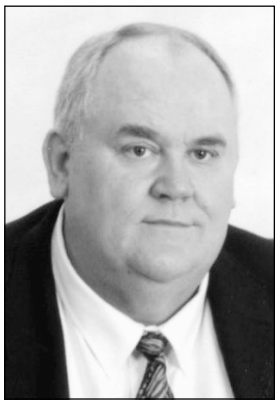
Clinical Education: We Aren't There Yet, but We're Making Progress!



Athletic training is a clinical profession. Without clinical skills, one cannot effectively practice the profession. All the knowledge in the world is of little value in treating injured athletes if it is not accompanied by clinical skills, which are developed only through clinical experience. So clinical education should be the heart and soul of athletic training professional preparation.

Why then is there so much debate concerning clinical education? Because too often students have had clinical experience rather than clinical education! Clinical experience involves working in the profession and picking up whatever knowledge and skills you can; clinical education is a systematic process of developing and refining clinical skills. One is chaotic, the other by design.

Traditionally, the underlying assumption on clinical experiences has been that you learn by osmosis—that is, if you spend enough time "on the job" you will develop clinical skills by reacting to the situations you are exposed to. Students are not all exposed to the same injuries during their clinical experiences, however, and therefore do not have equal opportunities to develop clinical skills. Some sports entail many more injuries than others, and within a given sport, the number and kinds of injuries vary from week to week and from year to year. Thus, learning from "putting in time" can involve too much "hit and miss."

Clinical education should be a structured, systematic process of developing and refining clinical skills. Assignments and responsibilities should grow in complexity as students master knowledge and skills. Clinical instructors must see students as learners, not just another pair of hands to get the job done. They will help get the job done, but that must be secondary to their education. The emphasis must be on learning.

Clinical and didactic education must always be integrated. Students should be led to acquire basic knowledge and skills first, then practice and refine those skills during clinical experiences that are limited in scope to their competence. While they are mastering the basic skills, they are also learning more complex skills in the classroom, which they will later integrate into their clinical experiences. As knowledge and clinical proficiency feed off one another, students are given increased clinical responsibility, always commensurate with their skill development. Thus, students' skills develop in an organized, systematic way, and the athletic training staff can be confident that they are able to perform assigned duties.

ATCs can provide clinical *experiences* just by having students follow them around, learn by watching, and ask questions; talking about what they are doing as they do it; and providing periodic in-service experiences. But clinical *education* requires structuring clinical experiences by assigning students progressing responsibilities, appropriately supervising students so that they have someone to turn to for help, constantly assessing their development, and matching their clinical assignments with their demonstrated mastery of prescribed clinical proficiencies. It means not allowing the need to provide athletic training services to dictate students' clinical assignments, spending more time with students, and helping them develop clinical skills by design rather than by osmosis.

What are the rewards? Better educated students, better prepared professionals entering the workforce, and therefore better health care.

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