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A Case Study of Athletic Training Educators' Sports-Care Responsibilities, Service, and Professional Advancement in Athletic Training Education Programs

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A CASE STUDY OF ATHLETIC TRAINING EDUCATORS' SPORTS-CARE RESPONSIBILITIES, SERVICE, AND PROFESSIONAL ADVANCEMENT IN ATHLETIC TRAINING EDUCATION PROGRAMS

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DEDICATION

This dissertation is dedicated to my family. To my mother Harriette Alley, who has never wavered in her support, to my brother and sister-in-law, Wade and Carmen Alley, who understood and supported me in obtaining the doctoral degree. To my sister and her partner Logan Alley and T.C. Morrow who always provided encouragement. Finally this dissertation is dedicated to the memory of my father, Homer Alley, who would have been so proud of his Marshall University graduate.

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ABSTRACT

A Case Study of Athletic Training Educator's Sports Care Responsibilities, Service, and Professional Advancement in Athletic Training Education Programs

Marshall University

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The purpose of this study was to examine the (1) extent of athletic training faculty members, who bear additional duties for intercollegiate sports care, (2) the beliefs of the faculty members who have intercollegiate sports care responsibilities related to these duties being credited for professional advancement, (3) the beliefs of faculty members related to having sport care responsibilities as part of their employment, and (4) faculty perceptions of intercollegiate sports care responsibilities upon promotion, tenure and contract renewal.

A sample of 655 certified athletic trainers was identified by the Board of Certification with the primary occupation designation of educator from a population of 7052 certified members who identified themselves as working in the college and university setting. There were 255 surveys returned for a response rate of 38%. The study utilized descriptive statistics, correlations and emergent category analysis.

Findings indicate that only 22% of athletic training educators surveyed had institutional sports care responsibilities. These athletic training educators who had institutional sports care responsibilities overwhelmingly indicated that these responsibilities should be counted toward institutional service credit for professional advancement. Reasons given include that (a) sports care responsibilities are part of the job, (b) there is not enough time for other activities, (c) it is a part of supervising students, and (d) it is a service to school and profession. Athletic training academic faculty members overwhelming believe that they should not have institutional sports care responsibilities. The reasons given for this were (a) lack of balance in responsibilities, (b) no time for sports care responsibilities, and (c) needing to spend more time on academic activities. Athletic training clinical faculty believed that they should have some sort of institutional sports care responsibilities. The reasons given were (a) relevance to the job and teaching, (b) an expectation to do clinical work, and (c) faculty can be active, but not necessarily with the institutions sports teams. Overall, athletic training faculty members do not believe that having sports care responsibilities affect one's chances of professional advancement.

CHAPTER ONE: INTRODUCTION

Athletic Training as a profession began with an identified need for onsite preventive and emergency treatment of collegiate athletes in the 20th century (Ebel, 1999; O'Shea, 1980). Since that time, the field of athletic training has evolved into an allied health profession recognized by the American Medical Association (AMA) in 1990 (Delforge and Behnke, 1999; Ebel, 1999; Perrin, 2007). Although this evolution has elevated the status of the profession and the collegiate pre-service programs, the change has not been without issues. This study seeks to examine one of these issues involving faculty serving in athletic training pre-service programs. More specifically, the study will center on issues related to the professional advancement of faculty that serve in the dual roles of instructor and institutional sports care provider.

Background

Athletic training emerged as a profession in the late 19th and early 20th centuries with the development of intercollegiate athletic programs (Ebel, 1999). In 1950, the National Athletic Trainer's Association (NATA) was established to "build and strengthen the profession of athletic training through the exchange of ideas, knowledge and methods of athletic training" (O'Shea, 1980 p. 2). During the early development period of the 1950s and 1960s, athletic training education at the college level was primarily a function of the physical education department with the goal for most of its graduates to become high school teachers in health or physical education. This created an employment opportunity for the athletic trainer. The curriculum was grounded in physical education and included some basics for enrollment in physical therapy schools, as well as basic and advanced athletic courses (Delforge & Behnke, 1999; Perrin 2007). The profession continued its growth in the 1970s with the additions of a certification exam, and modifications to the curriculum to include clinical experience with a certified athletic trainer

(Delforge & Behnke, 1999). At this time, athletic training was considered as an area of emphasis or concentration in physical education (Delforge & Behnke, 1999). The practice of athletic training was limited to secondary schools, intercollegiate athletics and professional sports programs (Perrin, 2007).

Development of a collegiate major in athletic training was the primary focus of the 1980s (Delforge & Behnke, 1999). While work was progressing on a major, the Professional Education Committee (PEC) of the NATA worked to obtain accreditation for athletic training education programs. In order to have an accredited athletic training education program, the profession needed to be recognized by the AMA. This recognition was granted in June of 1990 (Delforge &Behnke, 1999; Perrin, 2007). The process of accrediting athletic training education programs began in October of 1990 with a meeting of CAHEA (Committee on Allied Health Education and Accreditation) staff and the NATA Professional Education Committee as well as representatives from family, pediatric, and orthopedic medicine would form the Joint Review Committee on Athletic Training (JRC-AT). This committee's task was to develop standards that would direct athletic training education pre-service programs (Delforge & Behnke, 1999; Ebel; 1999).

Once the profession became an accredited allied health profession, the National Athletic Trainer's Board of Certification (NATABOC) began work toward redefining educational requirements. By 2004, all athletic training students had to possess a baccalaureate degree and graduate from an accredited entry level program. These changes ended the internship as a pathway to certification and helped to create many accredited collegiate pre-service programs for athletic training and provided regulation for these same programs (Delforge & Behnke, 1999; Perrin, 2007). With the addition of new accredited programs, credentialed teaching faculty

would be needed to administer these programs (Perrin, 2007). By 2011, there were over 350 accredited athletic training programs throughout the United States (National Athletic Trainers Association 2010). Additionally, the National Athletic Training Educational Task Force has recommended that no later than 2014 -2015, all students must have a degree in athletic training, that the minimum standard for entry into the profession will be the baccalaureate degree and the master's degree will be the foundation upon which to build athletic training post professional education ("Educational Degree Task Force" 2006).

Description of the Problem

The professional education of athletic trainers began to grow in the late 1980s as majors in athletic training were being implemented. Perrin and Lephart (1988) examined the demands made of athletic trainers in the tenure-track. In 1988, 80% of program directors had institutional sports care responsibilities with one or more intercollegiate sports, whereas 14% were denied tenure. In 2001 Perkins and Judd found that 43% of athletic training education program directors had a terminal degree and that 77% of those surveyed held a dual appointment with the athletic department. In addition, 14% of the program directors also held the position of head athletic trainer.

Currently, athletic training faculty are often assigned, either as part of their contract or as part of the school's tradition, athletic training duties with the institutions athletic teams. These non-teaching duties sometimes include evaluation, care, treatment and rehabilitation of sports injuries. In addition, faculty may be assigned to provide professional services at practices and competitions, to take on administrative duties, and to conduct clinical rotations (Brumels & Beach, 2008; Detwiler, 2010; Staurowsky & Schriber, 1998). These faculty members with dual responsibilities often find themselves dividing their efforts to fill the sports care provider role as

well as meeting scholarly requirements to obtain tenure, promotion, and /or contract renewal (Brumels & Beach 2008; Dewald &Walsh, 2009; Stuarowsky & Schriber, 1998).This study will examine the perceptions of athletic training faculty on the effects of dual role expectancies and whether they perceive that they are at a disadvantage when it comes to professional advancement because of these institutional sport care responsibilities.

Conceptual Framework

The professional literature on role overload provides a conceptual framework for conducting and understanding the results of this study. It explores issues caused by multiple role experiences. To that end, Goode (1960) first examined the conundrum of multiple expectancies. Goode suggests that individuals face "different types of role demands and conflicts which he feels as 'role strains' when he wishes to carry out specific obligations"(p. 484). Goode further states that satisfying one role may not allow adequate performance in another. The problem for the individual is how to make all of these roles workable (Goode, 1960). This theory is further refined by Kahn, Wolfe, Quinn, Snoek, and Rosenthal, (1964) as they describe various types of organizational stress. One of the stressors they explore is called role overload. Role overload occurs when employers or supervisors have expectations that an individual perform a variety of tasks that are "mutually compatible in the abstract" (p. 20), but the individual cannot meet due to time obligations. The individual has to prioritize his responsibilities (Kahn, et al. 1964).

In applying the role stress framework to the health professions, Hardy & Hardy (1988) further define role stress and role strain. Role stress comes from the system in which the individual is engaged, while role strain is felt by those who are experiencing the stress. They define role stress as "external to a role occupant, is a social structural condition in which role

obligations are vague, irritating, difficult, conflicting, or impossible to meet" (p. 165). The recipient of role stress may experience role strain with feelings of "distress, anxiety or frustration" (p. 166). These conditions of role stress and strain "may also prevent goal attainment for a role system and its occupants" (p. 159).

Hardy and Hardy (1988) developed a typology of seven different types of role stress, based on the problems health care workers found in meeting role expectations. One of these role types is role overload, which the authors define as "too much expected in time available" (p. 162). Hardy and Hardy indicate that although each role can be fulfilled adequately, a multiplicity of roles cannot be fulfilled due to time limitations. Additionally, these multiple roles and time limitations do not change over time.

Several authors have stated that athletic training faculty may have difficulty in achieving professional advancement due having many different tasks, such as teaching, clinical and administrative responsibilities (Brumels & Beach, 2008; Detwiler, 2010; Dewald & Walsh, 2009; Hertel, West, Buckley & Denegar 2001; Ingersoll, Palmieri, Laurent, Ray, Borsa & Perrin, 2005; Leard, Booth & Johnson, 1991; Perkins & Judd, 2001; Perrin & Lephart, 1988; Perrin, 2007; Sciera, 1981, Staurowsky & Schriber, 1998).

Various authors use slightly different terminology when describing role stressors (Hardy & Hardy, 1988). However, the phenomenon of role overload, which is the condition of an individual having multiple roles thrust upon him, will be used to provide the conceptual framework for this study (Hardy & Hardy, 1988).

This study employs a non-experimental, cross-sectional, descriptive, survey-research design constructed to collect perceptual data from the population (Borg & Gall, 1989). The purpose of this study is to explore the extent to which athletic training faculty have the dual roles

of faculty membership and sports care provider responsibilities for the institution. Additionally, this study will explore whether these dual roles may or may not impede professional advancement in areas such as promotion, tenure, and contract renewal. Although this type of non-experimental study does not lend itself to theoretical interpretation, but rather seeks to describe a condition within a professional academic setting, the conceptual framework of role overload will be used to enhance the complexities of the study and any findings there from.

Summary

As the need for more certified athletic training professionals with the terminal degree grows, faculty who are in the tenure track and similar positions will be expected to contribute much in the way of teaching, research and service as do other faculty members in similar professions. Athletic training faculty working in a collegiate setting may be working as instructors in an Athletic Training Education Programs (ATEP), as clinicians in the athletic department, or have a dual appointment in both education and athletics (Brumels& Beach, 2008; Staurowsky & Schriber, 1998). According to Dewald and Walsh (2009), service for an athletic training faculty comprises not only serving on university committees, but assisting with medical coverage for sporting events or instructing emergency medical personnel. In addition to the dual role of faculty member and sports care provider, athletic trainers, clinical contributions may not be recognized as part of their service component in terms of professional advancement (Dewald & Walsh, 2009; Hertel et al.). Dewald and Walsh also state that there is much inconsistency as to what constitutes service and that several institutions do not consider the use of job-related skills as service.

Statement of the Problem

Athletic Training faculty members have expectations as educators as well as institutional sports care responsibilities. This dichotomy of expectations raises the question of whether expectations for athletic training faculty are the same as those for other allied health faculty that do not have direct care provider roles. As athletic training faculty transition from other college departments such as the athletic, sports science, kinesiology, and education to allied health programs, what is the extent to which athletic training educators with faculty rank have institutional sports care responsibilities?

Athletic training faculty members are expected to provide service as part of the requirements for promotion, tenure and/or contract renewal. Are these sports care responsibilities included in the service expectations of faculty? Specifically, the question is this: Do athletic training faculty have institutional sports care provider responsibilities that are counted toward the service requirement for tenure, promotion, and/or contract renewal? If these extra duties are not recognized as part of the tenure, promotion, and contract renewal processes, do they affect the professional advancement of the individual and, in the larger context, the growth of the profession? Do these responsibilities affect the awarding continued employment in the form of professional advancement?

Research Questions

1. To what extent do faculty members in college and university athletic training departments bear additional responsibilities for institutional sports care?
2. What is the belief of athletic training faculty members that are assigned sports care responsibilities related to how these responsibilities should be credited in professional advancement decisions?

3. What is the belief of athletic training faculty related to the importance of faculty maintaining sports care responsibilities as part of their employment?

4. Do athletic training faculty members who have assigned institutional sports care responsibilities feel their professional advancement has been affected by these responsibilities?

Significance of the Study

It is important to ascertain the extent to which extra duties persist as remnants from past positions where faculty athletic trainers typically worked with intercollegiate athletic programs as part of their employment. As athletic trainers transition with the profession to the allied health care field, it is important to determine whether these non-clinical duties are perceived to hinder promotion, tenure or contract renewal. It is important that athletic trainers who are faculty have fair, appropriate opportunities to obtain promotion, tenure or contract renewal- not just for the academic advancement for the individual, but for the profession as a whole.

This study will be important not only to faculty athletic trainers who are seeking professional advancement, but to those in clinically-based programs in allied health who have expectations that are not part of the service expectation in tenure-track, promotion or contract renewal processes. Additionally, this study may be of benefit to those who direct allied health programs, kinesiology, or exercise science programs. Finally, this study may help those who make decisions regarding professional advancement.

Operational Definitions

1. Additional sports care responsibilities will be calculated from the self-reported perceptions to the *Survey of Athletic Training Service and Professional Advancement.*

2. Belief of athletic training faculty who are assigned institutional sports care responsibilities will be measured from the self-reported beliefs in the *Survey of Athletic Training Service and Professional Advancement.*

3. Professional advancement affected by additional sports care responsibilities will be calculated from the self-reported perceptions to the *Survey of Athletic Training Service and Professional Advancement.*

4. Perceptions of service requirements in their professional advancement will be calculated from the self-reported perceptions to the *Faculty Athletic Training and Sports Care Responsibilities Survey.*

Method

This study was conducted as a survey of certified athletic trainers with faculty rank in the United States. Subjects were selected from the National Athletic Trainers Association member database since the NATA is the leading national organization for certified athletic trainers. The certified athletic trainers were sent the *Survey of Athletic Training Service and Professional Advancement* based upon their position description in the NATA database. The questions were designed with Likert-style responses and then analyzed using SPSS data software.

Limitations

The limitation of this survey is that it was sent electronically by the Board of Certification's member database, which may somewhat bias the findings as this is a deviation from true random sampling. It should also be noted that this study relied heavily on individual respondent perceptions, which may or may not accurately portray the actual situation.

In addition the return rate of those faculty members with institutional sports care responsibilities was very low which may have biased the results and may not depict the actual situation.

CHAPTER TWO

REVIEW OF LITERATURE

Introduction

This chapter contains an in-depth review of the literature related to athletic training's history as a profession, the evolution of its status from an ancillary sport-related service to that of an allied health field, and the development of academic preparation programs for its practitioners. The literature review for the conceptual framework that will undergird the study is followed by discussion of the problem, the related research questions, and the significance of the study.

Background

Early History

Intercollegiate sports programs originated with early 20th century football competitions which were often fraught with frequent injury and sometimes even death. Treatment, of injuries in these early games was usually administered by a coach or a physician. As the need for improved treatment grew, the position of athletic trainer was developed to assist the coach in the care and conditioning of the athlete. As the profession continued to develop, the 1932 Olympic Games were held with professional athletic trainers providing services to participant athletes. An attempt to organize athletic trainers into a professional organization was made in 1938, but fell short due to the war effort and a lack of funding (Ebel, 1999; O'Shea, 1980; "Voices from the Past" 2006). In the interim from the end of World War II to 1950, athletic trainers aligned themselves by the athletic conferences that were established in the 1940s (O'Shea, 1980).

In 1950, due to the efforts of some of the early athletic trainers, Charles and Frank Cramer held an athletic training clinic in Kansas City, Missouri. It was at this clinic that the National Athletic Trainer's Association (NATA) was founded. The "purpose of this association was to build and strengthen the profession of athletic training through the exchange of ideas, knowledge and methods of athletic training" (O'Shea, p. 28). One of the early concerns of the new organization was the education and preparation of athletic training professionals. In response to this concern, the Committee on Gaining Recognition was created to examine professional preparation. This committee would later split into two committees: one for certification and one for education. The educational subcommittee would later become the NATA Professional Education Committee (NATA-PEC) which supervised athletic training education until June 1998 (Delforge & Behnke, 1999; Ebel, 1999).

The NATA-PEC established a model curriculum that was approved in 1959. This curriculum was rooted in physical education and included pre-requisite courses for physical therapy, as well as courses in basic and advanced athletic training. This model was established to provide an employment avenue in the high schools as athletic trainer and a high school physical education or health teacher as well as gain entry into physical therapy school (Delforge & Behnke, 1999; Ebel 1999, O'Shea, 1980; Perrin 2007). In the 1950s and 1960s there were few opportunities outside of school or professional sports settings in which an athletic trainer could be employed (Perrin 2007). This original curriculum model would not change until the end of the 1960s when the NATA began to approve courses of study in athletic training (Delforge & Behnke, 1999: O'Shea, 1980; Perrin, 2007). Throughout the early 1970s the curriculum was revised to reflect changes in the profession. By the end of the 1970s the curriculum model eliminated pre-physical therapy courses, and the requirement that students be health or physical

education majors. The secondary teaching certification requirement, however, was kept intact (Delforge & Behnke, 1999; Ebel, 1999; Perrin 2007).

The NATA also began to regulate its newest members through a certification examination (Delforge & Behnke, 1999; Perrin 2007). Certification for members was deemed necessary due to the inadequate compensation athletic training professionals received and the poor working conditions under which some athletic trainers were toiling. Additionally, it was claimed that many capable students did not become employed because their skills were not acknowledged (Ebel, 1999; McLean, 1969).

Due to the fact that there were a variety of ways through which an athletic trainer could receive his or her education, the NATA established four educational pathways that would enable one to take the certification exam (Delforge & Behnke 1991; Ebel, 1999; O'Shea 1980). These routes included graduation from an approved NATA curriculum program with two years supervision under NATA approved supervisors; a graduate in physical therapy school with two years of athletic training experience; apprenticeship or internship, which required proof of working 1800 clock hours under the supervision of an NATA certified athletic trainer, working high risk sports such as football and basketball, and proof of graduation form a college or university (Weidner & Henning, 2002) ; and "special consideration." These candidates had to pass an athletic training course and meet the state teaching requirement either by obtaining a minor in health or physical education or by completing an athletic training workshop for credit to receive an endorsement as a high school athletic trainer (National Athletic Trainers Association Board of Certification, 2007). The physical therapy and special consideration routes to certification were eliminated in the early 1980s but the apprenticeship route remained viable

until 2004 when it was eliminated due to accreditation and educational standardization (Delforge & Behnke, 1999).

Development of Pre-service Programs for Practitioners

The idea of an athletic training major was conceived in the late 1970s by Sayers "Bud" Miller, Chair of the NATA Professional Education Committee. It was also during this time that athletic training programs were expanding in number and in the number of courses. In 1980, the Board of Directors approved a resolution that all undergraduate athletic training programs offer a major in athletic training by 1986. Following Miller's death, however, progress on the major slowed, and the deadline for its implementation was extended to July 1, 1990.

Accreditation for athletic training education was pursued in the late 1980s by the NATA Professional Education Committee. In order to obtain accreditation for pre-service athletic training education programs by the American Medical Association (AMA) Committee on Allied Health Education and Accreditation (CAHEA), the profession needed official recognition. The Professional Education Committee under the leadership of Dr. Robert Behnke prepared the documentation, and after a year of public involvement by other medical groups, the AMA gave its official recognition to athletic training as an allied health care profession on June 22, 1990 (Delforge and Behnke, 1999; Ebel, 1999).

Once the profession received recognition, the NATA turned its attention to accreditation of educational programs. Needing a formal review process, the NATA Professional Education Committee along with CAHEA representatives formed a review committee with the co-sponsors of the American Academy of Pediatrics, American Academy of Family Physicians and the American Orthopedic Society for Sports Medicine. This committee would become the Joint

Review Committee on Athletic Training (JRC-AT) (Delforge & Behnke, 1999; Ebel, 1999; Perrin, 2007).

