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Executive Summary

What is the Athletic Therapy profession?

The Athletic Therapy profession is defined by the Ontario Athletic Therapist Association as "A health care profession that specialises in the prevention, assessment and care of musculoskeletal disorders (muscles, bones, joints) especially as they relate to athletics and the pursuit of physical activity" (OATA, 2009a).

What is a Certified Athletic Therapist?

A Certified Athletic Therapist is a graduate of a Canadian Athletic Therapists Association (CATA) accredited post-secondary program who has successfully completed the written and practical National Certification Examinations. A Certified Athletic Therapist uses the designation "Certified Athletic Therapist (Canada): the post-nominal initials being CAT(C). A Certified Athletic Therapist is also known as an Athletic Therapist.

Who has Endorsed the Profession of Athletic Therapy?

In the United States, the American Medical Association has endorsed Athletic Trainers (called "Athletic Therapists" in Canada) and their national certification body (the National Athletic Trainers Association Board of Certification). The AMA has recommended that Athletic Trainers be hired by high schools to manage injury prevention, diagnosis and treatment for high school athletes. Athletic Trainers are licensed or registered in all but one state. Between Canada and the United States, there is mutual recognition of the educational components of the accredited programs for Athletic Therapy and Athletic Training, and the skill levels and knowledge are virtually the same.

Who should consult with an Athletic Therapist?

Anyone with an injury related to physical activity can benefit from evaluation and treatment by a Certified Athletic Therapist. Athletic Therapists traditionally have worked with high level athletes, but they are used to and are comfortable working with any physically active individual. Principles and techniques designed for athletes are successfully employed on a routine basis for those less physically active than a professional or national level athlete.

History of Athletic Therapy

In 1965, a small group of Canadians who were National Athletic Trainers Association (NATA) members sought out like-minded professionals from across Canada to form a Canadian association similar to the NATA. They formed the Canadian Athletic Trainers Association (CATA). The original 10 founders of the CATA held the first convention and AGM in 1966.

A 1969 Task Force on Sports for Canadians found that elite level athletes were not getting the kind of medical care that was available in other countries (Safai, 2007). After two major games (1968 Mexico Olympics and 1974 Commonwealth Games), the opportunity arose to correct this problem with additional coverage provided by 'athletic trainers' and sports therapists (De Conde, 1990) at the 1976 Montréal Olympics (Flint, 2012).

In 1976, at the Annual General Meeting in Kingston, the name of the organization was changed to the Canadian Athletic Therapists Association (CATA). The name change was designed to convey the professionalism of Athletic Therapists in the eyes of the public, the government, and, other health care professions. This change in title from



'trainer' to 'therapist' recognized the specialized role of Athletic Therapists as an integral component of a health care team. In fact, the name change was in time for the use of the title: "Athletic Therapist" at the 1976 Montréal Olympic Games.

What began in 1965 as a small group of men seeking to develop an Athletic Training profession in Canada is now a strong, functioning health care profession made up of almost 1500 men and women across Canada. Athletic Therapists moved beyond the gymnasia of academia and the professional ranks to become well qualified clinical and field injury management specialists for all active Canadians.

Sport Injury Courses in Ontario

The OATA was a pioneer in the efforts to educate the general public in the prevention and management of sports injuries in Ontario. The Athletic First Aider program was the initial model upon which many successful government-funded and supported sports injury courses were based. The existence of the Athletic First Aider and Sports Injury Prevention and Care programs has resulted in an increased awareness within the sport community of the importance of the prevention and care of sports injuries and the role of the Certified Athletic Therapist as a health care professional. With the increased focus on mild traumatic brain injury (mTBI) and pediatric injuries, the OATA continues to play a significant role in the awareness, education and mitigation of sport injuries.

Athletic Therapy in Higher Education

Similar to the development of many professions, the first Athletic Therapists passed on their knowledge and skills via real life practice on the playing field or battlefield. With only a few formalized athletic training educational programs in Canada, the Canadian Athletic Therapists Association used Supervisory Athletic Therapists as mentors to help aspiring Athletic Therapists achieve certification after graduation from post-secondary institutions.

The Canadian Athletic Therapists Association in 1997 recognized the need to develop an approved curriculum of study and required institutions from across Canada to have their Athletic Therapy programs accredited. As of September 1999, all students wishing to certify with the Canadian Athletic Therapists Association are required to have graduated from an accredited Athletic Therapy program.

The quality assurance benchmark honed by Athletic Therapy students at accredited institutions is a direct result of the on-going meticulous academic reviews that occur at each institution by the Program Accreditation Committee (PAC). Further information about the PAC and the process can be found online at: www.athletictherapy.org/en/accreditation_application.aspx.

National Certification Examination

The Board of Certification for Athletic Therapy (CBoCAT) creates and administers the written and practical examinations based on all aspects of the CATA Scope of Practise and Competencies in Athletic Therapy. "This process ensures that successful Certification Candidates have demonstrated basic competence in Athletic Therapy and ensures the safety of the public as Certified Athletic Therapists provide Athletic Therapy services to active Canadians" (CATA, 2011).

The National Certification Examination (NCE) is one of the most stringent in the Canadian health care system. It is a process that ensures that Athletic Therapy Certification Candidates have successfully met the minimum standards for a Certified Athletic Therapist as set out by the CATA Scope of Practice and Competencies in Athletic Therapy.



It continues to meet new challenges by changing, adapting and adopting new policies and procedures. The NCE process is fair, valid, reliable and defensible. Since Athletic Therapists treat active Canadians, a stringent and discerning examination ensures safe and effective treatment.

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Governance

The OATA was formed in 1974 as a voluntary professional association to serve the collective interests of Athletic Therapists in the province of Ontario. The organization is a not for profit Corporation under the (Ontario) Corporations Act (Part V). The OATA is a regional chapter of the Canadian Athletic Therapists Association.

The OATA advocates for the interests of Athletic Therapists and the Athletic Therapy profession in Ontario. At the present time, the OATA has a membership of over 700. The OATA represents the profession to the public, governments, third party insurers and other stakeholders. The OATA also has the responsibility of governing in the public interest.

Regulation

In the same fashion that the CATA functions as a self-regulating organization for all Athletic Therapists in Canada, the Ontario Athletic Therapists Association (OATA) governs the profession of Athletic Therapy in Ontario. Many of the functions of an Ontario health regulatory College are already administered by the OATA and they include: ethics and discipline; professional development and continuing education; quality assurance; and registration. In essence, both the CATA and the OATA have been performing the function of a regulated health profession by protecting the public from the risk of harm through treatment received from an Athletic Therapist. Many Athletic Therapists are also registered with an RHPA College (e.g., chiropractic, massage therapy) and have additional qualifications to perform RHPA controlled acts such as acupuncture under lawful delegations.

All health care professions provide a service where there are risks and benefits to patients and the public. Athletic Therapy services also carry a risk of harm. This is why the education and certification of Athletic Therapists is so important. Athletic Therapy should be recognized by the Ministry of Health and Long Term Care as an independent regulated College. Athletic Therapy is a growing profession. The knowledge and skills of Athletic Therapists would be an additional source of quality health care to citizens of Ontario.

The prospect of the regulation of Athletic Therapists in their own health regulatory College; within the College of Kinesiologists or within some other College governed by the Regulated Health Professions Act (RHPA) would result in substantial opportunities for increased and extended health benefits insurance coverage for patients seeking Athletic Therapy services. RHPA regulation would doubtless increase the level of confidence that physicians and other regulated health care professionals would have in referring their patients to an Athletic Therapist. Additionally, RHPA regulation would help significantly with inter-professional collaboration and would substantially enhance the credibility and visibility of Athletic Therapy services with the public, insurance companies, employers, employees and other health care professions.



Practice Venues

Historically, Athletic Therapists worked mostly with elite athletes in a sport setting in university or college clinics or with amateur or professional teams. Now, Athletic Therapists are working in ever more diverse settings and with the broadened scope for the physically active individual, Athletic Therapists are interacting with physically active Canadians. Due to the increasing interest in life-long fitness, as well as the recognition of the skills and knowledge of Athletic Therapists, there are more opportunities for Athletic Therapists in employment in ever more diverse settings.

Athletic Therapists are now branching out from their traditional areas of employment in post-secondary schools and with national and professional sports teams to include: teaching and research; the industrial workplace; physicians' offices; orthopaedic surgeons clinics; secondary schools; private athletic therapy clinics including physician-led concussion clinics; health and fitness clubs; the performing arts; the Canadian Armed Forces; health related commercial enterprises such as insurance companies, ergonomic businesses and medical supplies and device companies.

Clayton, a Certified Athletic Therapist and Orthopaedic Physician's Assistant states that,

We need to somehow in this country get ourselves to a place where physicians are not overloaded with doing intakes on patients; where people who are highly trained can become the first level of response for getting somebody to see a sports medicine physician or an orthopaedic surgeon, and I think the Athletic Therapist is well versed in being able to do that (2013).

Athletic Therapists are educated and adept in performing triage and are used to screening patients and making the appropriate referrals. This screening process performed by Athletic Therapists can save physicians' and patients' time and save the health care system unnecessary expenditure.

Matheson et al. state that "Physician advice might be associated with short term increases in physical activity, but there is insufficient evidence of sustained changes" (2011, p. 1275). Thus, specialists like Athletic Therapists are required to improve exercise compliance. In addition, Athletic Therapists are very experienced in addressing the questions "When can I return to sport?" and "What activity can I safely do while my injury is healing?" If Athletic Therapists bring these formidable skills into the realm of a physician's office, the efficiency of the delivery of care for the patient, by the physician and the Athletic Therapist could be greatly increased. For all athletes, and in fact for everyone who consults an Athletic Therapist, the same high level of care is provided.

Expanded Practice Venues

Today, the future of employment for Athletic Therapists in Ontario is rich with potential. Athletic Therapists now not only provide health care to athletes, but to physically active Ontarians of all ages.

As part of the expanded role of Athletic Therapy, Athletic Therapists are in the right place and at the right time to assist the government in its Seniors Strategy.



We want Ontario seniors to feel safe and supported, and to remain healthy and independent for as long as possible. We want them to remain active and engaged wherever possible, so they are able to continue to achieve excellence as they grow older (Ontario Action Plan for Seniors 2013, p. 1).

The safety of secondary school students who participate in interschool sport is paramount. Having coaches or teachers with basic first aid training does not ensure the prevention of injury; correct assessment of injury; and appropriate return to school or play decisions. One way to improve these functions is to hire full-time Athletic Therapists within the schools so that both the field management of injury and evidence-based clinical skills are provided by a qualified health care professional.

In line with what our counterparts in the United States are doing with their armed forces and veterans, Athletic Therapists could be hired to provide Athletic Therapy services to the Canadian Forces and veterans.

Extended Health Benefits Insurance

The majority of Ontario extended health benefits providers now cover Athletic Therapy services as an insurable benefit. Nevertheless, not all private plans include Athletic Therapy as an option. Therefore, not all citizens with private insurance have access to Athletic Therapy services. Most Ontario sports associations offer Athletic Therapy coverage. In addition, many colleges and universities offer Athletic Therapy services as part of their student fees. Each plan however, offers varying degrees of coverage.

There is a variety of challenges with regard to extended health benefit insurance plans, including fewer insurers offering plans; plans becoming slimmed down in what they offer to keep employer costs down; differing levels of reimbursement for Athletic Therapy services in comparison to other health care professions; doctors being reluctant to refer patients if they have to pay out of pocket; and, a lack of knowledge about what Athletic Therapists can offer and how to access their services.

Athletic Therapy is already known among high-level athletes to be exceptionally effective for the recovery from injury, but Athletic Therapists are continually challenged to prove this claim. At this time, the OATA and its individual members are actively engaged in evidence-based practice research projects that will demonstrate the efficacy, patient satisfaction and cost effectiveness of the care provided by Athletic Therapists. The OATA has taken the initiative in creating and instituting the Program of Care research project presently mining this type of data among Ontario's Athletic Therapists.

A cost-effective group benefits plan developed by the insurance industry is to pool similar health care services like Athletic Therapy and physiotherapy together. This allows beneficiaries to choose the service that best suits their needs.

Athletic Therapy is an under-utilized health care service. It is in a position to make a significant difference in reducing health care costs by keeping people happier, healthier, with more mobility and in their own homes longer. It is clearly in the public interest to reduce the overall cost of health care by making greater use of Athletic Therapy services.

Athletic Therapists at Major Games

Athletic Therapists have been involved with providing health care to high level athletes at Major Games since before sports medicine became a recognized specialty within many professions. Pioneering Athletic Therapists

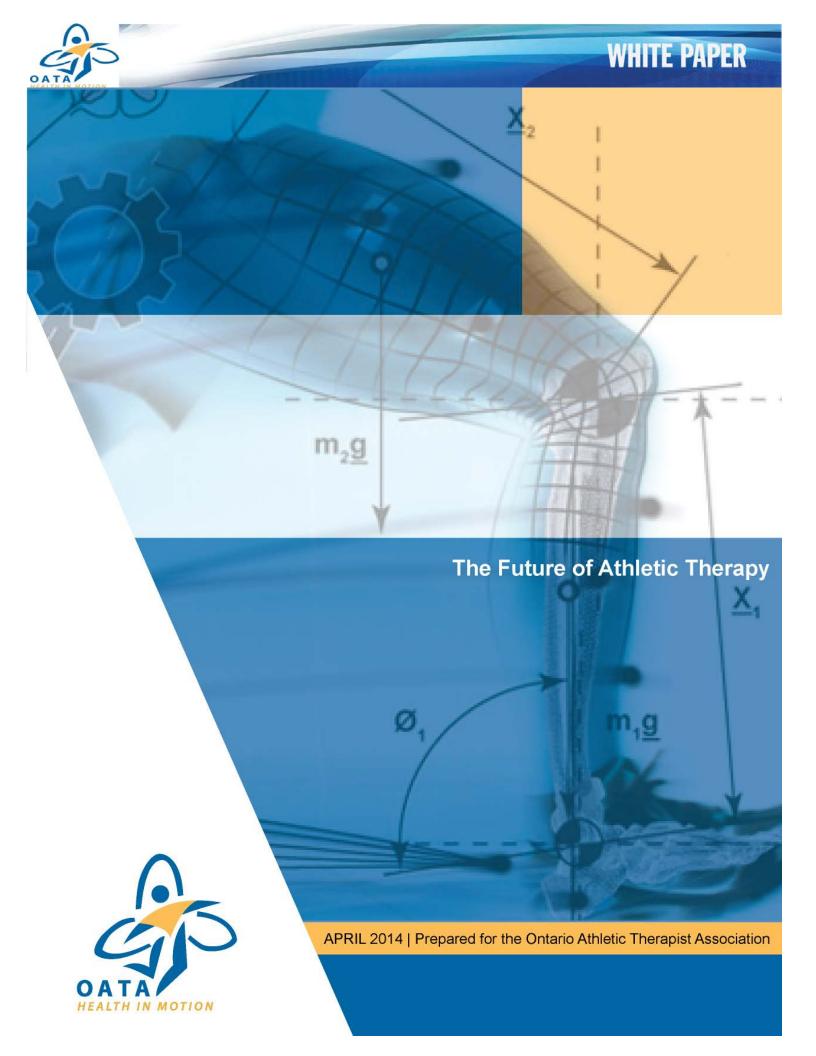


created a path for future Athletic Therapists by distinguishing themselves at major games as effective and sought-after providers of health care to athletes, officials and games' team members alike. Through Athletic Therapists' commitment to excellence, evidence-based therapeutic interventions and volunteerism, they continue to be an essential component of athletic support and consistent performance enhancement teams at Major Games.

Athletic Therapists consider it a privilege to be selected to represent Canada and serve on the Canadian Performance Enhancement Team (PET) at national and international Games. The OATA and CATA encourage their membership to work directly with national teams in order to better serve high performance athletes, gain greater



professional recognition among the NSO's, as well as to increase Athletic Therapy's representation at winter Major Games.





The Future of Athletic Therapy

Where will Athletic Therapy be in 2024?

Athletic Therapy is a growing health care profession with an unlimited number of active Ontario citizens who could benefit from the care of an Athletic Therapist. ParticipactionTM figures suggest that only 15% of Canadians aged 18-64 are getting sufficient daily physical activity (2013). As various agencies push for an increase in daily physical activity, the need for prevention, assessment and treatment of injuries and a safe return to physical activity is needed. This is the very niche where Athletic Therapists excel. Ten years from now the OATA should aim for Athletic Therapy to be the go-to health care profession for those Ontario residents who have added physical activity to their daily routine.

Athletic Therapy in 2024

Athletic Therapy will have been an RHPA regulated health care profession for many years and the benefits of this regulation to the citizens of Ontario will be self-evident. The model used for regulation was similar to that of the state of Ohio where athletic trainers, occupational therapists and physiotherapists are joined in one college (OTPTAT). Ontario residents are confident in knowing that they are protected from the risk of harm from this regulated health care profession.

Athletic Therapists are collaborating with, and have been fully accepted by, other regulated health care professions in the provision of patient centred care for physically active Ontarians.

The profession of Athletic Therapy is now fully integrated into Ontario's healthcare delivery system.

Athletic Therapists and physiotherapists have the same RHPA-authorized acts because both professions assess, diagnose and manage musculoskeletal injuries and conditions in a similar manner.

Since the inception of a College of Athletic Therapy, Athletic Therapists have been able to regulate their profession to control who can legitimately use their title. This has provided protection to the public from potential harm received at the hands of unqualified people fraudulently posing as Athletic Therapists.

Athletic Therapists are now leading the "Exercise is Medicine" approach to combat physical inactivity in Ontario residents. Elementary and secondary school initiatives by Athletic Therapists are providing guidance on safe, daily physical activity so that life-long enjoyment of physical activity and a healthy lifestyle are engrained.



The Athletic Therapy Research Foundation Inc. is providing funding for Athletic Therapy evidence based practice research in Ontario. It also provides scholarship support for Athletic Therapy graduate studies in the pursuit of masters and doctoral degrees. The Foundation has multiple awards recognizing the advancement of Athletic Therapy and Sports Medicine in Ontario.

Athletic Therapy evidence based practice is the primary focus of research relating to physical activity in Ontario. Also established by 2024 are data bases for detailing the incidence and prevalence of types of injuries associated with the pursuit of physical activity in Ontario, particularly in schools. These data bases complement other data bases from across Ontario, Canada and the United States since physical activity patterns in these jurisdictions are similar.

Evidence-based Athletic Therapy research has elicited exciting discoveries affecting all those who seek treatment for musculoskeletal conditions. Prevention strategies based on research evidence have significantly reduced the number of injuries sustained by young and old alike.

Every secondary school in Ontario that runs contact/collision physical activity programs has a full time Athletic Therapist on staff (full or part-time). These staff members oversee all physical activity with a focus on the prevention of injuries. Athletic Therapists operate clinics on-site in order to provide treatment for all students and staff who attend that school. Additionally, a sports medicine referral system is in place to send students and staff to specialists when appropriate. This school triage and referral system has greatly reduced the number of hospital emergency department visits. Since Athletic Therapists are educated in sound return to play principles and the protocol for the management of concussions, they are making the final decision on returning students to classroom learning and physical activity.

Athletic Therapists are employed in hospitals in three areas identified as needing more support: emergency departments, fracture clinics and as physician extenders. Athletic Therapists are working in hospital emergency departments conducting triage and treatment of physical activity related musculoskeletal injuries and concussions. This has reduced wait times and has aided physicians by relieving them of some tasks that are now performed by Athletic Therapists as physician extenders. Athletic Therapists are also providing assessment and treatment in fracture and sports medicine clinics operated by the hospitals and are assisting surgeons in the operating room.



Athletic Therapists are an integral part of Local Health Integration Networks (LHIN) both as physician extenders and in triage, treatment and patient education roles. Physician-operated clinics and Family Health Teams (FHT) now employ Athletic Therapists in these roles. Reducing the overall demand on physician attention and improving patient outcomes has resulted in decreased health care costs and expanded capacities for FHTs and similar clinics.

Athletic Therapy has benefitted from an increased emphasis on education at the graduate level. Masters and doctoral degree programs are available that provide essential education in conducting original research and evidence based practice for Athletic Therapists.

Athletic Therapists are providing physical activity and fall prevention programs for seniors both in congregant living and home care settings. These initiatives were based on the 2013 Ontario Action Plan for Seniors. These programs have resulted in reducing costs to the health care system by keeping seniors more active and living in their homes longer while keeping them less dependent on medication and hospitalization.

Since Athletic Therapists have been providing injury prevention programs and have liaised with the Arthritis Society of Ontario, there has been a reduction in the morbidity of arthritis. Ontario residents living with arthritis are living more comfortably and longer through Athletic Therapy related physical activity initiatives. These initiatives have resulted in a reduction in Ontario's health care costs.

For many years, Athletic Therapists have been contributing members of Ontario Physical and Health Education Association (OPHEA), Healthy Kids and Parachute Canada assisting in the development of safe physical activity programs in Ontario.

Around 2013, orthopaedic surgeons were beginning to hire Athletic Therapists in their clinics to assist with pre and post-surgical rehabilitation of patients requiring joint replacements. In 2024, orthopaedic surgeons routinely hire Athletic Therapists because of their command of anatomy, physiology and orthopaedic evaluations. The rehabilitation skills of Athletic Therapists and their focus on a safe return to physical activity have been particularly useful.

Athletic Therapy has become known to all Ontario residents through the raised profile of this health care regulated profession. Additionally, the branding of Athletic Therapy in Ontario clarified for the media the role of Athletic Therapy in physical activity and particularly high performance sport.



National Athletic Therapy Month has now been held for almost 20 years. This has helped inform the public about the services available from Athletic Therapists and improved the media's understanding of Athletic Therapy.

Athletic Therapists are entrenched as primary care providers at multiple Ontario sport events such as: Ontario Summer Games, Ontario Winter Games, ParaSport and Senior Ontario Games. Additionally, Athletic Therapists were crucial contributors of primary health care to the Toronto Pan Am and ParaPan Am Games in 2015.

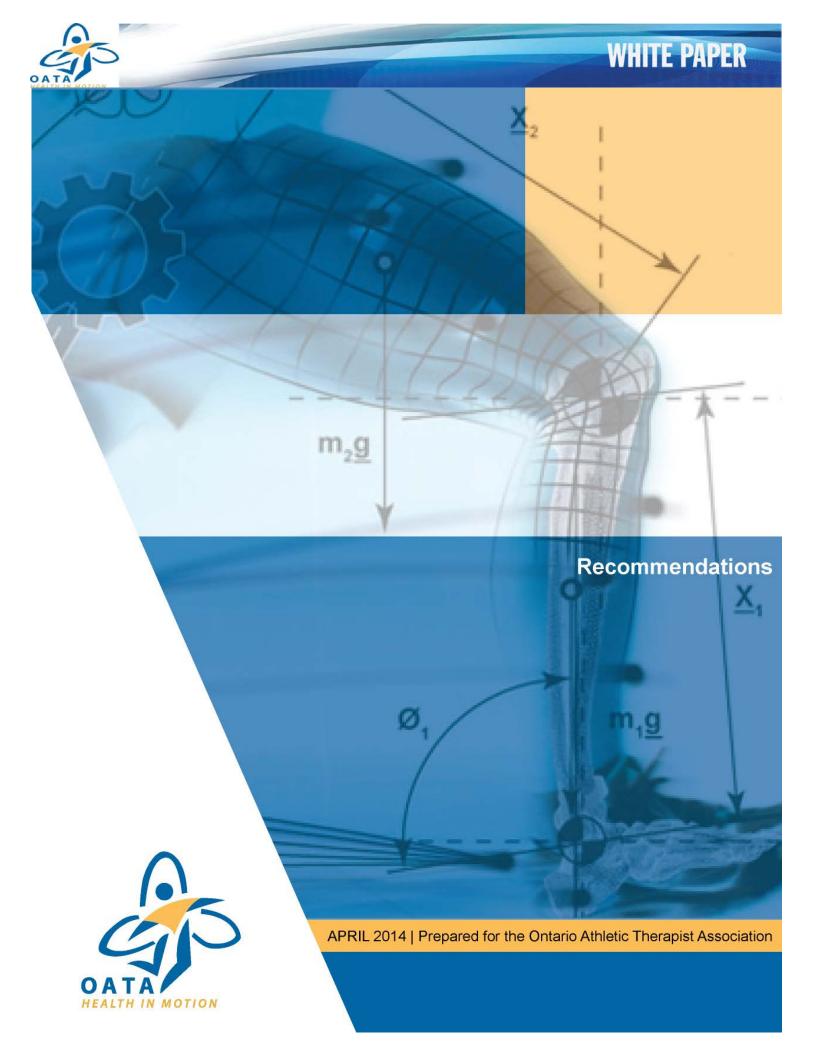
Athletic Therapists are now government employees providing proactive and reactive health care to all major police, fire and EMS departments.

Several years ago, the Canadian Forces created the trade of Athletic Therapy due to the overwhelming need for military personnel to remain in peak condition from boot camp through to retirement. The trade of Athletic Therapy was made equal to the trade of physiotherapy for the purposes of rank and promotion.

For many years Athletic Therapists have been providing primary care and rehabilitation to the entertainment industry. The services of an Athletic Therapist are regularly utilized by the combatants of Mixed Martial Arts (MMA) and World Wrestling Entertainment (WWE). Contestants in physical reality shows like the Amazing Race Canada; musical/dance acts like Riverdance; and, are regularly found on the production sets of action movies.

