Apprenticeship and Mentoring Framework

The traditional model of "learn-by-doing" (observation, hands-on, immersive) is equally important as academic, evidence-based learning/research or "book-knowledge"--the optimal learning situation is a blend of both. Kraemer (2005) described the rigorous processes of scientific studies and how findings received approval for publishing in peer-reviewed journals. Kraemer (2005) noted that such scientific studies could help bring an added dimension the practices of trainers/strength coaches--increasing understanding and broadening perspectives. "Bridging the gap" [between academics and the trenches] is a cooperative effort (Kraemer, 2005; Pierce & Nagle, 2005).

An apprenticeship/mentoring framework (plus a regional/national supporting network) would facilitate the transfer of academic to applied skills--elevating the health/fitness/wellness profession as a whole, providing a support structure for the fitness professional and an opportunity for the fitness professional to demonstrate real-world competence thereby reducing liability (risk management).

Benes, Mazerolle, and Bowman (2014) described athletic training (AT) clinicals as "socializing" students into their professional roles, and providing "authenticity, an essential step for learning" and retaining students in the AT program through graduation (p. 157). Mentorship was also found to be a significant component in student success/development by modeling professionalism (e.g. attitudes, values, and skills) during the clinicals and inspiring students (Benes et al., 2014). There are aspects such has empathy, stress management, critical thinking, communication, self-discovery, and diversity that cannot be taught inside a classroom (Benes et al., 2014). Clinical apprenticeship/mentorships elevate the health/fitness/wellness field by immersing students in real-world situations/duress facilitating the transition from theory to practice while providing supervision and guidance (safety net).

In many fields (health/fitness not excluded), the learning model has become a many-to-many relationship or "Community of Practice"--social learning, like a melting pot (Dornan et al., 2014). Dornan et al. (2014) described three learning outcomes for their blueprint for clinicals (or clerkships): real patient learning (contextualization, reinforcement, integration); affective learning (self-discovery, identity development); and practical learning (i.e. traditional metrics of knowledge, skills, attitudes, etc.). Dornan et al. (2014) also identified three support structures in the framework: organizational (curriculum support, continuity, sequencing, access and opportunities to practice); pedagogic support (individuals such as clinicians serving as instructors, mentors, supervisors, managers, preceptors, etc.); affective support (anyone in the learner's circle providing mental, emotional, and social supports; fostering confidence, motivation, and inspiration). A framework for experiential learning is important for addressing the whole-student (whole-person development/growth) and not just knowledge/skills competency.

A better-equipped health professional is a more robust individual, more capable of operating/complying to standards to help minimize liability (lines 1-4) in Risk Management Pyramid (Eickhoff-Shemek, Herbert, & Connaughton, 2008). Awareness and adhering to standards of practice helps to reduce risk of negligence and other torts. Apprenticeships/mentorships help novice practitioners (e.g. trainers/coaches) gain situational and discretionary awareness which cannot be taught by book-knowledge.

In order to address the whole-person/student education, apprenticeships/mentorships offer multidimensional and multimodal learning opportunities to synthesize theory into applied practice.

Chung 10.06.2015

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