The JRC-AT and CAHEA were charged with developing standards for pre-service programs at the bachelor's level which would become the "Essentials and Guidelines for an Accredited Educational Program for the Athletic Trainer." This document included information on course content and major pre-requisites and was approved by the AMA Council on Medical Education (CME) and the co-sponsors of the JRC-AT in December of 1991 (Delforge & Behnke, 1999; Ebel, 1999; Perrin, 2007). Barry and Highpoint Universities were the first two institutions to receive CAHEA accreditation in 1994 (Delforge & Behnke 1999).

The Committee on Allied Health Education Programs became the accrediting agency for certifying education programs after CAHEA dissolved due to a recommendation by the AMA to replace CAHEA with an independent body. After 1994, athletic training programs were then accredited by CAHEP until 2006 when the JRC-AT became an independent body and was renamed the Commission on Accreditation of Athletic Training Education (CAATE) (Commission on Accreditation of Athletic Training Education, 2011; Delforge & Behnke, 1991; Perrin 2007).

Education Reform Due to Accreditation

Other changes in educational policy were occurring to regulate the education of athletic trainers. According to Delforge and Behnke (1999), the NATA - PEC provided that NATA approved graduate programs would provide extended educational opportunities post-certification. This change eliminated the NATA approved graduate pathway to certification. In addition, this separated graduate education from entry level education and gave more impetus for research. Another change was elimination of the internship route to certification through efforts

of the Educational Task Force. This task force was formed in 1996 to examine educational practice and preparation (Delforge & Behnke, 1999; Ebel, 1999; Perrin 2007). Because internship candidates consistently scored lower on the certification exam, the Education Task Force recommended that route to certification be eliminated (Ebel, 1999; NATA Education Task Force, 1997). In addition, internship candidates lacked consistency in their educational experiences (Koehneke, 2003). By 2004, all candidates applying for certification had to complete a baccalaureate degree and a CAAHEP accredited program. This pathway is still the only way a student can sit for the examination (Delforge & Behnke, 1999; Ebel, 1999; NATA Education Task Force, 1997; Perrin, 2007).

The number of collegiate athletic training education programs increased dramatically after the second pathway was eliminated (Perrin, 2007). In 1998, there were 82 accredited athletic training programs (Delforge & Behnke, 1999). By 2011, there were 360 accredited programs (Commission on Accreditation of Athletic Training Education, 2011). The increase in the number of athletic training education programs has exceeded the number of athletic training faculty with a doctoral degree (Guskiewicz, 2008 Hertal et al. 2001; Hertal, Buckley & Denegar 2001; Perrin, 2007). According to Perrin (2007), those athletic training faculty with newly awarded doctoral degrees are being employed as athletic training program directors rather than researchers. This situation may place athletic training faculty at risk when applying for promotion and tenure.

The NATA Education Task Force (1997), in its Recommendations to Reform Athletic Training Education, made 18 provisions for change in athletic training education programs. Of these provisions, two were associated with aligning athletic training with allied health (NATA Task Education Task Force, 1997; Perrin, 2007). The first of these was Provision 11 which

indicated, “The NATA should encourage the development of multi-disciplinary education programs that coordinate athletic training with teaching, nursing, physical therapy, occupational therapy, or other appropriate baccalaureate level positions” (1997, p. 22). The reason behind this change is the idea that a multi-skilled professional can provide a broader range of services than a health care professional with a limited set of skills for about the same cost. The athletic trainer possesses many skills, ranging from emergency care to rehabilitation (NATA Education Task Force, 1997). The other provision stated “The NATA should encourage new athletic training education programs to consider aligning themselves in colleges of health-related professions” (1997, p. 22). The reason for this provision was that the curriculum for athletic training now resembled curriculum in other allied health professions. In addition, athletic training education programs that are housed within kinesiology or physical education may be at risk of elimination as these programs are being reduced (NATA Education Task Force, 1997).

The 1997 Recommendations to Reform Athletic Training Education called for higher standards of education for heading an athletic training education program. Prior to the 1997 recommendations, program directors with three years of athletic training experience were considered qualified to head an athletic training education program (Guidelines for Development, 1980; NATA Education Task Force, 1997). Although recommendations for a doctoral degree requirement fell short, it was deemed important for clinical instructors and program director to have a certificate of advanced quality. The rationale for this recommendation further suggested that individuals who possessed a terminal degree in educational administration or curriculum and instruction could find the content of such a program unnecessary (NATA Education Task Force, 1997). As a result of these

recommendations, more certified athletic trainers with a terminal degree are needed to fill faculty tenure-track positions in athletic training education programs (Hertel, 2001).

Athletic training as a profession is moving toward additional allied health areas that are not traditionally considered with its sports-based history. Some of these areas include performing arts, the NASA Space Program, the military and public safety (Kirkland, 2005; NATA Job Settings Web Page, 2010). For example, in 2006, Senator Craig Thomas of Wyoming introduced federal legislation to add athletic trainers as Medicare service providers. Such a change would not only give Medicare patients access to certified athletic trainers but would enable athletic trainers to be covered in the cost of providing services. This change could also help reduce expenses in the Medicare system through economical, quality care. The effect of this legislation is that many private insurance companies which follow Medicare procedures are now allowing for third-party reimbursement (New Legislation Introduced, 2006). Chuck Kimmel, in his address to the 2007 State of the Association address to the NATA Meeting and Clinical Symposium stated, "This legislation is not only about treating Medicare patients. It is about being recognized by the federal government as legitimate allied health care providers" (p.13). This federal legislation has been reintroduced to Congress as HR 2785, as the Athletic Trainers' Equal Access to Medicare Act of 2011 by Edolphus Towns, New York State's 10th District Congressional representative (NATA Legislative Alert Center, 2011).

Athletic trainers have been working not only for licensure at the statewide level, but in updating state regulation and reimbursement issues in recent years. In 2006, Michigan passed a licensing bill, and Utah, Tennessee, and Missouri upgraded their athletic training legislation (State Legislative Update, 2006). In 2007, licensing bills were passed in Montana , Washington and New Jersey that expanded the definition of who could be considered an athlete by specifying

any person who engages in heavy physical activity or sport (Making Progress in State Legislation, 2007). Vermont, in 2008, passed a law legislating coverage for physical medicine that is administered by athletic trainers, and Kansas updated its old legislation regarding athletic trainers as well (States' Progress Right on Track, 2008). In 2009, Wyoming and Maryland passed licensing legislation, whereas Mississippi updated its state legislation, and South Dakota eased reimbursement restrictions for athletic trainers (Lobbying for Progress, 2009). In 2010, West Virginia became the 47th state to regulate the practice of athletic trainers, while Wisconsin and Arizona updated their practice acts (Albohm, 2010). State legislation is important because it helps to protect jobs, aids in reimbursement efforts and recognizes the athletic trainer as a health care provider in that state (State Legislative Update, 2006).

Athletic trainers are also becoming more diverse in their work settings as well. Originally, practice settings were limited to college and universities, high schools, and professional sports teams (Perrin, 2007). Today, athletic trainers are working in hospitals and clinics, with the military, as physician extenders, in the performing arts, and in industry and public safety (NATA, 2010). Patients of athletic trainers include not only athletes, but those who have suffered musculoskeletal injury, those who are seeking to improve their strength, conditioning, and performance and those who have been referred by physicians (NATA 2010). It is the application of the athletic trainer's knowledge of the human body, sports medicine model, treatment and rehabilitation, and reconditioning of those who engage in physical activity that makes athletic trainers adaptable in a variety of work settings (Kirkland, 2005).

Issues Related to a Changing Profession

The changes outlined previously have altered the practice of the profession, but they also have significant implications for those collegiate faculty members who are providing the

education for the next generation of practitioners. In many institutions, athletic training faculty must not only fulfill the obligations of teaching, scholarship, and service, they are often required to provide athletic training services for the schools intercollegiate sports programs. These responsibilities create a tremendous workload for the faculty athletic trainer (Brumels & Beach, 2008; Dewald & Walsh, 2009; Judd & Perkins, Leard, et al, 1991 2004; Mangus, 1998; Perrin & Lephart, 1988; Sciera, 1981; 1991; Staurowsky E., & Schriber, 1998). The following discussion will outline the early studies of athletic training faculty and their institutional sports care responsibilities and will follow through the educational reforms of athletic training education in the late 20th century to the present day.

Faculty Studies of the 1980s

Early studies of athletic training faculty dealt almost exclusively with the athletic training program director (Leard, Booth & Johnson, 1991; Perrin & Lephart, 1988; Sciera, 1981). The National Athletic Trainer's Association Professional Education Committee (NATA-PEC) provided manuals for those schools who wanted to offer NATA approved undergraduate and graduate programs. These included qualifications and responsibilities of the program director and athletic training faculty. In 1980-81, NATA certification as an athletic trainer and a minimum of three years of experience were all the credentials that one required to become an athletic training education program director. In addition, the program director needed to be a part of the teaching faculty or graduate teaching faculty. At that time, the qualified program director was generally the head athletic trainer, but other qualified personnel- such as former head athletic trainer or an assistant athletic trainer with proper qualifications-could hold the position as well. In addition to these responsibilities, a program director was expected to publish, present at professional meetings and have an interest in research and the education of student

trainers (Leard, Booth, & Johnson, 1991; Professional Education Committee, 1980 – 1981, 1991; Sciera, 1981).

Athletic training faculty who taught basic, advanced and graduate athletic training courses needed to have NATA certification to teach in approved programs. Because of the interdisciplinary nature of athletic training at the time, faculty in biology, kinesiology, and liberal arts needed to be qualified in their respective areas of teaching. Faculty needed to be willing to aid students in attaining behavioral objectives in the undergraduate program and in attaining professional goals in the graduate program (Professional Education Committee, 1980 – 1982).

Sciera (1981) was one of the first to examine the responsibilities of an NATA program director. These individuals were responsible for the educational program for student athletic trainers as well as management of the delivery of health care for student athletes. At the time, the roles of the head athletic trainer and program director were not well defined. In the early eighties, most program directors were undertaking the administrative aspects of running an athletic training education program such as the sports that were to be covered and number of students assigned to each sport. Most of the early educational program directors were former head or assistant athletic trainers who wanted to decrease their clinical involvement or wanted to concentrate on teaching (Leard, Booth, & Johnson, 1991; Sciera, 1981).

Capel (1980) investigated burnout in 332 full and part- time certified athletic trainers in 13 western states. She studied various aspects of role stress and work demands such as the number of athletes that the athletic trainer treated as well as the number of hours in direct patient care per week. She found that role conflict and role ambiguity scores were low, although loci of control scores were somewhat higher. The number of athletes that these athletic trainers cared ranged from 0 - 1000 and the number of hours in direct patient care ranged from three hours to

90 hours per week. Capel performed a regression analysis to determine which, if any of the independent variables predicted burnout. While the mean scores for role conflict and ambiguity, loss of locus of control, and the number of hours in patient care were low, these factors predicted burnout. The number of athletes in an athletic trainer's care was not predictive of burnout. She found that burnout was less than in other helping professions, possibly due to the fact that many athletic trainers in the sample were either head athletic trainers or the only athletic trainers at their respective institutions and somewhat autonomous. Another reason for the low burnout rate was the idea that athletic trainers had time away from their athletes or an off-season during the summer months.

In 1987, Perrin and Lephart (1988) examined the role of the NATA curriculum directors who were clinicians as well as faculty and the effect on tenure and promotion. In their survey of 59 program directors, over 80% provided sports care responsibilities for intercollegiate athletics. These duties ranged from working with one intercollegiate sport such as baseball or football to holding the position of head athletic trainer. In their investigation of tenure for program directors, 39% had tenure track appointments, 20% were tenured and 15% had tenure denied. Twelve of the institutions made special arrangements for granting of tenure to their program directors. In terms of the criteria for promotion and tenure, teaching and publication were highly ranked, whereas athletic training service was ranked sixth out of eight items. This ranking created a dilemma for the athletic training education program directors. There were several reasons for this situation. First, an athletic trainer must be perceived as credible by students, yet balance a research agenda and full teaching load. Also, the program director needed to be aware of the expectations of the promotion and tenure committee, which may not appreciate the balance of patient care and time commitments involved. Finally, the program director who enjoys the

clinical aspect of profession may be discouraged by the lack of time spent with student athletes (Perrin & Lephart, 1988).

Bell (1989) surveyed athletic trainers at the 1989 NATA Annual Meeting and Clinical Symposium. Using the short form of the Minnesota Satisfaction Questionnaire, he examined job satisfaction rates for athletic trainers in different employment settings, finding that athletic trainers working in the four-year college and university settings had the lowest job satisfaction ratings of those working in all aspects of athletic training including professional sports, sports medicine clinics, or high schools. He also found that athletic trainers with no intercollegiate sports care responsibilities had high job satisfaction ratings when compared with those who had up to three sports for which they were responsible for. Job satisfaction diminished as athletic trainers reported an excess of three or more sports.

In the same study Bell (1989) investigated certified athletic trainers who had teaching responsibilities and those who did not. He found similar job satisfaction scores for each of the groups, with the teaching group having higher intrinsic satisfaction in the areas of creativity, use of abilities and responsibility. The non-teaching athletic trainers scored higher in extrinsic levels of satisfaction in areas such as supervision, compensation and recognition. Bell did not account for differences between teachers at the high school level and those at the college or university level. When examining the level of education, Bell found that those who had doctoral degrees or other post-master's work had lower job satisfaction than those who had master's or bachelor's degrees.

Faculty Studies of the 1990s and Early 2000s

On June 22, 1990, athletic training was officially recognized by the AMA and work was progressing on accrediting education programs (Delforge and Behnke, 1999). These studies

represent a transitional period from official recognition to the 2004 implementation of the Recommendations to Reform Athletic Training Education.

In 1991, Leard, Booth and Johnson examined the routes taken by athletic training program directors. In their interviews of 11 program directors, most indicated a desire to teach, followed by research, and ending with more time at home. About half of the education program directors, as well as head athletic trainers, felt that they should be involved in clinical supervision of students or working with an intercollegiate sport as well as teaching and evaluating students. When this sample of program directors was asked about the dual position of head athletic trainer and program director, six of the respondents indicated that each position should be separate because of the amount of work each required.

In 1998, Staurowsky and Schriber studied workload, compensation packages and performance evaluations of certified athletic trainers employed in accredited undergraduate educational programs. Their sample was composed of 70% faculty, while less than a third had administrative positions. The typical workload consisted of teaching, supervision of students and working with the athletic department. When broken down by time spent, these athletic trainers spent 40% of their time teaching and 30% of their time working with athletics. Of the 24 program directors who returned surveys, 50% had an intercollegiate sports responsibility. The typical athletic trainer in this study reported working 51 – 55 hours per week, and 24 subjects reported working more than 60 hours per week.

In analyzing performance, the athletic trainers were asked to rate the factors that their institution considered to be important. In terms of teaching, chair and student evaluations were rated important for promotion and tenure. In the area of research, 54% of respondents rated publications as important while 58% of the subjects rated presentations as important. An athletic

director's evaluation was important to 44% of the sample. In this evaluation, the researchers found that the "traditional faculty model" (1998, p. 248) of evaluation failed to examine 30% of the athletic trainer's work assignment. This assessment method places the athletic trainer in a quandary when he or she is evaluated in the same manner as other faculty who do not have the same clinical expectations (Staurowsky & Schriber, 1998).

In response to the growing number of athletic teams, longer sports seasons, and conditioning sessions, as well as liability concerns shifting from equipment manufacturers to college and university athletics personnel, the NATA created a task force to develop guidelines for intercollegiate athletics. This task force was made up of representatives from all three divisions of the NCAA, the National Association of Intercollegiate Athletics (NAIA) and the National Junior College Athletic Association (NJCAA), as well as representatives from the College Athletic Trainer's Society (CATS), the NATA College and University Committee, and the NATA Pronouncements Committee. In addition, there were representatives from the NCAA Competitive Safeguards and Medical Aspects Committee. The task force released the *Guidelines to Establish Appropriate Medical Care in Collegiate Athletics* in 2000 (Guidelines to Establish, 2000). These guidelines provided a way for colleges and universities to determine how much medical coverage they need based upon factors such as frequency and severity of injury in each sport. In addition these guidelines outlined the time needed to care for injuries as well as the administrative factors that could affect the athletic trainer's time such as teaching, budget, or supervision of student athletic trainers. Each sport has an assigned base health care unit. This health care unit is based on the risk of injury as well as the frequency of injury and time spent in caring for injury.

These base health care units are designed for sports teams of 40 members or less. One certified athletic trainer should be able to care for three to four teams per year or, one sport per season, or 12 health care units per year. Adjustments are made for out-of-season practice and conditioning as well as for teams with more than 40 members. The institutions' base health care units are added and divided by 12, which is the established load of one certified athletic trainer (Guidelines to Establish, 2000).

In order to account for an athletic trainer's administrative tasks, base health care units are assigned in terms of percentages of time that a task takes over the course of the year (Guidelines to Establish, 2000). In other words, if an athletic trainer teaches three hours, that would take up 25% of the athletic trainer's time or three base health care units, allowing for three units in patient care. These guidelines also imply that a full time faculty member teaching 12 hours cannot also be a health care provider based on this system (NATA, 2011). A base heath care unit of two is given if a task takes up 25% of athletic trainer's workload. Other duties if they take less than 25% of the athletic trainer's time are given a unit of two for 16%, a unit of 1 for 8% and a half unit for less than 8%. The grand total of the sports health care units and the administrative health care units are added together and divided by 12. So if an institution had a total of 56 base units, that institution would need four to five athletic trainers to provide adequate medical coverage. These are guidelines for institutions to use, and are not required by any organization or mandate (Guidelines to Establish, 2000).

The task force, in an effort to measure results, conducted a survey of more than 370 head athletic trainers in 2001 to see how new guidelines were being used. Thirty-nine percent of the athletic trainers had discussed the plan with their administrators, but had taken no action one year following the guidelines release. When comparing the guidelines with their own staffing, 38%

of those surveyed fell far below the recommended guidelines. However, 65% of those athletic trainers had applied some, but not all of the guidelines ("Task Force Continues Work," 2001). The guidelines have been revised in 2003, 2007, and 2010 due to injury-rate studies and rule changes which makes injury exposure more likely or frequent.

In 2001, Perkins and Judd repeated Perrin and Lephart's 1987 national study of athletic training education program directors. Although this study dealt with the program directors, it had implications for faculty in athletic training because program directors were regarded as clinicians as well as educators (Leard, Booth & Johnson; Perrin & Lephart, 1988; 1991; Professional Education Committee, 1980). By this time, the 1997 Recommendations to Reform Athletic Training Education had been accepted by the NATA Board of Directors. The program directors position had changed considerably since 1987 (Delforge & Behnke, 1999; Perkins and Judd, 2001). In 200l, 77% of the program directors had a joint appointment with the athletics department with 42% of those program directors being clinically active in an athletic training setting. Fourteen percent of the program directors also held the title of head athletic trainer, while 27% of the program directors held the title of assistant athletic trainer. In addition, 17% of program directors also had traveling duties with intercollegiate athletics. Less than half (43%) of the program directors held the rank of assistant professor (Perkins & Judd, 2001). In their sample of 113 program directors, 26% were tenured and an additional 26% were on the tenure track. The number of non-tenured program directors decreased from a 38% in Perrin and Lephart's 1988 study to 20% in Perkins and Judd's 2001 study.

Perkins and Judd (2001) analyzed the criteria for tenure and promotion, finding that teaching and administration were ranked highest by the program directors, followed by research and publication. In their study, 55% of program directors indicated that they perceived

publishing to be important, while 67% indicated presentations at conferences to be an important expectation. Service was perceived to be less important than teaching or publishing, and was perceived as "professional involvement" or community service at 79% and 72% respectively. Research and publication was ranked third in the program director's perception in the 1988 Perrin and Lephart study (Perkins & Judd 2001).

In examination of the two studies, Perkins and Judd (2001) found that the professional dilemma for athletic trainers was still relevant. According to Perkins and Judd, 42% indicated they were clinically active, with 17% still traveling with sports teams. The program director who wants to remain active clinically may have trouble balancing tenure and promotion requirements and juggling personal time. However, given the growing responsibilities of the program director, the athletic trainer may find it necessary to forfeit time in the athletic training room which may diminish credibility with student athletic trainers. In addition, this may create a problem for the program director who would like to remain clinically active as working with athletes is the primary reason for getting into the profession. If all of these problems remain unresolved, the program director may suffer from burnout or leave the profession entirely.

In another 2001 study, Fuller and Dewald examined the position of all athletic training educators in CAAHEP accredited athletic training education programs. These educators taught at least one athletic training course in the program. The study examined the number of hours per week worked, the number of hours worked in athletics and the number of hours worked directing student trainers. Within their sample, 22% were program directors, 27% were full-time professors, 22% were assistant athletic trainers and 14% were head athletic trainers. These educators indicated that they worked an average of 54 hours per week, were responsible for 10-40 advisees, and spent up to 70 hours per week supervising student trainers. In addition, athletic

training educators had multiple academic responsibilities such as serving on student and university committees, working with curriculum design, or laboratory direction. This study suggested that athletic trainers cannot continue with all of these activities and continue to be successful in the academic arena (Fuller & Dewald, 2001).

