I would like to thank the Executive Board of the Eastern Athletic Trainers Association for providing me with privilege and honor of presenting tonight's Pinky Newell Address. Pinky is a NATA Hall of Fame Athletic Trainer who was known as a leader, educator and innovator in the profession of Athletic Training. Pinky's influence and vision for the profession of athletic training is still evident today, 30 years after his retirement. It was his ability as a leader within our profession, that enabled him to convince the then one year old Eastern Athletic Trainers' Association to reach out and join fellow athletic trainers from around the country to create the National Athletic Trainers' Association. Without Pinky's vision and leadership the NATA that we all know and love would not be and the profession we have dedicated our lives to would not have the voice and the influence it has today. While I have attended every EATA meeting since 1992 and have listened and been inspired by some of the best and most motivating individuals in our profession in past addresses, I did not know Mr. Newell directly. It is my hope that my presentation tonight rises to the level where it could be judged worthy of his legacy and the legacy of the thirty Newell Address presenters who have come before me.

So what do I have to say that justifies keeping you all in your seats for the next 30 minutes and by doing so preventing you my fellow athletic trainers from enjoying the Collins Surgical Party. You already know that athletic training is the best profession in the world and its members provide the highest level of services to their clients, so what else can I tell you tonight, based on my years of working as an athletic trainer and leader within this incredible profession ? Well hopefully something worth listening to !

Having recently completed my time on the NATA Board of Directors, serving as District 1 Director, closing my own business, leaving my family to start a new career as a professional educator and serving as an athletic trainer for pop warner, high school, collegiate and professional athletes I think I have a unique view of our profession which I hope will inspire some of you to take on leadership roles in this profession to change it for the better.

My goal today is the same as it was in 1996 when I first volunteered to work on behalf of the profession. That is to ensure that the next generation of athletic trainers are as good at being an athletic trainer as those that came before them. I am therefore going to talk to you today about my views on improving the profession through retention of its best and brightest students by making changes in the athletic training educational paradigm as well as the scope of practice of athletic trainers in general. Some may argue that with only 2 years of full time academic experience I am ill prepared to discuss the intricacies of athletic training education, however I respectfully ask their patience as I use my over 25 years of experience as a clinician and employer of newly certified athletic trainers to bolster my relatively limited academic experience. Please bear in mind that I am a passionate man who has been given a platform and opportunity to share with you what I believe to be of critical importance to our profession as we begin a new chapter in the educational process of future athletic trainers.

Not because future athletic training students will hold a master's degree and will know how to perform a critically appraised topic on the latest therapeutic intervention but rather because they have the academic preparation, knowledge, confidence, expertise and experience to deal with an

athlete screaming in pain or a parent, coach or bystander giving advice which is neither appropriate nor necessary. The next generation of athletic training students and young certified athletic trainers will need to be as confident in their hands on athletic training skills just as much as their academic skills. They will need to assess an unconscious athlete and quickly determine whether they have a head or neck injury, cardiac emergency, heat stroke, sickle cell or diabetic emergency or some other condition which warrants their emergent response. They will have to know whether it is best to ice, heat, strap, brace or cast an injury. They will have to know what is the best rehab program for enhancing recovery after ACL reconstruction for a variety of different athletes playing a variety of different sports. They will quickly come to realize that every evaluative or therapeutic technique they employ will be influenced by the individual characteristics of each individual patient as well as sport that they play.

Their classroom and laboratory education will ensure that they fully understand what to do. Despite the quality of this didactic education it is only under the tutelage of an experienced mentor that they can learn how to fully implement this knowledge gained in the classroom in real life situations on real patients. Clinical instructors, mentors or in today's parlance, preceptors, are the only ones who can help them take all of the knowledge they have learnt in the class room and help them apply it in a real world setting when the bone is sticking out of the skin, or the parent wants to know why Suzie can't play with post concussion syndrome or why sometimes telling a coach that a kid is ready to play is as hard as telling them that they cant.

As a staunch early opponent of the entry level master's degree I have seen and now fully understand the rationale behind this transition in athletic training education. I freely admit that my early reservations with moving to the Master's degree were wrong and I now fully believe that it is absolutely necessary for our profession and support the decision of the strategic partners. With that said I do not think that requiring future athletic training students to obtain a master's degree will solve the performance issues often brought up by the supervisors of newly certified athletic trainers. In fact I am concerned that the very opposite may occur if early and extensive hands on clinical experiences are not mandated as part of the core curriculum in every Athletic Training Education Program above and beyond what is currently being required today.

