The year is 1987, and I’ve just graduated with my bachelor’s degree and shiny new ATC plaque in hand; I’m lucky enough to secure work as an outreach athletic trainer for the National Center for Sports Medicine in Arlington, VA. At that point, I didn’t even know what an “outreach” athletic trainer was, or what skills or knowledge were required to be successful in this new and emerging professional setting. In short time, I realized that I’d be working side-by-side with five licensed physical therapists (PTs), a licensed PT assistant, and an exercise physiologist while treating types of patients and injuries that I hadn’t yet experienced in my undergraduate education. On top of that, the clinic was tightly integrated with eight high-profile orthopedic surgeons, numerous nurses, medical assistants, and physician assistants who I was required to interact with on a regular basis as part of one of the premier sports medicine facilities in the region. If I was going to be an effective part of this dynamic and nascent sports medicine team, it was obvious to me that not only did I have to quickly learn my specific role and place as the first certified athletic trainer on staff, but also that I had to learn the roles and skills of each professional at the center, as well as teach them what I could contribute as a vital member of the team entrusted to provide the best care possible for our patients, most of whom incidentally, were not “athletes.”

In retrospect I now know that, largely because I was the first and only athletic trainer to work in this physical therapy clinic, I was abruptly thrust into what is now known as interprofessional collaborative practice (ICP). But despite this sudden and blunt immersion in ICP, I had no prior interprofessional education (IPE) to prepare me for these newfangled, on-the-job experiences confronting me from day one. To be blunt, not only was I personally in unchartered waters, so too were my colleagues who were initially most interested in what “ATC” stood for more than anything else. According to the World Health Organization, IPE is when “students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes” (p. 7). This represents a logical precursor to ICP, which is “when multiple health workers from different professional backgrounds work together with patients, families, carers and communities to deliver the highest quality of care” (p. 7).

In a recent edition of the Athletic Training Education Journal, the Interprofessional Education and Practice in Athletic Training Work Group published a formal commentary on IPE in athletic training, at the behest of the NATA Executive Committee for Education. Although the
authors take effort to disclaim any intention to serve as a directive for program implementation (i.e., accreditation standards), seeking rather to inform readers about the existing IPE literature and potential applications in athletic training education, their message bears considerable weight and potential influence on the way that future athletic trainers are to be educated. On the surface, the publication is a nice review of the various operational definitions, rationale, history, and summaries of some of the IPE research and practice from our colleagues in medicine, nursing, pharmacology, physical therapy, social work, and myriad other health care professionals typically involved in the hospitalized care of chronic and complex medical problems. Although the authors provide a nice summative table of the benefits and barriers to IPE from what’s reported in the literature, it is concerning that only two paragraphs of the more than eight pages of narrative are dedicated to athletic training specific issues—insight or application, real or postulated. To be clear, there are zero references to any original IPE- or IPC-focused research conducted with athletic trainers central to the thesis or analysis.

In 2014, Olson and Bialocerkowski published a systematic review of preprofessional IPE initiatives in undergraduate education that is of high relevance to the conversation regarding IPE initiatives and movements. Effectively reduced to a summary statement about the need for further research on the benefits of IPE by Breitbach et al., the critical findings of this timely systematic review are highly relevant to athletic training educators when considering the contextual relationships between athletic training education and the systematic review’s focus on preprofessional/licensure allied health education. In my reading of Olsen and Bialocerkowski’s paper, there are five distinct themes to be gleaned from their results:

1. There is a paucity of contextual and synthesized evidence on the effectiveness of IPE.
2. Most of the data reported in the literature on IPE programs and outcomes are from medical and nursing models, and because of inherent differences in scope of knowledge, pedagogical approaches, and practice domains, “IPE models should not be assumed as transferable into all allied health programs”.
3. There are large and obvious differences in students’ backgrounds and socioeconomic status, and, sadly, no evidence exists that documents the contextual differences between students’ differences/backgrounds and their IPE experiences.
4. None of the primary studies included in the systematic review reported any long-term outcomes related to changes in behavior, improvements in patient care, or administrative-level changes.
5. There exists considerable barriers to success of IPE programming, chiefly time, student exposure/background, lack of reliable information technology, a perceived difference in power and status between students in different fields, and low participation rates.

Olson and Bialocerkowski did report that IPE “works” in producing favorable “opinions” of the IPE among participants (perceptions) and, more so, that patient scenarios/simulations and clinical experiences in small groups seem to work best in changing short-term perceptions about other health care professionals’ roles and in improving communication and attitudes. However, the authors note that overall we lack an understanding of “what works for whom”, and that we know very little about how IPE works “in context” of the bigger picture of education and practice. In other words, IPE is, in the authors’ opinion, “a process, not an intervention”, and one that is too multifaceted and complex to study with simple intervention studies that ignore its complexity and context. Further, it’s clear that IPE studies have shown that implementing IPE has indeed been “feasible” in the institutions who have made it part of their curricula, but we just don’t know “how” it works, “why” it works, and how context will impact the desired outcomes. Given that the athletic training IPE commentary in the Athletic Training Education Journal mentions the potential for IPE to “improve patient outcomes” and “professional behaviors” numerous times, the data that supports point #4 above is of deep concern for athletic training educators already battle fatigued with chronic educational policy change and concurrent emphasis on evidence-based practice. More critically, if there exists no data whatsoever that IPE initiatives objectively improve patient outcomes or professional behaviors in athletic training education or practice (not to mention in our sister professions) and, at this point those lofty outcomes are merely hopeful projections loaded with potential, then how can we seriously consider requiring IPE as the next best thing for our profession and educational programming?