Fuller and Walker (2003) examined the characteristics of faculty positions from August 1999 through July 200l that were posted on the websites of the *Chronicle of Higher Education*, the *NCAA News* and the National Athletic Trainer's Association. Of the 282 positions posted, program directors comprised 43% of the openings, clinical coordinators covered 5%, assistant professors made up 45% and 7% of the postings were for instructors. According to this study, "a number of these jobs also required duel [sic] appointments or partial appointments in athletics" (January, 2003). The study did not indicate the nature of, or number of, athletic department requirements. Forty percent of total job listings were tenure track appointments, while 7 % were non-tenure track, and 53% were unknown. In those positions indicating a job title, 43% of those positions were program director positions that were on the tenure track, and 53% of assistant professor postings were tenure track appointments. Most of the jobs that were listed and required an advanced degree were at the rank of assistant professor or above. In job listings for program directors, 45% required a doctoral degree while 34% indicated a preference for a doctoral degree. For assistant professors, 51% of postings required a doctoral degree, while 39% indicated this as a preference (Fuller & Walker 2003).

Harman (2001) examined program directors' publication rates while pursuing accreditation. In this study, she examined all program directors that were either directing an athletic training education program or pursuing an accredited program for their institution. In examining workplace obligations, she examined the relationship between those program

directors that provided team sports coverage to those that did not. While her findings in this area were not statistically significant, she discovered that program directors who worked with sports teams had higher publication rates than those who did not cover sports teams. Harman concluded that program directors used travel time to write and review literature.

Post 2004 Studies

By 2004, all students sitting for the National Athletic Trainer's Association Board of Certification (NATA-BOC) examination had to possess a baccalaureate degree and have successfully completed a CAAHEP accredited pre-service program (NATA Education Task Force, 1997; Perrin 2007). This action resulted in an increase in the number of undergraduate entry – level programs.

Todden, in his 2007 study, investigated athletic training faculty at the 335 CAATE accredited athletic training education programs who had some clinical responsibilities. He examined perceptions of athletic training faculty with clinical responsibilities in regard to job satisfaction, career progress and success, promotion and tenure and their commitment to athletic training education. The athletic training faculty that he researched spent most of their time in the clinical setting. In the fall of 2007, the investigator sent an email asking program directors to identify qualified and willing participants for this study and then sent out consent forms and surveys to each CAATE Approved ATEP program, where the program director distributed the forms. His instrument was based on a survey used for physicians who spend most of their time in the clinical setting at an academic center. Respondents were asked to rate 21 items related to professional service and scholarship in terms of job satisfaction and promotion and tenure. Respondents were then asked about their career progress and success relative to their peers. The

final part of his survey investigated the clinical faculty member's commitment to athletic training education in regard to teaching, research, service and administration.

Todden (2007) found that most of his respondents were female, less than 35 years of age, had the rank of assistant professor, and the highest degree earned was at the master's level. He found that athletic trainers with clinical responsibilities found the greatest job satisfaction in patient care quality and relationships, peer relationships, teaching and advising. The least satisfaction was found in research, grant writing, journal editing and book publications. In his investigation of tenure and promotion, the clinical athletic trainers regarded the development of new clinical skills, teaching and student advising as the most important in attaining promotion and tenure.

When Todden examined differences between institutional types, he found some significant differences in job satisfaction and promotion and tenure. Faculty at baccalaureate institutions found teaching and advising to be of greater satisfaction than those in doctoral institutions who preferred clinical research. Clinical athletic trainers employed at doctoral granting institutions also indicated that research, grant writing and publishing were greater measures of tenure and promotion than those at baccalaureate institutions. When questioned about their clinical loads, clinical athletic trainers felt more job satisfaction in terms of good patient relationships when they had loads of 30 – 40% rather than those who had loads of 10 – 20%. When athletic training educators were questioned about their clinical load and progress toward promotion and tenure, faculty members indicated that when they had 20 – 30 % clinical loads, advances and excellence in patient care were measures of tenure. This was more so than those who had 10 – 20% clinical loads. Clinical athletic trainers having a 10% load or less

perceived that research and national committee membership were more important measures of promotion and tenure than those who had 10 – 20 % load or 20 - 30% load.

Regarding time spent in clinical activity, those educators spending more than 25 hours per week found more job satisfaction in the areas of patient care and having good patient relationships than those who spent less than 25 hours per week. Clinical athletic trainers who worked less than 25 hours per week believed that administrative and committee work were better measures of promotion and tenure more than those who worked over 25 hours per week.

When these clinical faculty members were asked what their perceptions about criteria for promotion and tenure; the better measures were quality patient care and relationships, excellent clinical practice, administration and committee work. However when asked what their institution would perceive as measures of promotion and tenure, scholarly endeavors such as grant writing, article publication, serving on committees, and book publishing were the indicators listed. When asked about their commitment to athletic training education, the clinical athletic trainers indicated that their careers would be based on teaching, service to patients, program administration and research. Finally, in terms of career progress, the clinical athletic trainers were ambiguous about their career success in comparison with academic peers but perceived in general that their career progress was faster than normal (Todden, 2007).

According to the 1997 “Recommendations to Reform Athletic Training” (Provision 12), new athletic training programs should be associated with colleges of the health professions. The risk of program duplication and similar course content to the health professions were cited as reasons for this move, which has been the subject of some debate. In 200l, Hertal et al. indicated that most athletic training departments were still located within physical education or kinesiology departments, with only 22% located in allied health. In 2007, Perrin found that 70% were still

housed in these departments six years later. Perrin thought that athletic training programs could remain in physical education or kinesiology, despite the difficulty in finding qualified faculty, and potentially decreasing budgets of kinesiology departments. Perrin recommended that kinesiology administrators should consider non-tenure track academic appointments for athletic training program directors as well as faculty that have substantial administrative or supervisory responsibilities (Perrin, 2005, 2007). Eaves' 2010 commentary reviewed the current literature and concluded that undergraduate athletic training programs ought to remain in physical education and kinesiology departments whereas graduate programs should be housed in the professional health programs. Some researchers believe that housing athletic training education programs in allied health would follow the medical model of promotion and tenure that is based more on clinical care (Eaves, 2010; Hertel, et al., 2001; Rich, Kedrowski, & Richter, 2008). This issue has yet to be resolved.

Conceptual Framework

To better understand and examine the complexities and stressors of athletic training faculty who shoulder intercollegiate sports care responsibilities in addition to their academic responsibilities, a structure for examination is needed. An appropriate conceptual framework to provide structure for this study is that found in the role-strain literature. The authors of the literature related to role strain have used a number of related labels to describe the phenomenon and the following section will review those terms before identifying the one best suited to the present study.

Goode (1960) articulated the idea of "role strain'' as the "felt difficulty in fulfilling role obligations" (p. 483) when examining an organization's social structure and activities. He viewed role relations as "role bargains" through which persons must continually choose actions

to reduce strain between or among them. The choice that a person makes determines the amount of time allotted to each role and to the organization and society as whole. Goode stated that "an individual may face different types of role demands and conflicts, which he feels as 'role strains' when he wishes to carry out specific obligations" (p. 484).

Many sources of role strain have been identified by Goode (1960). He indicated that there may be strain in work situations where technical skill conflicts with social relations, where there are moral questions versus secular questions and debates over quality versus quantity. Another source of role strain occurs when an individual has a number of role relationships with a variety of people. Roles may conflict with one another. If the individual satisfies role demands in one role, he or she may have difficulty in adequately fulfilling those of another. The individual cannot meet the expectations of all those who are in his "role network." Goode indicated that role strain is normal; however, a person can have too many role requirements that he has trouble meeting. Individuals must deal with the question of how to use their resources and adapt their skills to reduce role stain to a tolerable level.

Kahn, Wolfe, Quinn, Snoek, and Rosenthal (1964) expanded the idea of role strain to include role conflict. They contended that each individual has role behaviors imposed on him by other members within his role set and that these members of the role set have differing expectations toward that individual. One of the more complex types of role conflict is described as role overload. This occurs when employers have "quite legitimate expectations that a person perform a wide variety of tasks, all of which are mutually compatible in the abstract" (p 20). Kahn et al. indicated that the individual cannot do all the tasks expected within the time frame allotted, therefore finding it necessary to give priority to some tasks while delaying others. If an

individual cannot comply with all of the assigned tasks, he can become overwhelmed by expectations (Kahn et al., 1964).

Although Goode (1961) and Kahn et al. (1964) were primarily concerned with men in the labor force in general, Hardy and Hardy (1988) examined role strain in health care professionals. More specifically, they examined issues brought about by discordant roles and interactions within the role set. They deemed that role *stress* is the pressure placed on an individual, "a social structural condition [in] which role obligations are vague, irritating, or impossible to meet" (Hardy & Hardy, p 165). Role *strain*, on the other hand, is what the individual feels in response to the stress. An individual may experience a high level of stress in such conditions.

Hardy and Hardy (1988) identified several types of role strain in health care providers, one of which matches a type introduced by Kahn et al. in 1964: role overload. Their definition of role overload is an individual's having too many roles and not enough time to carry out each role adequately. Hardy and Hardy (1988) also indicated that role obligations and time limitations do not change, although people with work cycles that are periodic in nature may be able to adjust priorities to a certain extent.

Mobily (1987) studied socialization, role orientation and role strain in nursing educators. Taking the components of role strain from the literature, she devised a role-strain scale composed of 44 questions using a 5-point Likert-scale to determine the amount of stress felt by the role occupant. The Total Role Strain was a mean score determined by scale units on the role-strain portion of the questionnaire. The questionnaire contained items that dealt with the various components of role strain such as role ambiguity and role conflict. This scale was used along with a questionnaire dealing with socialization and role orientation.

In her 1987 study, Mobily found that 62% of her sample had terminal degrees either in nursing or another field, 82% holding the Ph.D. while 9.4% had an EdD. Those respondents who possessed master's degrees reported enrollment in a doctoral program. Most of the respondents had more than 10 years of collegiate teaching experience and had clinical as well as academic responsibilities. Most of the nursing educators spent more than nine hours in a clinical setting. In analysis of their academic role orientation, Mobily (1987) found that most nursing educators' actual orientation was in the area of teaching and research, whereas their ideal orientation would have included more research and less teaching. This finding may have been attributable to the study investigating nursing educators in large research-oriented universities (Mobily, 1987).

In her investigation of role strain, Mobily (1987) found that 20% of the nursing educators had a mean score of 3.5 or above which indicated a high degree of total role strain, while 30% of the nursing educators had a score of 3.0 -3.4 which indicated a moderate degree of role strain. Thirty-eight of the respondents fell into the low category of role strain with a score of 2.5 – 2.9 while 12% fell into the minimal category. When examining the source of the role strain, Mobily found that role overload was the highest rated among the subscale items with a mean score of 3.5, followed by role conflict with a mean score of 2.2. Using ANOVA, Mobily found the highest role strain scores occurred when teaching was emphasized over research and service. Mobily's work is important in that her scale is used in many athletic training role studies (Brumels & Beach, 2008; Charles-Liscombe, 2007; Henning &Weidner, 2008; Pitney, Stuart & Parker, 2008).

There have been a few studies that deal with role strain and athletic trainers (Capel, 1980; Charles-Liscombe, 2007; Hendrix, Acevedo, & Herbert, 2000, Henning & Weidner, 2008;

Pitney, Stuart & Parker, 2008). Capel (1986; 1990) examined burnout in athletic trainers in the 1980s and 1990s. In 1986 she measured burnout, role conflict and ambiguity, and locus of control with demographic variables such as contact hours and number of athletes assigned per athletic trainer. She found scores for burnout to be fairly low at that time, due to a large number of athletic trainers working by themselves, having an off-season, and perhaps receiving more positive feedback than in other health professions. Athletic trainers who had greater role conflict and ambiguity, external locus of control, a greater number of athletes to attend, and more hours spent with athletes had higher rates of burnout. Role conflict was the greatest predictor of burnout among the variables. Although these studies did not examine role overload, they were among the first studies to examine role stress in athletic trainers. In her most recent study, Capel (1990) examined reasons for attrition in certified athletic trainers. She surveyed athletic trainers about what they enjoyed about the profession and what made them leave the profession. The reasons most often cited for getting into the profession were working with athletes and the challenge it presented. The reasons most of the athletic trainers identified for leaving the profession were the long hours and excessive demands. Other reasons cited for having left the profession included "poor working conditions; work overload; role conflict; role ambiguity; [and] minimal decision-making power (…) in emotionally charged situations" (Capel, p 38).

In 2000, Hendrix, Acevedo, and Hebert examined stress and burnout in NCAA Division I university athletic trainers. These 118 athletic trainers were provided with five instruments that measured the individual's hardiness, social support, athletic training issues, perceived stress and burnout. Those athletic trainers who had a number of issues or concerns had higher levels of stress. While the dual roles of athletic trainer and curriculum coordinator were cited as possible causes of stress, this was not measured directly in this study.

Charles-Liscombe, in his 2007 dissertation, examined the degree of athletic training educators' role-strain and orientation along with their intentions to leave the profession. He surveyed 250 full time faculty athletic trainers who filled out six questionnaires. These documents included personal and employment information, an Academic Role Orientation Scale, an Academic Role Strain Scale adapted from Mobily's Role Strain Scale for Nursing (1987), and a series of questions relating to intention to leave the profession or their institutions.

All faculty members in this study held academic positions or held dual positions with athletics. Fifteen percent of the athletic trainers held dual administrative titles such as program director or head athletic trainer, 55% of the athletic trainers held only one administrative title, and fewer than 30% held a non-administrative title. The average workload was nearly 54 hours per week, with a minimum of 25 hours per week to a maximum of 100 hours per week. Time spent in clinical practice was nearly 16 hours per week, service responsibilities accounted for 12.25 hours per week, research accounted for 7.25 hours per week, and administrative duties accounted for more than 15 hours per week. The greatest amount of time was spent in teaching activities which accounted for more than 46 hours per week. Travel took the least time at three hours per week. Although these numbers provide some insight into the workload of athletic training faculty in this particular study, some of the numbers are questionable due to statistical analysis.

Turning to role strain in faculty athletic trainers, Charles-Liscombe (2007) found a weak, but positive correlation between the number of hours worked and total role strain $r(247) = .185$, ($p = 0.003$) and role overload, r(247) = .3549p,0.0010. In addition, role overload was the greatest source of role strain when compared with other types of role stress.

When investigating the characteristics of the role occupant, the individuals most likely to have problems with role strain were female, had five to nine years of faculty athletic training experience, held a terminal degree or were working toward a terminal degree. Instructors and assistant professors reported high levels of role ambiguity while clinical faculty experienced greater inter-role conflict. This type of conflict occurs when an individual is a member of a group and that membership leads to pressure from other groups. An example of this is the clinical athletic trainer feeling pressure from the coach to allow an athlete to play too soon following an injury (Kahn, et al., 1964). Charles-Liscombe (2007) found no significant scores for variables such as athletic affiliation, size of program, or stability of the program.

As a part of his study, Charles-Liscombe examined the actual faculty athletic trainer's role orientation, whereby athletic trainers delineate their responsibilities of teaching, service and research, against the ideal role orientation. Teaching was found to be most important in both their actual and ideal role orientation. Charles-Liscombe found that 50% of the respondents reported their actual role orientations of teaching and service having equal value. There were few athletic training faculty who emphasized research or service as being important. Their ideal role orientation would have been teaching or a combination of teaching and service. When asked about which role orientation was most suitable for an institution' s mission and goals, most of the respondents reported that a combination of teaching and service was most appropriate. When asked about what role orientation would be proper for athletic training education, the answer most frequently given was teaching and service.

In his examination of a faculty member's intention to leave the profession, institution, or athletic training education, Charles-Liscombe (2007) found few faculty athletic trainers who had

intentions of leaving. In faculty athletic trainers who had high role strain scores, however, more were likely to indicate leaving all aspects of athletic training and higher education.

In 2008, Pitney, Stuart, and Parker studied role strain in full-time physical education instructors and athletic trainers in the secondary school setting using a mixed-methods approach. After identifying athletic trainers who were working in the high school setting, Mobily's 1987 Role Strain Scale was adapted for use in the secondary setting and sent to a sample of high school athletic trainers. For the second part of the study, respondents were asked for further participation and provided contact information. Those individuals chosen to be interviewed were expressly chosen because they fell into one of four groups: high role strain, moderate role strain, low role strain and minimal role strain. The interviewees also had to be available on specific days and times for the telephone interview.

Sixty percent of the sample who completed the survey had low role strain scores. There was only one significant correlation, which was between the number of hours worked as an athletic trainer and role overload. A linear regression analysis was performed and the number of hours worked as an athletic trainer was found to be a significant predictor [*sic*] factor of total role strain. Further research discovered that as the number of work hours increased, the mean role strain scores also increased. Participants in this study worked 21 or more hours per week as an athletic trainer. In interviews with high school athletic trainers, higher degrees of role strain were perceived by those who were more accommodating in their roles. In other words, those who took on more responsibility as part of their jobs tended to have more role strain.

Henning and Weidner in 2008 investigated the problem of role strain in athletic-training-approved clinical instructors. These are individuals who provide clinical instruction, teach and evaluate athletic training skills. Henning and Weidner used a stratified random sample of

CAATE Approved Athletic Training Education Programs at NCAA Division I, II, and III institutions. Three athletic trainers from each school were asked to participate: the head athletic trainer, an assistant athletic trainer, and a graduate assistant. Again, the 1987 Mobily instrument was used and modified for use with clinical athletic trainers. Two versions of the Role Strain Inventory were used for head athletic trainers and assistant athletic trainers and one for graduate assistant athletic trainers. These surveys were administered during the spring of 2005 and fall of 2006 to get data during the busiest sport seasons. The participants represented all levels of NCAA divisions, both sexes, and all but one of the NATA's regional districts. Thirty-six percent of the head and assistant athletic trainers who were employed full time as athletic department employees served as approved clinical instructors, and 38% held dual position between athletics and an educational department. Division III had the highest number of dual appointments, whereas Division I had the fewest.

Investigation into the workload revealed that 78% of the head and assistant athletic trainers supervised three or more students per semester, and 85% were responsible for the care of more than 30 student-athletes per semester. However, only 31% of athletic trainers reported a workload of more than 40 hours per week. In looking at the graduate assistants, 88% were enrolled in nine or more hours, and 46% were in their first year of the assistantship.

Role strain among the athletic trainers was equally divided with 49% of the sample having higher levels of role strain and 51% reporting low levels of role strain. There were no significant differences based upon sex, number of athletes or other demographics. Within the different subscales, role overload had the highest mean score which provided for some of the overall role strain.

There was a higher degree of role strain for athletic trainers at the NCAA Division II level, although there were a higher number of dual appointments in NCAA Division III. There may less competitive pressure at the Division III level, providing for more balance in academic and clinical work.

The concept of role strain first articulated by Goode in 1961 has clearly taken on many forms and descriptions (Goode 1961; Hardy & Hardy, 1988; Kahn, Wolfe, Quinn, Snoek, and Rosenthal, 1964; Mobily, 1988). The term best related to this study, and will be used throughout is that of role overload, which according to Hardy and Hardy (1988) involves having multiple obligations that one cannot possibly meet. Faculty athletic trainers with institutional sports care responsibilities have not only academic demands, but institutional sports care demands that may not be met adequately.

Summary

The need for athletic training faculty is growing due to the expansion of athletic training programs in recent years (Guskiewicz, 2008 Hertal et al., 2001; Hertel, Buckley & Denegar 2001; Perrin, 2007). Athletic training faculty who are in tenure track and in similar employment situations will have to contribute in areas of scholarship, teaching and service, like those faculty in other professional areas. Athletic trainers may have faculty positions within the athletic training or kinesiology departments, clinical positions within the athletic department or have a dual appointment in athletics and athletic training education (Brumels & Beach, 2008; Staurowsky & Schriber, 1998). Dewald and Walsh (2009) indicated that service for an athletic trainer means not only serving on committees, but serving as athletic trainer for institutional sports teams. Clinical expertise as well as serving as an athletic trainer for institutional sports care may not be considered as service (Dewald &Walsh, 2009, Hertal et al., 2001 Perkins &

Judd, 2001). Dewald and Walsh also stated that there is much inconsistency as to what constitutes service, and that several institutions do not consider the use of job related skills as service.

