Academic Faculty and Clinical Staff: The “Growing Pains” of Education Advancement

Angela Perusek, EdD, ATC, and Malissa Martin, EdD, ATC, CSCS • College of Mount St. Joseph

Over the past 10 years, athletic training education has experienced dramatic growth in the didactic and clinical education of students. As a result of this educational advancement, new responsibilities have developed for the academic faculty, who primarily conduct the didactic side of student education, and clinical staff, who essentially administer patient care and assist with the clinical portion of the education equation. With any type of growth, natural institutional and professional “growing pains” occur that create opportunities for the academic faculty and clinical staff. These opportunities can be viewed by many as conflicts between the two groups on how best to educate students while still maintaining a good professional and working environment. As the education of athletic trainers evolves, conflicting issues are developing that must be addressed by athletic training education programs (ATEPs) across the country. These issues might have caused a lack of cohesiveness between the academic faculty and clinical staff. The lack of unification could be related to additional duties placed on traditional college athletic trainers and the control of the ATEP. The purpose of this column is to discuss issues associated with the growing pains of education advancement and to provide recommendations to resolve these concerns. In addition, it is important to note that the word conflict is used throughout this column as a descriptive term for the growing pains and should not be viewed as a negative feature of relationships within the athletic training profession.

Shift in Power

Many ATEPs are experiencing conflicting issues associated with their growing pains. One major issue is the formation of two separate departments, both administered by athletic trainers but with different goals and objectives. One is primarily concerned with the education of athletic training students, and the other is primarily concerned with providing clinical care for a diverse population of individuals. Starkey indicates that, before there were accredited ATEPs, there was only one athletic training department. Individuals in this department provided health-care services to athletes and educated athletic training students in a single academic and health-care-service program. The head athletic trainer, who was hired by the athletic department, was usually in charge of both the education program and the medical services. The assistant athletic trainers, who also were hired by the athletic department, helped with teaching and supervising students during practice and competitions and in the athletic training room. Classroom teaching was done by various athletic training staff members, and these individuals functioned as faculty. With the formation of accredited athletic training curricula, this single program was divided into two separate entities: (a) academic faculty and (b) athletic training clinical staff.

As a result of accreditation, the administrative control of the education program transferred from athletics to academics. Before accreditation, intercol-
legiate demands dictated the way students were educated and placed in the clinical setting, which caused an “athletic work mentality” in education programs. Once accreditation was established and academics took over the education of students, an “academic mentality” developed, wherein students’ placement in the clinical setting is determined by accreditation requirements, academic units, and the educational needs of the student rather than by athletic- and sport-coverage needs. For example, because of accreditation requirements, each athletic training student is placed with an athletic training staff member who is in charge of the student’s clinical-education experience and not necessarily with a sport that requires a great time commitment to medical coverage.

As a result of the academic mentality, three possible working structures can develop in the ATEPs: cohesive, noncohesive, and semicohesive. Some ATEPs work as a cohesive group, with both the academic faculty and the clinical staff making decisions concerning multiple areas of the curriculum. On the other hand, many educational programs operate as noncohesive groups in which athletic training staff has no input on any aspect of the educational curriculum, including clinical placement of students. In the middle, some ATEPs are semicohesive, sharing few but not all responsibilities for structuring the curriculum. Starkey reports that if the academic faculty and clinical staff do not work together, an “us versus them” mentality develops. Without strong integration of both groups, miscommunication about theories and techniques often develop, causing disunity and animosity between the groups. For example, according to accreditation requirements, students must first be instructed and evaluated in a formal classroom setting before employing a technique in the clinical or fieldwork setting on a patient or in “real time.” The athletic training staff might believe that the academic faculty is the instigator behind limiting the use of students in the clinical setting because this policy is enforced by the academic faculty. It might be perceived by the athletic training staff that the academic faculty is dictating to them the educational process they once controlled. These perceptions can promote disunity and animosity between the two groups.

This lack of cohesiveness between faculty and staff might also be influenced by the additional duties staff must shoulder in order to keep their approved clinical instructor (ACI) or clinical instructor (CI) status in accredited programs while meeting expectations for athletic health care. The next section provides examples of how personnel issues cause additional animosity among members of ATEPs.

Including ACI or CI in Athletic Trainers’ Job Descriptions

A personnel issue that can cause ill feelings among members of ATEPs is the expanding job descriptions of the clinical staff. Carr and Drummond explain that when an ATEP is developed, the athletic trainers providing health care for intercollegiate athletes usually become the program’s clinical instructors. According to Weidner and Henning, combining the caregiver role with instructional or supervisory duties, or both, renders the clinical instructor’s job description extensive and potentially burdensome. Martin explains that athletic trainers must now share time between athletic training students and clinical responsibilities, rather than concentrating only on patient care. For example, athletic trainers must review all injuries, discuss assessment techniques and treatment/rehabilitation protocols with the athletic training students, and complete student evaluations. Before accreditation these time-consuming duties, except for student evaluation, used to be completed solo by athletic trainers without much discussion or review. Before becoming ACIs or CIs, athletic trainers were not required to continually instruct students while providing health care, which made their job less demanding.

Martin suggests that in order to do both jobs properly, an equal balance between health care and education must exist. CIs must make a conscious commitment to the education program, as well as to the delivery of athletic health-care services. This does not mean, however, that CIs put athletic care second to student education. Rather, they accept the role of educator and develop an environment that encourages learning and professionalism.

Athletic trainers in a clinical setting of an accredited program should value their role as faculty in all aspects of their job, including the education and mentoring of students. Athletic trainers wishing to be CIs in an accredited program must develop a balance between the caregiver and instructor/supervisor roles to ensure that both jobs are performed to high standards.