Such a transition to an academic athletic training approach will require a paradigm shift. Practicing athletic trainers in these academic athletic training models must embrace the core competencies, be guided by a desire to teach in the clinical setting, and promote learning in a planned and systematic way. We can no longer leave meaningful patient encounters to chance, and the quality of the clinical teacher must outweigh the convenience.

A troubling trend in recent years is the number of students who are encouraged to find clinical placements on their own. Clinicians on my campus field multiple calls every semester from such students. Not calls from Program Directors or Clinical Education Coordinators, but from the students themselves asking about clinical placement. I have heard discussion of a potential database or matching service to align students with locations. Although this may be feasible, it is the responsibility of the program to properly appraise and train preceptors, analyze clinical sites (everything from policy to facility standards), and secure appropriate affiliate agreements. We run the risk of falling into the exact same trap of convenient over quality clinical education. Adult learners deserve some choice, but that choice

should be from a pool of appropriate preceptors and clinical locations dedicated to learners instead of a list of places “willing to take a student.” There is a hard truth that we need to accept; not everyone should be a preceptor, and some settings don’t meet the standards of an academic health care facility. Moreover, it is the responsibility of the program and the university to leverage available resources for clinical education and site development.

The overarching goal of our educational programs is to improve the quality of care our graduates provide to their patients. By producing athletic trainers in programs dedicated to the core competencies and fully embracing the academic medicine model, we will elevate the greater health care good. As educators, we are only one degree of freedom removed from the patients our students will care for as health care professionals. This proximity comes with tremendous responsibility. As an educator, I wish that my mistakes would only be mine, but that is naïve. We can pass our mistakes along to our students. We owe it to the patients who receive care to prepare our students in the best possible clinical environments. These environments need to practice academic athletic training.

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