Nearly 70% of athletic training departments are housed within schools or colleges of education and most still reside within department of physical education and/or kinesiology (Hertal, et al., 2001; Perrin, 2007; Rich, Kedrowski, & Richter, 2008). Rich, Kedrowski and Richter indicated that it is "likely that most-non health care faculty members are evaluated based on the traditional academic model of teaching, service and research" (p. 113). This traditional model may put athletic training faculty at a disadvantage when they have expectations for providing institutional sports care and these skills and responsibilities are not counted toward the service component in an athletic trainer's professional advancement. According to the 1997 Recommendations to Reform Athletic Training, the provision was made to "encourage new athletic training education programs to align themselves in college of health-related organizations" (p. 22). Many allied health departments use a medical model of professional advancement which emphasizes teaching, service, clinical service and clinical research (Borsa, 2005; Dewald & Walsh, 2009; Hertal, et al., 2001; Perrin, 2005; Perrin, 2007; Rich, Kedrowski, & Richter, 2008). Because most athletic training education departments are still housed in traditional physical education or kinesiology departments, most should be following traditional models of professional advancement through scholarship, teaching and service (Hertal, et al., 2001; Perrin, 2007; Rich, Kedrowski, & Richter, 2008).

Statement of the Problem

Athletic training faculty may be expected to provide care for institutional sports teams in addition to their responsibilities of teaching, research and service. According to recent literature

(Brumels & Beach, 2008, Dewald & Walsh, 2009; Hertal et al., 2001, Judd & Perkins, 2004), some athletic training faculty still provide clinical services for the institutions athletic programs, while others serve in both the athletic training education department and the athletic department. Rich, Kedrowski, and Richter (2008) stated that "little is known regarding the expectations of ATEP faculty" (p. 113). This lack of knowledge regarding faculty expectations raises the question of whether athletic training faculties have expectations that are not shared by other allied health personnel who may not have direct health care provider roles. For example, in a study of pre-tenured physical therapy professors, 41% of the sample had no time devoted to patient care, while 33% had less than 10% of their time devoted to patient care as indicated on distribution of effort forms (Harrison, Kelly, & Soderburg, 1996). More recent studies have indicated physical therapy faculties spend little to no time in patient care (Pagiarulo & Lynn, 2004). This was also found in nursing education literature as well (Cohen, Hickey, & Upchurch, 2009; Durham, Merritt, & Sorrell, 2007). If athletic training faculties have the expectation of providing health care, does this expectation put them at a disadvantage when seeking to advance professionally in terms of promotion, tenure or contract renewal?

Service to the institution, community and profession is a part of every faculty member's role in preparation for promotion, tenure or contract renewal (Preparing Future Faculty, n.d). Faculty athletic trainers are no different (Brumels & Beach, 2008; Dewald & Walsh, 2009; Hertel et al, 2001; Judd & Perkins, 2004). Service for faculty in general can mean anything from serving in the faculty senate, serving on departmental or university wide committees, advising of students, community service and membership or leadership responsibilities in state or national organization (Boyer, 1990; Preparing Future Faculty n. d.). For the faculty athletic trainer, service can mean serving on institutional committees, working national and worldwide sporting

events, presentations at state, regional and national meetings, and service to athletic teams within the institutions as well as outside groups (Dewald & Walsh, 2009; Perkins & Judd, 2001). According to Dewald and Walsh (2009) and Mangus (1998), however, institutions may not recognize the skill of athletic training as service, expecting the athletic trainer to place more emphasis on his or her career development.

In Boyer's *Scholarship Reconsidered* (1990), service for professoriate needs to be connected to their discipline and activities need to relate to the discipline. Boyer indicated that this type of service "is serious, demanding work requiring the rigor—and the accountability–traditionally associated with research activities" (p. 22). Service, in Boyer's view, is the scholarship of application. In terms of athletic training, it can be understood as applying new treatment techniques, working with athletes, working on a position statement, or aid in providing athletic training coverage to a high school or small college. This type of service or scholarship of application provides for the application of knowledge and skills that are unique to the athletic trainers working in an academic setting (Boyer, 1990).

The question that still persists is whether faculty athletic trainers who provide athletic training services to the institutions' athletic teams get credit toward their service requirements in their role as a faculty member. According to Staurowsky and Schriber (1998), 30% of the workload was composed of service to the athletic department, and of those who were not program directors, 50% had some type of athletic service responsibility. These authors recognized the demands of the faculty position and demands that are inherent in the athletic trainer's role. Staurowsky and Schriber (1998) indicated that the faculty review process failed to consider 30% of the athletic training faculties work responsibilities. The time-intensive nature of the athletic training duties was not accounted for in the traditional faculty role. Mangus (1998),

in his editorial, advocated the use of athletic training experience in the service component in the areas of teaching and research for professional advancement as a way to solve the problem of educating students and providing the clinical instruction needed. Perkins and Judd (2001) also recognized the problems in clinical practice. The issue was whether clinical practice should be weighed as a teaching, service, or research component in gaining promotion and tenure. Although the authors provided some solutions to accounting for clinical experience, the question remained unresolved.

In 2009, Dewald and Walsh examined the athletic training educator's role in the tenure-track position. The question of how to incorporate an athletic trainer's clinical skills is still an issue. Some athletic training faculty members still work with the athletic department. Dewald and Walsh indicated that "there is disparity in the service component of tenure" (p.145), and that most athletic trainers exceed their faculty colleagues in service. However this may fail to gain recognition by the institution and by the academic faculty.

Finally, do these expectations of providing care to institutional sports teams impede professional advancement in terms of promotion, tenure and contract renewal? Perrin and Lephart (1988) were the first to recognize that the time spent in clinical activity could interfere with promotion and tenure. They stated that the clinical educator who had service responsibilities was given little credit in the tenure and promotion process. Perkins and Judd (2001), who repeated Perrin and Lephart's study nearly 12 years later, would not find the answer to the dilemma of whether clinical activity should be counted as instruction, service or possible research. Judd and Perkins (2004), in examining program directors perceptions, found that to advance, the athletic training program director "must excel in teaching research, and service while assuming the added responsibilities in the ATEPD position" (p. 189).

In summary, faculty athletic trainers may have a dichotomy of expectations of being a health care provider as well as a faculty member. Nursing and physical therapy, professions closely associated with athletic training, have very little or no expectations of direct patient care for their faculty members (Harrison, Kelly, & Soderburg, 1996; Pagiarulo & Lynn, 2004). As athletic training education transitions from the realm of physical education and kinesiology to allied health, the extent of faculty expectations for direct health care needs to be examined. As Rich, Kedrowski, and Richter (2008) have indicated, little is known of the expectations for faculty. As faculty members, athletic training educators are expected to contribute to the faculty's mission of teaching, research and service (Brumels & Beach, 2008; Dewald & Walsh, 2009; Hertel et al., 2001; Judd & Perkins, 2004). However, if a large portion of the athletic training educator' s time is spent in service to institutional sports teams, should that service time be counted and how should that service be counted in the service requirement for promotion, tenure or contract renewal? Perkins and Judd in 2001 questioned the use of clinical practice and how it could be counted for teaching, service, or even research, but did not come to a conclusion. Finally, does the time spent in direct patient care of institutional sports teams impede professional advancement in terms of tenure, promotion and contract renewal for athletic training faculty and ultimately the growth of the profession? Most of the research performed in this area has been with program directors, not specifically with faculty (Judd &Perkins, 2004; Perkins & Judd, 2001 Perrin & Lephart, 1988). The NATA Task Force (1997) has recommended that more doctoral trained educators are needed in research and administration to help shape policy and research as well as instructing the next generation of athletic trainers.

Significance of the Study

Athletic training faculty members have had a long tradition of working with institutional athletic programs, beginning with the program director who was an athletic trainer as well as an educator (Perrin & Lephart, 1988). However, the profession is changing rapidly and those involved in education of athletic training students have research and service obligations depending on institutional requirements (Mangus, 1998). In addition some faculty may have expectations of working with institutional sports teams (Dewald & Walsh, 2009; Perkins & Judd, 2004). It is important to ascertain the extent to which extra duties persist as remnants from past positions where faculty athletic trainers typically worked with intercollegiate athletic programs as part of their employment. Rich, Kedrowski, and Richter (2008) have indicated that knowledge of faculty expectations is limited. It is important that athletic training faculty have fair and appropriate opportunities to pursue promotion, tenure or contract renewal depending on their employment situation. Knowledge of faculty expectations benefit not only faculty athletic training educators, but the profession as a whole in providing the research needed to enrich the profession as it continues to develop (Hertal, et al. 2001).

This study will be significant in terms of faculty expectations of athletic training faculty, of service expected and whether or not their service with institutional sports teams counts toward service in the research, as well as service and teaching triumvirate. The study will also be significant to those athletic training faculty who are seeking to advance through promotion, tenure, and contract renewal who wish to have a more clinically based approach. Those in clinically based allied health programs that have expectations that are not a part of their teaching research or service will find this study useful in examination of their service requirements. This study will also benefit those who direct athletic training education, kinesiology, or exercise

science or allied health departments. Finally, this study will be significant to those who participate in the promotion, tenure or contract renewal of athletic trainers and other allied health care providers.

CHAPTER 3: METHOD

The role of the athletic trainer as an educator, allied health professional and institutional sports care provider have continued to evolve since the 1996 Education Task Force Recommendation's for athletic training education were approved by the National Athletic Trainer's Association Board of Directors (Delforge & Behnke, 1999; Perrin 2007). As the profession has continued to grow, one of the issues facing athletic training faculty has been the professional advancement of the faculty member who provides institutional sports care responsibilities for the intercollegiate athletic program. The purpose of this study was to examine the extent to which athletic training faculty have institutional sports care responsibilities and their perceptions about these responsibilities in their professional advancement.

Research Questions

1. To what extent do faculties in college and university athletic training departments bear additional responsibilities for institutional sports care?
2. What is the belief of athletic training faculty that are assigned sports care responsibilities, related to how these responsibilities should be credited in professional advancement decisions?

3. What is the belief of athletic training faculty related to the importance of faculty maintaining sports care responsibilities as part of their employment?

4. Do athletic training faculties who have assigned institutional sports care responsibilities feel their professional advancement have been affected by these responsibilities?

Method

The purpose of this study was to investigate the extent of athletic training education faculty who also provide institutional sports care responsibilities, as well as well as their

perceptions about institutional sports care as service and its effect upon professional advancement. The research method used in this study is survey research. According to Charles and Mertler (2002) surveys are often used to investigate faculty loads and positions toward certain topics or ideas. The survey method is a cross-sectional study in that the data collected will come from a sample of a predetermined population (Borg & Gall, 1989). The research questions as well as the literature guided the formation of the survey instrument. This chapter will describe the population and sample, the survey instrument, procedures and method of data analysis.

Population and Sample

The Survey of Athletic Training Service and Professional Advancement (SATSPA) was sent electronically to the Board of Certification Certified Athletic Trainers with a professional designation of educator as their primary occupation. The total membership of the NATA is 27,458 with members working in various settings. Those working in the college or university setting compose 24% of the total membership. The population was further reduced by eliminating those persons indicating that they were professional athletic department or clinical staff (N= 4582 or 69.6% of college/university subcategory) (NATA Membership Statistics, 2010). Athletic training faculty generally work as full time academic faculty or have appointments in both academics and athletics (Brumels & Beach, 2008; Detwiler, 2010; Staurowsky and Schriber, 1998).

The number to be sampled by the investigator was determined to be 655 as determined by the Board of Certification who sent the survey to members whose primary occupation designation was that of an educator.

Design

This research is a descriptive cross-sectional case study as the results provide descriptions of the perceptions or attitudes that are held by a group (Borg and Gall, 1989). This study seeks to examine athletic training faculty members' perceptions of institutional sports care as service and its contribution to professional advancement. It is also cross-sectional study data that will be collected from a predetermined population of athletic training education faculty members (Borg and Gall, 1989).

Instrumentation

This study collected data via an instrument created by the researcher entitled *The Survey of Athletic Training Service and Professional Advancement* which was comprised of four sections. The first section was designed to collect information about the respondents and their sports care responsibilities, such as employment status, athletic classification, education and time spent in the current position. The second section gathered data related to the faculty members beliefs about institutional sports care responsibilities. The third section asked about credit for professional advancement. The fourth section collected demographic information such as employment status, athletic classification, education and time spent in the current position.

The survey was pilot tested for face validity with students currently engaged in a doctoral program. The survey was then examined by an expert panel of certified athletic trainers from a wide variety of backgrounds to determine reliability and validity (see Appendix A for a list of these individuals). These included a graduate athletic training program director, head athletic trainer of an NCAA Division II athletic program, an athletic training education program clinical coordinator, and head athletic trainer of an NAIA athletic program. After feedback was provided from the panel, improvements in the survey were made.

Data Analysis

Data for each participant, section, and survey item were analyzed using the SPSS data analysis software. Descriptive statistics was used to examine means and standard deviations. Inferential statistics were used to for t-tests and correlations. Emergent category analysis was used to analyze the qualitative data regarding beliefs toward institutional sports care responsibilities.

CHAPTER FOUR: RESULTS

Since its inception, athletic training has been associated with providing front line medical services for institutional sports programs by preventing, evaluating, and treating injuries and illnesses. However, as the professional knowledge base and expertise in athletic training has grown, the profession has evolved into an association with relationships not only with athletic programs, but also with other occupations and undertakings that emphasize physical activity. To this end, the certified athletic trainer is now considered an allied health care professional recognized by the American Medical Association (AMA, 1995-2012). Associated with these changes to the profession and recognition as allied health care providers, higher education programs for athletic trainers have appropriately changed as well. Just as faculty members in other allied health fields are expected to conduct research, contribute service to the institution, and instruct the next generation of health care professionals, athletic training faculty are also being held to these same expectations. The transition is not complete, however, and some athletic training faculty are still bearing the burden of providing medical service to their institutions' sports programs while also attempting to meet their teaching, service and research obligations. The purpose of this study was to examine the extent to which athletic training faculty continued to have these residual institutional sports-care responsibilities, and their perceptions of the effects of these responsibilities in their professional advancement.

Data for the study were obtained via a researcher-created electronically administered instrument titled *The Survey of Athletic Training and Professional Advancement* (SAPTA). The instrument was designed around the following research questions:

- To what extent do faculty members in college and university athletic training departments bear additional responsibilities for institutional sports care?
- What is the belief of athletic training faculty that are assigned sports care responsibilities related to how these responsibilities should be credited in professional advancement decisions?
- What is the belief of athletic training faculty related to the importance of faculty maintaining sports care responsibilities as part of their employment?
- Do athletic training faculties who have assigned institutional sports care responsibilities feel that their professional advancement has been affected by these responsibilities?

The survey was pilot-tested by students in an EdD program to determine content and face validity. The instrument was then evaluated by four certified faculty athletic trainers, all of whom had at least five years of clinical and teaching experience. Revisions were made to the instrument based on the feedback from these panels prior to distribution.

Sample and Population

The population was drawn from the National Athletic Trainer's Association Board of Certification e-mail list which included 655 (*N=655*) addresses of those members who listed their primary occupation as an educator. After an initial e-mail, two reminders were sent. A total of 255 participants responded to the survey; however, eight of those respondents opted out of participating. This number resulted in a response rate of 38%. Of those 247 (*n=247*) participants, 55 or 22% indicated that they had sports care responsibilities. Data were analyzed using IBM SPSS Statistics 19.

Demographics

There were 247 respondents to this survey, and of those respondents 200 answered the question regarding sex. Of the 247 who responded, there were 106 (43%) male respondents and 94 (38%) female respondents. Also of the 247, 185 were full time faculty members, and 12 were part-time faculty. The highest degree earned by the faculty included the PhD (*n*=65), the EdD (*n*=27) and the HSD (*n*=3). This is followed by those at the master's level with the M.S. (*n*=64), the M.A. (*n*=17), and the Med (*n*=12). Bachelor's degrees were the fewest with the B.S. (*n*=2) and the BA (*n*=1). Other professional degrees and doctoral candidates (*n*=11) made up the remainder of those who had advanced degrees.

Faculty athletic trainers were asked about their teaching load, clinical responsibilities, and time spent in administrative duties. Faculty reported teaching a range of 0 – 24 hours in the fall semester. The mean number of hours taught by the respondents was 9.2. The most frequently reported teaching load was 12 hours (*n*=42). This was followed by 9 hours (*n*=35) and six hours (*n*=33). Five faculty members indicated they taught no classes during the fall semester, and he reported that he taught 24 hours. For the spring semester, faculty athletic trainers reported teaching a range of 0 – 24 hours. The mean number of hours taught by the respondents was 8.74. The most frequently reported teaching load was 9 hours (*n*=45). This was followed by 12 hours (*n*=37) and by 6 hours (*n*=27) respectively. Six faculty members did not teach class in the spring, while one faculty member taught 24 hours.

When asked about their clinical responsibilities, most faculty members (*n*=100) indicated that they spent no time in clinical athletic training responsibilities. Faculty reporting the most time spent in clinical athletic training responsibilities (*n*=3) indicated that they spent 100% of

their time in clinical athletic training responsibilities. The mean percentage of time reported spent in clinical athletic training duties was 18.79%. When asked about their administrative duties, most faculty members (*n*=43) indicated that they spent 25% on these tasks, while 13 faculty members indicated that they spent no time and one reported 100% time spent in administrative duties.

When asked about the makeup of their sports programs, most of faculty indicated that they were affiliated with an NCAA Division I school (*n*=89), followed by NCAA Division III (n=44), and NCAA Division II (*n*=42) and NAIA (*n*=12) respectively. Of those who responded, 124 faculty members indicated that their institutions offered at least 14 or more sports, while 23 faculty members indicated that their institutions offered 10 or fewer sports. The faculty member was then asked if junior varsity sports were offered at their institutions. Although most (*n*=130) faculty declared that they had no junior varsity sports, 43 respondents indicated that their institution offered one to five junior varsity or club sports. When asked about their responsibility for these sports, 151 faculty members indicated that as staff, they were not responsible for junior varsity or club sports. There were 45 faculty members indicated they had a responsibility for junior varsity or club sports. Fifty-three faculty members indicated that they had 40 or more students formally enrolled in their Athletic Training Education Programs (ATEP), while 16 faculty members responded that they had 10 or fewer students in the program.

Major Findings

Research Questions

RQ1: To what extent do faculty members in college and university athletic training departments bear additional responsibilities for institutional sports care?

Of the 247 responses received, 55 (22%) indicated that there were expectations that they work with their institutions' intercollegiate sports care programs as part of their faculty responsibilities. These participants were asked about their time commitment to the sports care program in the number of hours per week. The range of hours worked per week was from zero to 75 hours per week with a mean of 36.8 hours. Respondents indicated they worked zero to three sports per semester with a mean of 2.2. With regard to the faculty member's clinical involvement in the intercollegiate sports care program, 23 (42%) responded that they were the primary sports care providers for home and away practices and competitions, whereas 20 (36%) responded that they were the primary sports care providers for home practices and competitions only.

In summary, of the 247 respondents, only 55 (22%) of the athletic training educators surveyed indicated having sports care responsibilities. Those 55 also indicated they had sports care responsibilities which required an average of over 36 hours per week and had responsibility for an average of two sports per semester. A total of 78% of these 55 had primary responsibility for either home events or both home and away events. It is important to note that 78% of athletic training educators responding to this survey indicate they do not have sports care responsibilities.

RQ2: What is the belief of athletic training faculty that are assigned sports care responsibilities related to how these responsibilities should be credited in professional advancement decisions?

Of the 55 participants who indicated that they had institutional sports care responsibilities, 48(87 %) indicated that they believed institutional sports care responsibilities should be counted as service to meet promotion, tenure and contract renewal guidelines. Five (9%) of the participants indicated that sports care responsibilities should not be counted as a part of the service requirement. There were two (4%) who did not respond to this question. In addition, 43 of these same 55 participants who had institutional sports care responsibilities indicated that institutional sports care responsibilities should be regarded as institutional service rather than community service. Only two participants indicated that it should be regarded as community service, while 10 (18%) did not answer this question.

An open-ended question sought to specify why athletic training faculty thought that these activities should or should not be counted as part of the service requirement. An emergent category analysis was performed on the qualitative data derived from this survey item and only one participant provided an explanation of why institutional sports care responsibilities should not be counted toward service. The other 32 respondents provided statements indicating their opinions as to why institutional sports care should be counted toward the service requirement. Five categories of answers emerged with the most frequent response category (n=11) indicating that athletic trainers needed to be able to count their institutional sports care responsibilities as service because it was part of their overall job expectations or within their contractual obligations.

The second-most frequently reported category (*n*=7) was amount of time needed to fulfill the responsibilities of caring for athletes, which left little time for other activities. The third category (*n*=4) was in the area of teaching and supervising student athletic trainers. Additional categories reported were service to school and profession (n =3), and time release for institutional sports care (n=3). Three comments did not fall into any category and were considered outliers. The verbatim comments can be found in Appendix C.

In summary, 87% of the 55 respondents who had institutional sports care responsibilities believed that they should be counted toward professional advancement, while 5% believed it should not. All but two respondents believed that these sport responsibilities should be counted as institutional service. However, 7% of the respondents did not indicate a service category. The verbatim responses can be found in Appendix D.