Athletic Therapists are time and money savers for Ontario industry. Prevention, recognition and early treatment initiatives have all helped to create a healthier and happier workplace resulting in decreased insurance costs, decreased workers compensation claims and lowered absentee rates.

During the last decade since the profession of Athletic Therapy joined the RHPA, Athletic Therapists have become an integral and indispensable part of multidisciplinary health care in Ontario.





Recommendations

Athletic Therapists should become regulated under the RHPA. RHPA regulation would doubtless increase the level of confidence that physicians and other regulated health care professionals would have in referring their patients to an Athletic Therapist. Additionally, RHPA regulation would help significantly with inter-professional collaboration and would substantially enhance the credibility and visibility of Athletic Therapy services with the public, insurance companies, employers, employees and other health care professions.

Continue to educate physicians about the benefits of utilizing the services of Athletic Therapists. As well, it would be advantageous to increase collaboration between Athletic Therapists, physicians, and other health care professionals.

Educate the public about Athletic Therapy and the distinct nature of this health care profession.

Continue to initiate and actively engage in original research and evidence-based practice projects that will demonstrate the efficacy, patient satisfaction and cost effectiveness of the care provided by Athletic Therapists.

Encourage insurance companies to allocate equitable levels of financial reimbursement for Athletic Therapy services in comparison to other allied health care professions. In order to provide a cost-effective group benefits plan, insurers could pool similar services together in silos such as Athletic Therapy, physiotherapy, massage and chiropractic, allowing the beneficiary to choose the service that best suit her/his needs.

Empower insurers, the RCMP, the Canadian Forces and veterans to directly access the care of an Athletic Therapist and receive direct reimbursement without the need of a physician's prescription.

Encourage opportunities for interprofessional collaboration: speaking opportunities at CASEM, OMA (Sport Med), SPC, OATA and CATA conferences.

Encourage opportunities to work with physicians in hospital-based settings such as operating rooms, triage and therapy in multidisciplinary clinics and as physician extenders.

The Ontario Boards of Education should employ Athletic Therapists full time within secondary schools to provide injury prevention measures and care for physical activity related injuries.

Continue to educate the media about using the correct Canadian term of "Athletic Therapist".

Encourage Athletic Therapists to expand into non-traditional occupational settings such as the workplace, seniors' homecare, the Canadian Forces and police forces among others.

Encourage liaisons with National Sport Organizations, Provincial Sport Organizations and ParaSport.

Establish graduate programs in Athletic Therapy.

Continue to encourage the volunteer commitment of Ontario's Athletic Therapists at Ontario Summer and Winter Games, ParaSport events, Special Olympics and Ontario's national athletes.

Seek representation on provincial and national safety, physical activity and injury prevention associations such as Parachute Canada and Ontario Physical and Health Education Association (OPHEA).



Encourage collaboration with other health care associations (e.g., Canadian Red Cross) for the production of physical activity safety manuals and course delivery.

Establish liaisons with the World Federation of Athletic Trainers and Therapists (WFATT) in order to create international student internships to promote global health.

Expand continuing education opportunities for Ontario's Athletic Therapists.

Use the title 'Athletic Therapy' in all promotions (e.g., names of Athletic Therapy clinics, promotional and marketing materials).



Introduction

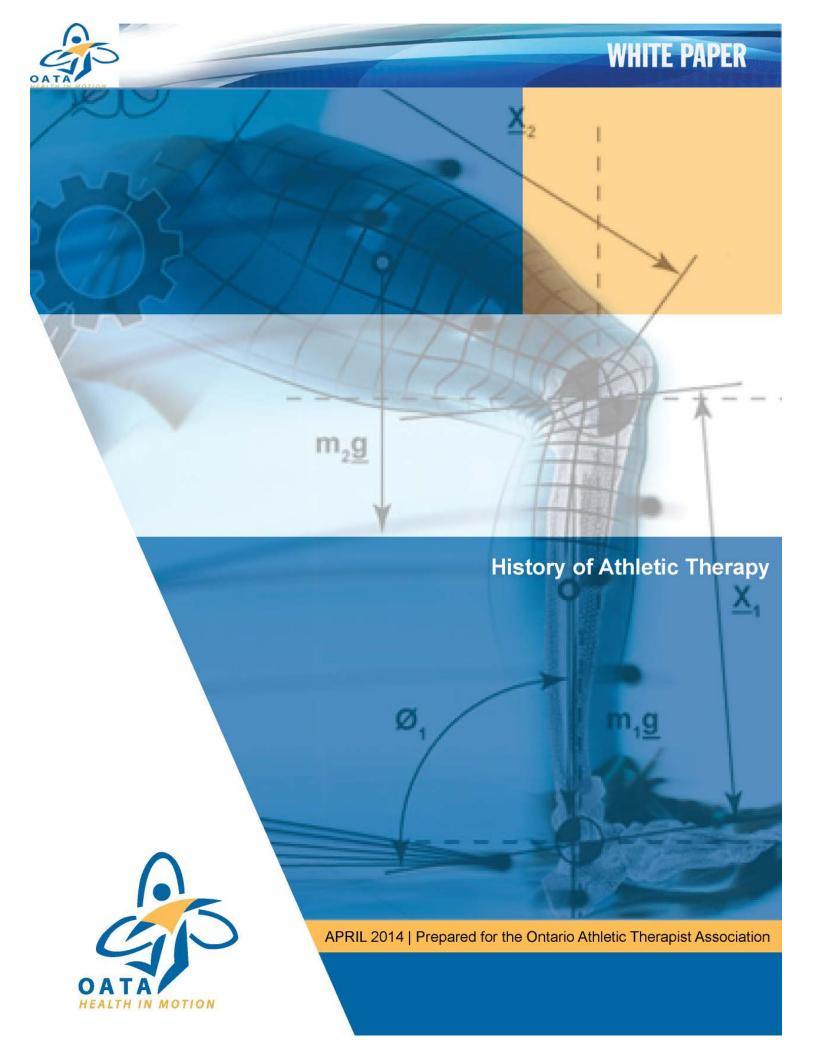
The purpose of this White Paper is to educate key stakeholders who are involved with the delivery of health care and the administration and development of sport, fitness and recreation in Ontario. These stakeholders include Ontario government officials, insurance companies, all levels of educational institutions, sport governing bodies and the general public who would benefit from knowing more about the profession of Athletic Therapy. The White Paper describes the professional profile of an Athletic Therapist including scope of practice, education, the core competencies of the profession, practice venues and opportunities. It describes the history and evolution of the Athletic Therapy profession, the current state of the profession and future development and employment opportunities.

The White Paper will help to raise awareness of the economic and health benefits provided by Athletic Therapists to Ontario's active population. The value of utilizing an Athletic Therapist to deliver health care to athletes has long been known in the sporting community. Their highly developed skills are of benefit however, to anyone in Ontario who is physically active.

Athletic Therapy is making a major contribution to the province's economy in the prevention of injury, the avoidance of hospitalization and early return to activities of daily living; thus minimizing work absenteeism and lost productivity. Athletic Therapy promotes the benefits of a healthy, active lifestyle by the use of prevention strategies, early injury evaluation, exercise and active rehabilitation.

From its beginning, Athletic Therapy has been concerned with the prevention and treatment of injury and the safe return to physical activity. It is obvious to athletes and coaches that prevention of injury leads to better performance. As a result, athletes who suffer injuries are rehabilitated with a goal of preventing a recurrence of the injury. Preventing injury, whilst improving fitness, is a worthy goal for all citizens in Ontario, not just athletes.

This White Paper demonstrates that the profession of Athletic Therapy can be a significantly stronger contributor to the delivery of health care in the province of Ontario and considerably improve the lives of the citizens therein.





History of Athletic Therapy

History of the Athletic Therapy Profession

The Ancient origins of Athletic Therapy can be found in the golden age of Greece in the writings of Galen and Hippocrates who are credited as the founders of modern medicine and health care. These great teachers observed and wrote about the use of: exercise, massage, manipulation, diet, hot and cold baths, and medicinal plants, to improve an athlete's performance. The Ancient Olympic Games were very important to the structure of Greek society. The athletes who competed in these games were aided by coaches and also by trainers of athletes. The trainer's role was to help athletes prepare for competition by preventing injury, caring for injuries when they occurred, returning athletes to training and competition safely and as soon as possible and maximizing their performance.

The profession of Athletic Training came into being at the end of the 19th century when American intercollegiate and interscholastic athletics became firmly rooted in the USA. They were better equipped than most to deal with sports injuries but historically formal education for the Athletic Trainer did not exist. Arnheim states that "...their athletic training techniques usually consisted of a rub, the application of some type of counterirritant, and occasionally the prescription of various home remedies and poultices" (2009, p. 1). After World War 1, the evolution of the Athletic Trainer occurred rapidly, primarily due to the emphasis on intercollegiate athletics in American schools.

In the 1930s, the profession progressed, but was severely hampered by the difficult years of World War II. It wasn't until the late '40s that, once again, university athletic trainers began to organize themselves into a more cohesive group. This became the foundation for the modern athletic therapist.

The Role of Athletic Trainers Historically In North America

Wherever there have been organized sports and sports teams in North America, there has been a need for coaches, managers and people to look after the athletes' injuries. In many cases, the coaches, teachers, parents and officials at games had to care for these injuries. There are still many amateur youth programs where the parents volunteer in a variety of roles. Usually the first parent is the "head coach", the second is "assistant coach" and the third the "trainer". Over time, especially since the end of World War II, a group of health care professionals dedicated to caring for athletes and their competitive needs has developed.

In the USA these professionals are called Athletic Trainers Certified (ATC). In Canada in 1976, the original name of Athletic Trainers was changed to Certified Athletic Therapists Canada (CAT(C)). As the profession developed post World War II, many military personnel who had trained as "medics", were involved in treating and then rehabilitating those who were wounded in battle. They had a combination of formal academic education and practical experience that made them a natural choice to become "athletic trainers" for military sports teams and, on discharge from the military, with universities, colleges and professional teams.

Another distinct group that became Athletic Trainers were ex-athletes and physical education teachers with an interest in helping injured athletes. Historically in Canada, on the semi-pro hockey teams, the second goalie was expected to not only open and close the gate during games but also to look after injuries, whether they had any



special training or not. Despite not having any formal training, these ex-athletes and physical education teachers sought opportunities for learning. Weekend courses and seminars were offered by professional Athletic Trainers and sponsored by sports equipment and sports medicine manufacturing companies. There were also correspondence courses and instructional newsletters offered by sports medicine suppliers such as Cramer's, and Johnson and Johnson. Cramer, a family-owned sports medicine supply company, first published its *First Aider* newsletter in 1932 and has been instrumental in the early development and the continuing education of the profession.

In 1950 the National Athletic Trainers Association (NATA) was formed in the United States. The profession of Athletic Training promoted more formalized education with college and university programs across the United States. American professional teams, universities and colleges all had Athletic Trainers to work with their athletes on a full-time, daily basis. Today, over 300 colleges and universities in the USA offer academic programs to educate Athletic Trainers at the bachelors, masters and doctoral levels. In the United States, the American Medical Association recommended as long ago as 1998 that every secondary school have a Certified Athletic Trainer on staff (1998 Annual Meeting of the American Medical Association: Reports of the Council on Scientific Affairs, p. 8).

The History of the Canadian Athletic Therapists Association

In 1965, a small group of Canadians who were NATA members sought out like-minded professionals from across Canada to form a Canadian association similar to the NATA. According to De Conde (1990), nine men met on April 24 at Maple Leaf Gardens with the objective of sharing the vision for an association in Canada to deal with common issues and concerns. The men involved were: Chuck Badcock of the Royal Military College in Kingston; Stu Langdon and Ken 'Tabby' Gow of Queen's University also in Kingston; Ed Anderson and Howie Ringham from the University of Toronto; Art Sargeant from the Ottawa Rough Riders of the Canadian Football League (CFL); Mert Prophet of the Toronto Argonauts also in the CFL; and, Bob Haggert and Carl Elieff of the Toronto Maple Leafs in the National Hockey League (NHL) (De Conde, 1990). The executive of this new organization consisted of: President, Mert Prophet; Vice President, Bob Haggert; Secretary-Treasurer, Stu Langdon; Eastern Director, Guy Girardeau; and Western Director, Sandy Archer. These individuals formed the Canadian Athletic Trainers Association (CATA), holding the first CATA convention and AGM in 1966.

During the late 1960s and early 1970s, Hockey Canada, the Coaching Association of Canada and the Sport and Recreation Centre in Ottawa were initiated. At the time, it was felt that Canadian athletes competing at major sporting events were not receiving the kind of health care that was necessary. A 1969 Task Force on Sports for Canadians found that elite level athletes were not getting the kind of medical care and technical services comparable to other countries (Safai, 2007). The elite level athletes attending the 1968 Mexico Olympics and 1974 Commonwealth Games recognized the need for enhanced medical care. The opportunity to correct this problem with additional coverage by Athletic Therapists and sports physiotherapists (DeConde, 1990) was accomplished at the 1976 Montréal Olympics (Flint, 2012).

The CATA recognized the need to have its own national certification standard separate from NATA's. To that end, the process was developed and the first CATA Certification examinations were offered in conjunction with the



CATA Convention in Winnipeg in 1975. This led to the designation Certified Athletic Trainer, Canada (CAT(C)). The CATA membership categories were comprised of:

Certified members, earning 50% or more of their incomes from the practice of the profession and having earned the designation CAT(C),

Associate members, active members who had not achieved the CAT(C) certification; and

Student members (later called Certification Candidates), members in the process of becoming certified members.

All other categories of membership that were seen as desirable for a general interest membership (that included many sports medical professionals including: sport physicians and surgeons, dentists, physiotherapists, nurses, high school physical education teachers, chiropractors and podiatrists) were terminated. This was intended to concentrate and limit the membership eligibility in a voluntary professional organization that would work for increased recognition of the professionalism of its members. In 1976, at the annual general meeting in Kingston, the name of the organization was changed to the Canadian Athletic Therapists Association (CATA) and a logo was presented (Figure 1).

The name change was designed to emphasize the professionalism of the profession in the eyes of the public, the



Figure 1. First CATA Logo 1976-1999

government and the professions that the CATA collaborated and worked with as part of a health care team. In fact, the association's name change coincided with the change in title to "Athletic Therapist", first used at the 1976 Montréal Olympic Games. The French translation used was: "Thérapeute du Sport", which has since been changed to "thérapeute du sport agrée". The CATA members were an important provider of health care services as part of the Host Medical Team in addition to the Canadian Olympic Team at the 1976 Montréal Olympics (Laws, 2013).

By the time of the 1979 Pan American Games in Puerto Rico, a consortium of the CATA, Canadian Association of Sports Sciences (CASS), the Sport Physiotherapy Division (SPD) and the Canadian Academy of Sport Medicine (CASM) became part of the Sport Medicine Council of Canada (SMCC), later known as the Sports Medicine and Science Council of Canada (SMSCC). These four professional organizations collaborated on sending qualified medical staff with Canadian teams participating in major international games (DeConde, 1990). To that end the SMCC became an excellent example of collaboration among sports medicine health care providers and National Sports Organizations (NSO) that were the beneficiaries of Sports Medicine services.

As a professional association, the CATA is dedicated to educating the public about the skills and services that Certified Athletic Therapists can provide as healthcare professionals. In 1999, a new CATA logo was unveiled with the motto: "A rapid return to work and play" (Figure 2). In 2003 the title "Certified Athletic Therapist" was registered as a Certification Mark by Industry Canada. This allowed the CATA to certify only those who met the defined standard thereby helping to protect the public from potential harm (Industry Canada, 2003).





Canadian ATHLETIC THERAPISTS Association

Association Canadienne Du Sport

Figure 2: Current CATA Logo

In the early 2000's the CATA established June as National Athletic Therapy Month. An annual country wide effort to increase the profile of Athletic Therapy to the public is initiated by each chapter, Athletic Therapy clinics and individual Athletic Therapists. The CATA website said for 2013 "Rapid Return to Work and Play" is the theme for this year's National Athletic Therapy Month. This June, Athletic Therapists across Canada will run events and programs in DES THÉRAPEUTES their communities to raise awareness of athletic therapy and its benefit to Canadians: a rapid return to work, play, sport and life" (CATA, 2013) (see Appendix 1).

Several other changes were made by the CATA to improve collaboration with other healthcare professionals and regulatory organizations globally. In 2000, the CATA became a founding member of the World Federation of Athletic Training and Therapy (WFATT).

Dr. Frances Flint, CATA President at the time of the WFATT formation, ensured that the title "Therapy" was included in the title of this new, global association. Japan, South Africa, Taiwan-ROC, the United Kingdom and the USA were the other WFATT founding members with the National Athletic Trainers' Association (USA) leading the way (Ferrara, 2006). The first President of the WFATT was Dr. Michael Ferrara of the NATA.

Canada regularly acts as host to the World Federation's international conferences. Membership in the WFATT was open to healthcare professionals in the fields of sport, exercise, injury/illness, prevention and treatment (www.wfatt.org/vision-mission). Thus, the OATA became a member of this global association in order to collaborate with world-wide health care professionals.

In 2006, the Canadian College of Athletic Therapy (CCAT) was formed as another step in the evolution of the Athletic Therapy profession in Canada. Québec Athletic Therapists have already become recognized as health care professionals under regulation issued pursuant to the Code Professionel. There are other provincial Athletic Therapy associations (i.e., Manitoba, Alberta) that are pursuing regulation in their provinces. Since healthcare delivery and regulation are provincial responsibilities, the best scenario for Athletic Therapy would be the formation of provincial health regulatory colleges.



Figure 3: WFATT Logo

The History of the Ontario Athletic Therapists Association (OATA)

By 1973, the interest in organizing sport in Ontario and providing the services of Athletic Therapists (trainers) had grown exponentially. There was a relatively small number of Athletic Therapists who were members of the CATA and/or NATA, working primarily for professional sports teams, universities and colleges as full-time professionals.



As the profession evolved there was a need to establish an organization in Ontario to meet the specific challenges and opportunities at the provincial level. There were several factors that encouraged the development of a provincial Athletic Therapy association in Ontario. One of the factors was the Ontario Ministry of Colleges and Universities' support for a formal Athletic Therapy education program. This support resulted in the inception of the diploma in Athletic Training and Management at Sheridan College in 1973. An additional impetus to establishing formal Athletic Therapy education was the identified need to provide Athletic Therapy services to the physically active public in Ontario. Since Canada intended to host the Summer Olympic Games in Montréal and the Paralympics in Toronto in 1976, there would be a need for a large group of Athletic Therapy professionals to volunteer to staff the host medical teams. This and future hosting responsibilities were other important factors in the development of a provincial Athletic Therapy association. In addition, there was also a need identified by the provincial Sport Governing Organizations (PSO) and the Ministry of Culture and Recreation to establish certificatelevel training programs for adult volunteers working with the numerous teams and sports as first-aiders and trainers. These courses for volunteer trainers were to mirror the Coaching Association of Canada's (CAC) coaching certification courses in both theory and specific sport skills. A final factor in the encouragement of the formation of a provincial association was an increasing demand for Athletic Therapy services by Ontario's high performance athletes. Thus the Ontario Sport Therapist Association (OSTA) was officially formed in 1974 and went on to become the first provincial chapter of the CATA.

The provincial government in the 1970s and 80s was interested in funding programs and supporting the development of sport in Ontario. Funding was made available to the OSTA as a provincial organization that would not have been available to the CATA as a national organization. The Sports and Fitness Division of the Ministry of Culture and Recreation made office space available to the OSTA at the Sport Ontario centre for provincial sports organizations. Additionally, funding was available to hire an executive director and to financially support some of the activities of the OSTA.

In May of 1974 the CATA Convention was again held in Toronto. In advance of the convention several meetings of interested Ontario-based Athletic Therapists were held to help plan the convention and also to talk about forming the OSTA.

In March of 1974, several athletic therapists met at the invitation of Fred Dunbar at the University of Guelph where he was head athletic trainer. The sports therapists attending that first Guelph meeting formed the core of what has become the Ontario Sport Therapists Association (Sport Ontario News, 1977).

The group included: David Wise, University of Western Ontario; Brian Gastaldi and Pat Bishop, University of Waterloo; Ed Nowalkoski, York University; Jamie Laws, McMaster University; Barry Bartlett, Sheridan College; John Moore, Ryerson Polytechnic Institute; and Fred Dunbar who became the first president of the OSTA.

Fred Dunbar was a catalyst in the development of the OSTA which subsequently became the Ontario Athletic Therapist Association (OATA). In 1974, some of the football alumni from the University of Guelph including John Wilson became Sports Administrators at Sport Ontario and facilitated the creation of the OSTA and funding for the part-time executive secretary Steve Zacher. Other champions of OSTA included Mr. Bob Secord, the Assistant Deputy Minister (ADM) for Culture, Sport and Recreation; Mr. Heinz Piotrowski, Vice-President of Adidas Canada; Mr. John Cooper, Vice-President of Cooper Sporting Goods; Dr. Robert W. Jackson, Chief of Orthopedic Surgery at Toronto Western General Hospital and Team Doctor, Toronto Argonauts Football Team; Dr. Charles Bull, Orthopedic Surgeon at Humber Memorial Hospital, Team Doctor York University and Team



Canada at the Canada-Russia 1972 Hockey summit; and Dr. Derek Mackesy, an Athletic Therapist who later became a Sports Medicine Physician at Queens University in Kingston. Fred Dunbar also served on the Advisory Council at Sheridan College, was the principal instructor in the courses that taught the skills and applied practical knowledge in Athletic Therapy and Equipment Management, and was the Head Athletic Therapist for the Toronto Argonaut Football Team for more than 12 years beginning in 1976.

One of the early goals of the OSTA was to increase the sport injury knowledge of volunteer trainers in amateur sport. The focus was on the prevention of injury in youth in sport and the appropriate care for these injuries. As a result, the OSTA developed three levels of certification. Funding for these programs was made available through the provincial government. The OSTA partnered with the Ontario Amateur Football Association, the Ontario Minor Hockey Association and other specific sports organizations to tailor and deliver the Level 1 Athletic First Aider and Level 2 Athletic Trainer programs. These courses were taught in various Ontario communities for many years.

During the 1970s the OSTA spent much of its energy focused on helping individuals on athletic teams and organizations to enhance the injury prevention and care at the grass roots level in the community. This aim was achieved, but on the horizon was a greater need for the profession of Athletic Therapy to achieve wider recognition as a health care profession in Ontario.



Figure 4: OATA Logo - 1970s

Tim Page assumed the role of the President in 1978 until 1985. In the early 1980s, Page along with a small core of executive members made a commitment to advance the profession by continuing to upgrade educational resources and offer courses such as the Athletic First Aider. These courses were offered to the major sport organizations including the Ontario Amateur Football Association, Ontario Soccer Association and with the Ontario Hockey Association. At this time numerous school boards in the Greater Toronto Area (GTA) along with progressive physical education teachers from outside the area jumped at the opportunity to learn how to better manage and mitigate sports injuries. Funding by individual sport governing bodies for the production of manuals and promotion of the Athletic First Aider temporarily disappeared. The concept of community education was resurrected later through the Sport Medicine Council of Ontario (SMCO) and the Safety

Resource Centre. This gave birth to a revised course called the Sport Injury Prevention and Care program (SIPAC).

Upon reflecting on his tenure as OATA President, Page recalls that:

Initially the focus of the OATA was to educate the sport public on sports injuries and to educate the sport governing bodies that had the means, the interest and the need to have that kind of support...Once SMCO started up, the focus changed to a more internal approach to governing ourselves, becoming better organized, and to lobby for third party insurance coverage provided by Certified Athletic Therapists. ...And it also became more focused on providing continuing professional education for Athletic Therapists and constantly improving their level of knowledge and skill (2013).



In 1985, Chris Broadhurst assumed the role of OATA President and keyed in more on one of Page's concluding objectives which highlighted enhancing the image of the Athletic Therapy profession. In addition, Broadhurst and his Executive brought a more business-like approach to the OATA by initiating and developing greater partnerships with the business and insurance communities. Professional development opportunities for Certified Athletic Therapists began to flourish during this time and numerous workshops at York University were made available. This was the beginning of a renaissance in Athletic Therapy in Ontario as there was a paradigm shift towards how Athletic Therapists conducted business and marketed their services. Athletic Therapy was now being added to health care benefit plans and insurance companies were interested in providing insurance benefits coverage for Athletic Therapy care. In concert with this new focus, a new OATA logo was designed with the Association's name highlighted by a stylized runner (Figure 5).

Marcia Franklin next carried the torch as President in the early 1990s and

demonstrated iconic leadership in terms of forging a future for Athletic Therapists as health care providers. Athletic Therapists were operating their

own clinics and becoming self-employed. Franklin was determined that Athletic Therapists would blaze a trail as self-employed health professionals serving the general public.

Four more young professionals assumed the role as President over the next decade (Karen Holland, Kathy Pye, Janice Holmes and Kelly Parr) (See table of Past OATA Presidents in Appendices). Each of these Presidents offered his or her unique abilities to govern the Association and dedicated themselves to the mission of advancing the health care of physically active residents of Ontario. Each leader has created opportunities in entrepreneurship



Figure 6: Current OATA Logo

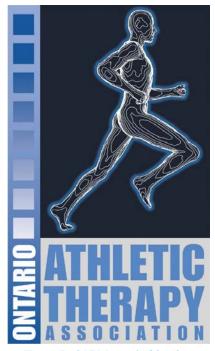


Figure 5: OATA Logo 1980/90s

and in business ventures in the health care sector for Athletic Therapists to enhance the health care of the citizens of Ontario.