Experiential learning has been a key component to joining our profession since its inception due to the fact that we work with humans who are often in distress and book knowledge while critical in our professional development will not fully prepare our students for the challenges they will face. As an internship route ATC I spent over 1500 hours learning the art of athletic training after obtaining my degree in physical therapy. I certainly learnt much more on how to be an athletic trainer under the tutelage of Frank George, Russ Fiore, Dave Murray and Joe Castro than I ever did sitting in a class room.

While the academic load on today's students has certainly increased the number of hours in experiential learning has not increased to the same degree in scope and intensity. My emphasis on increasing the amount of experiential learning in Athletic training education appears to be in line with what the presenters were saying in the NATA's latest webinar on degree transition which was released this week. In this presentation there were multiple references for the need for

high quality or high value clinical education for our students. This included clinical educational opportunities in a variety of job settings both traditional and nontraditional in nature, please pardon my use of outdated terminology such as that. It was even mentioned that programs may want to explore the use of full time clinical experiences for their students in order to prevent them from having to split their days between didactic and clinical education.

The development of high value, high quality clinical experiences for our students is critically important to their development as athletic trainers and cannot and should not be the sole responsibility of the athletic training education program. Programs will need to develop relationships with a wealth of clinical sites which offer a wide variety of experiences for all of the students within the program. These sites need to be staffed by preceptors willing and fully capable of fostering worthwhile experiences for the student not necessarily for the site or the preceptor themselves. It would be very wise for the BOC and CAATE to consider the judicious increase in the total number of high quality experiential hours students need to fulfill in order to graduate and sit for the exam.

It is important to note however that increasing the hours is not enough. The time spent in clinical rotations must also be meaningful, with action not observation on the part of the student. It makes no sense and provides little benefit for a student athletic trainer to watch the team physician, head athletic trainer or assistant athletic trainer performing all of the evaluations and or treatments at practice or in game situations. They must be involved in this process, either directly on the field or later on the side lines, if they are to learn the skills necessary to become an athletic trainer. Holding the water bottle or the radio will not prepare even the brightest student for someday actually preforming these same tests and measures on their own.

Clinical experiences, provided by you my fellow certified athletic trainers, MUST provide the student with hands on opportunities in real life situations. They cannot be our gofers or our errand persons. We as clinical instructors need to learn to step back and allow the student to start the evaluation process, watching and coaching as needed. This will be hard for us to do but the student deserves the opportunity to practice and learn the art of athletic training, as long as we can safely give it to them. I can honestly say that the first month I spent in an on campus clinic for our students was one of the hardest things I have ever done. I constantly had to stop myself from interfering with my students' evaluation and treatment processes. I had to learn how to let them learn and how to guide them through the process versus telling them what to do. As professional athletic trainers, there are many teaching moments that occur every day, we need to truly learn how to facilitate our students learning through direct patient care if we as clinical instructors truly want to transition ourselves into the preceptors our students need us to be. Research has supported these statements and has shown that early and direct exposure of athletic training students to working as an athletic trainer increases both student retention and satisfaction with their chosen profession thus keeping students within the profession while giving them the experiences that they need to succeed on their own.

One of my more vivid memories as a preceptor occurred while I was working in my old clinic with an AT student who was giving me a report on a rugby player who had fallen on the ball 4

hours previously during a game and was now in the clinic complaining of left shoulder, neck and upper quadrant pain. I listened to him as he regurgitated his patient's subjective complaints and his objective measures. He concluded his presentation by saying he thought the athlete may have a broken rib and should get an Xray. At that point I asked him to repeat the patient's subjective complaints and then calmly asked him if he ever heard of a German guy named Kehr? Well his eyes lit up and widened a bit and we both learnt something that day. He learnt that an athlete can injure their spleen and walk into a clinic 4 hours later and that often the subjective history paints a very vibrant picture that you need to pay attention to and I learnt sometimes a gentle question will teach a lesson that will last a life time. For those of you wondering, Yes, we sent the athlete to the ER and yes he had a contused and bleeding spleen!

To further emphasize the need for high quality clinical education I would like to share a recent experience with you, but first let me assure you and President Sailor that this did not occur at Fresno State ! While in an interview for a job teaching physical therapy students, I was asked how I measured competency in a student and specifically how I would determine whether a student was both safe and competent to practice as a physical therapist. My reply was that the best way to do this was not on a test but rather by observing them on a daily basis in real life situations as they perform the skills necessary for the job, ie a clinical experience either integrated or fulltime.