RQ3: What is the belief of athletic training faculty related to the importance of faculty maintaining sports care responsibilities as part of their employment?

Athletic training education faculty members were asked if the academic faculty should have institutional sports care responsibilities. Of the 199 respondents who answered this question, 121 (61%) indicated that they should not have institutional sports care responsibilities, while 78 (39%) indicated that they should have these responsibilities. An open-ended survey item asked for participants to specify reasons for their answers. Emergent category analysis was performed on the qualitative data gathered from this item. Among the answers given, four major categories emerged along with two minor categories. The most frequently reported answer for why they should have these responsibilities with 25 (10%) responses was the responsibility of maintaining current skills and education. A very similar theme with 24 responses was in the area

of teaching. Athletic training educators thought that it was important for their athletic training students to connect education with clinical practice. The third major category with 20 responses for why they should not was that educators need to concentrate on academic activities such as teaching, research, and grant writing. The fourth major category is in having a balance. There were 18 responses that the athletic training educator could not adequately balance the duties of educator and provide sports care responsibilities. The fifth category of answer with 11 responses indicated that athletic training educators should have the option or choice of having sports care responsibilities. The final category with six responses was that athletic training educators simply do not have the time for institutional sports care responsibilities. The verbatim responses can be found in Appendix E.

Athletic training educators were then asked if they believed that clinical athletic training faculty members who provide practical application or knowledge should have sports care responsibilities. Of the 198 participants who answered this question, 149(75%) believed that they should, while 49 did not. An open-ended question helped to clarify why respondents thought these activities should or should not be counted as part of the service requirement. An emergent category analysis was performed on the qualitative data derived from this survey item. Three major categories of answers emerged: (a) relevance to the job and teaching, (b) an expectation to do clinical work and (c) be clinically active, but not necessarily with the individual institution's sports program. In summary, although there is no general agreement among athletic training faculty related to the importance of faculty having sports care responsibilities, the academic faculty members clearly believe that they should not have these sports care responsibilities, while the clinical faculty members believe that should have sports care responsibilities. These findings are largely predictable. However most of the respondents who answered this question agreed

that athletic training clinical faculty should have some institutional sports care expectation. The verbatim responses to this question can be found in Appendix F.

RQ4: Do athletic training faculty members who have assigned institutional sports care responsibilities feel that their professional advancement has been affected by these responsibilities?

Respondents to the survey were asked whether they felt their sports care responsibilities contributed or impeded their chances of professional development. Fifty-five respondents (40%) indicated they had sports care responsibilities, and of those, 47(85%) shared their perceptions for this question. The greatest percentage, or 23.6% (*n*=13) of these faculty, perceived that having institutional sports care responsibilities had no effect on one's chances of professional advancement. Twenty percent of the respondents (n=11) of these faculty, however, felt that having sports care responsibilities greatly facilitated their chances of professional advancement, whereas 14.5% (*n*=8) of the faculty indicated that it somewhat facilitated their professional development. Those faculty who indicated that having institutional sports care responsibilities decreased their chances of advancement and those who felt that it greatly affected their chances of professional advancement returned the lowest figures at 12.7 % (*n*=7) respectively.

Sixty percent of the respondents to this question (*n*=149) reported they did not have sports care responsibilities. Of these 149 respondents, 43 (29%) indicated that institutional sports care responsibilities had no not effect on chances for professional advancement.

Twenty-five (17%) indicated that institutional sports care responsibilities somewhat facilitated chances of professional advancement, but another 17(11%) indicated that these

sports-care responsibilities greatly impeded one's chances of professional advancement. Eight (5%) indicated that institutional sports care responsibilities greatly facilitated one's chances of professional advancement. There were 37 (25%) of those faculty members with not institutional sports care responsibilities that indicated that this question was not applicable. Seventeen percent (n=43) of the sample did not respond to this question.

When data from both faculty with sports care responsibilities and those without, were aggregated, 22.0%, (*n*=56) indicated that having sports care responsibilities did not affect one's chances of professional advancement. Nearly 13% of all faculty (12.9%, *n*=33) indicated that institutional sports care responsibilities somewhat facilitated their professional advancement, while 10.2% (*n*=26) indicated that having institutional sports care responsibilities decreased their chances of professional advancement. Faculty who indicated that having institutional sports care responsibilities either greatly enhanced or greatly decreased their professional advancement were 7.5% (*n*=19) and 9.4% (*n*=24) respectively. This question was reported to not apply by 14.9% (*n*=38) of the faculty participants.

Additional analysis was performed using independent t-tests to determine whether there were any significant differences between responses for faculty members who had sports care responsibilities and those who did not. This finding was statistically significant at $p. < .01$ level of significance. When examining the means of each group, those with sports care responsibilities had a mean response of 2.87on a five point scale, while those without sports care responsibilities had a mean response of 3.83. (The means appear inverted due to the way the question was phrased in the survey. See Appendix B). This significant difference would indicate that these faculty members who had institutional sports care responsibilities were more

inclined to believe that these responsibilities increased their chances of professional advancement than did those who did not have such responsibilities.

In summary, the majority of faculty from both groups felt that having institutional sports care responsibilities had no effect on their chances of professional development. However, those faculty members that do have sports care responsibilities were more likely to feel that having these responsibilities increased their chances of professional advancement. This finding could be characterized as unexpected given the amount of time required for institutional sports care activities, which would seem to leave less time for pursuit of advancement. However, the findings indicate that 34.5 % of those with sports care responsibilities felt that these duties increased their chances of professional advancement.

Ancillary Findings

There were a number of ancillary findings with this research study. Pearson's *r* correlation analyses were run to determine relationships of the demographic data and the data related to the research questions. These ancillary findings follow.

Faculty Status and Percentage of Time in Clinical Activity

When examining the relationship between faculty employment status and percentage of time spent in clinical activities, there was a positive correlation of .301 (+.301) with an Alpha level of <.01. This statistic indicates a positive significant relationship between current faculty employment status and the percentage of time spent in clinical activity. This indicates that full-time faculty members were more likely to spend more time in clinical activity than those who were part time or adjunct faculty members. This finding is likely to be due to the fact that 22%

of faculty, almost all of whom indicated that they were full-time, had some institutional sports care responsibilities.

Faculty Employment Status and Highest Degree Earned

There was also a positive significant correlation of .242 (+.242) with an Alpha level of <.05 with faculty employment status and an advanced degree of PhD or an EdD or an HSD. This indicates a positive relationship between the degree earned and faculty employment status.

Degree Earned and Sports Care Responsibilities

A Pearson's *r* performed on the data indicated a positive correlation of .427 (+.427), with an Alpha level of <.01 between the data for the degree earned and whether or not the faculty member had institutional sports care responsibilities. This relationship indicates the less advanced the degree earned, the more likely the respondent would have institutional sports care responsibilities. Of the 55 faculty respondents who had sports care responsibilities, 33 faculty members with an MS degree or equivalent had sports care responsibilities, while only four with a PhD or equivalent had such responsibilities.

Belief in Sports Care Responsibilities Contributing to Professional Advancement and Degree Earned

There was a significant positive correlation of .231 (+.231) with an Alpha level of <.01 between institution sports care responsibilities contributing to advancement and highest degree earned.

Institutional Sports Care as Service

Finally, when asked to comment on institutional sports care as service requirements for faculty athletic trainers, most comments were related to having too much to do or not enough time to perform institutional sports care. Secondary comments were related to teaching, setting an example, and keeping skills sharp. There were three comments that were negative toward institutional sports care as service.

Chapter Summary

There were 655 faculty members surveyed for this study with 255 responding and eight who did not wish to participate for a response rate of 38%. It is important to note that 88% of athletic training educators responding to this survey indicate that they do not have sports care responsibilities. Of the 247 respondents, only 55 (22%) of the athletic training educators surveyed indicated having sports care responsibilities. However, these 55 overwhelmingly believe that these sports care responsibilities should be counted toward professional advancement, particularly those as institutional service credits. When faculty members were asked about their beliefs toward institutional sports care responsibilities, there was a clear difference between the academic faculty and clinical faculty. A majority of academic faculty indicated that they should not have institutional sports care responsibilities because of academic responsibilities and the need for balance in the workload. However some of the academic faculty felt that these responsibilities were beneficial due to the maintenance of clinical skills and for teaching duties. Clinical faculty indicated that they should have institutional sports-care responsibilities due to relevance to the job and an expectation of doing clinical work. There was no general agreement among athletic training faculty related to the importance of faculties

having sports care responsibilities. When data from both groups of athletic training faculty were analyzed, those with and without institutional sports care duties perceived that these responsibilities did not affect their chances of professional advancement. However, those faculty members who do have sports care responsibilities were more likely to feel that having these responsibilities increased their chances of professional advancement.

CHAPTER FIVE: DISCUSSION

Purpose

Historically, athletic training as a profession has been instrumental in the prevention, care and rehabilitation of sports injuries. Professionals who serve in this field are prepared in college programs just as other allied health professionals. These college programs are staffed with faculty members who have often been required to assume the role of classroom and clinical educators, as well as assuming responsibilities for institutional sports care. This additional service to sports teams however, generally does not negate the research and service expectations required for professional advancement. Determining the extent to which these sports care obligations have changed as athletic training has evolved as an allied health field is the purpose of this study. Specifically, this study sought answers to the following questions:

- To what extent do faculty members in college and university athletic training departments bear additional responsibilities for institutional sports care?
- What is the belief of athletic training faculty who are assigned sports care responsibilities, related to how these responsibilities should be credited in professional advancement decisions?
- What is the belief of athletic training faculty related to the importance of faculty maintaining sports care responsibilities as part of their employment?
- Do athletic training faculty members who have assigned institutional sports care responsibilities feel that their professional advancement has been affected by these responsibilities?

Population

The population for this study was 7,052 athletic trainers working in a college or university setting, working at NCAA Division I, II, and III and the NAIA as identified by the NATA Membership Statistics (2012). The sample for this study was 655 certified athletic trainers identified by the Board of Certification as having their primary occupation listed as athletic training educators. A total of 255 participants responded to the survey; however, eight of those respondents opted out of participating in the survey. This number resulted in a response rate of 38%. Of those 247 participants, 55 or 22% indicated that they had sports care responsibilities in addition to their teaching duties.

Methods

The names of 655 certified athletic trainers were chosen by the Board of Certification whose primary occupation was that of educator. An e-mail mass mailing was sent by the Board of Certification with the purpose of the study and the survey link were sent to these individuals. Once individuals responded to the link, they were provided with a letter of informed consent which provided contact numbers for the researchers and the IRB, as well as the opportunity to opt out of participation. After the initial e-mail, a reminder was sent out every two weeks for a six-week period. The survey was closed after this period.

The quantitative data were analyzed using SPSS 19 to generate descriptive statistics such as means and percentages while inferential statistics were used to generate t-tests and correlations. Emergent category analysis was used to analyze comments made by the respondents, which gave a more in-depth analysis of their beliefs toward institutional sports care.

Findings

The findings of this study, based on the sample, suggest that the number of athletic training faculty members who also have institutional sports care responsibility is decreasing. However , the 22% (*n*=55) who responded to this survey who did have these responsibilities indicated that they spent an average of 36 hours each week providing care for two sports each semester. Additionally, these faculty members believe this responsibility should be counted as service for professional advancement. The primary reason given for this belief was largely that it was required under contract with the institution. Other reasons included a lack of time for the care responsibilities and a lack of balance between training duties and education responsibilities.

The findings indicate that respondents believe athletic training academic faculty should not have institutional sports care responsibilities. Among the responses that were given for this recommendation were these: (a) a lack of balance between athletic training care duties and educators' responsibilities; (b) no time for institutional care responsibilities; (c) needing to spend more time on academic activities; and (d) allowing an option for sports care responsibilities. Among the responses that were given for having these responsibilities were these: (a) keeping skills current; (b) connecting teaching with clinical skills; and (c) having a balance of education and clinical activity.

When the data were disaggregated for those respondents who are considered athletic training clinical faculty and those who are considered to be athletic training academic faculty, there was a statistically significant difference in opinions about sport's-care responsibilities. The data indicate that respondents felt that clinical athletic training faculty should have institutional sports care responsibility, but this was not true for the educational faculty. The reasons given as

to why clinical faculty should have these responsibilities included (a) relevance to the job and teaching; (b) there is an expectation to do clinical work; and (c) clinical faculty should be active, but not necessarily with the respective institution's sports teams.

Overall, most of the faculty members surveyed believed that institutional sports care responsibilities affect one's chances of professional advancement. Even the faculty who did have sports care responsibilities was more inclined to believe that these responsibilities increased their chances of professional advancement than those who did not.

Analysis of the ancillary data revealed a positive relationship between faculty employment status defined as full-time and time spent in clinical activity. The positive relationship is likely to be due to the fact that 22% of faculty, almost all of whom indicated that they were full-time, had some institutional sports care responsibilities. Most athletic training faculty indicated that they did not have the time to participate in sports care responsibilities. Those who felt that having sports care responsibilities was beneficial were related to maintaining clinical skills and providing a role model for students.

Discussion

Athletic Training Faculty and Institutional Sports Care Responsibilities

As athletic training faculty have evolved from being primarily sports-care providers for the institution's intercollegiate athletic programs to providing instruction for allied health care professionals, the data, based on the sample in this study, indicate that there are very few educational faculty who are now providing institutional sports care responsibilities for their school's athletic program. According to this study, only 55 respondents or 22% of 247 participants had such responsibilities. The number having sports care responsibilities was less

than 25% of the total sample. This low number is indicative of other studies that have shown a decline in faculty sports care responsibilities (Bell, 1989; Fuller and Walker, 2003; Perkins and Judd, 2001; Perrin & Lephart, 1988; Staurowsky and Schriber, 1998). This trend may indicate that athletic training faculty members are becoming more like other allied health professionals who do not have extraneous duties or expectations. Recent studies of nursing and physical therapy indicate that individuals who teach in these professions have little or no obligation to duties in the field (Cohen, Hickey, & Upchurch, 2009; Harrison, Kelly, & Soderburg, 1996). Likewise, the data from this study suggest that athletic training faculty members are spending less time with institutional sports care responsibilities.

Institutional Sports Care Responsibilities as Service

Responding athletic training faculty who do have institutional sports care responsibilities indicated their belief is that those who do have these responsibilities should be able to credit them toward their service requirement in their professional advancement to meet tenure, promotion or contract renewal. One of the major reasons cited by respondents for this belief is that since sports care responsibilities were required and considered to be part of the employment, they should be evaluated and applied to professional advancement requirements. One respondent put it this way:

> It is a HUGE part of our job. I spend the equivalent of a full time job (on top of teaching a full course load) with my teams and it should count for something other than "service to the campus." If it's in my job description, I should be able to use it for reappointment, tenure, or promotion.

Other respondents who have institutional sports care responsibilities indicated that they should be counted as service because they involve service to students. “1-it is an extension and utilization of the knowledge and experience taught in the classroom setting. 2-It also serves as an internship setting where student trainers are taught and supervised.” In addition to service to students, some respondents indicated that these sports care responsibilities represent service to the institution and profession:

> Because these [sports care] responsibilities are a service to the institution and they represent the provision of health care services that saves lives and rehabilitates musculoskeletal injuries on student athletes. Aside from the services rendered to student athletes regarding health care, the provision of these services is also part of the teaching process of athletic training students. Athletic training students are assigned clinical responsibilities that require the supervision of faculty acting as accredited clinical instructors. The provision of health care and the teaching of these services go hand in hand so using these activities for promotion and tenure would be no different than teaching in the classroom. In fact, they would be more valuable because of the application of taught skills and health care procedures.

Yet another respondent said, “[I]t is work which clearly demonstrates proficiency in the field - which is by definition 'service to the university and the profession.” The final reason athletic training faculty with institutional sports care responsibilities indicated that this service should be counted toward the service component is the amount of time involved. On respondent said:

> [B]ecause we are putting in a tremendous amount of time treating and caring for athletes which can impact student athlete retention, however, it leaves us little time to do more

things on and off campus such as: serving on committees, promoting the program and university at off campus functions, etc.

Not all faculty athletic trainers with institutional sports-care responsibilities felt that these responsibilities should be counted a service. One faculty member stated, "They are not specifically related to academic endeavors or faculty responsibilities unless expressly related to student observation or experience." However, based on the quantitative and qualitative findings of this study, the majority of faculty athletic trainers in this sample who have institutional sports care do believe that they should be able to count these responsibilities as service to meet promotion, tenure and contract renewal guidelines.

Athletic Training Faculty Belief Toward Institutional Sports Care Responsibilities

Athletic training academic faculty. Athletic training academic faculty, as opposed to clinical faculty, responding to this study overwhelming believes that they should not have these institutional sports care responsibilities. A number of reasons were given for this, with the most common being that the education faculty need to concentrate on academics. One education faculty respondent from the survey said, "Most faculty have a full teaching load of 4 classes along with advising, research, grant, committee expectations. To expect someone to provide more time than the full time job faculty already entails is unrealistic. It also minimizes our profession." The issue of balance was also a reason athletic training academic faculty gave for believing that they should not have sports care responsibilities. One respondent believed this:

> After being in a dual role {both teaching and sports care responsibilities} for 7 years and having increased responsibilities every year, I would NOT recommend a dual position to someone considering it.(…) I feel that dual positions can almost be negligent in that the

> potential to sacrifice one or the other constantly occurs. One either sacrifices the best possible care that the athletes could receive or you sacrifice in the classroom. Both are equally important. Sometimes I feel that the dual position is doing a disservice to the profession because if you sacrifice on the academic side, then what kind of "product" or caliber clinician are we giving to the profession.

Still others indicated reasons for not having sports care responsibilities such as a lack of time:

> I've had sport responsibilities (…) in the past. [E]ven a 'minor' sport such as tennis requires a great amount of time from daily, clinical, class preparatory, and administrative duties. It would be impossible to have the time necessary to devote to tenure advancement if you were engaged in daily sport coverage.

Some athletic training academic faculty thought that having institutional sports responsibilities should be an option for the faculty member. One respondent from the survey said, "I don't think it should be a requirement, however in my own experience, helping out every once in a while keeps my clinical skills sharp." Other faculty indicated that faculty could be active, but not necessarily with the institutions sports teams. One respondent indicated, "Some faculty are involved with athletic training with organizations outside of the institution. While I think hands on practice is good for faculty, I don't know that institutional practice is the only option."

There was however, some athletic training faculty who believed that they should have institutional sports care responsibilities. Most of the reasons given for this belief were related to keeping their athletic training clinical skills current. One respondent from the survey said, "I think it allows you to stay up on your skills and it helps you to remember the 'shades of gray' in

the field that you sometimes lose sight of when teaching only." Closely related were comments related to teaching. One respondent said this: "Allows the students to see faculty doing what they teach and acting as role models." Although there was some ambivalence on this issue, the majority of respondents indicated that academic faculty members do not believe that having institutional sports care responsibilities is important to maintaining employment.

Athletic training clinical faculty. The majority of the respondent who are athletic training faculty that have clinical responsibilities believed that athletic training clinical faculty should have some institutional sports care responsibilities. An independent samples t-test was found to indicate a significant difference in what the academic faculty and the clinical faculty members believe about assigning institutional sports care responsibilities to the athletic training faculty. The clinical athletic training faculty members were more likely to believe in the appropriateness of having institutional sports care than the educational faculty. When respondents were asked why they had this belief, many respondents indicated that this was an expectation for a clinical athletic training faculty member. One respondent asked, "If they did not have sport care responsibilities, how would they be clinical faculty? To whom would they provide patient care if not institutional athletes?" This situation may be due to a lack of appropriate clinical sites other than in the institutional athletic program in which to practice clinical athletic training skills in some areas.

Even though the respondents indicated that clinical athletic training faculty members should have some institutional sports care responsibilities, answers to why they should have these duties were varied. Emergent category analysis data indicated three major categories of answers on this issue. The first of these is relevance to the job and teaching. One respondent answered, " For the same reason, it is important to stay current and I believe you can teach more

effectively in a clinical situation." Yet another respondent said, "Teaching makes one a better clinician." The second major reason is an expectation to have institutional sports care responsibilities. "(…) Clinical faculty are just that...clinical. It should be expected they work within the institutional sports arena." Yet another respondent stated, " If you are clinical faculty it should be implied that you are working clinically for the institution and with such title would mean you work in the sports care arena." Some respondents indicated that clinical athletic training faculty should have some sports care responsibilities, but not necessarily with the individual institutions' sports' teams. One respondent indicated that, "[c]linical faculty must maintain some level of clinical practice; but again, this does not have to be with the college/university setting." Another respondent indicated "Maybe (…) I can think of 6 or 8 examples of clinical care that do NOT involve sport participants."