In the 1980s and 90s achieving regulation as a health care profession within the Ontario legislative structure became a major focus of the OATA. One of the requirements of a regulatory college was financial self-sufficiency. The OATA established a special levy on its members to create the funds necessary to meet the requirements of a separate health regulatory college in Ontario.

Current President Drew Laskoski and the Board of Directors have worked tirelessly with the

government, other healthcare professions, regulatory consultants and others involved with the health care sector of our economy. Partnering with the CG Group has benefitted the OATA through their administrative and health care sector expertise. Along with the CG Group's many functions, a new OATA website was prepared; a new logo



was designed of a stylized athlete superimposed on the Ontario trillium; and, the motto of "Health in Motion" was created (See Figure 6). These efforts aim to position the OATA to make a positive impact on the quality of life of Ontario residents through cost-effective Athletic Therapy care.

The History of Athletic Therapy Education in Ontario

The Athletic Therapy profession originated because of the need to provide advanced injury care to active individuals who at the time were either servicemen competing on military teams during the Second World War or athletes on university or professional teams. From these humble beginnings, it was evident that a unique and specialized skill set was required for the health care of active individuals. This skill set, rooted in exercise therapy and injury prevention and care, eventually evolved through mentorships and established academic curriculums into the Athletic Therapy profession.

The Evolution of a Profession: The Early Training of Athletic Therapists

A small group of individuals received their initial athletic therapy education through a variety of sources. Some men served in the Canadian Armed Forces as medics or in the Physical Training Department while others were physical education teachers who had additional training in first aid and support techniques (Flint, 2012). A select few had certification and training from the National Athletic Trainers Association in the United States. Realizing a need for a specialized body to advance the profession in Canada, individuals from across the country (i.e., Chuck Badcock from Royal Military College; Stu Langdon and Ken (Tabby) Gow from Queens University; Ed Anderson and Howie Ringham from the University Of Toronto; Art Sargeant from the Ottawa Roughriders; Mert Prophet from the Toronto Argonauts; Bob Haggert and Carl Elieff from the Toronto Maple Leafs; and Gord Mackie from the Winnipeg Blue Bombers) discussed forming the Canadian Athletic Trainers Association (CATA) at a National Athletic Trainers Association Meeting in Chicago in June 1965 (Flint, 2012). The first meeting of the CATA in Canada took place in Toronto in 1966 (Laws, 2013).

Similar to the development of many professions these pioneers passed on their knowledge and skills, initially through mentorships in real life practice, usually on the playing field or battlefield. However, by the early 1970's, sport was growing exponentially and Canada was sending athletes around the world to international competitions. The push for the development of specific athletic therapy curriculums in higher education was due in part to the realization that elite athletes in Canada were not receiving the necessary care needed to excel at the international level (Safai, 2007) and at the intercollegiate level. Thus, formal educational programs in recognized institutions of higher learning were required to meet this demand.



Athletic Therapy in Higher Education: The Dawn of a New Health Care Profession

Athletic Therapy at Sheridan College

The City of Montréal had been awarded the 1976 Olympics and the Canadian Olympic Association (COA) was charged with providing healthcare to all the Canadian and visiting athletes. Canadian athletes in previous Olympics and other international Games were longing for specialized help. Athletic Therapist Chuck Badcock recalls how understaffed the previous Canadian medical and therapy support team had been at the 1974 Commonwealth Games in New Zealand (DeConde, 1990). Athletes would demand and expect better care at future competitions. This required a separate cohort of Athletic Therapists, physiotherapists and doctors who made up the core medical team for the 1976 Olympic Games (Bergeron, 2013). In addition, a host medical team of 150 Athletic Therapists and physiotherapists was required to service all the athletes from around the world. The preparations for the Montréal Olympics served as a partial stimulus to create a recognized academic curriculum that would professionally prepare students to care for not only elite athletes and their teams, but also for all individuals pursuing active healthy lifestyles (Laws, 2013a).

The first institution to pursue a formalized academic program was Montréal's John Abbott College. John Perry was the first director of the Athletic Therapy program at John Abbott. He was named as the Chief Athletic Therapist for the 1976 Montréal Olympic Games host medical team and later served as president of the CATA (Laws, 2013a). Sheridan College was the initial Ontario school to recognize the need for a physical activity related health care profession and responded to this challenge. Long-time Sheridan College professors, Barry Bartlett and Anne Hartley recall that in 1973, Sheridan College's Athletic Director John Cruickshank was searching for an Athletic Trainer to care for the Sheridan football team. He was surprised to learn that there were no Canadian trained Athletic Trainings. After initially seconding help from an American trained high school teacher who had a minor in Athletic Training, Cruickshank decided that this was an ideal time to start an Athletic Training and Management Program (Bartlett, 2013a).

The preparations for the Montréal Olympics served as a partial stimulus to create a recognized academic curriculum that would professionally prepare students to care for not only elite athletes and their teams, but also for all individuals pursuing active healthy lifestyles (Laws, 2013a).

Sheridan College applied to the Ministry of Education and was granted this new educational program called Athletic Training and Management. The advisory team for this new program was comprised of, amongst others, legendary sport injury icons Ed Nowalkowski, Dr. Charles Bull, Barry Bartlett, Dr. Tom Fried, Dr. John Zeldin, John Cooper, Fred Dunbar and program director John Cruikshank. Barry Bartlett was the founding coordinator of the program; Clyde Smith, Dick Ruschiensky and John Cruikshank were the first Teaching Masters (instructors). Evert Van Beek joined the team a year later. Anne Hartley joined the teaching faculty after graduating from the program in 1975. Fred Dunbar, Head Athletic Therapist for the Toronto Argonauts, was also very involved and played a significant and influential role (1980-89) as an instructor and role model for new student therapists. Dan Devlin, a former Athletic Trainer for the Edmonton Oilers, replaced Clyde Smith in 1977 and played an instrumental role in ensuring the integrity of the CATA certification examination process as Certification Committee Chairman. Some of these above instructors had dual qualifications as physiotherapists and Athletic



Therapists. Physiotherapists were hired from the beginning to ensure the clinical component (e.g., musculoskeletal (MSK) assessment and therapeutic modalities) was taught to the same standard as it was in a physiotherapy program. The emerging Athletic Therapy profession was viewed by the Canadian Physiotherapy Association as a competitor in the health care world (Timpf, 1988) so, by having physiotherapists teach certain MSK assessment and modality courses, it was felt that this new program could withstand greater scrutiny.

Sheridan College's Athletic Training and Management (Dip. AT&M) program was initially two years in duration and had about 40 students. The program was designed to educate students as Athletic Trainers who could treat injuries and help manage a sports team. In the first few years, the number of women accepted into the Sheridan program was limited because most of the jobs were with professional men's teams and university men's sports. The early female graduates were true pioneers who reversed the men only attitude. Wendy Hampson became the first female Head Athletic Therapist at a Canadian University (Laurentian) in 1978 (Hampson, 2013); while a few years earlier, Anne Hartley was the first female Head Athletic Therapist at a College of Applied Arts and Technology (Sheridan). However by the late 70s and early 80s more women were accepted into the Athletic Therapy program as the demand increased due to the expanding intercollegiate women's athletic programs (Hartley, 2013) and the new attitude towards women in predominantly male sports (Bartlett, 2013b).

In 1987, the Sheridan College program name was changed to Sports Injury Management (Dip. SIM) to better reflect an increased focus on prevention, immediate care and rehabilitation. By this time the term Teaching Master was replaced by the title Professor. The job market for Sheridan College graduates evolved to include the clinical area and consequently the content of the program was expanded to a three year diploma. Three years later in 1990, the program expanded again to include more focus on clinical placements. The Ministry of Training, Colleges and Universities encouraged the development of a four year applied degree. In 2002, the Ministry approved a four year Bachelor of Applied Health Sciences in Athletic Therapy at Sheridan College.

However by the late 70s and early 80s more women were accepted into the Athletic Therapy program as the demand increased due to the expanding intercollegiate women's athletic programs (Hartley, 2013) and the new attitude towards women in predominantly male sports (Bartlett, 2013b).

Athletic Therapy at York University

In the early 1970s, the faculty in the School of Physical Education and Recreation at York University in Toronto recognized the need for more educational programs in sports medicine. York University was one of the universities in Ontario that decided to undertake the process of creating a new specialization for the prevention and management of injury in physical activity. York was a natural choice to take a leadership role in sport medicine because of its long association with pioneers in the Athletic Training profession. Mert Prophet was the first President of the CATA and one time Head Athletic Trainer at York University. He was influential in mentoring many early therapists. In the early 70s, faculty member Dr. Robert Woodburn and Head Athletic Therapist Ed Nowalkowski taught the initial Athletic Training course. Dr. Charles Bull, a well-known physician, was instrumental in initiating the first sports medicine clinic at York University, working with Athletic Therapists to provide care for athletes from York University and the surrounding area (Flint, 2013). As demand grew for education specific to



Athletic Therapy, Dr. Frances Flint spearheaded the development of an Athletic Therapy program at York University from its infancy to highly successful undergraduate and graduate programs.

In 1988, the first proposal for a new program within the School of Physical Education, Sport and Recreation was called "Sport Therapy". After three years of proposals and committee approvals, the new certificate program was initiated. This program became a CATA Accredited Educational program and officially changed its name to the Athletic Therapy Certificate (ATTH). Students within the program worked with the York University varsity sport teams providing sport injury coverage. Additionally, students had placements with other universities and colleges in the Toronto area. Opportunities for clinical placements were available on campus under the direction of Certified Athletic Therapists.

The Athletic Therapy Certificate program was initially designed to be taken concurrently with an undergraduate honours degree program in Kinesiology and Health Science. Very soon however, it was recognized that a graduate approach in Athletic Therapy was needed in Canada. Applicants who already had undergraduate kinesiology degrees from across Canada and around the world were interested in taking Athletic Therapy at York University. To date, numerous students have graduated from York University with either a combined honours bachelors degree in kinesiology and the Certificate in Athletic Therapy (BA or BSc, ATTH); a masters degree and Certificate in Athletic Therapy (MA, ATTH) or a stand-alone Certificate in Athletic Therapy (ATTH). These highly successful graduates are now contributing to the prevention of injury, sport injury management and athlete health care throughout the world.

The CATA's Mentorship Model

The CATA's mentorship model for training Athletic Therapists provides a strong support system for Certification Candidates. In the 1970s many student therapists' first experience was providing injury management under the tutelage of the university's Head Athletic Therapist. Fortunately, individual academic courses in athletic training were starting to be offered in physical education and kinesiology programs. These courses were usually co-taught by professors and or the Head Athletic Therapist. Many university students who decided to continue in Athletic Therapy pursued further education at Sheridan College. Others chose to pursue post-graduate work such as the masters degree program at the University of Alberta under the direction of Dr. Steve Mendryk. Although the CATA certification process was in place as of 1975, many graduating students could not find a job without the prerequisite of attaining certification as an Athletic Therapist. This was especially true of graduates who could work as an employee of a physician in Ontario Health Insurance Plan's (OHIP) "G" code funded clinics. By the 1980s many employers started to demand certification. In the absence of formalized



athletic training programs across Canada, the Canadian Athletic Therapists Association used Supervisory Athletic Therapists as mentors to help graduates achieve certification.

In this non-traditional pedagogical environment the Supervisory Athletic Therapist was responsible for ensuring the student therapist achieved the required technical skills and knowledge during their preparation for the National Certification examination. This sometimes informal relationship lacked academic rigour and consistency. Students



relied solely on the expertise of their supervisor to prepare them for the gruelling written and oral practical examinations required to obtain their certification as an Athletic Therapist. This model was only partially successful as evidenced by the limited number of student therapists who could achieve the high standard set forth by the Association to pass the examination. Part of the problem was due to students receiving a heterogeneous array of courses from universities without a formal program like Sheridan College or York University. This approach failed to adequately prepare students for the certification examination, with occurrences like this happening all across the country. In 1997 the CATA recognized the need to develop an approved curriculum of study and required institutions to have their Athletic Therapy programs accredited. This new model was developed and overseen by the CATA Program Accreditation Committee (PAC). As of September 1999, all students wishing to certify with the Canadian Athletic Therapists Association were required to have graduated from a CATA accredited Athletic Therapy program.

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Athletic Therapy Program Accreditation at Educational Institutions

Both York University and Sheridan College's programs have previously met the educational criteria outlined by the CATA Program Accreditation Committee. It should be noted that the CATA requires this in addition to the normal academic review at the college and university level which includes approvals required at the individual department, then faculty and senate level. This further level of academic scrutiny by the PAC employs a thorough and exhaustive process to fully evaluate the courses, the faculty and facilities through actual on site campus inspections and interviews. Dr. James MacLeod was the Chairman of the newly formed PAC when he announced in April of 1998, that Sheridan College's Sports Injury Management Program was to become the first post-secondary program in Canada to become accredited. Today, there are 7 CATA accredited programs across the country.

The quality assurance benchmark honed by Athletic Therapy students at accredited institutions is a direct result of the on-going meticulous academic reviews that occur at each institution by the Program Accreditation Committee.

Further information about the PAC and the process can be found on line at: www.athletictherapy.org/en/accreditation application.aspx.

The Future of Athletic Therapy Education

Currently students are required to complete 1200 hours of experiential education including 600 hours in clinical placements and 600 hours in field placements. The combination of working in a therapy/medical clinic along with working in the field in an exercise, sporting or industrial environment has produced graduates with skills that equip them to pursue a multitude of health related careers. This requires the educational objectives of curricula in Athletic Therapy to continually expand and be flexible in response to the industry needs and to the diverse



employment opportunities where entrepreneurial graduates are creating new and innovative work (McKenzie, 2013).

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Accreditation Committee.

The technology employed to educate Athletic Therapists is being revolutionized by the same technology helping nursing and medical students. Although hands on practical sessions using cadaver labs and palpating fellow students have been the norm to learn anatomy, new advances have allowed for more real life learning. Computer software now enables students to study the human body in three-dimensional planes, which allows for greater understanding and exploration.

Both Sheridan College and York University now utilize high fidelity manikins in the teaching of first responder skills and emergency management of injuries. Kirsty McKenzie, a professor at Sheridan's Athletic Therapy program, explains how incorporating new software design and Human Patient Simulation (HPS) manikins into the curriculum will help future students obtain a higher level of learning through the exercise of critical thinking (2013). McKenzie states:

Students in Athletic Therapy will have access to both high and low fidelity manikins throughout their curriculum in the Emergency Care courses. This will help achieve higher levels of cognitive learning as students will be required to utilize their problem-solving skills when assessing and managing a situation in its true environment. Students will have the opportunity to actually view situations such as deadly bleeding, unresponsiveness, anaphylaxis, cardiac arrest, etc., and complete the necessary life-saving procedures on the manikin (Kirsty, 2013).

The innovation in pedagogical technology has had a ripple effect throughout the entire Athletic Therapy curriculum and in the classroom. This is evident in the use of additional software platforms (e.g., Moodle) along with the implementation of advancements made in the realms of therapeutic modalities, rehabilitation approaches, strength and conditioning techniques, taping procedures and equipment and bracing technologies (McKenzie, 2013).

Future students will be referring to their portable tablets and smart phones and downloading apps for everything from storing data immediately on sideline concussion tests and musculoskeletal assessments, to searching for a diagnosis using a patient's signs and symptoms and guided by step by step algorithms. Record keeping and SOAP notes (Subjective; Objective; Assessment; Plan) will almost certainly become entirely electronic in the future (Flint, 2013).

The future of medical and therapy education including Athletic Therapy has to be based on evidence based practice. Dr. Richard DeMont, a professor of Exercise Science and Athletic Therapy at Concordia University, strongly advocates that a profession must be grounded in research if it is truly to be considered a profession and not a skilled trade. Hence, more research oriented coursework must be embedded in the curriculum or specific graduate opportunities such as York University's graduate program must be available to assist the Certified Athletic Therapist to recognize the importance of evidence based practice and critical analysis.



The Athletic Therapist's education and role in health care has evolved from one rooted in one of Hippocrates' most famous quotes "Exercise is Medicine". Centuries later Matheson and his group of medical colleagues from around the globe would reiterate a similar message that emphasizes the critical role that sport and exercise medicine plays in the prevention and treatment of chronic disease (Matheson et al., 2011).

Current and future educators in Athletic Therapy must not only remain up to date with the latest technology but they also must embrace original research and evidence based practice. By using research and evidence based practice, Athletic Therapy students will have the best opportunity to analyze functional human movement. This analysis helps the student to determine the exercise and therapies needed to restore full function and optimal active healthy living to physically active Ontarians.

Currently students are required to complete 1200 hours of experiential education including 600 hours in clinical placements and 600 hours in field placements.

Sports Injury Courses in Ontario

The Athletic First Aider

In the mid-1970s, the Ontario Sport Therapists Association (OSTA), later known as the Ontario Athletic Therapist Association (OATA), developed three levels of certification for adult volunteer trainers. These courses were to mirror the Coaching Association of Canada's (CAC) coaching certification courses in both theory and specific sport skills. The CAC had a component of its Level 1 theory certificate that dealt with sports injuries, but the OSTA courses were meant to offer a deeper level of understanding and skill for the volunteer trainer. These courses were known as the Athletic First Aider and Athletic Trainer courses. They taught a broad array of information relating to sports injuries, their prevention, recognition and treatment.

The group involved in developing these programs included: Fred Dunbar from the Toronto Argonauts; Ed Nowalkoski from York University; Dave Wise from the University of Western Ontario (UWO); Jamie Laws from McMaster University; Brian Gastaldi and Pat Bishop from the University of Waterloo; and, Tom Kearney from Brock University. The OSTA partnered with the Ontario Amateur Football Association (OAFA), the Ontario Minor Hockey Association (OMHA) and other specific sports organizations to tailor and deliver the Level 1 Athletic First Aider and Level 2 Athletic Trainer Courses. The first level one courses were offered at UWO in London, and York University in Toronto in 1974. The first level two courses were offered at McMaster University and York University.

In 1978, Tim Page, an Athletic Therapist in Toronto and OATA President at the time, injected new life into the program. He did so because he felt it was necessary for the OATA to "...re-establish a presence within the sports community" (2013). The Sport Medicine Council of British Columbia (SMCBC) was successfully running its Athletic First Aid Program, so based on the SMCBC format; the OATA Athletic First Aider Program was renewed.

In 1980, a Participant Manual was produced based on the already developed Instructor's Manual. It was created by the first OATA Education Committee comprised of Wendy Hampson from Laurentian University, Ross



Hodgkinson from Lakehead University; James Dobson from the Ontario Provincial Basketball team; Joseph Kenny from Brock University; and was edited by Tim Page, OATA President. The original Participant Manual manuscript, from which copies were generated, was produced for free by Cambrian College in Sudbury and original artwork was prepared by a Physical Education student from Laurentian University. The OATA received support and encouragement for the program from the City of Toronto Board of Education and their Physical Education teachers; the Ontario Amateur Football Association; the Ontario Soccer Association; and the Ontario Hockey Association. These sponsors printed the manuals, helped with the organization of the courses and ran the clinics. Dave Smith from Nova Seal, a Toronto based therapy supplies company and a big supporter of the OATA and CATA at the time, provided materials needed for the demonstrations, and Heinz Piotrowski from Adidas provided some clothing items for the instructors (Page, 2013).

Clinics were run by Certified Athletic Therapists largely in the Greater Toronto Area (GTA), but were also run in Sudbury and Thunder Bay. Since there was no funding for the program, Page ran many clinics for the City of Toronto Board of Education Physical Education teachers and sports coaches in exchange for printing of the manuals. The need for and the success of the program were noted by both the Ontario Soccer Association and the Ontario Football Association where it was adopted and adapted to fit into their Trainer Certification programs. At the same time, based on the OATA model, the Hockey Trainers' Certification Program was being developed by Robert Firth of the Ontario Hockey Association with which OATA members were intimately involved.

By the mid 1980's, there were a number of forces at play that caused it to once again lose momentum. Not only was there a lack of administrative and financial support to run the program, but the OATA changed its focus from educating the public, to that of developing Athletic Therapy as a profession. The Sports Medicine Council of Ontario also had been formed by that time. It recommended the formation of the Safety Resource Centre with one of the Centre's mandates being to educate the general sporting public about sports injuries. This resulted in the development of the government-funded and administered Sports Injury Prevention and Care Course (SIPAC). Members of the OATA were instrumental in the development of this program and used the Athletic First Aider as a model.

The OATA was a pioneer in the efforts to educate the general public in the prevention and management of sports injuries in Ontario. The Athletic First Aider program was the initial model upon which many successful government-funded and supported sports injury courses were based.

Sports Injury Prevention and Care Program - SIPAC

In the late 1980s there was increasing concern about injuries in community sport. As a result, the Ontario Ministry of Tourism and Recreation conducted a needs assessment study. The outcome of this study showed a need to improve safety in sport and in recreational activities stating that "Volunteers in the field of sports and recreation needed a standardized course to have a positive impact on the prevention and care of sports injury in their communities (Ministry of Tourism and Recreation, 1990a)". The Ministry decided to create a hands-on training course in the prevention and care of athletic injuries to be administered to parents, volunteers and others involved in minor sport in Ontario. The Ministry called it Sport Injury Prevention and Care (SIPAC) program. The program was primarily designed to teach participants how to develop and rehearse an emergency action plan, basic



emergency skills and first aid procedures. It also taught participants how to recognize and deal with injuries that do occur, as well as recommending appropriate follow-up care.

Under the direction of Diane Merrick, Safety Consultant, Community and Safety Initiatives section, Sports and Fitness Branch, the Ministry turned to the Ontario Athletic Therapists Association, and specifically, Barry Bartlett, a Certified Athletic Therapist and Teaching Master at Sheridan College's Sports Injury Management program, to develop the content and delivery of the program. Some of the material was adapted from work created by Evert van Beek, also a Certified Athletic Therapist and a Teaching Master at Sheridan College, for the Coaching Association of Canada's Level 1 National Coaching and Certification Program (NCCP) theory component. The result was an 8 hour practical SIPAC course, complete with a Participants' Workbook and a Course Conductor Guide. The guide was then validated by several members of the Ontario sports medicine community (Bartlett, 2013b).

The OATA was a pioneer in the efforts to educate the general public in the prevention and management of sports injuries in Ontario. The Athletic First Aider program was the initial model upon which many successful government-funded and supported sports injury courses were based.

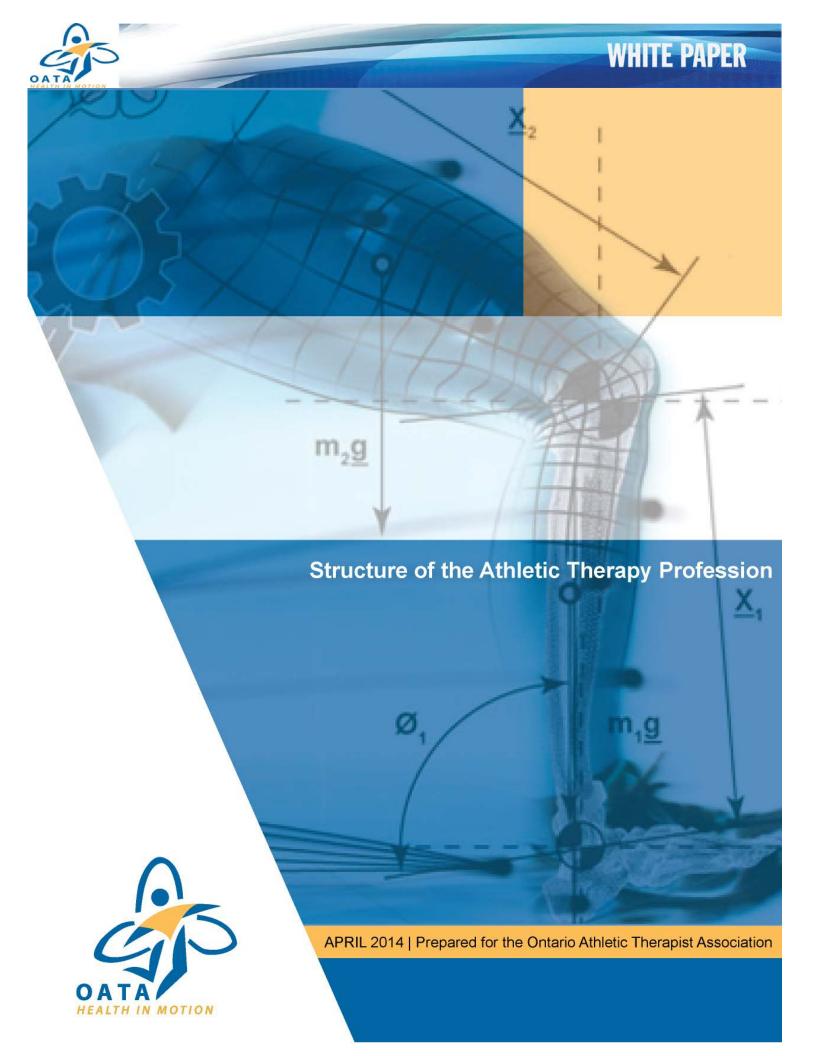
Van Beek, Bartlett, and Phil Morgan, a master course conductor with the NCCP, were given the task to train course conductors from across the province. The Ministry graciously subsidized this training in Toronto. Trained Athletic Therapists from across the province became the cornerstone for delivering the program (Bartlett, 2013b). In 1989 pilot courses were begun and by 1990 the full program was launched (MTR, 1990a).