When I followed up with my interviewer and asked why the question was asked I was told of a recent senior student with a 4.0 grade point average, who had failed their final clinical rotation because they could not handle the rigors they experienced while working full time on the final clinical rotation despite their incredible grades. This concerns me and it should concern you as well, as there would appear to be a significant disconnect if a senior 4.0 student is able to progress through a highly reputable doctoral program which is ranked well nationally and still be unable to handle their last clinical affiliation. Obviously there would appear to be a disconnect with the curricular design if a student is able to demonstrate didactic excellence yet lack clinical competence. As an athletic trainer and educator I want to ensure that as a profession we and all of the strategic partners take steps to avoid a similar fate for future athletic training students. This deep concern for the future of this profession and its future students is in fact the genesis for this portion of tonight's talk.

Besides improving the amount and quality of experiential learning opportunities for our future students I am also concerned that the transition to the master's degree will bring additional pressure on athletic training educators and their program chairs from University and College administrators. The proposals submitted by programs to justify the creation or maintenance of graduate education programs often comes with stipulations as to the number of enrolled/graduating students whose tuition is either fully or partially funding the program.

Programs are therefore strongly encouraged to enroll and maintain enough students to meet the minimum number that they submitted as part of their proposal to the college or university. As you can imagine as a practicing athletic trainer, I did not fully understand the impact that this could have until becoming a full time faculty member. As of December 2015, there are 95

ATEPs whose three year aggregate first time pass rate is below the 70% threshold set by CAATE. Furthermore, as a member of the board of directors I was told that there were programs that failed to graduate a single student who could pass the BOC exam on the first attempt. At the time I was working as an athletic trainer and running a clinic and wondered to myself how can this be. How can programs graduate students who could perform so poorly on the BOC exam.

I now believe the answer lies to some extent on the pressures real or implied that graduation rates are important in higher education. They most certainly are to school administrators and often by default the faculty who work beneath them. These Athletic training education programs exist within the respective institutions despite abysmal BOC first time pass rates because academically they are still graduating or enrolling an adequate number of students in their program to keep the institution happy, financially.

Perhaps CAATE should be pushing Deans, Provosts and Presidents to be looking not at graduation rates or enrollment numbers as a measure of a program’s success but rather at BOC first time pass rates. Accreditation standards can and should be used to quickly and mercilessly weed out those programs who fail to meet the standard as well as entice the growth and development of all programs to ensure student success. Using accreditation standards to weed out ineffective programs is not new in academia or even healthcare and having just gone through the physical therapy accreditation process I can tell you that a three year aggregate first time pass rate of less than 90% is grounds for being placed on probation and requires immediate action on the part of the program to demonstrate that it is taking steps to improve pass rates. We owe it to the students and their families, who invest significant time and money into their education, and we owe it to the profession as well as to the public. This is especially true when one considers the fact that a new athletic trainer is often far more likely to be making critical and emergent decisions in their first year as a licensed professional than any physical therapist will be asked to make over the course of their entire career.

These pressures I have discussed are not unique to athletic training and exist in many other professions who have transitioned from baccalaureate to more advanced degrees. Because this is not a unique problem we do not need to invent a solution but only need to see what other medical professions have done to minimize these pressures on their educators in order to ensure the success of the profession as much as the students themselves. We can then choose the most appropriate techniques for athletic training and implement them judiciously.

As a mentor and friend once said to me its time to look at what model we are using to educate our students. Perhaps we could continue the didactic education of our students as we have in the past and increase the number of hours of hands on clinical work similar to the medical model of extended clinical internships. I think Mr. Newell would agree that the practical hands on application of knowledge is fundamental to the core values of athletic training education especially when one recognizes that we are asking our students to learn considerably more today than what was required even a decade ago. Ultimately and despite the greater breadth and depth inherently found within Masters level education, students emerging from these programs in the future will ultimately be considered generalists whose education has prepared them for the rigors

of the BOC examination, similar to other medical professions who have enhanced their entry level degree. The medical model of education recognizes this and allows programs to educate students to the level necessary to successfully pass the BOC examination on the first attempt but also allows programs to offer additional didactic and experiential opportunities strategically matched to their students interests by providing classroom and clinical experiences that will allow students the opportunity to prepare themselves to enter specific employment settings within the diverse profession that is athletic training.