In summary, there does not seem to be a general consensus among athletic training clinical faculty about the belief of maintaining institutional sports care responsibilities as part of their employment. The clinical athletic training faculty believed that there should be some institutional sports care responsibilities due to teaching and job relevance. However, some clinical athletic training faculty believed that sports care responsibilities could be accomplished outside of the institutions' sports programs. This difference in belief could indicate that many athletic training academic faculty members have become more like other allied health education practitioners who have little or no patient care responsibilities (Cohen, Hickey, & Upchurch, 2009; Harrison, Kelly, & Soderburg, 1996).

Institutional Sports Care Responsibilities and Professional Advancement

Survey respondents perceived that institutional sports-care responsibilities did not affect their chances of professional advancement. When the data were disaggregated separating those with institutional sports care responsibilities and those without, a significant difference was found. Those faculty members with institutional sports care responsibilities were more likely to believe that these responsibilities contributed to their professional advancement than those who did not have these duties. This finding was somewhat unexpected in that institutional sports care responsibilities could have interfered with professional advancement, however 34.5% believed that it somewhat facilitated professional advancement. This finding is likely due to the fact that those with sports-care responsibilities and teaching duties have little time for serving on committees, advising, or serving as a faculty representative. In addition, some faculty members who provide sports care responsibilities may feel that these responsibilities are service to their school instead of more traditional service activities.

Comments by those who have these responsibilities indicate that there is little time for other faculty activities: "Clinical education is both academic and practice/service-based. However, this takes an absorbant [*sic*] amount of time. We do not usually have the same amount of time as other faculty to get involved in research or other scholarly activities." Another respondent said this:

> [B]ecause we are putting in a tremendous amount of time treating and caring for athletes which can impact student athlete retention, however, it leaves us little time to do more

things on and off campus such as: serving on committees, promoting the program and university at off campus functions, etc.

Those athletic training faculty who have sports care responsibilities do not have the time to attend to other faculty activities, so some other activity has to contribute to their professional advancement. Since this time is spent not only in institutional sports care responsibilities, but in teaching students and in contributing to the institution and profession, clinical athletic trainers may be more disposed to believe that these responsibilities contribute to professional advancement.

Ancillary Findings

Employment Status and Clinical Activity. One of the ancillary findings was a positive correlation between full-time faculty status and the amount of time spent in clinical activity. This indicates that full-time faculty members were likely to spend more time in clinical activity. This is likely due to the fact that 22% of faculty members of the entire sample, almost all of whom indicated that they were full-time, had some institutional sports care responsibilities.

Institutional Sports Care as Service. The respondents were asked to comment on institutional sports care as service requirements for athletic training faculty members. Most of the comments were related to not having the time to devote to institutional sports care responsibilities:

> Realistically, it is difficult for full time faculty to have blended positions with the service, teaching, administrative, (for PDs) and scholarship requirements. Ideally, it would be great to continue involvement in clinical practice, but considering the previous, time, and salary, it is very difficult in many cases.

Another respondent indicated, “Unfortunately, the rest of academia doesn't even know what athletic training is to understand our normal responsibilities. Having sport coverage would have detrimental effects on promotion and tenure.”

There were some respondents who indicated that having institutional sports care was beneficial. Most of these comments were related to being a role model for students:

> If we want our students to become athletic trainers and promote our profession, we need to promote it also. Too many educators want to sit in front of a computer and come up with ‘perfect world, real time scenarios’ for students; our world isn't perfect, and real time, should be real time. If students see us in our real positions, they will be better professionals.

Still others indicated the need to keep and maintain skills: “I strongly believe professors need to get out in the field and stay current. I covered a local high school for a (…) colleague and I learned so much. I teach differently because of that experience.” Finally some comments were negative toward institutional sports care as service: “If faculty are part of a tenure track line, it is counterproductive to have them responsible for institutional sports care responsibilities. This becomes a tenure killer! Not enough time is allotted to develop lines of research.” To summarize, the respondents were divided on whether or not institutional sports care responsibilities should be counted toward the service requirement.

Conceptual Framework

Role-overload theory provided the conceptual framework for this study. This phenomenon of role overload occurs when an individual has more roles than the time allotted to carry out each role (Hardy & Hardy, 1988; Kahn, Wolfe, Quinn, Snoek, & Rosenthal, 1964). In

previous studies that have examined this experience among athletic trainers, role overload levels were found to be low or moderate (Capel, 1986; Charles-Liscombe, 2007; Hendrix, Acevado, & Herbert, 2000; Henning & Weidner, 2008, Pitney, Stuart, & Parker, 2008). The findings from this study indicate that role overload were very low or non-existent. Specifically, the findings of this study revealed that only 22% of the athletic training faculty members responding to the survey had sports care responsibilities.

However, if the remarks of the 22% of the sample population are considered as indicators, it is possible to speculate that role overload factors are present among that specific group of faculty that do have the dual roles of faculty and care providers. These faculty members reported several issues in their reasons for believing they should have or have not institutional sports care responsibilities. One respondent said: "(….) Responsibilities and documentation requirements have increased exponentially over the years, creating a situation where staff members are performing two [j]obs. Each aspect, [e]ducation and [s]ervice suffers. Still another respondent said this:

> I left this setting 6 monts [*sic*] ago after being there for 3 years. It was very difficult to balance academics (students) and sports (care for athletes). If you focus on one then the other suffers. Then you end up working more hours 12-14 for very little pay.

Some of the respondents felt conflicted on this issue. One faculty member states it this way:

> This is a tough question because I see the value in having a split assignment. But I can attest to the fact that it is virtually impossible to provide quality of care to the athletes

> while trying to maintain and succeed in a faculty position. I also feel that it is a disservice [*sic*]to our profession to continue to fulfil[*sic*] both roles at the same time.

Still another faculty member said this:

> Yes and No. I say yes because I feel that those that are providing the didactic education should still be practicing at some level. I say no because it's next to impossible to do each aspect of the job at 100% consistently which is what the students and student-athletes deserve.

In summary, there have been low-to-moderate levels of role overload among athletic training faculty. Today, based on a limited sample, there are very few faculty athletic training members with institutional sports care responsibilities. This is consistent with other studies (Capel, 1986; Charles-Liscombe, 2007; Hendrix, Acevado, & Herbert, 2000; Henning & Weidner, 2008, Pitney, Stuart, & Parker, 2008). However, there is a small percentage of these professionals who acknowledged that a balance of roles is necessary. Others remain conflicted on this issue. As the profession continues to advance as an allied health profession, the possibilities for role overload will continue to diminish, at least that are caused by having institutional sports-care responsibilities and conflict with faculty roles.

Conclusion

The findings of this study indicate that very few of the respondents have institutional sports care responsibilities as part of their employment. The 22% of respondents, who have these responsibilities overwhelmingly, believe that these responsibilities should be counted as institutional service credits toward professional advancement. Among the reasons cited for this were that sports care is part of the position, it is a service to students, institution, and profession,

and amount of time involved in providing sports care responsibilities. Athletic training faculty with only academic responsibilities overwhelmingly believed that they should not have institutional sports care responsibilities due to the demands of the academic career and issues of employment balance, and a lack of time. However, the athletic training academic faculty who believed that they should have some sports care responsibilities cited the reasons of keeping clinical skills current and role modeling for students. Others were divided or thought it should be an option for the faculty member. Conversely, athletic training clinical faculty believed that they should have some institutional sports care responsibilities. They were more likely to believe in the appropriateness of these duties than the educational faculty. However, the reasons cited were more varied and included relevance to the job and teaching, an expectation they would have such responsibilities and an expectation to do clinical work, but not necessarily with the institutions sports programs.

Overall, athletic training faculty believed that having these institutional sports care responsibilities did not affect their chances of professional advancement. Faculty who had institutional sports care responsibilities, in fact, were more inclined to think that these responsibilities increased their chances of professional advancement than those who did not have these duties. Most athletic training faculty indicated that there was no time to devote to institutional sports-care responsibilities due to the demands of the academic career. However, those who thought of these responsibilities as beneficial related them to teaching and maintaining clinical skills.

Implications for the Profession

Administrators and program directors need to understand that faculty members with institutional sports-care responsibilities have demands on their time that others in faculty roles do not face. These responsibilities leave little time for committee meetings or serving as faculty representatives, or other typical university-service-oriented activities. These sports-care responsibilities should count as service based on responses reported herein, because they are a part of the job expectation,(i.e., providing a service to instruction of the athletic training student and providing a service to the institution's intercollegiate athletic program).

As the profession continues to grow, faculty who have institutional sports care responsibilities are becoming the exception rather than the norm. Increasingly, they are becoming more like faculty in other allied health professions, such as those in nursing and physical therapy.

There is a clear difference in the beliefs of the academic and clinical faculty members toward institutional sports care responsibilities. Alternative service expectations could be developed for those who have academic roles and those who have clinical roles, not unlike the case of medical schools who have tenured and non-tenured faculty. In addition, there needs to be a service option for those who wish to practice in athletic training, although it is not required in a faculty role.

Overall, institutional sports care responsibilities are not perceived to affect one's chances of professional advancement; however, those who had these responsibilities were more inclined to think that these responsibilities contributed to professional advancement. Athletic training

faculty members who have or take on a dual role need to be aware of service expectations and how these expectations fit into their institution's plan for professional advancement.

Recommendations for Further Research

1. Further research should include an examination of athletic training faculty members who can count their institutional sports care responsibilities as service and how those hours are credited.
2. An inquiry should be made into how athletic training faculty members came by the belief that having institutional sports-care responsibilities aids in promotion, tenure or contract renewal.
3. Further research should include an examination into other areas besides institutional sports care as credits for service for athletic training faculty. As athletic training has expanded into industry, performing arts and other physically active professions, there are numerous opportunities for service.
4. An investigation of service requirements for athletic training faculty members by Carnegie Classification rather than by NCAA or NAIA designation could be undertaken. This may reveal some insights into service for athletic training faculty based on additional institutional demographics.
5. Further studies should examine the systems of promotion for those athletic training clinicians who are not considered to be faculty members. This could include those who work in institutional sports care and those who work outside of academic institutions.
6. A study investigating appropriate levels of clinical activity would be for education faculty to maintain clinical skills could further contribute to research in the field. Many

athletic training education faculty members cited the benefits of having such activity to maintain clinical skills.

7. Further research should examine how much time should be required and what an appropriate level of clinical activity would be for those athletic training faculty or approved clinical instructors who supervise athletic training students. Many respondents indicated the necessity of role modeling for student athletic trainers.
8. There should be an examination of the different types of contracts between those of athletic training faculty and those in other allied health fields within institutions and between institutions. This may reveal some differences in expectations.
9. There should be a comparison between the service expectations of both academic and clinical faculty between those who are housed in the schools of health and physical education or kinesiology, and those who are housed in schools of allied health.
10. Further research should include a closer examination of teaching and research assignments of both academic and clinical faculty members and the amount of time spent in each of these duties.

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APPENDICES

APPENDIX A: EXPERT PANEL

1. Peggy Blackmore-Haus, M.S. ATC
   Head Athletic Trainer
   University of the Cumberlands
   Williamsburg, KY 40769

2. Janet Rorrer, M.S. ATC
   Assistant Professor of Biology
   University of Charleston
   Charleston, WV 25304

3. Michelle Sandrey, Ph.D.
   Graduate Athletic Training Director
   West Virginia University
   Morgantown, WV

4. Curtis Zeilenga M.S. ATC
   Head Athletic Trainer
   University of Charleston
   Charleston, WV 25304

APPENDIX B: SURVEY INSTRUMENT

Survey of Athletic Training Service and Professional Advancement

1. As part of your faculty responsibilities, are you expected to work with your institution's intercollegiate sports programs?

   □ No (skip to #8) □ Yes

   Intercollegiate Sports Care Responsibilities

2. How would you best describe your time commitment to the institution's intercollegiate sports program in hours per week? (hours /week)_____

3. What is the extent of your clinical involvement with your institution's intercollegiate sports program?

   □ I am clinical only (No coverage of practice or competition).
   □ I am the secondary sports care provider for home competitions only.
   □ I am the primary sports care provider for home competitions only.
   □ I am the secondary sports care provider for home practices and competitions.
   □ I am the primary sports care provider for home practices and competitions.
   □ I am the secondary sports care provider for home and away practices and competitions
   □ I am the primary sports care provider for home and away practices and competitions
   □ Other (please specify)_____

4. How many sports do you work with each semester?

   □ 0 □ 1 □ 2 □ 3 or more

5. Which intercollegiate sports are you responsible for working? Please check all that apply.

   Men's Sports
   □ Baseball
   □ Basketball
   □ Cross Country
   □ Football
   □ Golf
   □ Gymnastics
   □ Soccer
   □ Swimming & Diving
   □ Tennis
   □ Track & Field (Outdoor)
   □ Volleyball
   □ Wrestling

   Women's Sports
   □ Basketball
   □ Cheerleading
   □ Cross Country
   □ Field Hockey
   □ Golf
   □ Gymnastics
   □ Soccer
   □ Softball
   □ Swimming & Diving
   □ Tennis
   □ Track & Field (Outdoor)
   □ Volleyball

□ Other (please specify)_____

Other (please specify)_____

Perceptions of Athletic Training Faculty with Sports Responsibilities

6. In your opinion, should athletic training faculty that have any institutional sports care responsibilities be able to count these activities as "service" to meet promotion, tenure or contract renewal guidelines?

□ No □ Yes

6a. Why?

Faculty Maintaining Sports Care as Part of Their Employment

7. In your opinion, what professional advancement category should institutional sports care responsibilities be attributed?

□ Institutional Service □ Community Service
□ Other (please specify)_____

8. Do you believe that athletic training **education** faculty should have institutional sports care responsibilities?
□ No □ Yes

8a. Why?

9. Do you believe that athletic training **clinical** faculty should have institutional sports care responsibilities?
□ No □ Yes

9a Why?

11. Ideally, what percentage of an athletic training faculty member's time should be allotted to institutional sports care responsibilities? _____

Effects of Sports Care on Professional Advancement

12. At my institution, I feel that one sport's care responsibilities:

□ Greatly facilitate one's chances of professional advancement
□ Somewhat facilitate one's chances of professional advancement
□ Do not affect one's chances of professional advancement
□ Decreases one's chances of professional advancement
□ Greatly impedes my chances of professional advancement
□ Not Applicable

Please tell us about yourself and your institution – Check the box that best describes you

13. Please indicate your sex.

□ Male □ Female

14. What is your current faculty employment status?

□ Full-time Faculty □ Part-time Faculty □ Adjunct Faculty

15. What is your institution's athletic classification or affiliation?

□ NCAA Division I □ NCAA Division II □ NCAA Division III □ NAIA

16. How many course credits do you teach in an academic year?

Fall_____ Spring_____

17. Approximately what percentage of your work time is spent engaging in clinical athletic responsibilities?_____

18. Approximately what percentage of your work time is spent engaging in administrative duties?
_____

19. What is your highest degree earned?

□ Ph.D.
□ Ed.D.
□ HSD
□ M.A.
□ M.S.
□ B.A.
□ B.S.

Other (please specify)_____

20. How many varsity sports are offered at your institution?

□ 14 or more

□ 10 to 13
□ Less than 10

21. Is your staff responsible for junior varsity or club sports? □ No □ Yes

22. How many Junior Varsity or Club Sports are offered at your institution?

□ 5 or less
□ 6 - 10
□ 11 – 15
□ More than 15

23. How many students are formally enrolled in your athletic training education program?

□ 10 or less
□ 11 - 15
□ 16 - 20
□21 - 25
□ 26 – 30
□ 31 - 35
□ 36 - 40
□ More than 40

24. How many years have you spent in your current position?

□ Less than 2 years
□ 2 – 4 years
□ 5 – 7 years
□ 8 – 10 years
□ More than 10 years

25. If there are any comments you would like to make regarding service requirements for faculty athletic trainers, please make them here.

APPENDIX C: IRB APPROVAL

MARSHALL UNIVERSITY
www.marshall.edu

Office of Research Integrity
Institutional Review Board
401 11th St., Suite 1300
Huntington, WV 25701

FWA 00002704

IRB1 #00002205
IRB2 #00003206

March 2, 2012

Michael Cunningham, Ed.D
Leadership Studies, MUGC

RE: IRBNet ID# 305491-1
At: Marshall University Institutional Review Board #2 (Social/Behavioral)

Dear Dr. Cunningham:

Protocol Title:	[305491-1] A Case Study of Athletic Training Educator's Sports Care Responsibilities, Service and Professional Advancement
Expiration Date:	March 2, 2013
Site Location:	MUGC
Submission Type:	New Project APPROVED
Review Type:	Exempt Review

In accordance with 45CFR46.101(b)(2), the above study and informed consent were granted Exempted approval today by the Marshall University Institutional Review Board #2 (Social/Behavioral) Designee for the period of 12 months. The approval will expire March 2, 2013. A continuing review request for this study must be submitted no later than 30 days prior to the expiration date.

This study is for student Rachael Alley.

If you have any questions, please contact the Marshall University Institutional Review Board #2 (Social/ Behavioral) Coordinator Bruce Day, CIP at 304-696-4303 or day50@marshall.edu. Please include your study title and reference number in all correspondence with this office.

APPENDIX D: VERBATIM RESPONSES QUESTION #6a

6a. In your opinion, should athletic training faculty that have any institutional sports care responsibilities be able to count these activities as service to meet promotion, tenure or contract renewal guidelines?

1. because with the time that is dedicated to the athletic teams there is no "extra" time to dedicate to advancing your degree. At my campus, raises come with additional hours towards our next degree. Mine would be doctorate.

2. Because these responsibilities are a service to the institution and they represent the provision of health care services that saves lives and rehabilitates musculoskeletal injuries on student athletes. Aside from the services rendered to student athletes regarding health care, the provision of these services is also part of the teaching process of athletic training students. Athletic training students are assigned clinical responsibilities that require the supervision of faculty acting as accredited clinical instructors. The provision of health care and the teaching of these services go hand in hand so using these activities for promotion and tenure would be no different than teaching in the classroom. In fact, they would be more valuable because of the application of taught skills and health care procedures.

3. 1-it is an extension and utilization of the knowledge and experience taught in the classroom setting. 2-It also serves as an internship setting where student trainers are taught and supervised.

4. I believe I am a better teacher because of my work in the field. Also, I always have students with me, and the hands on experience they get is the most valuable experience they will get in the classroom

5. The amount of time, effort, and mental/ physical stress endured during these seasons is equal to, if not surpasses, that involved with education/ faculty-only responsibilities

6. They are not specifically related to academic endeavors or faculty responsibilities unless expressly related to student observation or experience.

7. Fifty percent of my workload at the university is in Athletics. The university would never grant me tenure or promote me based on just my teaching responsibilities, etc., which is six credits.

8. Clinical education is both academic and practice/service-based. However, this takes an absorbant amount of time. We do not usually have the same amount of time as other faculty to get involved in research or other scholarly activities

9. if we are titled faculty and are contributing to the success to students (on and off the field) I believe this should be recognized a service. That is why they have the title of clinical (assistant, associate, or full) professor. Clinical being the key word.

10. I receive 3 FTE's/semester for my continued work in the athletic training room. I put in a lot of time working with my team which takes away time to care for my classes. It's a service to the university so I should get FTE's.

11. I would assume these positions would be joint appointments and both would have some sort of annual performance eval that would be separate.

12. because we are putting in a tremendous amount of time treating and caring for athletes which can impact student athlete retention, however, it leaves us little time to do more things on and off campus such as: serving on committees, promoting the program and university at off campus functions, etc.

13. I feel all ATC's should be evaluated in the classroom as well in the athletic training facilities as well as their other duties in the college., such as chairing committees,and participation in other on campus meetings and committees.

14. As a dually positioned faculty member the vast majority of my time is spent in the intercollegiate athletic programs and should be noted as time towards the institution just as a faculty only position notes their time for research and other things of that nature.

15. If initially part of the responsibilities, it should be considered as part of all skills presented to working the job, whether faculty or not.

16. The teaching responsibily adds on time to an already hectic schedule, but just since we work in athletics we are not eligible for tenure.

17. What we do is important, it is a 1/3 of my job responsibilities.

18. AT education involves far more than didactic education. Clinical education is not just the responsibility of the clinical instructors. However, workload reassignment should be consistent with time spent clinically. It can be a challenge to communicate that to non-AT faculty.

19. These sports not only require most of my time but they also put me infront of not only the institution but also the public. I am constantly asked by the public about my position and the requirements that go along with it.

20. it is work which clearly demonstrates proficiency in the field - which is by definition 'service to the university and the profession’.

21. I do. Because I teach while I work with football. I have students assigned and I mentor them during my sport responsibilities.

22. It is part of my contract and responsibilities. Just like any other job, you are graded on what you contractual responsibilities are.