Based on feedback from participants, the Ministry mandated the design of a companion Taping and Wrapping course that was four hours in length. The course was created by Joe Kenny, Head Athletic Therapist at Brock University and Lindsay Healey, Certified Athletic Therapist and SIPAC co-ordinator (Kenny, 2013). Once designed, the program was delivered by the same Course Conductors, with the SIPAC course being a prerequisite and ultimately it became a valued part of the program. The course was offered through the Ontario Sports and Recreation Centre, which later became Sport Alliance Ontario (SAO) (Bartlett, 2013b).

The SIPAC program ran for approximately 10 years with courses being offered across the entire province. In the year 2000, the SAO identified a need to add an easily recognized credential to the program. The Canadian Red Cross became a partner in the venture providing an internationally recognized standard and certificate. The revised program included a certificate in first aid and CPR and skills and knowledge specifically related to sport injury. This new program met "...the standards of both the sport community and Workplace Safety and Insurance Board [WSIB] regulations" (Sport Alliance Ontario, 2001). Jim Bilotta, a Certified Athletic Therapist at Brock University and SIPAC instructor, was asked to be part of a four member working group formed from the CRC, SAO and OATA tasked with revising the SIPAC course. They renamed it Sports First Aid. Athletic Therapists from across Ontario were trained as instructors and the program was launched in the fall of 2001 (Bilotta, 2013; Sport Alliance Ontario, 2001).



The impact of the program has resulted in an increased awareness within the sport community of the importance of the prevention and care of sports injuries and the role of the Certified Athletic Therapist as a health care professional.





Structure of the Athletic Therapy Profession

Athletic Therapy Scope of Practise

What is the Athletic Therapy Profession?

The Athletic Therapy profession is defined by the Ontario Athletic Therapist Association as

A health care profession that specialises in the prevention, assessment and care of musculoskeletal disorders (muscles, bones, joints) especially as they relate to athletics and the pursuit of physical activity (OATA, 2009).

Who is a Certified Athletic Therapist?

A Certified Athletic Therapist is a graduate of a CATA-accredited post-secondary program and who has successfully completed the written and practical National Certification Examination. A Certified Athletic Therapist uses the designation "Certified Athletic Therapist (Canada): the post-nominal initials being CAT(C).

Athletic Therapy in Ontario is governed both by the Canadian Athletic Therapists Association (CATA) and the Ontario Athletic Therapist Association (OATA).

An Athletic Therapist must be a member in good standing of both associations to have the right to the title: Certified Athletic Therapist.

The Scope of Practice of a Certified Athletic Therapist

The OATA has defined the Scope of Practice of an Athletic Therapist as the following:

The practice of Athletic Therapy is the diagnosis and treatment from the point of injury along the continuum of care, or physical disease, disorder or dysfunction to rehabilitate function, relieve and manage pain and includes the prevention of physical injury, disease, disorder or dysfunction (OATA, 'Scope of Practice').

The CATA further defines the practice of Athletic Therapy by describing the separate components of an Athletic Therapist's Scope of Practice. The following sections are drawn from the CATA's document, *Scope of Practice*.

Injury and Illness Prevention

Individuals who are able to easily perform their activities of daily living and get enjoyment from their ability to exercise are generally healthier and are less often affected by illness and injury. Physical activity-related injury and illness is often unavoidable and it is important that prevention be top of mind. Athletic Therapists have the



knowledge and skills to identify injury and illness risk factors associated with physical activity. They are constantly concerned with prevention and with all phases of training and competition. Athletic Therapists plan and implement all components of a comprehensive injury and illness prevention program and accept the moral and ethical responsibility to conduct them safely.

Many sports require the use of protective equipment. In order for such equipment to be effective it must fit properly and be maintained correctly. Athletic Therapists help individuals with the selection and fitting of sporting equipment consistent with the physical characteristics and needs of individual athletes and the demands of participation in specific sports activities. Also, they check that protective equipment is in good working order and that broken equipment is repaired or replaced as needed in accordance with national and international standards for design and construction (Canadian Consumer Products Safety Act, Canadian Standards Association (CSA), and National Operating Committee on Standards for Athletic Equipment (NOCSAE^{TIM})). In addition, Athletic Therapists conduct routine pre-season and pre-game site surveys to ensure the playing venue is safe from hazards and they collect and interpret environmental data through the use of appropriate instruments. With this data they advise administrators and employers on the risks of physical activity during extreme weather conditions based on guidelines and policy statements from professional organizations.

Athletic Therapists have the knowledge and skills to identify injury and illness risk factors associated with physical activity. They are constantly concerned with prevention and with all phases of training and competition.

In advance of active participation, Athletic Therapists regularly perform postural and musculoskeletal evaluations to identify potential issues that may lead to injury. They may also perform pre-season athlete health screens either with a team physician or independently, to identify health concerns that might jeopardize an athlete's health. Upon finding any issues, they ensure the situation is addressed either by therapeutic interventions or by referral to a medical specialist. Athletic Therapists instruct proper warm up and cool down procedures to prevent injury, encouraging these practices prior to and after all physical activity. They also apply prophylactic taping and strapping techniques and perform pre-event manual therapy techniques as needed. Conditioning programs are designed and employed to further prevent injury by improving specific areas such as strength, flexibility, cardiovascular conditioning, balance and reflexes.

Athletic Therapists are well educated and knowledgeable about the types of medication commonly prescribed in sport. They are familiar with the banned and restricted drugs and methods as outlined by the World Anti-doping Agency (WADA). When travelling with teams, they are often the first person athletes ask for advice regarding the use of over-the-counter (OTC) or prescription drugs. They also ask whether the drugs are on the WADA banned list or not. Athletic Therapists have the moral and ethical responsibility to intervene in situations of known use and/or abuse of legal and illegal drugs and methods. When an athlete is selected to provide a sample for doping control, Athletic Therapists are usually called upon to accompany the athlete. This requires that they be very familiar with the process of sample collection to ensure that the process is followed correctly and that any irregularities are noted and documented. The Athletic Therapist is a team representative when he or she accompanies the athlete and therefore is in a position to counsel and support the athlete through the process.



Athletic Therapists are highly skilled at recognizing potential and real risks of injury caused by the environment. They apply sound ergonomic principles resulting in effective remedial solutions. These skills can be applied anywhere people are physically active including the industrial workplace.

Urgent Injury Care

Athletic Therapists are responsible for the care of an injured athlete during all practices and games. They understand such legal concepts as standard of care, legal consent, negligence and omission as they apply to the performance of their job. In preparation for a sporting event, or in the workplace, they design and implement an Emergency Action Plan (EAP) specific to the venue. The EAP details the logistics of the provision of care during an emergency and describes the plan for the injured individual's entry into the emergency medical system. As part of the EAP, Athletic Therapists search out appropriate emergency care facilities and services, initiating contact and collaborating with them in the care of the injured athlete. In addition, they assign personnel for emergency care coverage within the EAP; develop emergency communication and transportation systems; and are responsible for appropriate reporting and record keeping of all injuries and conditions.



In the event of an urgent injury Athletic Therapists will provide injury or

illness assessment, basic emergency life support and recognition and management of acute traumatic neurological dysfunction. They apply first responder skills including life sustaining techniques and immobilization devices, followed by the utilization of transportation strategies in accordance with accepted standards (e.g., Canadian Red Cross). In addition, they are highly cognizant of the risk factors associated with exposure to blood and body secretions and take all preventative precautions to protect themselves and the individual.

Athletic Therapists have the responsibility to triage the injured athlete and to make a determination as to whether the athlete is able to safely return to play; must be withdrawn from play and cared for on the sidelines; or requires stabilization and transport to an urgent care facility. Athletic Therapists have the skills, knowledge and authority to make sideline return to play decisions that are in the best interests of the athlete's health and well-being. If the Athletic Therapist deems it safe for the athlete to return to play, he or she may apply aseptic wound care techniques, taping, strapping, padding, splints or braces; or modify protective equipment. As well, they understand and apply medical, legal and ethical protocols embrace governing the referral of an injured or ill individual for medical services.

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Injury Assessment and Rehabilitation

Post injury, Athletic Therapists assess and rehabilitate injuries and conditions using evidence-based contemporary techniques. They accept the moral and ethical obligation without bias or prejudice to provide rehabilitation to the injured or ill individual to the fullest extent possible. In addition, they recognize the need to remain abreast of current theory and practice in the field of sports medicine. They respect and embrace the roles of attending physicians and other medical and paramedical personnel in the treatment and rehabilitation of the individual and respect the protocol of confidentiality of medical information. Athletic Therapists search out appropriate medical and paramedical specialists and other health care providers in order to build a referral base for their practices. They research accepted protocols governing the referral of individuals for medical, personal health, psychological or social services. As well, they gather and disseminate appropriate educational materials and deliver programs to educate their clientele and affiliated persons and groups (e.g., parents, coaches, administrators).

Athletic Therapists reach a diagnosis by first conducting a thorough physical assessment of the injury or condition, accepting the injured athlete's physical complaint(s) without personal bias or prejudice. They collaborate interprofessionally with physicians and sports medicine specialists when advanced diagnostic tests are required. They may choose to consult and refer to allied health care specialists (e.g., massage therapists, podiatrists and sport psychology consultants). A comprehensive and individualized rehabilitation/reconditioning program is then designed and implemented. The plan's goals, objectives and physical and psychological evaluation parameters (e.g., muscular strength, range of motion, motivation, and apprehension) are determined and thoroughly discussed with the individual. Athletic Therapists are familiar with commonly used techniques of primary and reconstructive surgery and understand the role and function of prescription and OTC pharmacological agents used in the medical treatment of common injuries and illnesses. During the rehabilitation process, they communicate directly with the surgeon regarding recommended stages of progression and are the liaison among the surgeon, the athlete, the parents and coaching staff concerning the athlete's progress.

Athletic Therapists select and employ a variety of therapeutic modalities (e.g., ultrasound, cryotherapy, electrical current therapy, LASER). They are highly skilled in applying soft tissue and joint mobilization techniques including pre and post-event massage procedures. Contemporary measurement, functional testing and strength equipment are utilized (e.g., isokinetic devices, dynamometers) in designing rehabilitation programs. They design and implement athlete and sport specific therapeutic exercise programs (e.g., proprioceptive techniques, strength conditioning and cardiovascular maintenance exercises) that are tailored for the sport, the injured areas and any uninjured areas of the body. These procedures in the first instance are designed to help athletes prepare to give an optimal performance and secondly, to help them to recover fully as quickly as possible after each practice or competition. As well, they apply supportive taping and strapping techniques and select and apply prophylactic braces and supports.

A serious injury can be a very frightening experience for any individual. The diagnostic and rehabilitation process can be long and complicated, fraught with delays, plateaus and frustrations. In order to have as successful an outcome as possible, it is essential that the individual not only understand the process, but is also an active participant in the rehabilitation. Athletic Therapists always take the time to educate the individual about the injury or illness and are highly skilled and experienced at understanding and explaining the rehabilitation process. They also provide information on the principles of nutrition, weight control, active rest, fluid intake, general health maintenance and personal hygiene. With express permission of the injured or ill individual, Athletic Therapists



provide health care information and counselling to parents, coaches and/or the employer pertaining to the physical, psychological and emotional health and well-being of the individual.

Athletic Therapists have the administrative skills and knowledge to manage and operate a multi-disciplinary clinic based on sound administrative policies and procedures. They understand the principles related to the development and submission of budget requests and purchase orders, bidding procedures and the acquisition and maintenance of supplies and equipment. They search out the local, provincial and federal safety and sanitation standards for health care facilities, therapeutic modalities and other equipment. They have the skills to create and keep records and forms required by law (e.g., accident reports, documentation of treatment and rehabilitation programs). Additionally, Athletic Therapists are skilled in the development of emergency communication and injured athlete transportation; selection and management of Athletic Therapy staff members and volunteers and the financial requirements of running a business. Physicians and allied medical professionals commonly work alongside Athletic Therapists in clinics. Athletic Therapists who manage these clinics are also skilled in the principles of recruitment, selection, employment and utilization of these professionals.

The goal of rehabilitation is to promote an environment conducive to optimal healing and to prepare the individual for a safe return to sport or for safe reintegration into an active lifestyle.

The Athletic Therapist, in cooperation with all performance enhancement personnel, and members of the health care delivery team, is an integral part of a total service to maximize the performance and welfare of the individual. Concomitant with the execution of this role, the Athletic Therapist nurtures an attitude of positive health (CATAc).

Who should consult an Athletic Therapist?

Anyone with an injury related to physical activity can benefit from evaluation and treatment by a Certified Athletic Therapist. Athletic Therapists traditionally have worked with athletes, but they are used to and are comfortable working with any physically active individuals. Principles and techniques designed for athletes are successfully employed on a routine basis for those less physically active than a professional or national level athlete. The ultimate goal of Athletic Therapy is to maximize the performance and welfare of the active individual. (CATA, 2013c).

National Certification Examination

History

By the 1970's, many people were calling themselves "trainer", "sport therapist" and other similar titles. They were graduates of Sheridan College in Oakville Ontario, U.S. schools and physiotherapy schools in addition to having been mentored while working with professional sports teams. Norm Calder, a long-serving member of the CATA certification examination committee, recalls that the CATA Board of Directors at the time felt it was necessary to



become a more professional organization by instituting a certification process. Calder says that CATA agreed that they needed,

A uniform way of making sure everyone who was calling themselves a trainer or sport therapist had a solid and similar baseline of knowledge. They also felt that a professional designation would enhance the chances of getting liability insurance, recognition by provincial federal health care systems, better salaries and open new areas to expand into (2013).

Having a certification examination would also give the CATA a list of members who had a standardized credential from which they could choose "when called upon to provide trainers, both for national and international events" (Timpf, 1988).

It was also becoming apparent that putting a certification process in place would help to,

Entrench the credibility of the CATA against allegations by the Sport Physiotherapy Division of the Canadian Physiotherapy Association that the athletic therapists were not, in fact, qualified practitioners. The physiotherapists, who viewed the CATA as a rival and a threat to their professional preserve, felt their challenge to be justified. They perceived themselves to be better qualified in the field of injury treatment and rehabilitation due to their specified university training. The athletic therapists did not have a specific university program for professional training. Instituting a certification process was one way for the CATA to defend the competence of its members (Timpf, 1988).

Pat Clayton, the first Chair of the Certification Committee, recalls that he had a very difficult time convincing the membership to accept the idea of a certification examination. "The older members could not understand why an examination was necessary but they accepted the idea once they understood taking this big step forward would give the CATA credibility" (2013). Finally, in 1972 a motion was passed requiring "all members of the C.A.T.A. be required to write an exam in order to ascertain the qualifications and status of all members" (Timpf, 1988).

Calder recalls the Board of Directors believed that "The candidates had to have a good academic knowledge but also good skills. In order to test these, it was felt that both a written and a practical component must be taken and very high standards would only be accepted" (2013).

Jamie Laws was the Head Athletic Therapist at McMaster University from 1973 to 75 and became certified at the first national certification examination. He recalls that,

The CATA Board of Directors knew they wanted a similar examination process to that of their American counterparts, the National Athletic Trainers Association (NATA), but not the same. They wanted to have standards as high as or higher than the NATA in order to maintain the hard fought gains in professionalism (Laws, 2013b).

Clayton acknowledges that sports medicine team physicians from across Canada such as Dr. Bob Jackson from the Toronto Argonauts Football Club, Dr. Vince Murphy from the Calgary Stampeders, and Dr. Jack Alexander from the Saskatchewan Rough Riders were instrumental in advising the CATA on how to define themselves as a profession and how to set up the certification examination (2013). Based on their advice, Clayton contacted the President of the Canadian Medical Association (CMA) and worked closely with the CMA to define what a certification program should look like. They reviewed the initial examination "...to make sure it was within what



they felt to be appropriate standards for this very young profession. That assistance was really critical in allowing us to get going" (Clayton, 2013). Clayton says that there was "no doubt" that the CMA verified and validated the initial certification examination and process (2013).

The first certification examination was held in June 1975 in Winnipeg at the Viscount Gort hotel in conjunction with the national conference. (Hartley, 2013b; Laws, 2013b). The application requirements for Certification Candidates were a university degree in a related field and 1200 hours of practical experience. Anne Hartley, retired professor from Sheridan College, recalls that there were 8-10 people who attempted the first examination. There were two students, herself and Joseph Piccininni, and the rest were Athletic Trainers working with professional sports teams or at universities, physiotherapists or individuals who had learned from mentors. In the morning, there was the 3-4 hour multiple choice examination followed by a 2-3 hour oral/practical examination (Hartley, 2013b; Laws, 2013b).

The CATA certification committee required that the first examiners had to be NATA certified. The examiners worked with professional teams or at universities (i.e. Sandy Archer from the Saskatchewan Rough Riders; Ed Nowalkowski from York University; Chuck Badcock and Gord Mackie from the Winnipeg Blue Bombers; Mert Prophet from the Toronto Argonauts; Dan Diebert from the Montréal Alouettes; Al Millier from the University of Winnipeg; and, Pat Clayton from Royal Military College) (Laws, 2013b).

The exam itself rapidly earned a reputation for being extremely difficult. Many candidates failed; but, said Glen Bergeron [past CATA president], the Association had to make the exam overly difficult rather than the reverse, or surrender its hard-earned gains in professionalization (Timpf, 1988).

In an effort to better prepare Certification Candidates, a system of Supervisory Athletic Therapists (SAT) was established. These were Certified Athletic Therapists from across the country who agreed to mentor and sponsor Certification Candidates and guide Candidates' in their studies as they prepared for the examination. As well, in 1983, the CATA Journal began to publish articles and sample questions on typical examination topics in an effort to expose the Candidates to the kind of knowledge required.

In an effort to help Ontario's Certification Candidates prepare for the examination a number of dedicated OATA members in the mid-90s, developed and offered formal simulated practical examination sessions in advance of the examination. These real life practise sessions became useful tools for Certification Candidates in their preparation. They were, and continue to be, well attended.

In the late 70s, Dan Devlin, an instructor in the Sheridan College program and a physiotherapist, became the Chair of the Certification Committee. Devlin was instrumental in improving the integrity of the examination by making it more reliable (Bartlett, 2013). In 1982 the Certification Committee amended the process, dividing the written and oral/practical portions into separate sections to be completed on the same day. Later, the written examination would be offered a number of months prior to the oral/practical and one was required to pass the written examination before attempting the practical. This changed in the 2000's so that either portion could be attempted first. The National Certification Examination continues to be reviewed semi-annually.



Written Examination

The four hour written examination was developed over a three day period in 1974 by senior members of the CATA. Multiple choice questions were borrowed from university physical education programs and Sheridan College's Athletic Training and Management program, as well, new questions were created. "Some written questions may have come from the NATA process" (Laws, 2013b). Also, "members were asked to approach team doctors and other knowledgeable individuals to collect questions suitable for a questionnaire" (Timpf, 1988).

The examination was based on anatomy, rehabilitation techniques, types of injuries, signs and symptoms, kinesiology, muscle movement, and emergency situations. With help from the academic community, a weighting was applied to each area with respect to how many questions were in each section. They used feedback from the first set of candidates to attempt the first certification examination and made adjustments accordingly (Calder, 2013).

Steve Dzubinski, the long serving Chair of the Certification Committee says that in 1994, the Examination Review Committee (ERC) was tasked with making the examination reliable, valid, and defensible. It was felt psychometrics were important "to make sure we were doing the right thing. We needed someone to confirm we were following the right principles" of examination design (Dzubinski 2013).

In that same year, the Division of Studies in Medical Education, a psychometric testing agency from the University of Alberta was hired to assist in the development of the written examination. The ERC was first tasked with examining the competencies in the field of Athletic Therapy followed by the development of a blueprint that could be followed for question creation. The psychometric testing agency also taught the group techniques for creating valid and reliable multiple choice examination questions following sound psychometric principles (Dzubinski, 2013; Bergeron, 2013a). Bergeron says "This was important to ensure that we could create a defendable exam and to follow evidenced based procedures for passing or failing our candidates" (2013a). After six years of development, the revised written examination debuted in 2000.

In its quest to validate the written examination, the ERC had every multiple choice examination question reviewed by groups of actively practising, well respected Certified Athletic Therapists from across the country. To this end in 2004-2005 each of the eight members of the ERC chose an expert group from within her/his respective communities across Canada and reviewed every question in a section of the examination. Each question was given a Nedelsky (item difficulty) value, clarity of the wording and content was questioned, and relevance of the material to the profession was examined. This exercise produced a written examination that was defensible, reliable and valid (Dzubinski, 2013). After 14 years, the examination process continues to evolve while following well established psychometric principles.

Practical Examination

In 1974 the practical examination was designed by the same members as the written examination. It included five stations: taping, evaluation, conscious and unconscious emergency, rehabilitation and CPR (Calder, 2013; Laws, 2013b).



As the profession grew in the 80s it was recognized that the practical examination was too labour intensive in terms of examiners needed and the CATA needed to be able to process Certification Candidates with greater efficiency. It was shortened to the two, 90 minute station format it is today, with each station becoming a more comprehensive test of practical knowledge through a case study format (Dzubinski, 2013).

Current National Certification Examination

Presently, the Canadian Board of Certification for Athletic Therapy (CBoCAT), a standing committee of the CATA, is responsible for all aspects of the National Certification Examination (NCE). It is usually comprised of 25 volunteer CATA members fulfilling such roles as question creation, purchasing of equipment and supplies, organizing the examination sites and examiners. The CBoCAT states on the CATA website that "the National Certification Examination evaluates an Athletic Therapy Certification Candidate on all aspects of the scope of practice of Athletic Therapy" (CATA, 2011). The mission statement of the CBoCAT is that the NCE is to be delivered,

...in a fair and equitable manner through a collaborative process that incorporates the principles of sound formative evaluation and psychometrics. This process ensures that successful Certification Candidates have demonstrated basic competence in Athletic Therapy and ensures the safety of the public as Certified Athletic Therapists provide Athletic Therapy services to active Canadians (CATA, 2011).

The CATA claims that "the certification process is one of the most stringent in the Canadian health care system" (CATAb). To verify this claim, an internet search of other similar professions' certification/registration examinations (Chiropractic, Nursing, Massage, Physiotherapy, Sport Physiotherapy, Occupational Therapy, and Paramedic) was conducted on July 21, 2013. The search determined that the profession of Athletic Therapy requires the most number of supervised practicum hours, plus the most advanced level of first aid certification (First Responder or equivalent) prior to applying to attempt the examination.

Competencies in Athletic Therapy

The NCE is based on all components of the Athletic Therapy scope of practice. The CBoCAT has outlined these components in a blueprint document titled *Competencies in Athletic Therapy* (CATA, 1998). The competencies are separated into three domains:

Cognitive

Psychomotor

Affective



In addition, an Athletic Therapist's scope of practice has been separated into six functional dimensions:

Prevention

Recognition and evaluation

Management, treatment and disposition

Rehabilitation

Organization and administration

Education and counselling

A Certification Candidate is required to demonstrate a basic level of competency in the six domains and the following knowledge dimensions (CATAa):

Basic sciences

Behavioural sciences

Applied sciences

Managerial sciences

Theory and research

The CBoCAT then creates both the written multiple choice questions as well as the scenarios for the practical portion, based on the aforementioned competencies and referenced from textbooks applicable to the profession. A list of 130 reference textbooks is available on the CATA website.

Written Examination

The written examination is composed of 200 single-answer multiple-choice questions and is written in a 3-hour period. The questions are based upon the Written Examination Blueprint that was created by the Examination Review Committee and approved by the CATA. This blueprint reflects the Competencies document where each cell in the blueprint has been assigned a numerical value that determines the relative importance of that cell in the overall performance of a Certified Athletic Therapist. Each question of the examination can be placed in one of the cells in the blueprint (CATAa).

The written examinations are held twice per year at two rotating locations. They commence simultaneously across the country, with the potential for individually proctored locations. To be successful on the written portion of the NCE, the Certification Candidate must achieve a score equal to or higher than the passing score value determined for that particular examination (CATAa).



Written Examination Development and Creation

The written portion of the NCE is produced, administered and scored by a psychometric testing agency contracted by the CBoCAT. The examination questions are created by the Examination Developers (EDs) of the CBoCAT following sound psychometric principles. Included in this, each question receives a Nedelsky item difficulty value. Dzubinski explains that,

Initially, a 70% pass for each examination was required but this didn't account for whether it was a difficult or easy examination. If you have 250 difficult questions then no one is going to pass but if you have 250 easy questions then everyone will pass. By assigning item difficulty to each question it makes it a defensible score (Dzubinski, 2013).

The psychometric testing agency accepts the questions and formats them into a question bank of approximately 1000 questions. Twice per year the psychometric testing agency draws up an examination choosing questions that fit the written examination blueprint and determines the passing score for that examination. The examination is previewed by two EDs before being returned to the psychometric testing agency for final changes and dissemination to the testing sites. After the examination has been written, the psychometric testing agency scores the examination and creates a statistical analysis for each question that is then sent to two EDs for a key validation exercise. This process ensures that the written examination is valid, current, relevant and fair.

