Terminology: A Rose is a Rose, but According to Whom?

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part II of a series

Education reform has provided an exciting and necessary boost to athletic training education. Particularly in clinical education, though, new terminology has become a primary source of confusion among educators and regulators alike.

This two-part series has tried to clarify those terms, identify differences in their uses and provide interpretations of those terms. Part I examined terminology associated with the personnel and settings in clinical education.

Part II describes terminology concerning the types of, and processes in, clinical education. Readers can refer to the NATA Education Council Web site at www.cewl.com to find a recently revised/expanded listing of these terms and their definitions, synonyms and references. *(Statements in quotation marks in this article are taken from that site either directly or conceptually.)*

The Athletic Training Educational Competencies describe the cognitive, psychomotor and affective domains and clinical proficiencies that fall into one of 12 content areas that must be taught in CAAHEP-accredited programs. The clinical proficiencies synthesize similar cognitive, psychomotor and affective teaching objectives and describe them in terms of measurable clinical outcomes. As such, the clinical proficiencies are replacing clinical hours as the measure of a student's clinical progression and eligibility to sit for the certification examination and are the basis for a student's clinical education.

The student's clinical learning must include **clinical education experiences** and **field experiences**. Although both of these occur in athletic training practice settings, there are significant differences between the two.

clinical education experiences

Clinical education is where the clinical proficiencies are taught, practiced and evaluated and includes the classroom, laboratory and clinical settings. Clinical education requires the "constant visual and auditory interaction" between an Approved Clinical Instructor (ACI) and the athletic training student.

field experiences

Field experiences are similar to clinical education in that they occur in athletic training practice settings and require supervision, but that's where the similarity ends. Students fulfilling a field experience are directly supervised by an ATC or other health care provider appropriate for that setting and who can "physically intervene on behalf of the student or the patient."

In programs where all clinical athletic trainers are ACIs, there may be minimal perceived distinction between clinical education and field experience. All student exposures would be classified as clinical education.

Much of the confusion between clinical education and field experience stems from the apparent lack of supervision. In both clinical education and field experience, athletic training students are expected to have direct, on-site supervision. The use of walkie-talkies, cell phones and/or video cameras does not meet the JRC-AT or NATABOC definition of supervision.

In situations such as those previously mentioned and during instances where a student travels with a team or is not accompanied by a clinical supervisor where there is no direct, on-site supervision, the student assumes the role of a **first responder**.

first responder

A first responder has additional, specialized training that allows him/her to assist in the evaluation or recognition, stabilization, initial treatment and disposition of an individual who is injured or suddenly takes ill; these tasks are achieved using minimal equipment.

First responders are trained in first aid and CPR techniques. A first responder's responsibility includes referral to appropriate medical personnel or facility. An unsupervised athletic training student, therefore, would be limited to activities such as prophylactic taping, stretching, first aid and referral of injured/ill athletes. Without supervision, performance expectations and restrictions of the student can be compared to those of a coach traveling with the team unaccompanied by an ATC.

Other athletic training functions such as return-to-play decisions, modality or rehabilitation treatments are out of the realm of an unsupervised student. It is the responsibility of the institution that places the student in a first responder position to understand and accept the litigious risk involved. In these instances the institution must provide an appropriate position description with required qualifications for the first responder.

summary of differences

Supervision of an athletic training student occurs at two levels. The specific term used depends on the individual supervising and the situation in which the supervision occurs.

Direct supervision occurs when an ACI is planning, directing, supervising, instructing and evaluating an athletic training student in clinical proficiencies during clinical experiences. For direct supervision to occur, the ACI must be in constant visual and auditory contact with the athletic training student.

Field experiences occur when the student is in a clinical situation, working with patients/athletes and under the supervision of a health care professional who may not necessarily be an ACI but who is qualified for that specific clinical environment/situation. That supervisor is also responsible for planning, directing, supervising, instructing and evaluating the student and must be present to intervene and assure proper care is provided to the patient/athlete.

During any experience in which the athletic training student is not supervised, the student acts only as a first responder, not an athletic training student.

learning over time

The NATA Education Council and the JRC-AT use the term "learning over time." This is the process by which a topic is presented in a logical progression to the athletic training student. "Learning over time includes the addition of more complex information, stages of instruction such as introduction, in-depth understanding, technique instruction, application and modification of a concept or skill."

The JRC-AT requires that an ATEP be able to demonstrate that athletic training students are learning over time. Evidence of learning over time includes assessing students for their progressive development of skills from structured classroom environments to practical application in clinical environments.

Consider how the concepts of supervision and learning over time are interdependent. Clinical supervision could be viewed as a continuum, with direct clinical supervision on the far left and supervision on the far right.

On this same continuum, we have initial skill acquisition on the far left and skill mastery on the far right – learning over time.

It is important not to restrict learning over time with tiers of psychomotor-oriented checklists that emphasize activity on the far left of this continuum. This approach does not recognize that learning over time is the integration of multiple behaviors (cognitive, psychomotor, affective) into different contexts (settings, patients, situations).

Clinical proficiencies are not a collection of unrelated chunks of skills. For instance, a Lachman test must be blended with a history, some observation, palpation, etc. Without this integration, and progression in doing so, a Lachman test is clinically useless – even if we have mastered this isolated skill.

Further, a student must learn the proper "affect" in dealing with a person who has an ACL injury rather than dealing with the injury alone.

Learning over time is a systems model, not a block of isolated, unrelated activities. Certainly, students should become more proficient with chunks of psychomotor clinical skills. However, ATCs use multiple behaviors (cognitive, psychomotor, affective) that all need to be learned and progressed simultaneously. This process needs to be taught and transferred to athletic training students.

exposure requirements

Exposure requirements are based on the JRC-AT Standards and Guidelines and are divided into four categories: upper extremity intensive, lower extremity intensive, equipment intensive and general medical. The category titles are essentially self-explanatory.

"**Upper extremity** intensive sports are those sports that include a high number of upper extremity injuries such as swimming, gymnastics and throwing sports. **Lower extremity** intensive, then, are sports dealing with primarily lower extremity injuries such as soccer, track and basketball. **Equipment** intensive sports have a higher-than-average requirement for protective equipment and include sports such as football, men's lacrosse and ice hockey, with helmet and shoulder pad equipment as a minimum requirement. Finally, **general medical** exposures are those experiences where students are likely to see a high incidence of general medical conditions and involve clinical instructors who may be physicians, physician assistants, and nurse practitioners."

"Students should obtain adequate experience with team and individual sports, men's and women's teams, and high-risk and low-risk sports during their assignments."

Until 2004 when only athletic training students who have completed coursework in an accredited curriculum will be eligible to take NATABOC certification examination, this terminology is not official.

However, it behooves all involved with athletic training education to begin acclimating to these terms and their definitions as put forth by the JRC-AT, Education Council and NATABOC.

This "new" terminology associated with the types of, and processes in, athletic training education should be useful in communicating new approaches, particularly those in clinical education.

Note that many terms are synonymous. However, it is important to use the correct terminology to communicate with other educators and those branches of the profession dealing with education, and it's equally important to understand the concepts underlying these terms as they are applied in education programs. nn