23. if it is part of one's job expectations then it should be rated with the results going to your overall evaluation

24. The amount of involvement and time commitment necessary to meet the needs of the student-athletes, the athletic training students and other job responsibilities is on the job training that 'books' and research cannot sometimes offer.

25. Need to be treated as Faculty. No other faculty position involves 7 days a week, late nights, holidays, and overnight travel plus teaching and supervision of students.

26. They have an additional download that they should be compensated got since most fo not receive overtime pay.

27. It is a HUGE part of our job. I spend the equivalent of a full time job (on top of teaching a full course load) with my teams and it should count for something other than "service to the campus." If it's in my job description, I should be able to use it for reappointment, tenure, or promotion.

28. This counts at our university, hopefully it does at most. This is service to the institution and clinical education/supervision of students and should be credited as such.

29. They often put more time in covering their sports than outsiders realize and are able to use this real-life experiece in their classroom setting.

30. Even though I am given credit for my services, I exceed the number of credits I am released to atheltics. Essentially, I work more than 18 hrs/wk (6 credits) in athletics

31. This is part of a contractual obligation set forth that clearly outlines the criteria that needs to be met to be considered for contract renewal or promotion. In regards to tenure, I believe that the criteria is more encompassing and, although sports care responsibilities should be considered, there are many other variables that must be considered to determine tunure of a faculty member.

32. It is part of their job description.

33. Its equivalent to a 3 credit course (I get a 3 credit release). I work with students as an ACI too.

APPENDIX E: VERBATIM RESPONSES QUESTION #8a

8a. Do you believe that education faculty should have institutional sports care responsibilities?

1. you don't use it you lose it! take some of the load off of the institutional trainer

2. Sometimes educators without clinical experience are out of touch.

3. Time

4. Only in certain situations in our program I would like one of our faculty to have dual role.

5. Faculty should have the ability and administrative support to maintain some type of clinical practice, but this should also be tempered by the other demands of their faculty role. These clinical practice roles may not work well with institutional sports though because the faculty member will need complete control of their time and college sports tend not to allow for that independence.

6. Limited responsibilities in order that students are able to see the didactic athletic trainers in the clinical setting.

7. The budget or the college do not give that kind of priority of hiring athletic trainers in the faculty setting only. They are hired in dual appointments.

8. I have research, teaching and service responsibilities. I would have to decrease something in another area. I am in education because I like teaching and research. I chose this job over others because there were no sports care resposibilities. I practiced for years and keep up on the research. I don't think it would improve my teaching, it would pull me in too many directions

9. It is important, in my opinion for educators in the field with students. 1. to assess first hand how the student is doing, clinically; 2. for the student to see the educator in practice

10. Those that do not tend to forget the amount of stress, time, etc. that is a part of coverage.

11. Allow clinical opportunity for students to 'connect' didactical/ role play scenario with real live events

12. It is nice for them to have some hands on experience to relate in the class room.

13. I feel that education faculty should participate in care responsiblities. But as a part of their contract there should be no specified required assignments. It is excellent for students to see the faculty in the athletic training room using their skills and interacting with the students and athletes. However faculty have so many other requirements on the educational side that required responsiblities shouldnt exist.

14. Very difficult to coordinate teaching schedules, research schedules, and ever changing athletics schedules. I believe it is nice for faculty to work with athletes, but I do not believe it is essential and in most cases doable.

15. I think it would depend on the size of the ATEP. We have approximately 150 students and it would be difficult to carry out my responsibilities as the clinical coordinator and cover/travel with a sport. But we have part-time instructors who do have sport responsibility which I feel is appropriate.

16. It would be difficult with all other responsibilities

17. They should have the same responsibilities as other faculty at their institution

18. I think it allows you to stay up on your skills and it helps you to remember the "shades of gray" in the field that you sometimes lose sight of when teaching only.

19. It should be allowed if the credit huors can be balanced. Many will volunteer to be able to "stay in" the profession, interact with ATS and maintain skills.

20. Only if is the AT's choice

21. This is a tough question because I see the value in having a split assignment. But I can attest to the fact that it is virtually impossible to provide quality of care to the athletes while trying to maintain and succeed in a faculty position. I also feel that it is a diservice to our profession to continue to fulfil both roles at the same time.

22. Yes and No. I say yes because I feel that those that are providing the didactic education should still be practicing at some level. I say no because it's next to impossible to do each aspect of the job at 100% consistently which is what the students and student-athletes deserve

23. In my experience the sports care responsibilities begin to overshadow the education responsibilities and the individual becomes less effective in one or both environments.

24. I believe you should practice what you are teaching to stay connected.

25. Although I do, I do not believe that everyone should. I feel the classroom to clinic teaching is great for our ATEP students

26. I believe they should have some responsibility for health care. I did not for quite awhile and I realized how out of touch I was becoming. I am a better teaching by keeping my hand in it.

27. As leaders, mentors, and Teachers it becomes imperitive to display both academic and hands on practical instruction. Allows for qualitative analysis of corp instructor/educator evaluation.

28. only if they have specialized expertise

29. mixed with this. If time and workload allows, there should be some type of integration of patient care

30. Keeps them in the practice arena

31. I believe that the education faculty should in some capacity have sports care responsibilities even if it is contract work. Otherwise, they will not have the hands on immediate experiences that are so important in our educational process and the knowledge of our students.

32. I am very much in favor of a clinical faculty model. Unfortunately in our current model (athletic supervised) there seems to be a challenge balancing faculty and athletic training service. I have held dual appointments in the past and, in my experience, athletics doesn't understand the term part-time.

33. Teaching, scholarship, and service are the criteria upon which other university faculty members are being judged. Adding sports responsibilities (in most universities) puts an undue burden on the ATEP faculty members.

34. It's great in theory, but in practice it's not feasible.

35. Education workloads are already overburdening. Why not hire more ATs and divide the responsibilities? Also there is little consideration from Athletics for the daily demands of education duties, so scheduling courses and activities around travel and capricious coaching decisions is complex.

36. Not as a requirement, but I belive they should remain active clinically. We never stop learning and our clinical experiences will only make us better instructors. If faculty are required to do it, it would only decrease the available clincial positions.

37. Professional practice to maintain the skills they teach in the classroom

38. AT education faculty should have the volume of past clinical experiences in institutional sports care, but, not necessarily they should have to be involved in such a care on a continuous basis.

39. This needs cautious and careful planning due to the greater emphasis on faculty to publish or perish. Sports care responsibilities keep the faculty current and demonstrates to students that they can walk the talk.

40. Most educators go into teaching b/c they don't want the extra hours that providing sports care requires. Usually people with families want to get out of the sport care part of things, so they may gravitate toward teaching.

41. The nature of academic responsibilities are sufficiently complex without having a third party dictate schedule for practice coverage and game coverage.

42. Having worked in both situations, I can say that faculty cannot concentrate on being the BEST instructor they can be when trying to juggle sport coverage, AND the service ATCs can't give adequate attention to their athletes when they are trying to prepare for classes, etc.

43. At a doctoral-granting institution, the focus/emphasis on scholarship demands on tenure-track and tenured faculty (grantsmanship and publication) supercede the requirement of having a clinical practice. While I'd like to maintain a clinical practice to enhance the teaching and service aspects of my position, it just isn't feasible at my institution.

44. While the contact faculty would have with SAT's is beneficial, it is not reasonable. Most faculty have a full teaching load of 4 classes along with advising, research, grant, committee expectations. To expect someone to provide more time than the full time job faculty already entails is unrealistic. It also minimizes our profession. Athletic dept. need to provide adequate ATC's from inside their department rather than relying on academics for a cheaper alternative for labor to get everything covered.

45. Theoretically yes as it benefits the students being taught realizing that the teacher can not only teach but perform enhancing credibility. Having sports care responsibilities also enhances good will and team work with staff. However, if we as educators wish to uphold our academic credibility, healthcare credibility, compete for research grants and attain tenure, providing the CURRENT level of athletic care is a difficult and unrealistic goal.

46. If on tenure-track, this is outside of responsibilities required and will detract/overload from the necessary activities. If in a clinical faculty role, then may be more appropriate, but in limited capacity.

47. the time it takes to maintain compliance and coordinate the curriculum can be decreased for clinical coverage.

48. In some regards I do...one reason is to just stay active in the traditional setting, but if you have research responsibilities then that may be an exception.

49. The demands of an accredited program I feel that niether the ATEP students or the student athletes would be getting was is need in reference to education (clincal and didactic ed.) or care (student-athlete).

50. I believe it should be their choice if they want to work clinically or not. But I do feel it supports their expertise in the eyes of the student if they continue to work clinically.

51. Some faculty are involved with athletic training with organizations outside of the institution. While I think hands on practice is good for faculty, I don't know that institutional practice is the only option.

52. Balancing teaching, research, and service is already a challenge for faculty seeking tenure and promotion--sports care responsibilities are often not considered during this process.

53. Too many other responsibilities with ensuring compliance with national accreditation and ensuring teaching, learning, and assessment with educational competencies

54. Depending on the institution the number of faculty and/or staff athletic trainers may not constitute time or space for both responsibilities

55. My actual answer would be yes and no. Yes, because I feel that purely academic faculty can lose sight of the clinical aspect if they're no longer directly practicing ATs. I guess it would also depend on how much clinical experience they had to begin with as well. I have been in a dual position for 7 years now and my academic and administrative duties have increased but my sport assignments have not changed, so at this point, I feel that it's extremely challenging to be able to both aspects of the job well; to be able to put 100% into both,

56. Quality educators should have a few years of actual clinical (hands-on) work before becoming an educator. Unfortunately many do not. In those cases, it would be good for that faculty to do some sports care, but it must be agreed upon by all parties involved (faculty member, Dept. Chair, Head AT, Athletics Director).

57. I believe the work load would be too heavy to do both. However, in some cases I believe it would be beneficial because it keeps the educators "current" in the practice of athletic training

58. If you are not using it, you will lose it. When I am teaching I draw off of the injuries that we currently have and the students learn more by seeing it through from beginning to end.

59. As a dual position i find it harder and harder to separate my time so I feel having the institution make the position separate would be a good idea and helpful.

60. One should be a tenure track faculty and must focus on teaching, administrative responsibilities for ATEP, research, publication, mentoring thesis.

61. provides clinical expertise

62. It is hard to put 100% effort into both. One or the other is going to suffer.

63. Instructors should regularly involve themselves in the disciplines they teach. Athletic training "on the field" evolves and instructors would do well to experience these changes as they are happening versus hearing about them years later at a continuing education event.

64. That should be the responsibility of a dedicated AT team. There is not enough time in the day to do both

65. Educators already have many duties to perform. If they do have to then they should get some release time from teaching in order to compensate for the sports care responsibilities.

66. Often, their appointments are as educators, but the Athletic administration views them as part of the Athletic Training Staff. So, an institution will say that they have 12 Full time Athletic Trainers, but the bulk of the work falls on 4-6 Athletic Trainers, because the rest always working on the education aspect of their positions.

67. Reduces time available for professional development. Not consistent with other disciplines on campus.

68. I don't really like how you phrase the question because you force it to be dichotomous when it's not. It's really a continuum instead of an either/or . At institutions like mine (research intensive - very high productivity), there are no "education" faculty. There are tenure track and clinical track faculty. Tenure track faculty are expected to have very high productivity in generating new knowledge and publishing it and gaining extramural support to continue it. In addition to this, we also teach. A typical tenure track load here is 40% teaching, 50% research, 10% service. If you don't generate significant extramural funding of your research salary two years in a row, you face a pay cut. There is NO TIME for these kinds of faculty to also do clinical care. In fact, doing so puts them at a competitive disadvantage for attaining tenure and promotion when compared to faculty who do not have clinical care duties and can therefore dedicate more time to scholarship. Research faculty contribute to student education in different, but no less important, ways than clinically practicing faculty. We (researchers) provide the WHY while they(clinicians) provide the HOW. Together we produce excellent practitioners.

69. Clinical education is not just the responsibility of the clinical instructors. Didactic education is only half the educational process.

70. Because it is imperative for us to maintain credibility by treating patients - not necessarily traveling with teams

71. If you are a tenure track faculty, the balancing act of sports coverage, research, teaching, and service would just be too much. If you are not tenure track faculty, I think it would be a great idea to have sports care responsibilities.

72. an ideal world yes. Faculty may be able to provide more teachable moments and/or highlight aspects from class (ie. EBP) that students may not normally see with non-faculty clinical supervisors. Students see if/how faculty may manage/handle clinical responsibilities similarly/differently than non-faculty supervisors.

73. Maintaining accreditation standards and the responsibilites of a dept and/or program are time intensive and it would be difficult to meet the needs of both academics and athletic team coverage. Mostly due to the random schedules sport teams maintain. Care in terms of rehabilitation and AT room duties would be manageable, but I would leave it as an option. Most faculty in an ATEP have too many duties from teaching a full load, scholarship, and university service that would not allow for time to do health care coverage.

74. Faculty should be required to provide patient care for 4-6 hours per week without full responsiblity as coordinators of care for a team

75. This depends on the expectations for tenure and clinical coverage expectations.

76. Limited. Practice what you preach.

77. personal experience: practicing strongly dictates how and what is taught to the students.

78. Believe split positions allow for a stronger integration and provide better educational experiences for students.

79. It keeps us sharp in current trends. If I didn't cover my sport, how would I share my expertise?

80. I feel they should choose to engage in clinical responsibilities, but, these can occur in a variety of means. It also depends upon the institution and faculty loads.

81. It is hard enough to prepare for taking care of athletes in addition to prep for courses. My opinion someone gets short changed in the long run.

82. Allows the students to see faculty doing what they teach and acting as role models.

83. No - intercollegiate athletics, rec sports, health services should not be dependent upon a faculty member to have adequate services/coverage. However, it is important for AT faculty to still keep some form of clinical practice.

84. Not specifically due to the workload with the education. However, I do believe that clinical experience brings invaluable teaching points.

85. Their students can see the instructor make decisions in real time.

86. To stay fresh in the field of current practice

87. Some institutions will not see this service as comparable with teaching and research assignments.

88. I think it is important for educational faculty to stay connected and maintain their clinical skills by engaging in at least some direct patient care. Preferable working with students as an ACI. It is just an incrediblely valuable way to connect didactic and clinical education and scaffolding critical thinking.

89. Education faculty should focus on education and staying up to date on new research, etc.

90. If the faculty member is 100% academic then there should be no sports care responsibilities.

91. They should in a limited capacity because I feel that you still need to be in the Athletic Training Room.

92. It creates a conflict of interest

93. I think it helps the students seeing their instructors participate clinically similar to MD's practicing on the floor of hospitals

94. I think the conversation for where these responsibilities would exist and how they would be weighted in terms of reappointment, tenure, and promotion is individual to each campus organization and is not a concern of the profession of Athletic Training.

95. YES - keeps them in the trenches of reality to what the students and AT staff face on a daily basis. Can't teach what you are no longer used to... practical application goes beyond EBM

96. I believe it is important to have AT faculty in the classroom that are actively practicing or have sufficient practicing experience. I don't think that this needs to necessarily be with the same institution that they are faculty but they should be (or have) practiced in some form. Maybe we can begin to establish definitions of "sufficient" practicing experience to be considered for faculty appointments.

97. I answered no, but I think it really depends on the size, type, and mission of the institution. Tenure-earning faculty should not have a sports assignment, especially if the research expectations are significant.

98. I believe it is helpful to have students see your clinical skills, but I don't feel this should be a responsibility due to workload.

99. As much as I like to be in the athletic training room and provide clinical AT services, it got to the point that I wasn't able to do everything I needed to do relating to my administrative and teaching responsibilities. I believe my teaching was not effective.

100. Maintain skills and be available for students in clinical setting.

101. this is a chalenging questoin - in the academic environment, tenure is of utmost importance. New tenure track faculty need to focus on what their chari/dean perceive as being important to their advancement in the instiurion. I do think educational faculty need to be experienced and work out some way to remain clinically active - this is the model for PT and phsicians - i.e. team doctors...the difference is that they are paid extra for covering teams or for doing clinical work.

102. The students in the program need to see that you apply what you teach.

103. Although these responsibilities must be clearly defined and articluated as part of the tenure track equation for the institution.

104. time committement interferes with ability to perform scholarly work

105. Only if there is adequate staffing to support both the academic programs and patient care services independently

106. Due to the pressures of scholarship, teaching and service...unless the demands of teaching and scholarship are reduced service can be performed in a multitude of non-time intensive activities.

107. Due to the pressures of scholarship, teaching and service...unless the demands of teaching and scholarship are reduced service can be performed in a multitude of non-time intensive **activities.**

108. I think that there needs to be a direct connection to what is taught in the classroom to what students are being exposed to in the clinical setting. Faculty members are typically the most up to date with current research which is where many students don't see applied in the clinical setting

109. Responsibilities and documentation requirements have increased exponentially over the years, creating a situation where staff members are performing two Jobs. Each aspect, Education and Service, suffers.

110. Lack of time. I think it would be benefiicial to stay involved clinically as it helps teach, but with education there is so much time required for teaching and administration it would be an additional time constraint

111. makes them more rounded and involved in actual care-giving and decision making

112. If they have a dual role as defined by their contract, then yes. Otherwise, I would say no.

113. We are too busy.

114. maybe - depending on situation

115. Faculty should focus on teaching and research to improve the overall body of knowledge of the profession

116. Maybe not team assignment but an opportunity to "spell" the clinical staff so that they can catch a break. This should be an option at the University level.

117. Faculty, especially tenure track, have too much to worry about.

118. It is simply to difficult to balance between the two. I think providing sports care is important and still do it as a contract athletic trainer but cannot commit to a full season with a team.

119. Not unless they choose to.

120. So they can practice what they preach. Teaching holds me accountable in the athletic setting and practicing allows me to determine whether what I am teaching is current and relevant to the field.

121. I believe that if the faculty receive appropriate compensation for their work it would a good responsibility to have for the following reason: Similar to orthopaedic surgeons learning "on the job" from other orthopaedic surgeons, our students can learn and develop their skills under the supervision of their instructors and the instructors can maintain a quality level of skill themselves by spending more time working on their craft.

122. While I think it's important for educational faculty to be current in their knowledge and skills, this can be accomplished by other means. To require faculty to have sports care responsibilities is the purvue of their employer and not that of the NATA CAAHEP.

123. Not as a requirement. Will vary widely by size, scope, and mission of the institution. Too broad to distinguish across all instiution types. You will need to address this in your limitations.

124. It is a very sgtrong bridge between didactic and clinical education

125. If not, there tends to be a disconnect that occurs over time.

126. Ideally maybe yes. Realistically, this is difficult to achieve with the job responsibilities of a full time faculty member.

127. There's no time in our work loads. I do think it is good for the students to see us working with patients though, so if something could be worked into the course load, it would be a good thing.

128. Minimal clinical involvement is good for the faculty member (keeping them current in professional practice), good for the clinical staff (allows more implementation of EBP) and good for the students in the ATEP (seeing faculty practicing makes students respect the opinions of faculty more)

129. So that they can bring real world situations into the classroom

130. I believe that holding two roles pulls the educator in too many directions and creates interrole conflict.

131. I think they should be allowed to be involved but not required. The schedule of a faculty member is not always conducive to the schedule of a clinical ATC.

132. However in the current climate of requirements for promotion and tenure this is almost impossible

133. It depends on the faculty's strengths. Some may want to focus more on research or service in our profession while others may want the sports care responsibilities.

134. With the CAATE always changing guidelines it is very difficult to have sufficient hours to maintain proper accrediation and provide quality athletic training services to athletes. It can be done, yes, but with what quality?

135. Time and university requirements. I do think if we could do it, it would enhance our classroom

136. Helps keep your skills up to date. Allows students to see that you are able to do what you are teaching.

137. If we are part of a tenure tack faculty line, we should not be part of the sports care area too.

APPENDIX F: VERBATIM RESPONSES QUESTION #9a

9a.Do you believe that athletic training clinical faculty should have institutional sports care responsibilities?

1. same as above

2. Teaching makes one a better clinician.

3. Transfers into their teaching effectively

4. Clinical faculty must maintain some level of clinical practice, but again, this does not have to be with the college/university setting.

5. Isn't this the definition of "clinical AT faculty?"

6. It is impossible to be in two places at once.

7. It depends on the set up I the facility. if their responsibilities are to ensure student learning than it may involve some sports care responsibility, but it shouldn't be the emphasis.

8. It is a part of our profession.

9. Relevance for the student's sake.

10. Split priority and one will suffer (generally supervision and clin. education)

11. Same reason as above.

12. If demands of the job allow, then yes they could. However, I don't feel in most cases it is essential and doable.

13. This is where the students get clinical exposure and experience.

14. The clinical component is important. They are teaching the students in the clinical setting.

15. Again, I think it allows ATs to keep perspective that you lose when you don't are for the other side of things. But then I also think clinical faculty should also have teaching responsibilties too.