Questions that are flagged by the psychometric testing agency are reviewed by the EDs for correctness of the question, misleading distracters and incorrect answers. Decisions are made about the disposition of the question. Options could be to leave the question as it is, change the response or remove the question from scoring. Once the key validation exercise is complete, results are returned to the psychometric testing agency for final scoring. The final scores are sent to the Membership Services Committee for dissemination to the Certification Candidates.

After each examination the psychometric testing agency produces a full statistical analysis for each question used on the examination and statistically problematic questions are flagged for review by the EDs. All questions used on the previous examination, particularly the flagged ones, are reviewed for relevance and correctness of information. References are checked and updated and obsolete or poorly written questions are reworded or deleted.

Practical Examination

The final step is a practical examination that objectively examines each of the six domains of Athletic Therapy. This is made up of two, 90 minute stations using a case study format: a field station with four sections to evaluate on-field management procedures and supportive taping/bracing procedures; and a clinical station with three sections to evaluate injury assessment and management procedures including modality applications. Each field station has four Certified Athletic Therapists: a model, two examiners and an assistant examiner. Each clinic station has three Certified Athletic Therapists: a model and two examiners (Dzubinski, 2013).



A Certified Athletic Therapist can only become a model or examiner after attending the Examiner Accreditation Seminar run by the CBoCAT (Dzubinski, 2013). All examiners and models volunteer their time but they receive continuing education credits towards their maintenance of certification (CEU) and their expenses are paid.

The scenarios are designed by the CBoCAT as per the Practical Examination Blueprint (CATA, CATA National Certification Examination Handbook). This blueprint reflects the Competencies document where each cell in the blueprint has been assigned a numerical value which determines the relative importance of that cell in the overall performance of a Certified Athletic Therapist. Each aspect of the practical examination can be placed in one of the cells in the blueprint.

The examiners and model record the performance of the Certification Candidate on a marking sheet created by the EDs. A skill that was done well by the Certification Candidate is marked as 'Acceptable'. A skill that was done poorly or not at all is marked as 'Unacceptable'. The marking sheet is then scored in a separate scoring room immediately after the practical examination at which time a Pass/Fail score is applied. A Certification Candidate will receive a passing score if she/he has passed each section (field and clinic) with a score of at least 60%, and an overall score of 70%.

Fairness and Objectivity versus Subjectivity in the Practical Examination

Every effort is made to reduce subjectivity in the practical examination by the CBoCAT:

Examiners must attend the Examiner Accreditation Seminar before they are accepted as examiners or models.

Models meet prior to the examination to review the scenario and standardize how they must portray their injury and how they are to interact with the Certification Candidate.

Every effort is made to neutralize bias and maintain flexibility in the evaluation of the Certification Candidate's performance. The goal of the examination is to ensure that the Certification Candidate performs in a safe and effective manner.

No questions are asked of the Certification Candidate by the examiners. All communication is between the Certification Candidate and the model. If an examiner questions whether a skill was done well, the examiner is to ask the model for clarification.

All questions asked of the examiner and model on the marking sheets are objective in nature. There are no subjective questions such as "were they safe?"

The marking sheets are scored immediately after the Certification Candidate has completed the practical examination. If it is determined that there is a large discrepancy between examiners' results on the marking sheets, the markers will speak with the examiners to clarify the situation.

An exercise similar to the key validation done in the written examination is also performed for the practical examination. If a pattern or trend of poor performance is noted with a particular performance element during the examination, an evaluation is done to determine the value of this element. A decision is then made on the inclusion of this element in the final scoring of the examination (Dzubinski, 2013).



Challenges for the NCE

The examination is very complex requiring a large committee of certified members to volunteer their time. It is sometimes difficult to find suitable members to sit on the committee.

Approximately, 150 or more Certification Candidates attempt the NCE annually which requires a great deal of administrative work for it to run smoothly. One of the challenges is to find enough examiners and models to volunteer their time to administer two NCE's per year. Another challenge is to accommodate all the Certification Candidate requests to attempt the NCE not only with regard to having enough examiners and models, but also equipment and appropriate physical space to accommodate the needs.

The profession of Athletic Therapy is constantly changing and adapting to new medical advances as they occur. In order to ensure Athletic Therapists have accepted evidence based practise skills, it is necessary for the CBoCAT to continue to keep the questions used in both the written and practical examination current, relevant and correct. This requires that the members of the ED not only keep current themselves, but that they constantly review the questions and make the necessary changes.

Approximately, 150 or more Certification Candidates attempt the NCE annually...

To ensure the consistency of answers for both written and practical examination questions, it is necessary that the CBoCAT maintain a broad list of text books representing the profession. In order to design these questions and answers, the ED members must have unlimited access to these resources. Sometimes it is challenging to acquire enough text books from the publishers for all ED members.

Maintaining a high inter-grader reliability for the practical examination is of paramount importance. Because examiners have graduated from a multitude of institutions and have differing experiences, it is a challenge to ensure that they all grade using the same standardized criteria.

Future Direction of NCE

By using psychometric strategies, improving inter-grader reliability and using standardized practical examination scenarios the subjectivity of the practical examination has been mitigated. The CBoCAT plans to soon utilize standardized patients as models in the practical portion of the NCE. This will further standardize the process by limiting actual and perceived bias which further enhances the validity of the examination.

The Athletic Therapy profession is constantly evolving requiring the NCE to adapt and change as well. The format of the NCE will continually be revised as needed to improve validity, reliability, and feasibility. Revisions will be guided by psychometric analyses of Certification Candidate results, inter-grader validity and reliability tasks.



Conclusion

The NCE is one of the most stringent in the Canadian health care system. It is a process that ensures that Athletic Therapy Certification Candidates have successfully met the minimum standards for a Certified Athletic Therapist as set out by the CATA Scope of Practise and the Competencies in Athletic Therapy. It continues to meet new challenges by changing, adapting and adopting new policies and procedures. The National Certification Examination is fair, valid, reliable and defensible. Since Athletic Therapists treat active Canadians, a stringent and discerning examination helps to ensure the safety of the public.

Governance

Mission Statement

The OATA's mandate is to provide leadership and support to over 700 Athletic Therapists in Ontario. The OATA represents the profession to the public, governments, third party insurers and other stakeholders (OATA, 2009b).

The OATA was formed in 1974 as a voluntary association to serve the collective interests of Athletic Therapists in the province of Ontario. The organization is a not for profit corporation under the laws of Ontario. The OATA is a provincial chapter of the Canadian Athletic Therapists Association (CATA) and all members of the OATA must be members of the CATA and must abide by its by-laws, policies and procedures. With respect to ethics and discipline, all OATA members are subject to the rules of both the OATA and the CATA and any issues with respect to ethics and discipline may be dealt with at the provincial and/or national level.

The OATA is comprised of six classes of voting and non-voting members. Voting members include two classes: Certified members and Associate members. Members in good standing are each entitled to one vote. Non-voting members are composed of four classes: Certification Candidates; Member Emeritus, Honourary and Inactive.

Each year at an Annual General Meeting a portion of the membership is elected to the Board of Directors for a two year term in such a fashion that there are always some opportunities for change and for continuity. The Board of Directors governs the profession in the best interests of the members on a day to day basis from one Annual General Meeting to the next.

The various Directors are assigned portfolios and at the present time the portfolios include: Governance; best practices; finance; membership; third party insurance; social media and marketing; sponsorship; conferences; research and evidence-based practice; scope of practise; and education.

The OATA Board functions as a team, managing the business and affairs of the Association and dedicated to advancing the profession and serving members' needs. Over the past couple of years the Board has updated the Association's By-Laws and Governance structure and has created committees and working groups to work on three key priorities: regulation and scope of practice; branding, positioning and improving communications; and



continuing to build a platform for evidence-based practice to secure third party insurance and proof of efficacy (OATAb).

The OATA performs the role of advocating for the interests of Athletic Therapists and the Athletic Therapy profession.

Regulation

Health care across Canada, and indeed in Ontario, is overseen by various provincial Ministries of Health whose responsibility it is to ensure access to appropriate health care; ensure public safety in health care; and ensure that ethical approaches to health care are maintained. In Ontario, there are 26 regulated Colleges and over 250,000 health care practitioners governed by these Colleges which are overseen by the Ministry of Health and Long Term Care. Since licences are not used in Ontario health care regulation, the only route open to health care professions is through Colleges' regulation and registration.

During the early 1920s in Ontario, a number of health care acts were adopted which began the process of recognizing and regulating health care professions through professional regulatory bodies. The Drugless Practitioners Act (DPA) was the most comprehensive, creating a classification of health care professionals entitled 'drugless therapists'. Inclusion in the Drugless Practitioners Act and other similar acts was at the time considered to be recognition of legitimacy in health care. By definition, a 'drugless therapist' was any person who,

...practises or advertises or holds [themselves] out in any way as practising the treatment by diagnosis, including all diagnostic methods, direction, advice, written or otherwise, of any ailment, disease, defect or disability of the human body by methods taught in colleges of drugless therapy or naturopathy and approved by the Board... (Government of Ontario, 2007).

The profession of Athletic Therapy did not exist in an organized fashion at that time deemed sufficient for regulation under the DPA or otherwise.

Athletic Therapy, or its precursor Athletic Training, is not new to the process of health care regulation. However, at the time of the initiation of the Drugless Practitioners and other Acts in 1925, Certified Athletic Therapists did not exist in Canada. Prior to the formation of the Regulated Health Practitioners Act (RHPA), Regulation 278 of the Drugless Practitioners Act was amended to include the following for a group identified as 'Trainers'. "This Regulation does not apply to or affect trainers for athletic or sporting clubs or associations so long as they confine their services to members of such clubs or associations during their training or playing season" (Government of Ontario, 2007). Unfortunately, this amendment to Regulation 278 was very restrictive, limiting practitioners identified as 'trainers' to sporting events or athletic clubs during their playing seasons. It is likely that this group of 'trainers' was singled out because of professional sports where American Athletic Trainers were recruited to work with the Canadian teams and athletes, particularly professional baseball (Toronto Blue Jays in 1977). When Athletic Therapy did become an organized health care profession in Ontario in 1974, an application was made to the Drugless Practitioners Act and the profession did come close to being regulated; but, actual regulation under the DPA never occurred (O`Reilly, 2000).



In 1990, the American Medical Association officially endorsed Athletic Training as an allied health profession (Prentice, 2006).

In terms of regulation, the profession of Athletic Training in the United States is considerably further ahead of their Canadian counterparts. In 1990, the American Medical Association officially endorsed Athletic Training as an allied health profession (Prentice, 2006). This endorsement has helped the National Athletic Trainers` Association (NATA) in its endeavours to move regulation ahead in the United States. Forty-nine states have some form of regulation or licensing, with the 50th state currently in the process of regulation. Within those 49 states, there is considerable variability in the mode of regulation used, with 43 states using licensing for the Athletic Trainers, two states using certification and four having registration (National Athletic Trainers Association, "Athletic Training,"). The most ideal format for regulation of athletic training seems to exist in Ohio where occupational therapists, physiotherapists and athletic trainers (OTPTAT) are regulated through a single regulatory body. This combination of allied health care professions into one regulatory body seems to best reflect an effective, integrated body where scopes of practice, knowledge and skills align.

Being recognized as a regulated health care profession in Ontario is an extensive process involving multiple guiding and controlling factors. The Ontario Ministry of Health and Long Term Care has the responsibility to ensure that all residents are provided with the best possible health care while safeguarding Ontarians from medically-related harm. When a health care profession is successful in obtaining a review by the Health Professions Regulatory Advisory Council (HPRAC) to be evaluated for the formation of a regulatory college, the HPRAC performs an extensive evaluation and then submits recommendations to the Minister of Health and Long Term Care.

HPRAC utilizes two primary criteria in evaluating if a health regulatory college should be formed. The primary criterion is the determination if what the particular health care profession does meets the `risk of harm threshold`. In this case, does a profession engage in decisions that could cause harm to the public? HPRAC is most concerned if there could be a significant potential risk of harm through the duties or actions of the health profession; and, if the interventions used by the health care profession could cause significant physical or mental harm to the public (Health Professions Review Advisory Council, 2011). The second criterion involves a number of factors relating to the appropriateness of the health care profession for regulation and whether there are any salient factors why the profession should not be regulated. Specific criteria include: a) Professional autonomy; b) Educational requirements for entry to practice; c) Body of Knowledge and Scope of Practice; d) Economic impact of regulation; e) Regulatory mechanisms; f) Leadership`s ability to favour the public interest and membership support and willingness of the profession to be regulated; and, g) the Health system impact including inter-professional collaboration and labour mobility (Regulation of a New Health Profession under the Regulated Health Professions Act (RHPA), 1991)). The process of evaluation for regulation goes through various phases including research and analysis by HPRAC; the completion and submission of a proposal by the applicant; an extensive stakeholders` consultation; and finally, an analysis of data and recommendations to the Minister.

A number of categories of information germane to the process of regulation are evaluated by HPRAC including:

- 1. Relevance of the proposed self-regulating group to the Ministry of Health and Long Term Care.
- 2. The risk of harm to the public.
- 3. The sufficiency of supervision.



- 4. Alternative regulatory mechanisms.
- 5. Body of knowledge of the profession.
- 6. Education requirements for entry to practice.
- 7. Ability to favour or support the public interest.
- 8. Likelihood of compliance with regulation.
- 9. Sufficiency of membership size and willingness to contribute.

In the early 1980s, the Ontario Athletic Therapist Association submitted an application to the Health Professions Legislation Review (HPLR) addressing each of these categories in order to form a College of Athletic Therapy within the province. In 1984, Athletic Therapy was one of 39 groups of the 133 applicants selected by the Health Professions Legislation Review (HPLR) to proceed toward regulation. These 39 groups responded in a second submission to comments and questions raised by the HPLR. In 1986, Athletic Therapy failed to meet specific criteria and was not accepted as one of the 24 new colleges recommended by HPLR. The primary impediment to regulation for Athletic Therapy was the insufficiency of membership size.

For many years, the Canadian Athletic Therapists Association (CATA) has recognized the need for regulation. Under the CATA Athletic Therapy is a self-regulated profession in the strictest sense of the term "self-regulation". The CATA oversees the scope of practice of its members; guiding the profession's educational standards; accrediting educational institutions; and monitoring ethical practices and professional discipline. In the same fashion that the CATA functions as a self-regulating organization for all Athletic Therapists in Canada, the Ontario Athletic Therapists Association (OATA) governs the profession of Athletic Therapy in Ontario. The majority of the functions of a health regulatory College are already administered by the OATA and they include: ethics and discipline; professional development and continuing education; quality assurance; and registration. In essence, both the CATA and the OATA have been serving the function of a regulated health profession by protecting the public from harm through treatment received from an Athletic Therapist.

Athletic Therapists in Alberta, Manitoba and British Columbia are actively seeking regulation in their respective provinces, in some cases with Kinesiology. In Manitoba, Kinesiologists and Athletic Therapists are working together towards regulation as distinct professions in a single College. In Québec, the scope of practice for Athletic Therapists is acknowledged under a regulation issued pursuant to the Code Professionel. One of the primary strong points of CATA certification is that the credentials are portable across the country and accepted by every CATA chapter. Regulation may require a provincial examination in legislation, ethics and jurisprudence for Athletic Therapists practising in Ontario.

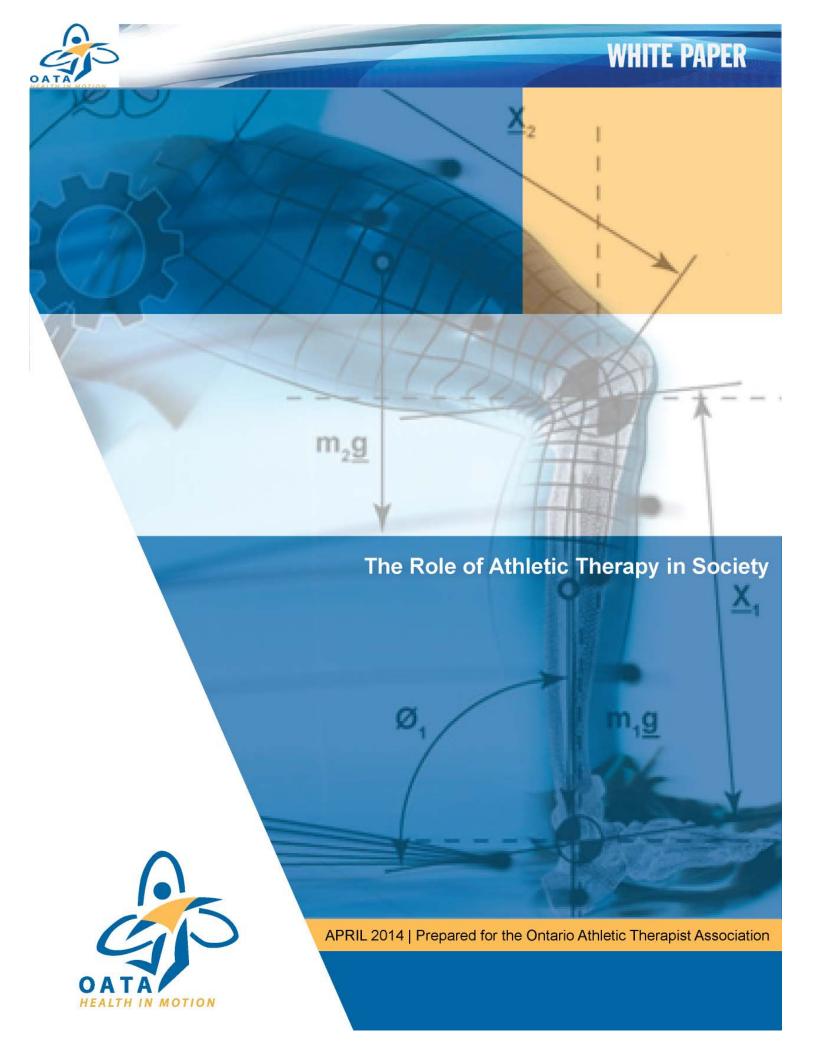
The OATA, with the support of the CATA, has advocated for the regulation of Athletic Therapy under the RHPA in order to enhance public protection and inter-professional collaboration. The OATA believes that the case for the regulation of Athletic Therapy under the RHPA is self-evident and compelling — at least as compelling as some of the professions already regulated or seeking regulation under the RHPA. Athletic Therapists have a well-recognized, post-secondary education, certification standard; and, scope of practice that qualifies them as a distinct health care profession deserving of independent regulation. The Ministry of Health and Long-Term Care agrees



but takes the position that the profession is too small to warrant or support its own College and has urged the OATA to seek an alliance with an existing or proposed College (e.g., Physiotherapy). Nevertheless the OATA notes that other health care professions (e.g., denturists, midwives) with fewer members have their own health regulatory colleges under the RHPA. The OATA initiated discussions with a number of existing colleges and with professions seeking RHPA regulation. Some of those discussions continue. The OATA believes that in the current environment the best, although not the ideal fit for Athletic Therapists, is to be regulated as a class of members, or at least as a specialization, within the College of Kinesiologists.

The OATA believes that the case for the regulation of Athletic Therapy under the RHPA is selfevident and compelling — at least as compelling as some of the professions already regulated or seeking regulation under the RHPA.

All health care professions provide a service where there are risks and benefits to patients, Athletic Therapy services also carry a risk of harm. This is why the education and certification of Athletic Therapists are so important. Athletic Therapy should be recognized as an independent regulated College. Athletic Therapy is a growing profession. The extent of the knowledge and skills of Athletic Therapists would be an additional source of quality health care to the citizens of Ontario.





The Role of Athletic Therapy in Society

Practice Venues

In recent years the practice opportunities for Certified Athletic Therapists has seen a dramatic change, both in types of locations and with types of clients. Historically, Athletic Therapists worked mostly with elite athletes in a sport setting in university or college clinics or with amateur or professional teams. Now, Athletic Therapists are working in ever more diverse settings and with the broadened scope of the physically active individual.

Following the American sport scene, Certified Athletic Trainers were employed primarily in professional sports, colleges and universities In the 1980s and '90s in the United States, the specialized education of Athletic Trainers in the management of sport-related injuries was being recognized. In the late 1990s, a push began for the employment of Athletic Trainers in high schools where contact sports were prevalent. In 1998, based on a proposal from the American Academy of Pediatrics, the American Medical Association (AMA) Council on Scientific Affairs adopted the policy that recommended the hiring of Certified Athletic Trainers in all high and middle school athletic programs. The policy was adopted by the AMA in order to provide a higher standard for the prevention and care of athletic injuries for young athletes at all levels of sport (Lyznicki et al., 1999).

In Canada, as in the United States, the same trend of hiring qualified health care professionals has reflected the changes in health care for athletes. Certified Athletic Therapists have adopted similar high standards in terms of the management of concussion and traumatic brain injury that are found with professional and Olympic level athletes. For all athletes, and in fact for everyone who consults an Athletic Therapist, the same high level of care is provided.

Now, due to the increasing interest in life-long fitness, as well as the recognition of the skills and knowledge of Athletic Therapists, there are more practice opportunities for Athletic Therapists in ever more diverse settings. In August of 2013, the Ontario Athletic Therapists Association, through the CG Group, conducted an employment survey of its members (Figures 1 and 2). The statistics showed that 87% of Ontario's Athletic Therapists were employed in the profession. Seventy per cent of the members worked in a private clinic, a health/fitness or sports facility and/or with sports teams; 1% worked in a hospital setting and 8% worked in the academic field. Six per cent of the respondents indicated that they were independent contractors; 8% were sole owners of their own business and 7% worked in a multidisciplinary setting (OATA, 2013). This illustrates that circumstances have changed, over the course of the last 30-40 years. When Athletic Therapists once only worked with professional teams and in colleges and universities, it is now evident that Athletic Therapists are employed or work in a number of diverse practice settings.



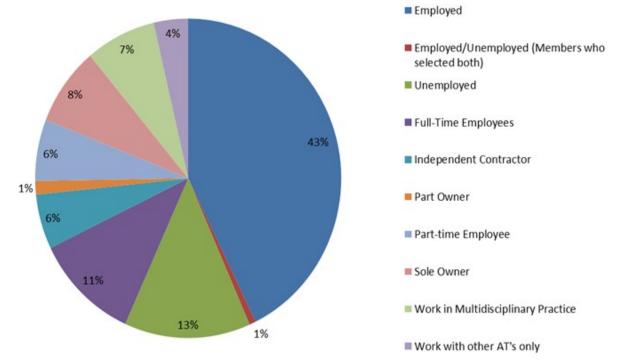


Figure 7. Members Employment Results

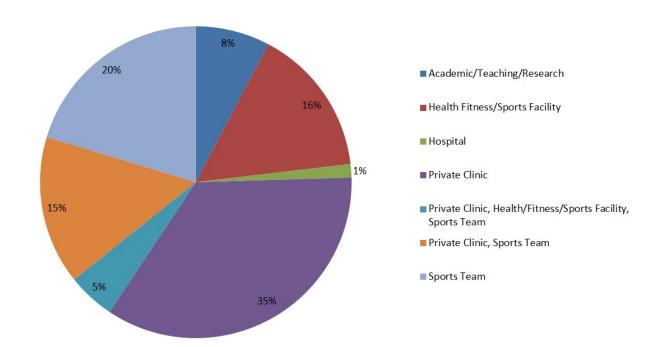


Figure 8. Members Place of Employment



Universities and Colleges

One of the original practice venues for Athletic Therapists in Canada has been universities and colleges and continues to be one of the primary practice venues for Athletic Therapists. Flint (2012) states, in the Employment Opportunities chapter of *Core Concepts in Athletic Training and Therapy* by Hillman, "Across Canada, more than 90% of university and college varsity programs employ Athletic Therapists, both in the treatment of student athletes and the teaching of Certification Candidates in CATA accredited programs".

In a university or college clinic, Athletic Therapists provide a continuum of care that takes the injured student athlete through injury prevention, the onset of injury through to return to play. The Athletic Therapist provides expertise and manages the care of the injured individual. This includes injury prevention, on field emergency and acute care, assessment and rehabilitation of injuries, as well as conditioning and nutrition programs. Appropriate return to play criteria are utilized that result in the athlete's safe return to activity.

In a 2006 CATA survey of its members, the majority of members indicated that the fall and winter were the busiest seasons, during which they worked between 80 and 100 hours per week. An Athletic Therapist will expect to spend many hours, not only doing clinical rehabilitation, but also providing care at varsity sports events. Ontario University Athletics (OUA), the governing body for Ontario university sport, has mandated that a Certified Athletic Therapist must be in attendance at all OUA hockey and rugby games (OUA, 2013). The standard of care for Ontario universities is to provide a Certified Athletic Therapist for collision sports such as football, hockey and rugby. The home team is responsible for the provision of care for both teams.

In most colleges and universities, the Athletic Therapist is directly employed by the institution. As well as working in the clinic rehabilitating athletes, sometimes the Athletic Therapist works part-time teaching courses in sports injuries, supervising student therapists or doing other administrative work within the institution. Often, Athletic Therapists are seconded to serve on the institution's Occupational Health and Safety Committees and Employee Wellness programs.