With a little planning and coordination I can easily see the same Athletic Training Education Program offering a Masters degree in athletic training with concentrations in areas as diverse as industrial, corporate or ergonomic medicine as the more traditional concentrations of adult and adolescent medicine to name just a few. For example an adult sports medicine concentration would provide athletic trainers who desire to work with athletes at the collegiate level or beyond the opportunity to fully explore the various medical issues and conditions affecting the adult population. This type of education would allow the athletic training student to explore the wide variety of preexisting or developing medical conditions inherent to athletes 18 and over that may impact their medical care and which would be absolutely vital to be aware of in regards to the evaluation, treatment and prevention of injury. Similarly a concentration in adolescent medicine would be crucial for athletic trainers who wish to work in the secondary school setting in order for them to deal with the various developmental, medical, psychological and learning issues inherent to this population of athletes.

The overall curriculum would still be focused on passing the BOC examination but would allow the individual athletic trainer to more fully explore the nuances of the athletic population and or job setting that they desire to work with upon graduation. This could be done through elective as well as advanced course work as well as experiential learning in those specific regions that most interest them. This type of concentrated learning, while not fully "specialized" would make a newly certified athletic trainer much more competitive as compared to their peers for their chosen employment setting. Similarly, athletic training education programs offering these concentrations would find themselves much more attractive to students who desire an educational program targeted for their chosen job setting. This would ultimately aid the athletic training education program in recruiting and retaining the most qualified and motivated students.

While I have dedicated the first portion of this speech to education of future generations of athletic trainers. I would like to take my last few minutes to discuss some potential changes coming to the athletic training scope of practice. Today athletic trainers are expected to; enhance performance, prevent injuries, provide emergent care of the injured as well as evaluate and treat the physical active. Athletic Trainers function in almost every conceivable medical arena with a variety of age groups and with an ever increasing level of patient complexity. Yet we continue to be underpaid for our knowledge and skills and what's worse is that not every athlete let alone physically active individual has access to an athletic trainer.

Increasing the scope of athletic training practice without first increasing salary and job opportunities is counter intuitive and will further drive the requirements to become an Athletic Trainer higher without rewarding athletic trainers financially for their efforts.

I wonder is there another medical professional willing to take on the legal and financial liability of suturing a wound when the average salary for a 25 year old newly certified athletic trainer is $34,000 a year. Do we as knowledgeable and skilled professionals truly believe that this increased exposure to liability risk will not be associated with an incremental increase in our malpractice insurance, driving up the cost of being an athletic trainer.

Yes its cool to suture someone up, yes I would love to do it, but why would any of us increase our liability exposure without a commensurate increase in salary? We can not afford to keep increasing the knowledge skills and abilities our students and our practicing athletic trainers need to have, if we do not first increase their pay. Failure to do so will result in educating our profession right out of existence.

Which brings up my final point which is retention of the best and brightest.

Prior to stepping down as district director, I asked a quick survey to be conducted of the students who receive EATA, D1 or D2 scholarships to see where they are working and in what capacity. While it was not conducted scientifically nor had a large enough sample size for scientific analysis, the number of high quality students recognized by our association for their excellence, who were no longer working as athletic trainers and were now pursuing other career paths was astonishing and very disappointing. If we don't fix our salary issues and increase our employment opportunities we will continue to lose some of our best students to more lucrative professions, especially if we ask them to learn more and spend more money on their education without first ensuring that average entry level salaries are increased and more opportunities for advancement are provided.

We need to support the NATA and NATAPAC at all levels to mandate an appropriate number of athletic trainers in every school with an athletics program. As Past NATA President Thornton once said increasing the demand for athletic trainers in the secondary school setting will have an immediate effect on salaries for all athletic trainers. Perhaps in the future a young athletic trainer will have the opportunity to turn down the no or low salary, no benefits job with the local college for a full and appropriate salary and full benefits package at the local high school. When that happens on a regular basis the entire profession will take a giant leap forward in ensuring that the best and brightest of our students stay within the profession we all know and love so much.

In closing I would like to thank the EATA for the opportunity to talk to you my fellow athletic trainers about a profession that I love so much. I hope that my experience has allowed me to present ideas that would be welcome not only to athletic trainers working on the sidelines but to athletic trainers working in the class rooms. I know we all want to ensure that this wonderful

profession continues to progress in skill and knowledge while continuing to provide its patients and clients with the highest level of services.

And Finally I would like to thank my wonderful wife Judith Ullucci who has some how managed to keep myself and our three children on the right track despite the numerous occasions where my service to the profession of athletic training has taken me away from my duties as husband and father.