16. Many are already working as staff athletic trainers inaddition to serving in a Clinical role. Not every program can have separate ATEP faculty and then full-time ATEP Clinical staff. While a few may the rest of us work in the real world.

17. good interaction with ATS

18. Again, I'm torn on this question for the reasons above but answered it differently because of the 'clinical' term. In this case, there is a designated clinical component and that could justify a sport care component.

19. For the same reason, to keep fresh/current; lead by example

20. Highly related.

21. We utilize many clinical instructors who do not work with institutional sports teams - AT's do not always work with institutional sports and it is the responsibilty of educators to open up clinical sitesso that students are aware of additonal job settings

22. I feel that it should be elective to serve as an ACI for an ATEP. Not everyone is cut out for teaching in that setting.

23. For the same reason, it is important to stay current and I believe you can teach more effectively in aclinical situation.

24. In order to earn more income.

25. exposure to various techniques and varied athletic populations

26. mixed with this. If time and workload allows, there should be some type of integration of patient care

27. Again, practice is key to clinical teaching

28. That what a clinical faculty typically is, an individual hired to engage in clinical activity associaed with a professional degree.

29. It depends on the position, but in some cases it would be appropriate.

30. Maybe. What do you define as clinical? I can think of 6 or 8 examples of clinical care that do NOT involve sport participants.

31. Same as above but it applies to them even more.

32. Professional practice to maintain the skills they teach in the classroom

33. Clinical AT should be exposed to such responsibilities on a continuous basis in order to have a thorough knowledge of the current problems and the changes in clinical care.

34. It is not necessary. It adds an additional burden to an already fully employed individual.

35. Keeps their on field skills sharp.

36. If they did not have sport care responsibilities, how would they be clinical faculty? To whom would they provide patient care if not institutional athletes?

37. I think it is important for students to see their ACIs in "action." It is important for our students to see what life in the world of Athletic Training is really like.

38. This is a different issue... we have split appointment staff, and split appointment graduate assistants who maintain sports care responsibilities and teach in our CAATE-accredited program. The sportscare "half" of their job overwhelms the the teaching part, and often times, our students suffer from the staff's lack of time to prepare for lectures and labs.

39. Clinical faculty if contracts are negotiated right provide for a reduced or minimal teaching load. Clinical faculty are just that...clinical. It should be expected they work within the institutional sports arena.

40. How do you define clinical faculty?

41. But in a limited capacity - and more for teaching purposes and less health care to athlete/patients.

42. I think it is good the the CC is in clinical practice because it provides a vital link between academia and clinical practice

43. The demands of an accredited program I feel that niether the ATEP students or the student athletes would be getting was is need in reference to education (clincal and didactic ed.) or care (student-athlete).

44. I believe it should be their choice if they want to work clinically or not. But I do feel it supports their expertise in the eyes of the student if they continue to work clinically.

45. that is what a clinical role involves, but it doesn't have to be to the institution, it can be with outside organizations.

46. If clinical responsibilities, including sports care responsibilities, are part of their main job description.

47. As part of their workload, a clinical faculty member should be active clinically.

48. If employed in a clinical setting there may not be opportunity for both

49. They are already providing sports care responsibilities to the athletic treams. I interpret institutional sports care as care for non-athletes (students/faculty/staff) seeking care for injuries from intramurals,activities of daily living, etc

50. If you're referring to positions like a clinical coordinator, then yes. If you are overseeing clinical assignments then you should still be practicing clinically yourself. Perhaps at a lower level or less demanding sport since you have to also observe your clinical sites.

51. I think that ATs should, ultimately, do what they are best at. Not all clinical ATs are good classroom educators (or clinical educators, for that matter). Again, if all constituents agree it is positive, then okay.

52. Because our clinical faculty are the ACIs that our students work with - therefore, they should be practicing athletic training.

53. If you are clinical faculty it should be implied that you are working clinically for the institution and with such title would mean you work in the sports care arena.

54. I am not clear what clinical AT faculty means. Those who belongs to athletic dept. and serves as an ACI should have responsibilities covering institutional sports. Faculty hired within the academic department should NOT have responsibilities above unless compensated by the athletics.

55. provides clinical expertise

56. Help facilitate connection of ATS from textbook to clinical practice

57. They are working with the athletes as well, so why not cover practice and get to know the athlete and their injury better.

58. Same rationale as above.

59. I only answer no becuase they need to have an advanced degree to be eligible to teach. so if they meet eligability, then the answer is yes

60. I dont have an opinion

61. I do not know exactly what you mean by "clinical". Are you speaking about clinical education lines or clinicians who see patients?

62. At my institution, in order to qualify for a clinical faculty line, you MUST have some part of your job duties that are clinical. Our ATEP is housed in the College of Medicine where most clinical faculty are physicians who see patients for most of their time and also teach or do research in addition. In our ATEP, the clinical duties for clinical faculty can be in patient care (not just with sports) or it can be clinical supervision / clinical coordination of student clinical

rotations. Faculty in these kinds of roles need to stay clinically fresh in order to do their job duties adequately.

63. Clinical education is not just the responsibility of the clinical instructors. Didactic education is onlf half the educational process.

64. If you are not tenure track faculty, I think it would be a great idea to have sports care responsibilities in order for clinical skills to stay fresh and for students to see the faculty member use what he/she has been teaching.

65. Ideally, yes. Keeps clinical faculty current with the profession/competencies, etc.

66. Depends on their exact role as clinical faculty. Probably is different from institution to institution. Some have full teaching loads and other duties related to the standards focusing on clinical education. I do think that all faculty and perhaps more so with clinical faculty, should be somewhat active clinically. But that role should be limited. I don't see academic faculty having time to meet the needs of a sport assignment.

67. I think a clinical contract infers clinical responsibilities.

68. same as 9

69. for the same reason(s) as #9 - the clinical ATs

70. If they teach the skills, they should absolutely be practicing them.

71. I feel that they should have clinical responsibilities, but, these can occur in a variety of means

72. The same reason as above.

73. same as #4

74. Clinical experience for a clinical faculty is valuable for teaching points.

75. To stay fresh in the field of current practice

76. Some institutions will not see this service as comparable with teaching and research assignments. If release time can be awarded for this service then I think it would be preferable if clinical faculty has sports care responsibilities, but it wouldn't have to be with that institutions sports.

77. Depending upon the job description. I think it is important for clinical faculty to be curent on their skills. If the person is the clinical director then I do not believe they should have responsicibilities in theclinic since they have to have enough time to be able to visit all clinical sites.

78. The clinical faculty are just that - faculty who are clinically active taking care of patients. These would be the preceptors.

79. same

80. they are clinical

81. Only as it relates to establishing lines for serving as a preceptor or as a means to educate clinically(e.g. taking on students).

82. Same reason as above in #10

83. I am unsure of how clinical AT faculty are being differentiated in this context. If it refers to ACI's, then I do not think that they MUST be specifically affiliated with the institution. If it refers to dual- appointment faculty then I do think that they should obviously have some sort of clinical responsibilities. If they are being compensated by the institution for such responsibilities, they would likely be employed then with the affiliated institution.

84. Again, I answered no, but I think it depends on the size, type, and mission of the institution. It also depends on the teaching load and administrative responsibilities assigned to the faculty member.

85. They typically teach fewer classes and can manage doing both roles.

86. Same as above

87. Clinical faculty should be clinically active, otherwise they should be classified as instructors or other academic rank.

88. Same as #4

89. I"m not really clear as to whom you refer. If you mean those that hold a clinical assistant/assoc. professor role, then that is how I answered.

90. ideally the clinical instructors should be practicing in the clinic to provide students with exposure to patient care

91. There are not the same scholarship and teaching responsibilities.

92. Only if the academic load is minimal. Responsibilities and documentation requirements have increased exponentially over the years, creating a situation where staff members are performing two Jobs. Each aspect, Education and Service, suffers

93. Being involved in a clinical practice would only enhance ones ability to educate

94. ??? they already do....I do not understand this Q

95. If they have a dual role as defined by their contract, then yes. Otherwise, I would say no.

96. I do not understand the difference between clinical faculty and education faculty-they are both faculty members.

97. maybe - depending on situation

98. A responsibility of being a clinical faculty is to participate in clinical practice.

99. It makes them a more effective clinician.&

100. Depends on the set-up of every school. At times, since all of our faculty also have sport responsibilities, it can be difficult to provide enough time in the day to do rehab on our patients due to working around class schedules and it would be great to have someone who could always be around to help out.

101. While I think it's important for clinical faculty to be current in their knowledge and skills, this can be accomplished by other means and is the responsibility of the educational program. To require any faculty to have sports care responsibilities is the purvue of their employer and not that of the NATA CAAHEP.

102. What does clinical athletic training faculty mean? Clinical implies provision of care or it may imply clinical education. This question does not make good sense.

103. It simplifies instruction when a clincial faculty member is responsible for a particular group of athletes

104. Same reason as above

105. It makes the most sense to have clinical athletic training faculty have institutional sports care responsibilities because this allows the students to gain experience in a live clinical environment.

106. Maybe I am reading this wrong, but I'm assuming that by 'clinical', you mean they are working with the student-athletes.

107. This is why they are hired, to provide sports care and teach

108. At our institution a clinical professorship simply means they teach more credit hours and do not have research responsibilities. As such, I believe that holding two roles pulls the educator in too many directions and creates interrole conflict.

109. See above. I do think clinical faculty may have more flexibility but again, I think her role in spors would be limited.

110. I may be misinterpreting the question but doesn't the title clinical mean they will be providing care?

111. That is their main job (clinic). Some schools (such in PA) all athletic trainers are considered faculty members.

112. Be seen in the clinical setting

113. same as #4

114. This is what they do. They are clinicians.

APPENDIX G: VERBATIM RESPONSES TO QUESTION #25

25. If there are any comments you would like to make regarding service requirements for faculty athletic trainers, please make them here.

1. In my experience, the issue of faculty service requirements is more a factor of the institution's Carnegie classification than its NCAA Division classification. This factor needs a greater amount of focus.

2. In the state of California athletic trainers are hired as classified employees at the same pay level as janitors. A few fortunate athletic trainers are hired as faculty with release time to perform their training room responsibilities. I have 16 years experience as an athletic trainer but when offered a full time position it is mandatory to start at the entry wage position without taking any years of experience into account.

3. Seriously- this counts as research to satisfy a terminal degree....good grief are they watering down academic requirements

4. Questions 6 and 7 are fundamentaly flawed. In #6, are you referring to educational faculty or clinical faculty? The answer willbe very different based on the specific role you are referring to. The same can be said for #7. If you are referring to educational faculty, then I would say the answer is more neutral, whereas for a clinical faculty member, their sport care responsibilities are very important.

5. If we want our students to become athletic trainers and promote our profession, we need to promote it also. Too many educators want to sit in front of a computer and come up with "perfect world, real time scenarios" for students; our world isn't perfect, and real time, should be real time. If students see us in our real positions, they will be better professionals

6. I am employed by an NJCAA Div II athletic institution. It was not an option in question 15. We have 5-10 students enrolled in the athletic training transfer program each year.

7. Now that I'm close to the end here, I have realized that I have completed this survey before! It may skew your results!

8. I strongly believe professors need to get out in the field and stay current. I covered a local high school for a pregnant colleague and I learned so much. I teach differently because of that experience.

9. My current position doesn't allow for clinical work. It would be something in addition to my full time responsibilities or as another part-time job. It would be good to be integrated and time is allocated for it.

10. Question 6 can not be answered as written, there must be institutional autonomy on this issue. Your question requires a percentage answer.

11. Unfortunately, the rest of academia doesn't even know what athletic training is to understand our normal responsibilities. Having sport coverage would have detrimental effects on promotion and tenure.

12. Your apparent definition of 'clinical' work as institutional sports is overly narrow, especially in light of our emerging clinical practices

13. While I am not required to cover sports here I occasionally help out and am paid per diem. I also work per diem for other institutions and local high schools and tournaments.

14. I teach at an institution in Canada that is accredited by the Canadian Athletic Therapists' Association.

15. Please refer to comments on Q4. Unless clinical practice is required by the Accrediting Agency it will be black mark on a faculty members path towards promotion and tenure. Look @ how Engineering, Architect, and Nursing accrediting agencies do this.

16. Not every athletic trainer wants to provide AT services to the university as part of their service requirement to the institution. Most faculty want to optimize their service component. FOr me, I chose service that provides the university/program with community involvement to better educate on Athletic Training and the program the university has.While it is easy to provide service to the institutional athletics, it does not truly provide the profession with education of the public; which we hope will create a better understanding of our profession and a potential for more jobs locally.

17. My situation is somewhat unique in that I have full-time employment as a faculty member, but also work part-time clinically at one of our affiliated sites. I only cover one sport at this site so the amount of time spent in the clinical setting is dependent on the time of year. I don't want my situation (which is quite rare) to affect your results.

18. If sport responsibilty was seen as service, I feel that haveing a clinical professor serve time in the athletic training facility would be benifical for all involved parties. My only concern would be how can an instituation manage this type of position if the Athletic Department and the Educational department are seperated?

19. My clinical and administrative athletic training duties are mainly due to my position as the Clinical Education Coordinator

20. I think it is important for faculty to "practice what they preach" so to say as it is difficult to teach something you have never or rarely have done. It may not always be an option though as time and budgets are tight.

21. After being in a dual role for 7 years and having increased responsibilities every year, I would NOT recommend a dual position to someone considering it. It would have to be exactly the right situation. I feel that dual positions can almost be negligent in that the potential to sacrifice one or the other constantly occurs. One either sacrifices the best possible care that the athletes could receive or you sacrifice in the classroom. Both are equally important. Sometimes I feel that the dual position is doing a disservice to the profession because if you sacrifice on the academic side, then what kind of "product" or caliber clinician are we giving to the profession. I hope that makes sense. I constantly feel that I could be both a better clinician and educator if I only had the time to do both 100%.

22. Optimal - AT educators should not teach until they have at least 3 years as a clinical (hands-on) AT in the profession (all educators, not just PDs or CIEs). Without that, they are missing key experiences that inform teaching. If that is missing, then they SHOULD do some work with teams, but it must be part of their academic load. Otherwise, the faculty will be pulled in too many directions and not do well in any.

23. n/a

24. Keeping up with the demands of the profession with some responsibility clinically, provides anecdotal information. Although this demand would need less instruction in the classroom to make for accommodations.

25. I don't think it should be a requirement, however in my own experience, helping out every once in a while keeps my clinical skills sharp. I am often called over to the ATR for my manual therapy and spine management skills

26. Question 6 is problematic. You don't break it down by type of appointment. Research faculty should have 0, clinical at least 25%. Also, you present this topic dichotomously and it is not. Clinical duties can and should vary depending on the type of appointment and the nature of the position. A research faculty member can't do clinical care and survive in the dog-eat-dog world of extramural grants and publishing. Clinical faculty (who don't have the same publish or perish demands) CAN and SHOULD do clinical care as part of their appointment. We should NOT be so narrow as to think that this is exclusively limited to intercollegiate athletics or club sports however. We are a major medical center and my clinical faculty practice in a variety of settings including as physician extenders, in rehabilitation centers, in outreach care to an urban school district for ImPACT testing and pre-season physicals, for coverage of local club sports events, USA Rugby, etc. Clinical Coordinators work in organizing and overseeing student field experiences counts as clinical work at my institution as well. There is more to the world than just

intercollegiate athletics and we need to broaden our understanding of the roles of Athletic Trainers and ATEP faculty.

27. This survey does not make sense. You have not provided operational definitions of professional advancement, education faculty, clinical faculty. Do you really mean tenure track, non-tenure track? Professional advancement may not have anything to do with these concepts if you are not employed as a faculty member. A better question is what is the system for clinical promotion/advancement for AT clinicians who are NOT faculty.

28. My answers above specified dual appointment repsonsibilities in "an ideal world". Practically, I believe that AT faculty with clinical responsibilities end up "signing up" for 2 positions. Athletics will take up much more than the reassigned time provided.

29. I think it is valuable to for others to see academic faculty to be clinically active. It shows they can practice what they "preach". Likewise, I think it is important for clinically practicing ATs to teach in the classroom as it shows they understand the competencies that students are currently being taught. However, it is difficult for ATs to fulfill both roles to a high degree because each one alone can/should be a full time job responsibility. I teach 12 TLE per semester and I have 3 hours for clinical coordination duties. I provide patient care for 15 hours per week in a local sports medicine clinic and provide occasional weekend tournament/game coverage. Just the 15 hours per week takes away a lot from my ability to do some of the administrative duties of teaching and clinical coordination. The benefit is it keeps me current with injury care and rehabilitation. Plus I enjoy both roles. As I noted befoe though, one needs to meet their primary job role and then may be able to do additional duties with sports/health care or teaching I do think sport care can be accomplished if release time is given from the faculty member's duties. .If release time is alloted and the faculty members full time teaching load is decreased, then time providing care could be equivalent to the amount of release time given. Ex, most faculty loads are 12-15 hours of teaching. Most are given 3 release hours for research/scholarship. If they were given 3 release hours for sports care, then perhaps 20 to 25 percent of their time could be devoted to sport care if they have an overall load of 12 to 15 hours respectively.

30. Question 6 left me unable to respond. I believe the amount of time AT faculty should spend in clinical or athletic service depends on the faculty member and their clinical maturity and area of expertise.

31. Get the the point of recognizing overload and help the AT staff fight for more help or get in there and help. This is why we burn out and you are left with ACI's that don't care of strained ATEP-Athletics programs and AT staff.

32. I've had sport responsibilities at this institution in the past. even a "minor" sport such as tennis requires a great amount of time away from daily clinical, class preparatory, and administrative duties. It would be impossible to have the time necessary to devote to tenure advancement if you were engaged in daily sport coverage.

33. I am very interested in this topic. In fact I have submitted and been approved to pursue such a question as part of my sabbatical work at my institution. The work is entitled "Retraining of an Athletic Training Faculty Member through Immersion". The sabbatical involve me engaging in athletic training services at a number of different venues.

34. With accreditation standards to enforce, it is extremely hard to justify and delineate job responsibilities as a dual faculty member and clinical ATC. How do you define a 25% Athletic Trainer?

35. Above questionclarification: Have been at institution for 26 years position classified as Profession, Administrative, Technical (PAT) This year College recognized us for our teaching and swithched our positions to Clinical Faculty. Therefore 25 years PAT (teaching and AT service) 1st year Clinical Faculty (teaching and Head Athletic Trainer.

36. Clinical track faculty should engage in clinical care (20% of their load). Tenure track faculty should engage in research and scholarship. I happen to do both but I am tenured.

37. We do not have an educational athletic training program at my university. I am a research faculty member in a medical division and have no clinical or educational responsibilities. I am 100% research.

38. This is an interesting idea but in the effort to make the survey shorter it is hard to capture the wide variety of program types and job descriptions. I think the definition of service is off the mark. Good luck.

39. With split positions, the faculty member is able to teach in the classroom and then demonstrate in real life later in the day, which is great for the student. In my situation, there is no mechanism by which faculty are evaluated for the work they perform outside of the classroom (in athletics), whihc is NOT good for the faculty member.

40. If faculty are part of a tenure track line, it is counterproductive to have them responsible for institutional sports care responsibilities. This becomes a tenure killer! Not enough time is allotted to develop lines of research.

41. Realistically it is difficult for full time faculty to have blended positions with the service, teaching, administrative (for PDs) and scholarship requirements. Ideally, it would be great to continue involvement in clinical practice, but considering the previous, time and salary it is very difficult in many cases.

42. I left this setting 6 monts ago after being there for 3 years. It was very difficult to balance academics (students) and sports (care for athletes). If you focus on one then the other suffers. Then you end up working more hours 12-14 for very little pay.

43. Although I am sure that some faculty believe that doing patient care helps them "stay in touch" with current trends in the field, I believe faculty have enough to attend to including, but not limited too, staying abreast of all latest developments in health care, creating new knowledge, disseminating knowledge, and serving the profession. Therefore, requiring faculty to also provide clinical care detracts from these other critical roles. That said, each institution is different and has different aims and objectives and as such you can find many number of role requirments for faculty.

44. I'd like to see our profession move from the entry level BA/BS degrees and into a more prominent role of Master's Degree.

Curriculum Vitae

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Education

Marshall University
Doctor of Education in Educational Leadership, 2012

Indiana State University
Master of Science in Physical Education with Specialization in Athletic Training, 1985

University of Southern Indiana
Bachelor of Science in Communications (Journalism), 1983

Certifications

Board of Certification
Certified Athletic Trainer 1986

West Virginia
Registered Athletic Trainer 2010

Professional Experience

1991 – 2004
Assistant Athletic Trainer & Instructor University of the Cumberlands

2004 – 2006
Athletic Trainer for Whitley County High School

2006 – 2012
Adjunct Instructor and Athletic Trainer for University of Charleston

2009
Adjunct Online Instructor for Mountwest Community and Technical College

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