In the early years, as well as providing injury care, the Athletic Therapist was responsible for managing what was often a small clinic: sourcing and purchasing equipment and supplies, maintaining electrotherapeutic modalities, and training student therapists. While Athletic Therapists are still primarily front line clinicians they are now also assuming more managerial duties being responsible for larger clinics involving more complex day-to-day operations. In recent years, clinics have become physically larger, with more and varied personnel such as doctors, massage therapists and chiropractors. Some of these clinics now treat an expanded clientele base including the general student population, faculty, staff and, in some cases, the general public. Additionally, many of these larger clinics provide enhanced opportunities for experiential education for students in health care disciplines.

Post Secondary Teaching and Research

With an increased emphasis on evidence-based medicine and best practises, more Athletic Therapists are pursuing masters and doctoral degrees. Athletic Therapists who hold masters or doctoral degrees are sought after by the institutions that offer CATA accredited programs to become faculty members, to not only teach, but to conduct original research as well. It is becoming more common, therefore, to find Athletic Therapists actively conducting or involved in primary academic or scientific research at postsecondary institutions.



Athletic Therapists who run clinics in universities or colleges often teach a variety of sports medicine courses in the Health Science disciplines. Some Athletic Therapists are also employed as instructors in undergraduate medical degree programs teaching clinical assessment skills and foundational sciences.

With an increased emphasis on evidence-based medicine and best practises, more Athletic Therapists are pursuing masters and doctoral degrees.

Secondary Schools

Due to an increase in sport-related concussions, as well as the increased emphasis on daily activity for students, the secondary school system in Ontario would benefit greatly from the employment of Certified Athletic Therapists. It is unrealistic to expect school coaches or teachers to provide appropriate sport injury coverage. Indeed, making decisions about whether an injured athlete may continue or return to play may also put coaches in an ethical and moral dilemma (Flint and Weiss, 1992). Employing Athletic Therapists in schools ensures ethical and appropriate health care for student athletes.

It would be ideal to have Certified Athletic Therapists employed throughout the Ontario secondary school system. Injuries that occur at the post-secondary level and beyond may have stemmed from poorly identified or managed injuries that occurred during high school interscholastic sport (Lyznicki et al., 1999). Many Independent Schools in Ontario (Upper Canada College, Appleby College, Ridley College and Trinity College School) employ Certified Athletic Therapists and in some cases have on site clinics that are part of the school. This school-based work environment includes clinical care as well as field event coverage.

Julie Earl MacDonald is a Certified Athletic Therapist at Trinity College School in Richmond Hill, Ontario. She is employed full time as an Athletic Therapist at the school and provides services to both the students and the staff.

My role is all-encompassing. I manage all injuries and health emergencies (sport related or otherwise), I order and manage all of the equipment and supplies for the clinic as well as team first aid kits (about 20 in total per season), I manage all AT appointments and maintain the medical records, I assess and treat students and faculty with sports injuries, I provide field coverage for all home games... I provide the AT host coverage for all home tournaments, I created, manage, and implement the school concussion protocol (includes RTL and RTP)..., I made some connections with local sports docs and urgent care centres for referrals, I give a taping seminar to the Gr 12 exercise science class every year, I lead teams through dynamic warm-up programs as well as conditioning sessions... (2014).

According to Earl MacDonald, her program is very well supported by the students and parents. The coaches and teachers 'love it', she says because her involvement allows them to coach or teach and not be responsible for dealing with injuries. Of specific note in this time of concussion awareness, Earl MacDonald states that, "The concussion program especially has been extremely well received" (2014). This is an example of a fully functioning Athletic Therapist effectively supporting the prevention and care of students within the Ontario education system.

In the United States, the American Medical Association (AMA) recommended as long ago as 1998 that every secondary school have a Certified Athletic Trainer on staff (AMA, 1998). In Canada, it is typically only the



independent schools that have the financial means to hire an Athletic Therapist. Thus, the elementary and secondary schools that do not have an Athletic Therapist on staff must make do with coaches and teachers making the challenging return to play decisions for their student athletes. This is not only difficult for a coach whose emergency care skills are often lacking, but also places them in an ethically and morally challenging position deciding, for example, whether their best athlete can continue to play or not (Flint and Weiss, 1992). This multifaceted problem is becoming more evident with the situation surrounding concussions in secondary school student athletes. The role of Athletic Trainers as first responders to athletes suffering concussion in competition is well recognized. They are key to performing triage and to guiding the complex care of concussed athletes.

In the United States, the emphasis on hiring Athletic Trainers in the secondary school system continues, particularly now encouraged by the employment of best practises resulting from the concussion epidemic. As long as interscholastic sport continues to have a central focus in Canadian secondary schools, it is wise for the Canadian school system to learn from the experiences of their American counterparts and employ Athletic Therapists.

In the United States, the American Medical Association (AMA) recommended as long ago as 1998 that every secondary school have a Certified Athletic Trainer on staff (AMA, 1998).

Professional Sports Teams

Athletic Therapists can be found as members of the medical team for a variety of professional and semi-professional sporting organizations such as: the National Hockey League, Canadian Football League, National Lacrosse League, the National Football League, National Basketball Association, Major League Baseball, Major League Soccer, National Basketball League, Major Junior "A" hockey teams and their farm teams. "Every single professional sport team in Toronto has Certified Athletic Therapists in their systems of athlete management (football, hockey, basketball, soccer, baseball, lacrosse)" (Flint 2012). In Canada, as in the United States, every professional team employs Athletic Therapists or Athletic Trainers in a leadership role within the integrated health care team.



Prior to becoming an orthopaedic surgeon in Toronto, Dr. Veronica Wadey was the Certified Athletic Therapist for Team Canada Men's Volleyball in the early '80s. As an example of an integrated health care team, in 1986, recognizing that these high level athletes needed varying types of health care, she designed a plan, found the experts and implemented an athlete-centred interprofessional health care team for the volleyball team (Wadey, 2013a).



Similar to working in the polyclinic at the Olympics, Dr. Wadey's plan had a multi-faceted approach to health care. The paradigm she designed included an Athletic Therapist as the lead; a physical therapist with expertise in the axial skeleton; orthopaedic surgeons; a family physician knowledgeable in the musculoskeletal system; sports psychologist; optometrist; dentist; nutritionist and exercise scientist. Dr. Wadey is emphatic when she states that,

The key personnel in this model of care are the Athletic Therapists as they are the true front line health care providers during practices and games. They travel with the team and realistically make the team their responsibility and use the other health care providers to support their efforts. The team is offering a community service and is also offering educational opportunities to develop the future health care providers. It shows how an Athletic Therapist can work as an integral part of a health care team. Whether this is a patient or an athlete, there is absolutely no difference and I see this paradigm as being completely transferrable (2013b).

It shows how an Athletic Therapist can work as an integral part of a health care team. Whether this is a patient or an athlete, there is absolutely no difference... (Wadey, 2013b)

Private Clinics

According to a 2013 OATA practice survey, 55% of Ontario's Athletic Therapists practise in private fee-for-service sports medicine clinics. In some cases, Athletic Therapists are sole owners of their own clinics. They work either by themselves or in collaboration with other health care professionals such as physicians, physical and occupational therapists, kinesiologists, massage therapists, chiropractors, osteopathic manual therapists, and sport science experts.

Working in a clinical setting treating active Canadians is a specialty for Certified Athletic Therapists because of the educational programs and practical experience in accredited programs. Certified Athletic Therapists are particularly well suited for clinical work because of the focus of helping injured Canadians get back to their desired functional level of activity (Flint, 2012).

Athletic Therapists in this setting may work part of the day assessing and rehabilitating clients, but their services may be contracted out to local schools or sports teams to provide event coverage. Other duties may include clinic management, research, administration, clinic marketing or promotion.

As well as working in a clinical setting, it is becoming more common to see Athletic Therapists providing health care services to clients in their own homes. Due to the lack of individual mobility (e.g., heart and stroke issues, major injury, lack of transportation), some clients may not easily be able to travel to a clinic. Athletic Therapists excel at orthopaedic evaluation and the development and implementation of individualized rehabilitation programs. Adapting to individual home circumstances and improvising appropriate care to return the client to his or her desired level of functional activity are strengths of Athletic Therapists. These skills make Athletic Therapy a desirable home based health care service.



The scope of practise of Athletic Therapy overlaps with a number of other health care professions. It is not unusual therefore, for Athletic Therapists to have dual or multiple certifications and registration in more than one health care profession and College and to provide those services in a clinical and/or field setting.

Concussion Clinics

There is significant evidence that the rate of concussion reporting is on the rise. Recent research indicates that since 2003-2004, emergency room visits for mild traumatic brain injury (mTBI) or concussions have increased by 58% (Fu, 2012). Statistics Canada reports that in 2009-2010, an estimated 98,440 people, 2.4% of the population aged 12 and over, sustained a head injury (Statistics Canada, 2011). The website for Concussions Ontario says that "The incidence of mTBI is 600/100,000, however, due to lack of recognition and missed diagnoses this number may be twice as high (Concussions Ontario, 2013a).

Missed or misdiagnosed concussions are a major problem in Ontario because the ramifications for the individual can be significant. Dr. Jason Mihalik, a Certified Athletic Therapist, Assistant Professor in the Department of Exercise and Sport Science at the University of North Carolina, and Co-Director of the Mathew Gfeller Sport-Related Traumatic Brain Injury Research Center states that "While most concussions do resolve within a couple of weeks of the injury, many result in persistent symptoms that may last weeks, months, or even years" (Clinical Journal of Sports Medicine Blog, 2013). Mihalik says that a missed diagnosis may see the athlete return to play before all the signs and symptoms have fully resolved. Returning to play too soon and receiving a second blow could result in Second Impact Syndrome which often has catastrophic consequences including death.

Many sports organizations are implementing concussion prevention, recognition and management programs. In 2012, as a result of the increasing occurrences of concussions, Ontario's Ministry of Education introduced new legislation that, if passed, will require school boards to develop policies and guidelines surrounding the prevention, recognition and management of concussions and head injuries to its students. Chris Markham, the Executive Director and CEO of the Ontario Physical and Health Education Association (OPHEA) states "Ensuring that children and youth have safe and healthy spaces in which to live, learn and play is crucial to enabling lifelong physical activity. Addressing concussions and head injuries is a critical component of creating and maintaining a healthy environment" (OPHEA, 2012).

A Certified Athletic Therapist is often the first health care professional on the scene at the time an athlete sustains a concussion during sport. The Certified Athletic Therapist possesses the specialized skills and knowledge needed to effectively recognize concussions. The Athletic Therapist, is, therefore, well positioned to provide immediate care to the athletes at the time of their injury.

With the growing interest in the field of concussion management, many clinics in Ontario and a variety of practitioners are now offering services in this field. According to the proceedings from Concussions Ontario's 2013 3rd Summit on the Concussion/mTBI, "Over 30 clinics in Ontario treat mTBI/concussions, and these range from out-patient acquired brain injury clinics to sports medicine and community clinics". Questions are now being raised



however, about the definition of a concussion clinic. Questions such as: "What services are being provided?", "What are the core competencies of the practitioners providing the care?", "Who should be regulating these clinics" (Concussions Ontario, 2013b)?

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The Athletic Therapist is uniquely positioned to provide a continuum of care for the injured athlete from injury prevention, the onset of injury, to concussion monitoring and rehabilitation, through to safe return to play. Athletic Therapists employ multiple tools in concussion management. These measures include computerized programs, neurocognitive testing tools such as Sport Concussion Assessment Tool (SCAT3) and Balance Error Scoring System (BESS). These instruments are utilized both for baseline testing as well as for post-concussion return to play criteria. This information allows Athletic Therapists to provide athletes with concussion prevention strategies, skills and appropriate education to prevent concussions from occurring. The primary goal is always to prevent injury from occurring, but the secondary goal is to prevent injury reoccurrence.

More emphasis is being placed on the recognition that concussions can create lifelong impairment and should be properly evaluated and treated. Dr. Bayley, Medical Director of the Brain & Spinal Cord Rehab Program at Toronto Rehab, in his summary at the Concussions Ontario's 2013 3rd Summit on the Concussion/mTBI, conducted research on Ontario concussion clinics. He stated that his research suggests that,

No clinic offered what is considered "ideal" concussion treatment, and the areas of highest incidence do not have enough concussion clinics to meet demand. Education for primary care physicians, coaches and the general public on concussion symptoms, prevention and management were lacking and that the wait times in Ontario to see a concussion specialist need to be reduced (2013).

Certified Athletic Therapists are one of the best-educated professionals to recognize and manage concussions. They are ideal health care professionals to address these issues by providing effective and timely pre and post-concussion services, as well as public education about the dangers of concussions.

Health and Fitness Clubs

Athletic Therapists have been employed in health and fitness clubs for many years. They may work part of the time as strength and conditioning specialists or as fitness instructors. Additionally, many Athletic Therapists have opened their own clinics within health clubs to service the injury care needs of the club members. This provides an ideal link for the prevention, assessment and treatment of fitness related injuries.

National, Provincial and Recreational Sports

Athletic Therapists work at every level of sport from the grass roots amateur and arm chair athlete to the top tier of Canada's elite athletes. They are regularly seen providing care at sporting events around the province including



local club events, charity sponsored 'Fun Runs' and Ontario-level championships. Not only are they providing care, but often they are involved at the managerial level organizing the medical team coverage for the event.

At the national level, Athletic Therapists are integral to the health of Canada's national athletes. Dedicated Athletic Therapists work directly with a team or athlete on a year round basis where the team or athlete trains and travels internationally to competitions to provide dedicated care. This is a central aspect to the successful development of the athlete as it provides a continuity of care both at home and on the road.

Athletic Therapists are selected by National Sports Organizations as members of the Health Care Team for National and International events such as Olympics, Paralympics, Pan American Games, World University Games, Francophone Games, Commonwealth Games and Canada Games. In particular in Ontario, Athletic Therapists have been members of host medical teams as a part of volunteer public service at events such as the Ontario Summer and Winter Games, Ontario ParaSport Championships, Special Olympics, and Master Games.

Athletic Therapists work at every level of sport from the grass roots amateur and arm chair athlete to the top tier of Canada's elite athletes.

ParaSport

The first Paralympic Games hosted in Canada were held in Toronto as companion games to the 1976 Montréal Olympics. The Chief Medical Officer was Dr. Robert Jackson who was the Chair of orthopaedic surgery at Toronto Western Hospital. He was the team orthopaedic surgeon for the Toronto Argonauts Football Club and was known as the father of arthroscopic surgery in North America. He recognized the value of Athletic Therapists were part of the host medical team for the games. Athletic Therapists have played an important role with athletes with physical disabilities ever since.

Athletic Therapists have a long history of providing health care to ParaSport athletes, not only in a clinical setting, but also volunteering at provincial ParaSport championships or international events such as the Paralympic Games. In addition, Athletic Therapists are employed by individual national teams accompanying ParaSport athletes to international competitions. Kelly Parr, an Athletic Therapist with Tennis Canada's wheelchair athletes says that "ParaSport athletes, due to their disabilities, really need medical personnel to travel with them" (2014). At events, Athletic Therapists offer pre-competition readiness measures (e.g., therapeutic treatment, massage, prophylactic taping). The Athletic Therapist can help to fit and modify the athlete's specialized protective equipment to better prevent injury and optimize performance. They also provide immediate care to urgent injuries acquired during play and make decisions as to whether the athlete can return to the competition. Post-injury, ParaSport athletes need to access clinical Athletic Therapy services. Some ParaSport athletes require the services of an Athletic Therapist on an ongoing basis due to their particular special needs. Parr says that these athletes can be reimbursed for Athletic Therapy through the same avenues as able-bodied athletes – either through their NSO's, national sports benefits programs (e.g., CAIP), or through extended health care benefits.

Additionally, Athletic Therapists work as ParaSport classifiers where athletes are evaluated and grouped together according to the degree of function resulting from their disability. This helps to level the playing field among ParaSport athletes. Parr is also an internationally certified classifier with Tennis Canada. She says that classifying



these athletes' disabilities requires the Athletic Therapist to have significant knowledge of physical disabilities (e.g., cerebral palsy, paraplegia); neurological and orthopaedic evaluation; functional movement assessment both in and out of the competitive arena; and of the specific sport's technical requirements.

An Athletic Therapist provides a number of distinct benefits when travelling with ParaSport athletes. Their familiarity with all aspects of the sport is a great benefit. The Athletic Therapist can tailor the services they provide to the athlete's individual needs because Athletic Therapists recognize the different performance challenges of each athlete. Additionally, the Athletic therapist recognizes the importance of good personal hygiene and infection prevention protocols and is able to assist the athlete in these matters.

Athletic Therapists are aware of the special challenges faced by ParaSport athletes in addition to the injuries that can result from competition. Athletic Therapists have the skills and knowledge to provide ParaSport athletes with competent and effective health care whether it is in a clinical or a field setting.

The Performing Arts

There are many human endeavours that may not be classified as sport, but are extremely athletic in nature, such as show business performers, musicians, theatrical performers and dancers. For the past 30 years or more, Certified Athletic Therapists have been employed by dance companies such as National Ballet of Canada and Riverdance. Circus organizations such as Cirque du Soleil have been long-time supporters of hiring Athletic Therapists. Athletic Therapists are also employed by Disney travelling shows and touring musical bands to work with their performers and crew while on the road.

Physician's Offices

Some orthopaedic surgeons and family physicians understand the role of an Athletic Therapist in helping athletes prevent injury and recover more quickly. They have seen Athletic Therapists working in a team situation and they would like to have those skills available to their patients, and preferably in their offices. The services of an Athletic Therapist have the potential to reduce a patient's morbidity, reduce the length of stay in hospital and speed up the rate of healing and recovery. These benefits of Athletic Therapy are realized through thorough musculoskeletal assessments and rehabilitation, whole body exercise, early return to activity, home care advice and the application of bracing and support techniques. As a result of these patient benefits and due to increased patient satisfaction, physicians are beginning to request the engagement of Athletic Therapists in their care.

In the fall of 2013, the University of Calgary Sports Medicine Centre in Calgary Alberta, started an Acute Knee Injury Clinic under the direction of orthopaedic surgeon Dr. Nick Mohtadi. The clinic trains and employs Certified Athletic Therapists as 'non physician experts' to provide assessments to injured clients. Dr. Mohtadi says "They [non physician experts] are Certified Athletic Therapists who are able to evaluate and manage knee injuries according to evidence-based clinical practice and standardized treatment algorithms" (University of Calgary, 'Sport Medicine,'). This example of a non-physician expert role may become more prevalent. For example, in 2013, an Ottawa orthopaedic surgeon advertised for an Athletic Therapist to assist in his fracture clinic. Increasingly,



physicians are employing Athletic Therapists in their offices and clinics as a result of them seeing the benefits that Athletic Therapy can provide to their patients.

The services of an Athletic Therapist have the potential to reduce a patient's morbidity, reduce the length of stay in hospital and speed up the rate of healing and recovery.

Industrial Athletes

As Athletic Therapy's focus evolves to include more "active Canadians", the needs of the industrial athlete have come to light. These are the labour intensive industrial jobs such as mining, forestry, oil and gas and physically taxing factory work. The workplace environment, not unlike the sports world, can be a place of repetitive movements, static postures, awkward positions and lifting and bending movements that stress workers' tissues. Similar to athletes, commonly seen injuries can include macrotauma, such as fractures and dislocations; and microtrauma or repetitive strain injuries including tendinopathy and neuropathies like carpal tunnel syndrome. (Pearson, A). The industrial workplace may be considered by some to be a non-traditional area for Athletic Therapists. The CATA however, describes an Athletic Therapist's Scope of Practice as "...the prevention, immediate care, and reconditioning of musculoskeletal injuries" (CATAc).

An example of an Athletic Therapist working in this non-traditional environment is Rob Joseph, who has been providing on-site Athletic Therapy services to industry since 2005 in British Columbia. Joseph believes there is little difference between the athlete and the industrial worker with respect to the stress and strain placed on the body. After working for a number of years with the athletes of Cirque du Soleil he wondered "Why wouldn't we perform the same interventions with all these other



people who work with their bodies everyday as we do with these professional athletes" (2014)? Due to the similarity between the industrial worker and the athlete, the skills and knowledge of an Athletic Therapist are well suited to working in this type of environment.

With the recognition of the parallels between athletes and the industrial worker, the sport medicine model of health care is becoming increasingly accepted in industry as the desired approach both for injury prevention and active injury treatment. The sports medicine model of health care has two key differences from the traditional disease-based medical approach: there is greater emphasis on prevention; and the response to injury and the entry into the medical system for assessment, immediate care and rehabilitation is faster with an on-site Athletic Therapist. In the United States, new businesses that offer this sports medicine model of care are providing on-site Certified Athletic Trainers to offer injury prevention, emergency treatment and on-site rehabilitation. One such business, The Industrial Athlete, Inc., claims on its website that,

These three components can increase your profits by reducing costs while treating your employees like pro athletes. You save money by reducing insurance claims, premiums and out-of-pocket healthcare expenses,



while lowering DART [Days Away/Restricted or Transfer Rate] rates and OSHA [Occupational Safety and Health Administration] and recordable injuries. At the same time, by keeping employees on the job or returning them to work sooner, we lower Human Resources related expenses while maintaining higher productivity and profits (The Industrial Athlete, 2013).

The sports medicine model of health care has two key differences from the traditional disease-based medical approach: there is greater emphasis on prevention; and the response to injury and the entry into the medical system for assessment, immediate care and rehabilitation is faster with an on-site Athletic Therapist.

Colleen Creighton, a Certified Athletic Therapist and past CATA President, echoes this point. As one of the Athletic Therapists employed by ErgoRisk Management Group in British Columbia, she was contracted to run an on-site Athletic Therapy clinic for a forest products company in British Columbia where she treated the workers for either on-the-job or off-the-job acquired injuries. She says that she was the intermediary step between the injured worker and a worker's compensation claim. An injured worker would come to her during the work day on company time and receive an assessment and treatment. She would then provide education to the worker about prevention and management of the injury. The benefit to the employer of these interventions would be that a compensation claim would not need to be filed and the benefit to the worker was their injury would be addressed more quickly and efficiently. Creighton states that,

The benefit for the company is a decrease in man hours lost (either from trips to the off-site therapist in town which was calculated at approximately 3 hours per trip); decrease in the number of WSIB claims (I was able to provide therapy that allowed them to stay at work); and, of course, a cost savings for the company which, at the time, was calculated at about 6 million dollars per year (2013).

Following the American experience, there are increasing employment opportunities for Certified Athletic Therapists in Canadian industry to assess injuries, design and oversee fitness and rehabilitation programs for employees, and to investigate the root cause of injury in order to enact prevention based programs. Joseph's company is one such business that believes if employees understand how their bodies work, they will make more informed choices about their postures and movement. He knows companies located in remote locations have challenges accessing medical services, so he brings his services to them. His business provides on-site Athletic Therapy services, individualized physical assessment of the worker; movement analysis; injury treatment supervised rehabilitation programs; ergonomic education; pre-work exercise routines; and injury prevention presentations (2014).

Joseph's main premise however, is prevention. In his presentation to industrial companies, he explains to management that it is in their best interests to be proactive by preventing an injury from occurring, rather than being reactive and having to pay the costs involved with returning the worker to pre injury status. He asks management if they can see the value of paying for a one time, 60 minute physical evaluation of a worker during the work day. Joseph explains,



If I can provide an easy way for workers to address their weakness, give them a program to address that weakness and prevent an injury from occurring or, prevent one from getting worse – overuse injuries in particular – this can save companies millions of dollars (2014).

Joseph says that a secondary, but no less important benefit of workers being able to move better is that "...they will feel better, have fewer aches and pains, they will be less grumpy, less irritable and more focussed on the work" (2014). Additionally, employing injury prevention strategies allows the worker to enjoy a full, healthy and active way of life outside of work resulting in fewer claims for both physical health and mental health issues, such as depression.

...there are increasing employment opportunities for Certified Athletic Therapists in Canadian industry to assess injuries, design and oversee fitness and rehabilitation programs for employees, and to investigate the root cause of injury in order to enact prevention based programs.

Challenges

The provision of Athletic Therapy services as part of an extended health benefit plan is always a concern for employers who are focused on keeping the cost of benefits to employees as low as reasonably possible. Both Joseph and Creighton say that it is difficult to get the message across to the employer that being proactive by spending a little money up front will result in a more productive workforce, increased revenue and significant cost savings in the long-term. In this situation, employers might be able to access Employee Assistance Programs in a group benefits plan that allow employees "...to seek assistance before their daily issues become problems that can impact their ability to be present and productive at work" (Robertson and Waechter, 2010).

Another challenge is employee scepticism about the program. Joseph says workers are used to being told by other health professionals that having aches and pains is a normal part of life and ageing and that there is nothing that can be done. Joseph believes that instead of encouraging workers to accept the limitations of a current injury or condition, it is better to offer Athletic therapy which will provide the worker with active treatment, individualized exercise programs and a plan to return the worker to productivity. The culture of some industries encourages workers to keep working regardless of injury or illness and this may lead to serious consequences not just for themselves but also for their co-worker if something tragically goes wrong. Athletic Therapists are used to dealing with this attitude in the sports world. They are in a better position than most to help the worker to understand what they need to do to overcome the injury and return to work in a way that is safe for both themselves and for their co-workers.

The cost of accessing services is always a barrier. Anything that can be done to lower or eliminate the barrier to accessing Athletic Therapy services is in the best interest of both the employee and the employer. "One must make a strong case to an open-minded company, which is the greater challenge in these tough economic times." (Creighton, 2013).

Athletic Therapists are ideally suited to working in an industrial environment for a variety of reasons. Joseph says,

The skill set that Athletic Therapists have is dealing mostly with musculoskeletal injuries. Sprains and strains are the injuries primarily seen in this type of work environment and that is ideal for Athletic Therapy. Our evaluation skill set separates us from kinesiologists (2014).



As well, since the scope of practise of Athletic Therapists includes emergency care, industrial incidents such as heart attack, stroke, concussion and major traumatic injuries can also be well managed by an Athletic Therapist. Not only do Athletic Therapists have a valued skill set, but they are also used to performing these skills in a less than ideal sporting environment. Athletic Therapists are adaptable to circumstance; this is another reason why Athletic Therapists are ideally suited for working in the industrial environment. It is not lost on Canadian businesses that time is money, and so companies are beginning to recognize the direct benefit of employing Athletic Therapists (Creighton, 2013; Flint, 2012). Creighton points out that,

Providing a service that both saves the company money and saves the worker time is valuable. This allows the worker to feel that the employer cares about them. It is a positive value when this is a direct reflection of the health and safety policy and philosophy of the company (2013).

Athletic Therapists can be essential health care providers in the industrial workplace in Ontario, offering high-level health care based on the well-accepted sports medicine model.

The skill set that Athletic Therapists have is dealing mostly with musculoskeletal injuries. Sprains and strains are the injuries primarily seen in this type of work environment and that is ideal for Athletic Therapy. Our evaluation skill set separates us from kinesiologists (Joseph, 2014).

Canadian Forces

In an article by the NATA called "Current Status of ATCs in the Military: A report for the National Athletic Trainers' Association" the author says of the US military,

Given the fact that musculoskeletal injuries remain the single greatest impediment to mission readiness, there is a need for health-care professionals that can bridge the gap between health promotion, recreation, fitness and sports and medicine, a seemingly perfect match for the Athletic Training profession (2013).

Since the US has seen significant benefit from employing Athletic Therapists in their military, perhaps it is time for Canada to review its policy with respect to hiring Athletic Therapists as a recognized health care profession within the Canadian Forces.

According to Jocelyn Hanna, a Certified Athletic Therapist employed as a medical technician in the Canadian Forces (CF), "presently, all physical rehabilitation for members is performed by physiotherapists: either physiotherapy officers (commissioned officers within the CF) or civilian physiotherapists. If CF members want Athletic Therapy services, they must go off base and pay for it themselves" (2013). Physiotherapy is a trade in the Canadian Forces. All regular forces service personnel may attend a base physiotherapy clinic staffed by full-time commissioned officer physiotherapists where they can receive free therapy. Hanna says there are some careers on Canadian Forces bases where Athletic Therapists are employed as rehabilitation specialists working directly with injured members in the Soldier On program (2013). Athletic Therapists' work in the Soldier On program implies that their unique skills and knowledge are valued by the CF, despite not being fully integrated into the mainstream military.



In the United States, "Military service academies have long recognized the skills of Certified Athletic Trainers" (2013, Current Status of ATCs in the Military *a report for the National Athletic Trainers' Association*). In Canada, the Royal Military College (RMC) in Kingston has long employed Certified Athletic Therapists. Chuck Badcock, a CATA Hall of Fame inductee and member of the Royal Canadian Army Medical Corp., was the first Athletic Trainer from 1964-1970; followed by Pat Clayton from 1970 to 1979 (Hudson, 2013; Clayton 2013b). Clayton, a Certified Athletic Therapist, Past CATA president, retired Head Athletic Therapist with the Calgary Stampeders and CATA Hall of Fame inductee, says that,

I have good memories of RMC. I was given officer status allowing my family and me, for example, to have access to the Officer's mess. I was treated with a tremendous amount of respect by the cadet wing and officers of the time. As well, I was inducted as an Honorary Graduate of the class of 1975 of the Royal Military College of Canada. This is a very unique honour not bestowed on many civilians (2013).

Every cadet is expected to participate in sport of some kind whether it is intercollegiate or intramural sport. Clayton's mandate was to provide care to every cadet, all RMC staff and their families. He extended the work of Badcock and created a full service rehabilitation clinic at the school. He worked in conjunction with a civilian physiotherapist who was contracted to the military working out of the base hospital. After the physiotherapist left, a military physiotherapist was brought in, whereupon Clayton's role was diminished to only "...looking after things that happened on the base and to travel with the teams. On-going rehabilitation was removed from the College and moved to the base hospital" (Clayton, 2013).

After Clayton left, the position was occupied until 1983 by Steven Silver, another Athletic Therapist. In 2005, once again, the military hired a Certified Athletic Therapist, Joanne Hudson, who states that presently, she is the "only Certified Athletic Therapist employed by the Department of National Defence" (2013). Her primary duties at RMC are to provide emergency care at varsity sports events and to provide Athletic Therapy services to injured civilian students (undergraduate, post-graduate, and CF Reserve personnel). Hudson says that she is allowed to assess any injured athlete – civilian and regular forces Officer Cadets – however, she must refer injured Officer Cadets to Health Services for treatment and rehabilitation by a physiotherapist (2013). Unfortunately, this practice and format does not recognize the full range of skills of a Certified Athletic Therapist within a highly demanding military educational environment.

The military encourages its members to be involved in military sporting events that provide some employment opportunities for Athletic Therapists. Hanna says, "There is the Canadian Forces Athletic Trainer's Program (CAFATP), where there are civilian Athletic Therapists, CF medics, fitness staff and physiotherapists who provide coverage for various sporting events ranging from regional tournaments to international championships" (2013). Mike Kristy, a Certified Athletic Therapist, is the commanding officer of the 1909 Collingwood Army Cadets COATES (Cadets Orders Administration Education System). As well, he volunteers as an Athletic Therapist with CF sports teams. He states that the CF unfortunately calls these people 'athletic trainers' and they can be anyone employed in the CF with an interest in becoming a 'trainer'. The only requirement is that they must hold a First Responder certificate and a Level One taping course (2013). This is far below the skills of a certified Athletic Therapist and once again highlights the necessity of employing skilled and qualified practitioners.

Kristy was the Athletic Therapist for the Canadian Forces men's soccer program for six years. In 2013 he was inducted into to the Canadian Forces Sports Hall of Fame Honour Roll in 2013 as an Athletic Therapist.



According to an article written about this honour by John Edwards for the Collingwood Connection Newspaper in 2013 (where he was identified directly as an Athletic Therapist in the Canadian Forces),

He also played an integral role in educating new trainers and developing the program. He attended numerous CF National Sport events providing athletic therapy to hundreds of Armed Forces members over the years. Kristy was also sought out by other countries, including Ireland, Brazil and Barbados, to provide expertise in manual therapeutic skills when key players were injured (Edwards, 2013).

Such honours and recognition of the profession can only help the CF recognize the skills of Certified Athletic Therapists and how these skills can be used in the health and well-being of CF personnel.

Victoria Cleary, a Certified Athletic Therapist and master corporal medical technician in the reserves, has worked a number of military sporting events. She was hired officially as a medic but once assigned to a team, she was encouraged to utilize her Athletic Therapy skills even though her professional qualifications were not officially recognized (2013). Even Kristy expressed his frustration with the lack of recognition as an Athletic Therapist, stating that he is allowed only to provide Athletic Therapy services to cadets and not to members of the regular forces (2013).

Cleary is the owner/operator of her own Athletic Therapy clinic in the town of Petawawa adjacent to Canadian Forces Base Petawawa. She works with another Athletic Therapist treating the general public, as well as many CF members. The CF does not offer extended health benefits for Athletic Therapy services because physiotherapy is covered for all CF members on the base. Having worked in on-base military physiotherapy clinics in the past, she knows that the physiotherapists are often stretched to capacity. Kristy says that when this happens, the base surgeon can refer to local therapists, although he has never heard of a referral to an Athletic Therapist (2013). Regardless of the fact that CF members do not receive reimbursement for Athletic Therapy, they continue to seek out her assessment and rehabilitation services. Cleary's clinic offers a variety of Athletic Therapy services, with concussion assessment and rehabilitation rising steadily as a highly sought-after service. She says as well as her own, there are other private Athletic Therapy clinics located near CF bases in other cities such as Kingston and Collingwood that see military clientele. Individual military service members are actively seeking out Athletic Therapy services off-base, which suggests that these services are valued.

A related field where Kristy says Athletic Therapists may practise with the Personnel Support Program (PSP) in the Canadian Forces Morale and Welfare Services sector. These are civilians who provide services to promote the health and well-being of the CF regular and reserve force members, retired and former CF members, military families, Department of National Defence employees, NPF (Non Public Funds) employees and RCMP personnel. In this program, Kristy says that Athletic Therapists may be employed as fitness instructors, recreation leaders, or as a link between the physiotherapist and the fitness instructor as "The person [who] designs programs for [the] injured so they can get back to regular duty" (Kristy, 2013).

Cleary states that in the United States, there are many Certified Athletic Trainers directly employed in the US military. According to the 2004 article, Current Status of ATC's in the Military: a report for the National Athletic Trainers' Association, ATC's are highly utilized in the US Marine Corps, Navy and Coast Guard, but there are fewer opportunities in the Air Force and Army. Cleary goes on to say that,

There are enough of them that they have even created a branch of military ATC's in the NATA. In Colorado, the US military has created the World Class Athlete Program where many ATC's work and I



was encouraged to work for a time to gain experience to bring back to the Canadian Armed Forces (Cleary, 2013).

Kristy adds that for the military's sport teams the US primarily uses Certified Athletic Trainers and that they are contracted out per event.

Cleary feels the major obstacle to the Canadian Forces following the American lead of hiring Athletic Therapists is money. "There is no money to hire Athletic Therapists, and now, with cutbacks, there is even less money" (2013). Forty years ago the CF didn't need computer technicians but now they cannot function without them. In a similar vein, perhaps the time has come for the CF to investigate the financial advantage of hiring Certified Athletic Therapists who may be able to look after military personnel and return them to active duty in a more effective and cost efficient manner.

Hudson believes one major barrier to Athletic Therapists being recognized as a profession in the CF is because of its unregulated status across the country. She was told directly that this was the reason why she was being prevented from treating Officer Cadets (2013). Both Clayton and Hudson believe that another barrier is the lack of "education of the CF Health Services (at Headquarters level as well as at the local bases) in what Athletic Therapy is and how it is suited to the CF members' lifestyle, health & well-being" (2013). Kristy takes this one step further and includes a lack of education at "...not just the medical branch, but special ops branches and operational generals" (2013). Another barrier Hudson describes is that she feels that the CF desires a high level of "...standardization of care for its members" such as members presently receive with the standardized procedures the physiotherapists are required to follow. She believes that the CF are concerned that "If there are too many disciplines doing different things then it is difficult to standardize health services across the country (Hudson, 2013).

...Perhaps the time has come for the Canadian Forces to investigate the financial advantage of hiring Certified Athletic Therapists who may be able to look after military personnel and return them to active duty in a more effective and cost efficient manner.

For members of the military, access to an Athletic Therapist would be a great boon. Military personnel need to be mentally, physically and emotionally in optimal condition in order to perform their roles and duties. The demands of the modern military personnel of the army, navy and air force are similar to high performance athletes competing at the professional and Olympic levels. The solution for the Canadian Forces would be to classify Athletic Therapist as a health profession or as a profession to which members of the CF can have access. This would then reduce the barriers that members of the CF and veterans experience with respect to accessing the benefits of Athletic Therapist that they so richly deserve. These highly motivated individuals deserve the care that an Athletic Therapist can provide to return them to active duty safely, with full function and as quickly as possible.

Health Related Commercial Enterprises

Athletic Therapists are employed with insurance companies; ergonomic businesses concerned with a healthy workplace, work style and work station analysis; medical supply companies (e.g., therapy equipment and supplies)



as well as medical device companies (e.g., braces, surgical equipment). "It is advantageous to hire Certified Athletic Therapists, primarily because of the education these health care professionals bring to the table, making them ideal to evaluate insurance company claims or sell specific medical equipment" (Flint 2012). Fred Dunbar, President of Dunbar Medical in Mississauga, prefers to hire Athletic Therapists because of their knowledge of Athletic Therapy products and their experience with athletes and the sports they play. Due to the extensive clinical and field experience Athletic Therapists have been exposed to they have a breadth of knowledge concerning injuries, medical equipment and supplies that is highly sought after by these commercial enterprises.

Expanded Practice Venues

Athletic Therapy has grown and evolved in Canada since it began in the 1950s. Numerous positive milestones have occurred over the years that have collectively shaped the profession to where Certified Athletic Therapists have now become valued and recognized health care providers in Ontario. Today, the future of employment for Athletic Therapists in Ontario is rich with potential. Athletic Therapists now not only provide health care to athletes, but also to physically active Canadians of all ages: whether they are industrial athletes, week-end warriors or a 95 year old swimmer. Private clinics continue to be a major practice venue as are university and college clinics as well as working with professional, semi-professional and their development and feeder teams. Many new avenues are beginning to show promise and with some targeted education of the health benefits of Athletic Therapy, these prospects will expand.

Seniors' Strategy – Home and institutionalized based therapy

The Ontario government reports that the numbers of seniors in Ontario will more than double by 2036 and those over age 90 will triple, the result of which will have a profound impact on our society (Government of Ontario, 2013b). The impact of an aging society is well documented including for example, greater use of the health care system due to increasing incidence of illness, injury, disease and chronicity. Spurred by these statistics, in 2012 the Ontario government tasked Dr. Sinha, Director of Geriatrics at Mount Sinai and University Health Network hospitals, to lead the development and implementation of a Seniors' Strategy. In his report, he identified a number of core issues and themes that need attention in Ontario including,

Providing the right care, at the right time and in the right place means we have to strengthen and invest more in our home and community care sector... Continuing and strengthening this commitment to invest more in home care and community services will do much to support Ontarians staying healthy and staying at home longer (Sinha, 2013).

Following Dr. Sinha's report, in 2013 the government's Ontario Seniors' Secretariat released a plan for Ontario: Ontario's Action Plan for Seniors. Its stated goal is,



We want Ontario seniors to feel safe and supported, and to remain healthy and independent for as long as possible. We want them to remain active and engaged wherever possible, so they are able to continue to achieve excellence as they grow older (Government of Ontario, 2013b).

Among the report's many points, it recognizes that "Physically active older adults are less likely to experience illness and they are also less likely to fall" (2013b). Preventing illness and falls has the beneficial effect of reducing emergency department visits, hospitalizations and premature long-term care home placement. In an effort to meet these goals, an action plan was created with a stated commitment toward increasing the number of fall prevention programs and exercise opportunities available to seniors. Athletic Therapists are a natural fit for the



provision of these programs having extensive experience in providing individualized rehabilitation, exercise programs, gait training and therapeutic intervention to Ontario's physically active population. Proprioception exercises (e.g., balance exercises to prevent falls) are an integral part of Athletic Therapy rehabilitation programs for athletes, thus it would take little effort to adapt these programs and administer fall prevention programs to seniors.

Home Based Athletic Therapy

Ontario's baby boomer generation is continuing to stay active longer and is demanding more surgical and therapeutic interventions from the medical community, to enable them to continue to participate in their regular activities of daily living. The boomer generation has changed the face of health care by demanding to have joints repaired and replaced, rather than suffering with the status quo. As a result, there is an increasing demand for Athletic Therapy services from this segment of the population, whether in a clinical or a home-based setting. In some cases, due to the lack of individual mobility, (e.g., heart and stroke issues, major injury, lack of transportation) some Ontarians may not easily be able to travel to a clinic. In these cases, seniors can utilize in-home Athletic Therapy services either through private businesses or through publicly funded agencies.

The model of home based rehabilitation services is receiving more attention from the government as a result of Dr. Sinha's point that "...Ontario needs to provide the right care in the right place" (Sinha, 2013). With the ballooning costs associated with institutionalized long-term care, the provincial government is actively seeking ways to enable seniors to stay in their own homes as long as possible. At the national level for example, after their 2013 Council of the Federation meeting, the provincial premiers announced a working group to develop a Seniors Care Initiative (The Council of the Federation, 2013). This initiative will examine efforts to prioritize home care over institutional long-term care and identify several innovative models of care.

With this in mind, Athletic Therapists' specific skills are well-suited for providing Athletic Therapy services to seniors in their own homes. Athletic Therapists excel at disability evaluation; the development and implementation of individualized rehabilitation programs; are intimately familiar with working with active individuals; and are effective at adapting to individual home circumstances and improvising appropriate care for the client.



For the senior population, offering private in-home Athletic Therapy services meets the goal of the Action Plan for Seniors by supporting people in their efforts to remain in their own homes and in their own communities for as long as possible. This service has the resultant beneficial effect of reducing the cost to the taxpayer by decreasing unnecessary visits to the hospital and the necessity of seniors entering government-funded long-term care facilities.

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Institutional Based Athletic Therapy

As well as providing Athletic Therapy to seniors in their own homes, Athletic Therapists, in concert with other allied health professionals, could be better utilized to provide general exercise programs, fall prevention strategies and specific rehabilitation services to individuals in long term care homes. Since keeping seniors active is one of Ontario's goals to reduce the cost of health care, employing Athletic Therapists to design and implement programs to increase the mobility, strength and balance of seniors would go a long way to ensuring Ontario's seniors live long and live well.

One of the outcomes of the major reforms to publicly funded physiotherapy and delivery launch by the Ontario Government in 2013 was the establishment of a separate program and funding for falls prevention, activation and exercise programs for seniors. These programs can be provided in long-term-care homes, retirement homes, community centres and the like and can be provided by regulated as well as unregulated practitioners, as long as they have expertise in the field. The OATA has crafted a template for seniors falls prevention, exercise and activation program that could be offered by Athletic Therapists and, thereby, establish a footprint for Athletic Therapy in this important and growing healthcare segment. The OATA is working with the Unionville Home Society in Markham to launch a pilot project in mid-2014.

Physicians' Offices

Dr. Gordon Matheson, a sports medicine orthopaedic surgeon at Stanford University, claims that research has overwhelmingly shown that regular physical activity reduces morbidity, lowers mortality and that it is "the most effective single therapy" (2011). He relates the troubling statistic that 50% of Canadians do not meet the national recommended guidelines of 150 minutes of moderate to vigorous intensity aerobic physical activity per week (2011; Canadian Society for Exercise Physiology, 2013). "Humans were designed for movement, but physical activity has been factored out of our daily routines" (Matheson, 2011). Maintaining and improving mobility and functional movement are an important part of physical re-training and are at the core of the daily work of the profession of Athletic Therapy.



Athletic Therapists are a natural fit for the provision of these programs having extensive experience in providing individualized rehabilitation, exercise programs, gait training and therapeutic intervention to Ontario's physically active population.

Presently in North America, the model of health care delivery is disease-based, which rewards volume of care rather than efficiency. Increasingly, the evidence shows that greater effort needs to be applied to injury prevention - both occurrence and recurrence - through patient education and early injury recognition. Matheson reports that in the United States only 8% of patient office visits include counselling or education related to physical activity (2011). Further, he states "In the USA, 62% of the population consults physicians less than four times per year, including 15% with no visits at all. But the time needed to meet preventive, chronic and acute care requirements significantly exceeds the time physicians have available for patient care" (2011). Matheson firmly believes that "Our disease-based medical system cannot expect physicians to be the only care coordinators for every stage of chronic disease including its prevention" (2011). Athletic Therapists' education and skills are well-suited to helping both alleviate the pressure on physicians and to provide preventive and reactive education on appropriate physical activities for injured patients.

Pat Clayton, a Certified Athletic Therapist, is also certified as an Orthopaedic Physician's Assistant. He believes that "We need to somehow in this country get ourselves to a place where physicians are not overloaded with doing intakes on patients; where people who are highly trained can become the first level of response for getting somebody to see a sports medicine physician or an orthopaedic surgeon, and I think the Athletic Therapist is well versed in being able to do that" (2013). Athletic Therapists are educated and adept in performing triage and are used to screening patients and making the appropriate referrals. This screening process performed by Athletic Therapists can save physicians' and patients' time and save the health care system unnecessary expenditure.

Matheson et al. state that "Physician advice might be associated with short term increases in physical activity, but there is insufficient evidence of sustained changes" (2011). Athletic Therapists are very experienced in addressing the questions "When can I return to sport?" and "What activity can I safely do while my injury is healing?" If Athletic Therapists bring their formidable skills into the physician's office, the efficiency of the delivery of care for the patient could be greatly enhanced.

In 2008, Marjorie J. Albohm, then President of the NATA, stated that over the past 10 years there is a significant push by American orthopaedic surgeons to hire physician extenders to enhance their practises (American Academy of Orthopaedic Surgeons, 2008). The role of physician extenders is to triage patients; evaluate musculoskeletal injuries and report the findings to the physician; take patient histories; fit crutches and braces; develop rehabilitation programs and educate patients on injury prevention, nutrition, training and conditioning (Xerogeanes, 2007). In some cases, after specific training, Certified Athletic Trainers are even assisting doctors in the operating room.

Although some orthopaedists have been using ATs as physician extenders for 25 years, the concept really began to grow about 10 years ago. As more physicians look to refine and enhance their clinical staff, they're asking themselves, 'What mix of professionals is best suited to musculoskeletal health care in my practice?'" Ms. Albohm says, "Athletic trainers are increasingly viewed as a key part of that team (AAOS, 2008).



Athletic Therapists are very experienced in addressing the questions "When can I return to sport?" and "What activity can I safely do while my injury is healing?" If Athletic Therapists bring their formidable skills into the physician's office, the efficiency of the delivery of care for the patient could be greatly enhanced.

Although Canadian Athletic Therapists have been working in multidisciplinary clinics for many years this trend is just beginning to occur. Dr. Veronica Wadey has had experience both as an orthopaedic surgeon at Sunnybrook Hospital in Toronto, and previously as a Certified Athletic Therapist. When told of the trend in the United States, she was not surprised given her intimate knowledge of the skills of a Certified Athletic Therapist. She can see Athletic Therapists working closely together with orthopaedic surgeons in a hospital setting "...in the capacity of advanced practise therapists" working to reduce Ontario's wait list for musculoskeletal procedures in general as models of care are integrated into the health care system (2013). She suggests that a "Coordinated effort among all health care providers, similar to what we see with national medical teams whereby Athletic Therapists, physiotherapists and chiropractors all work together will need to be encouraged, developed and implemented in a sustainable fashion to ensure successful use of resources" (2013).

Matheson et al. believe that sport and exercise medicine can play a major role in preventing chronic disease due to its multidisciplinary, integrated and holistic approach. He says, "For four decades, sport and exercise medicine clinicians have been required to treat the 'whole patient', which requires collaboration not only with medical specialties and other professions such as athletic training, physical therapy, nutrition and sport science, but also with coaches, administrators, sport agents, the media and legal groups" (2011). Wadey says, "As a profession of surgeons and physicians, we wonder what we can do to bring these people into the system to utilize their tremendous skill sets in assessment in a more functional manner. I would fully support the team of therapists to complete an objective assessment of each patient, provide education for optimizing their musculoskeletal health pertaining to exercises and preventive strategies, while allowing me the opportunity to spend at least some quality time with patients to assure them that they are being followed in a team effort" (2013). Athletic Therapists already work well in collaborative settings as suggested by Matheson and Wadey. Athletic Therapists are utilized more and more assessing and triaging at sports medicine clinics, orthopaedic injuries clinics, fracture clinics, hospitals, multidisciplinary and physicians' offices. The use of Athletic Therapists therefore, is worthy of increased emphasis in a patient centered, integrated, collaborative health care system.

Hospitals

Athletic Therapists are an under-utilized professional resource that could provide greater efficiencies in the hospital system in Ontario. Dr. Wadey, because of her background, recognizes this and suggests that,

Utilizing this human resource to help complete initial musculoskeletal assessments in general for various models of care including: sports, spine, hip and knee orthopaedic trauma to name a few, may assist in providing the essential human resources to potentially help these models of care move forward in a cost effective way, while potentially optimizing access to suitable care. Currently, physiotherapists and occupational therapists are completing assessments that could also be performed by either Athletic



Therapists or chiropractors educated in a similar fashion to what the current advance practice therapists experience. What may be interesting to see is the presence of all health care providers assisting with the assessment and follow-up of these patients, actually assisting in the operating rooms and including this type of practice pattern as an option for obtaining additional education. The presence of other health care providers in the roles of assessors, potentially providing operating room assistance, and management of patients on the wards and outpatient clinics may resemble physician assistants seen in the United States (2013).

If the funding formula for hospitals and health care delivery to patients in a hospital setting could be expanded to include the services of an Athletic Therapist Dr. Wadey feels that significant cost savings, increased efficiencies and greater patient satisfaction could be achieved within the health care delivery system. Additionally, the skills of an Athletic Therapist are a perfect match in the hospital domain being used in crutch fitting, wound care, taping, bracing, splinting, and assisting in the operating room and in patient education. In the same way that an Athletic Therapist can be utilized in a multidisciplinary sports medicine clinic outside of a hospital setting, an Athletic Therapist could be utilized more often in the hospital environment for improved patient centered care.

Health Promotion/Injury Prevention

Dr. Wadey believes that Athletic Therapists need to also focus in the area of injury prevention. She sees Athletic Therapists working more closely with the exercise science community and working on health promotion in the community and potentially with industry. Dr. Wadey says "There is a large market in the workers safety insurance field. Opportunity may exist if Athletic Therapists partner with occupational health physicians in the development of injury prevention and health promotion programs to optimize work place environments. Athletic Therapists may potentially impact industry with the development of specific exercise programs specific to optimizing these work environments, and thus minimize days away from work resulting from musculoskeletal related conditions and generate a more positive work place. It is all about worker safety, athlete safety and health promotion: that is what you do" (2013).



Matheson et al. (2011) are also proponents of prevention based medicine. They recognize that the Athletic Therapy profession already possesses the key components of the knowledge, skills and attitudes needed and that it is actively utilizing this expertise in the field of chronic disease prevention. "The larger medical profession needs to recognise and support these efforts and provide cohesion and structure for the work" (2011). The scope of practise of Athletic Therapy includes the prevention and care of athletic injuries, making Athletic Therapists well suited to take the lead in the prevention and management of physical activity related injury.

Workplace Clinics

More workplaces are emphasising healthy lifestyles and are providing fitness opportunities, therapy clinics and inhouse sports activities to their employees. Presently, for example, some police services in Ontario provide reimbursement for Athletic Therapy services however, the onus is on the officer to search out an appropriate therapist and then travel to an off-site clinic. A 2013 WorkSafeBC article highlighted the Athletic Therapy services



provided to the Vancouver Police Department (VDP). A Certified Athletic Therapist operates an on-site Athletic Therapy program that offers exercise programs, mobility work, high performance conditioning, injury rehabilitation, prevention and education. The offering of this service made the VDP "...the first municipal government organization to provide in-house therapy services to its workers" (An Athletic Therapists Perspective, 2013).

In Ontario, the Workplace Safety Insurance Board (WSIB) states that one of its primary foundations is the 'Better at Work' principle. In explaining this principle, WSIB cites the American College of Occupational and Environmental Medicine, "Strong evidence suggests that activity hastens optimal recovery while inactivity delays it ... Other evidence indicates that remaining at or promptly returning to some form of productive work improves clinical outcomes as compared to passive medical rehabilitation programs" (Workplace Safety and Insurance Board Ontario, 2013). Exercise and physical activity is the foundation of Athletic Therapy. Athletic Therapists regularly employ strategies and skills that safely return athletes to full participation: these are the same skills desired in the workplace that will safely return workers to productivity through graded progressive functional activity.

Rob Joseph, the owner TREBOR Solutions Inc., firmly believes that there is a market for providing Athletic Therapy services to the industrial athlete. He says there is definitely potential to expand the industrial base to include ski hills, mines, oil and gas companies, and fire departments. The evidence is growing to show that it is a win-win scenario for the company and the worker if on-site Athletic Therapy services are provided. With an Athletic Therapist's special skills in injury prevention, musculoskeletal assessment and rehabilitation through client specific exercise, the provision of on-site Athletic Therapy care is a perfect match for the workplace.

Regrettably, in Ontario, the *Workplace Safety and Insurance Act* prohibits the WSIB from paying for healthcare services rendered by practitioners who are not regulated under the RHPA, which obviously includes Athletic Therapists at this time.

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Secondary School System

Clayton states that in Calgary, Alberta, there is a movement by the local school board to hire Athletic Therapists who also have teaching certificates (2013a). These Athletic Therapists would teach, but would also provide Athletic Therapy services to the student-athletes. While this may be a solution in Alberta, it does require the addition of teaching credentials to the already extensive Athletic Therapy qualifications.

The ideal situation for the prevention of injury and the appropriate management of school-related sport injury would be for Certified Athletic Therapists to be employed full time throughout the Ontario secondary school system. This employment would involve full time clinical and field management of injuries related to physical activity without the requirement for teaching. Injuries that occur at the post-secondary level and beyond may have stemmed from poorly identified or managed injuries that occurred during interscholastic sport (Lyznicki et al,



1999). Many Independent Schools in Ontario (Upper Canada College, Appleby College, Ridley College, Trinity College School) employ Certified Athletic Therapists, and in some cases have on site clinics that are part of the school.

Hotels/Cruise Ships

Hotels and cruise ships that have a fitness centre on site as well as on board dance shows may consider having an Athletic Therapist available on site or on call to provide services to guests and staff. In light of a recent pool related death aboard a cruise ship, the hiring of Athletic Therapists would ensure a higher level of first response and lifesaving potential.

Canadian Forces

The US military has begun to recognize the "...benefit of having certified athletic therapists employed to deal with either field injury situations or in clinical treatment post injury. In particular, concussions or mild traumatic brain injuries sustained by soldiers during combat, has increased the interest in having Certified Athletic Therapists available to assess and treat soldiers" (Flint, 2012).

A case to hire Athletic Therapists has been presented to the CF in the past, but was unsuccessful. According to Hudson, the CF did ask however, if there were enough Certified Athletic Therapists to be able to support each base, including deployed operations (2013).

Kristy believes that a way for an Athletic Therapist to become employed in the Armed Forces is through the Personnel Support Program. He says, "You can quickly move up and if you have the Athletic Therapy background you can work a lot of sporting events and it can be a part of your contract" (2013).

Cleary says that even though Athletic Therapists presently are not hired on base, it seems that military clientele actively seek out Athletic Therapy services in private clinics near CF bases. From her own experience, she recommends that if Athletic Therapists want to work with the military, to situate private clinics near CF bases. Hudson says that if a clinic near a CF base wishes to treat more military clientele it must apply to the local base/wing Health Services. If accepted, the clinic will then be included on the list of clinics to which CF members can be referred should the base physiotherapy department be booked to capacity (2013).

A number of years ago, Cleary was offered a job working with the military's Special Forces. Although she declined, she feels there may be future opportunities for Athletic Therapists to be hired in the Special Forces (e.g., Joint Task Force), since they have an entirely different budget (2013).

Hudson believes that the barriers to the CF employing Athletic Therapists are formidable, but not insurmountable. One way to break down the barriers she feels is to petition the CF and educate Health Services about the value and benefit of including Athletic Therapy as a 'trade' within the Department of National Defence.



Fitness Facilities

The interest in fitness continues to trend upwards among Ontarians in response to the evidence illustrating the negative health effects of inactivity and the benefits of an active lifestyle. As more fitness enthusiasts seek to improve their fitness levels, more fitness centres, groups and clubs are springing up. Many people want to utilize the services and equipment in a centre but there are risks involved with being on a program without appropriate instruction.

Athletic Therapists can play a key role in this area because they can give guidance to people through all levels of exercise. Their advice and intervention can mitigate muscle soreness and overstrain injuries because of their knowledge of correct exercise principles and injury prevention strategies. If an injury or emergency situation does occur, the Athletic Therapist is on site and available to evaluate and manage the situation.

Sports camps, Training Centres and Coaching Clinics

Athletic Therapists are the ideal providers of health care at summer camps, sports camps and sports training centres. Athletic Therapists are trained and familiar with working in a collaborative manner with camp doctors and nurses. Prevention of injury is of paramount concern for athletes and with the Athletic Therapist's knowledge of how to recognize the potential for injury due to faulty equipment or site surfaces, these skills would be of particular use in camps and training centres. Additionally, the athletes who do become injured or ill would benefit from an Athletic Therapist's expertise in injury assessment, emergency management, injury rehabilitation and graduated return to safe participation.

Performing Arts

The performing arts are physically demanding. Athletic Therapists already have a role to play in assisting these performers with their injuries. In Ontario there are several Athletic Therapists who work specifically with performing artists. In light of the increasing numbers of specialized performing arts programs, there is an expansion of participation in the performing arts. Since many parents encourage their children and more children are becoming involved in the performing arts, there is an ever-increasing need for the services that an Athletic Therapist can provide.

ParaSport

Sport has been encouraged for the physically disabled for over 100 years, but began to gain momentum after World War II in an effort to assist the large number of war veterans and civilians who had been injured during wartime. The Paralympics is the international games for the physically disabled with which Canadian Certified Athletic Therapists have had a long involvement. ParaSport athletes are requesting the services of Athletic Therapists because they know that Athletic Therapists are familiar with their special challenges, in addition to having the education and the skills needed to treat and rehabilitate injuries incurred during competition.



ParaSport national sport governing bodies recognize the value of Athletic Therapy by incorporating Athletic Therapists with their national teams as they travel to competitions worldwide. Not only do they provide Athletic Therapy services; but also medical services related to the athletes' special challenges. They are also increasingly being employed to act as sport classifiers for events. These classifiers determine the level of ability for each athlete based on the specific medical condition, physical challenges and sport.

A new trend in ParaSport is National ParaSport Academies such as the National Paratriathlon Academy at Carleton University in Ottawa and Wheelchair Basketball Canada's National Academy at the University of Toronto in Toronto. These year-round academies aim to provide access to centralized facilities that offer programs and services to the ParaSport athletes. Larry McMahon, operations director, Triathlon Canada states that they plan to host nationally broadcast webinars on many topics "...including training, sport-science, medical and nutrition to reach active members across the country" (Canadian Paralympic Committee, 2013). As Paralympic sport grows with increasing numbers of sponsors and increased national and provincial government involvement and funding, opportunities to work with Canada's high performance ParaSport athletes continue to increase.

Extended Health Benefits Insurance

History

According to Dr. Glen Bergeron, past CATA president, the need for insurance coverage for Athletic Therapists' patients was recognized in the 1980s. Dr. Bergeron stated "that the membership wanted to earn a living at this profession outside of working with a team. We thought that this would be another feather in our cap that would give us more credibility in the health care community" (2013).

Manitoba was the first CATA regional chapter to be successful in obtaining private extended health benefits coverage (Bergeron, 2013). In the early 1980's, the Province of Manitoba had established a fund for provincial athletes to be reimbursed for injury treatment. Coincidentally, the Province was in the process of forming the Sport Medicine Council of Manitoba and added a mandate to find funding for athlete health insurance. The Council was able to negotiate a plan with Manitoba Blue Cross and "after considerable negotiations and political manoeuvring, we [Athletic Therapists] were included" (Bergeron, 2013).

When Blue Cross was asked if it would cover other active Manitobans who were not provincial athletes, it did not want to be the first benefits provider and thereby set a precedent for other insurers. When Bergeron (2013) negotiated with Great West Life Insurance Company and they agreed to provide Athletic Therapy as a benefit on its plans, Blue Cross followed suit. This was the start that led to Athletic Therapy being an insurable benefit under more and more EHB policies.

In Ontario, in the late 1970s, the Ontario Minor Hockey Association (OMHA) recognized the benefits of its hockey players seeing an Athletic Therapist for injury care. Robert Firth, of the government-sponsored Hockey Ontario Development Committee (HODC), was the driving force behind the creation of the Hockey Trainers Certification Program. He knew the so-called "trainers" for Ontario's hockey teams needed to be educated. He put together a Medical Advisory Board and a board of consultants enlisting a number of OATA members to help



design and teach the program around the province (Laws, 2013). The program was officially launched in November 1980 and continues to this day (Hockey Development Centre for Ontario, 2013).

Shortly after the introduction of the HTCP, Hockey Canada put into place an extended insurance program that parents could purchase. In the policy, the services of a Certified Athletic Therapist were specifically named as a preferred provider due to Hockey Canada's respect for the knowledge, skills and dedicated service of Athletic Therapists. Dr. Jamie Laws, a Certified Athletic Therapist who was involved in the creation of the program, states that based on the success of Hockey Canada's HTCP and its extended insurance program, numerous other sports organizations followed suit specifically naming Athletic Therapy as a preferred provider (2013).

Shortly after the introduction of the HTCP, Hockey Canada put into place an extended insurance program that parents could purchase. In the policy, the services of a Certified Athletic Therapist were specifically named as a preferred provider...

In 1982, the Canadian Athlete Insurance Plan (CAIP) began to offer a benefit package to Canada's athletes wherein Athletic Therapy is a specifically-named benefit. Its website claims that its program has "...become well recognized in providing the most comprehensive insurance protection for sport accident and overuse injuries to Canada's athletes at all levels while inside Canada and outside Canada" (CAIP, 2012). Enrolment in the program is available to "...all Canadian athletes, coaches, managers and officials who are members in good standing of a sport governing body, such as a National Sport Organization, Provincial Sport Organization, Canadian Sport Centre, established Sport Teams, Leagues or Clubs" (CAIP, 2012).

Insurance at post-secondary institutions began to appear in the 1990s when students - other than varsity athletes - faculty and staff began to request rehabilitation from their on-campus Athletic Therapists. Today, many Ontario universities and colleges, recognize the benefits of providing on-site rehabilitation and offer Athletic Therapy coverage for their students, faculty and staff. These benefits include: reduced time away from work to attend treatments; absenteeism; return to work in a shorter period of time; and, reduced morbidity (Laws, 2013).

Present Day Coverage and Challenges

Private insurance coverage is not mandated by the federal or provincial government. Private plans are negotiated among employer groups, employee groups and associations with insurance providers, with consulting firms (e.g. Mercer) playing a large role in the development of the policy terms for large employers and brokers playing a large role for medium-sized and small employers. According to research conducted by The CG Group, extended health benefits payments generated \$17.4 million for Ontario physiotherapists in 2012 (bearing in mind that OHIP payments for physiotherapy totaled approximately \$110 million that year as well); \$12.7 million for chiropractic; \$12.4 million for massage therapy; \$3.9 million for naturopathy (about the same number of practitioners in Ontario as Athletic Therapists); and, \$1.9 million for osteopathy. On a proportionate basis, Athletic Therapists should be generating at least \$1.5 million annually in extended health benefits payments.



The total value of the services of an Athletic Therapist are not easily recorded when they are working in a multidisciplinary clinic and billings are submitted by the clinic for the overall care. When patients value the services of an Athletic Therapist so much that they are willing to pay for it out of their own pockets it becomes difficult to accurately track the amount paid for services provided. Most Ontario insurance benefit providers now offer Athletic Therapy services as an insurable benefit (see Table 1). Nevertheless, not all private plans include Athletic Therapy as an option. Therefore, not all citizens have access to EHB coverage for Athletic Therapy services.

Challenges that remain include:

- Health care visionaries recognize the benefit of professional collaboration. In Ontario, the Ministry of Health and Long-Term Care has specifically mandated the Health Professions Regulatory Advisory Council to conduct its reviews with an eye to the promotion of interprofessional collaboration and to breaking down the barriers to such collaboration. Unfortunately, many traditional professions are so concerned about protecting their specific scopes of practise that they are not open to referring patients to Athletic Therapists who might well provide significant benefits to their patients in a co-managed treatment plan. Dr. Veronica Wadey, an orthopaedic surgeon who originally trained and practised as an Athletic Therapist, has an exceptional insight into the benefits of robust professional collaboration. She suggests that a "coordinated effort among all health care providers, similar to what we see with national medical teams, whereby athletic therapists, physiotherapists and chiropractors all work together, will need to be encouraged, developed and implemented in a sustainable fashion to ensure successful use of resources" (Wadey, 2013). Athletic Therapists value the opportunity to work in an interprofessional setting. One major barrier to collaboration with other health care professionals is the lack of regulated status in Ontario, unlike our American counterparts, where virtually every state has some form of regulation of Athletic Trainers.
- Some insurance companies allocate inequitable reimbursement for Athletic Therapy services in comparison to other allied health care professions (e.g., physiotherapy, massage therapy). There may be less reimbursement on a per visit basis or less in the global budget. This discourages the individual who has to pay more to access Athletic Therapy services.
- There are some plans where a referral from a medical doctor is still required prior to receiving reimbursement. In areas of Ontario where a person does not have a family physician; or there is a lengthy wait for an appointment; or where a physician refuses the patient's request; there is a potential that injury healing time can be significantly lengthened and/or complications may occur (Laws, 2013).
- Members of the RCMP and Canadian Forces require prior medical approval to access and be reimbursed for Athletic Therapy services.
- Physicians are reluctant to refer their patients to a service provider where the patient must use his or her own funds to pay for the care.
- There is a general lack of knowledge among health care professionals about how to appropriately refer their patients to an Athletic Therapist and what specific services an Athletic Therapist provides.



The profession of Athletic Therapy is not well-profiled by the media in Canada. The media incorrectly identifies Athletic Therapists as 'trainers' because they default to the American terminology. This misidentification has meant that the sporting public lacks a clear understanding of the depth and breadth of the skills utilized by the Athletic Therapy profession. The sequela of this is that members of the general public are not aware of how they could benefit from the knowledge, skills and judgement that Athletic Therapists have acquired through their education and treatment of elite athletes.

While Athletic Therapists have been working in the sports field for many years Athletic Therapy is still not known as a specific health care profession by the general public and many other health care professions. Due to a lack of recognition for Athletic Therapy as a distinct health care profession and due to a lack of a deeper understanding of the role of Athletic Therapy in health care, some other health care providers will claim they have a comparable skill set and claim they can provide the same care as an Athletic Therapist.

The reason Athletic Therapists have a long history of working with teams, colleges and universities is because of the respect for the knowledge, education and skills that are utilized in the sports environment. There are many physically active people within the province of Ontario who could benefit from this skill set.

Ontario Insurance Companies that Accept Athletic Therapy as an Insurable Benefit

Allsport Insurance Marketing LTD.	Blue Cross	
The Canadian Life Assurance Company	The Citadel Assurance	
Clarica	The Co-Operators	
Dejardins Financial Security	The Economical Insurance Group	
Empire Life	Equitable Life Of Canada	
Great West Life	Greenshield	
Imperial	Industrial-Alliance Pacific	
Liberty Health	Manulife Financial	
Maritime Life / Aetna	Most chamber of Commerce Programs	
Premier Life Insurance Company	Reliable Life Insurance Company	
Standard Life	Sunlife Financial	
Wawanesa Life		

Table 1. Ontario Insurance Companies that Accept Athletic Therapy as an Insurable Benefit



What sport governing organizations cover Athletic Therapy services?

Most Ontario sports associations offer Athletic Therapy coverage. Each plan however, offers varying degrees of coverage, from the Ontario Football Alliance's annual coverage of \$300 to the Canadian Athlete Insurance Plan's gold package of up to \$1500.

Future of Athletic Therapy and Extended Health Benefits Insurance Coverage

It would be a mistake to assume that Athletic Therapists are unique in the challenges they have faced and continue to face in obtaining extended health benefits coverage for their patients. For various reasons, other professions such as physiotherapy, massage therapy, optometry, chiropractic, podiatry and chiropody are continuously challenged to retain or obtain coverage as well as reasonable monetary coverage limits. The OATA can learn from the experience and successful strategies of these professions. Traditionally, employees have looked to their employer to provide them with a health benefits plan. As costs rise, Ontario employers are facing significant challenges to offer an extended health benefit plan that will keep their costs low allowing them to remain competitive in a globalizing economy, while not hindering their corporate growth and profitability. A report by Mercer Canada states that "Some challenges are outside the organizations' control including an unsettled economy, a higher Canadian dollar and the impending retirement of the baby boom generation" (2011). Other challenges are the increasing cost of health care benefit premiums, shrinking government health programs, increasing labour costs, and pressure from head offices often outside Canada to reduce costs related to health benefits.

Ontario Sporting Associations Athletic Therapy Benefits Coverage (as of January 2014)

Association

Ontario Baseball Association Ontario Basketball Association Ontario Football Alliance Ontario Track & Field Association Ontario Wrestling Association Slo-Pitch Ontario Association **Ontario Soccer Association Ontario Speed Skating Association** Ontario Judo Association **Ontario Boxing Association Ontario Rowing Association** Ontario Volleyball Association Canadian Athlete Insurance Plan CFL Players' Association NHL Officials' Association Hockey Canada Rugby Canada

Table 2. Ontario Sporting Associations Athletic Therapy
Benefits Coverage

The Mercer report states that since 2007 Canadian employer

health care costs have increased approximately 29% and continue to rise (2011). Employer strategies to keep their costs down include shifting costs to employees and instituting Wellness and Employee Assistance Programs (EAP) to prevent illness and injury. "Unfortunately, the coming cost wave will require employees to pay more or have less choice and financial protection in benefit arrangements of the future" (Mercer, 2011). This may mean that employers/employees may buy very simple packages that leave employees to select their own services. It may also translate into fewer visits, lower co-payments, lower reimbursement limits and effectively less reimbursement coverage for therapeutic treatment. Alternatively, employees may become more selective when choosing a health care professional. This may work in the favour of the person who chooses Athletic Therapy.

The regulation of Kinesiologists will intensify price competition in the rehabilitation sector. Even though their scope of practice is restricted to public domain acts, Kinesiologists can be expected to try to increase their market



presence and penetration by being, and presenting themselves as being, a lower-cost alternative primarily to physiotherapy, but also to chiropractic. This presents two challenges for Athletic Therapy. As long as Athletic Therapy remains unregulated it will be difficult to justify higher fees than those of regulated rehabilitation professionals such as Kinesiologists. If Athletic Therapists become regulated by the College of Kinesiologists it may be more difficult (but certainly not impossible) to charge substantially more than Kinesiologists, unless there is evidence to support the price differential.

Athletic Therapy is already known among high level athletes to be exceptionally effective for the recovery from injury, but Athletic Therapists are continually challenged to prove this claim. Independent recognition of the skill of Athletic Therapists is already evidenced by the owners and general managers of sports teams who choose to hire Athletic Therapists to safely return their highly valued athletes to competition in as short a time as possible. The OATA and its members have made a profession-wide commitment to demonstrate this assertion through evidence-based practice, which Matheson et al advocate as essential to proving value (2011). Presently, the OATA as an organization and its individual members are actively engaged in evidence-based practice research projects that will demonstrate the efficacy, patient satisfaction and cost effectiveness of the care provided by Athletic Therapists. This is exemplified by the initiative in creating and instituting the Program of Care research project and mining this type of data among Ontario's Athletic Therapists.

Another pressure on health benefits is Canada's aging population. According to Statistics Canada, 14.8% of the population was 65 and older in 2011, up from just 8% in 1971. Within the next two decades, that number is expected to rise to 22.8% (Robertson and Waechter, 2010).

Canada has one of the largest baby boom (those born between 1946 and 1965) populations in the world. As this generation ages, medical conditions, absence, disability and life insurance costs will increase. Until baby boomers retire, employers will face increasing demands on benefit programs due to demographic change. The worsening health status of Canadians will exacerbate the situation with higher obesity rates driving medical, drug and disability rates through increased risk from diabetes, heart disease and other medical conditions. Rates of smoking are much lower than a decade ago, but those that still smoke are highly resistant to quitting (Mercer, 2011).

As baby boomers retire, these previously fully-insured employees are buying their own insurance plans; are choosing not to purchase a plan but to pay for services as needed; or are participating in retiree benefits plans. Often these retiree benefits plans are slimmed down versions of what they had before. "Since the late '90s there has been a growing-shift away from employers providing group health and dental coverage for retirees. According to a 2011 LIMRA [Life Insurance and Market Research Association] study, nearly 80% of Canadian employers do not offer retiree benefits to non-union employees" (Robertson and Waechter, 2010).

As more workers retire, the loss or reduction of a benefits plan may very well have a significant effect on Athletic Therapists working in private fee for service clinics.

One positive note is that employers seem to be continuing to offer employee health benefits. Robertson and Waechter, in an article titled *Small Wonders, A Special Report* state that,

One important tool for recruiting and retaining key hires is the employee group benefits plan. Three-quarters of companies with between 20 and 99 employees offer some type of health benefits program, and that number rises to 93% for employers that have between 100 and 499 employees (2010)



While there is an increase in the senior population, these baby boomers are living longer and are generally more active. The result is an increased demand for a range of physical activity programs for seniors (e.g., retirement homes, Ontario Senior and Masters' Games). Engaging in physical activity increases the need for injury prevention as well as the treatment of injuries. Staying physically active longer has the beneficial effect of reducing the demand for institutional care (e.g., hospitals, long-term care residences). It is recognized that it is in the public interest to empower seniors to stay in their own homes and enjoy a healthy lifestyle. The more active people are the less medication they will need; the fewer health care conditions they are likely to have; the lower the chance of complications; thus reducing morbidity and, concomitantly, reducing the cost to the health care system. Since Athletic Therapists are experts in the provision of injury prevention and treatment, this fits naturally into the Certified Athletic Therapists' domain.

In response to employers' concerns regarding increasing costs, the insurance industry has developed a number of solutions, services and tools that can provide a cost-effective group benefits plan. One such tool is where a number of similar services are pooled together, such as Athletic Therapy, physiotherapy, massage and chiropractic allowing the employee to choose the service that best suits her/his needs. Bergeron (2013) believes that "we should be promoting this more and more" among our membership

The prospect of the regulation of Athletic Therapists in their own health regulatory College; within the College of Kinesiologists or within some other College governed by the Regulated Health Professions Act (RHPA); would result in substantial opportunities for increased and extended health benefits insurance coverage for patients seeking Athletic Therapy services. RHPA regulation would substantially enhance the credibility and visibility of Athletic Therapy services with insurance companies, the public, employers, employees and other health care professions. Additionally, RHPA regulation would help significantly with interprofessional collaboration and would doubtless increase the level of confidence that physicians and other regulated health care professionals would have in referring their patients to an Athletic Therapist.

In summary, Athletic Therapy is an underutilized health care service. It is in a position to make a significant difference in reducing health care costs by keeping people happier, healthier, with more mobility and in their own homes longer. It is clearly in the public interest to reduce the overall cost of health care by making greater use of Athletic Therapy services.

In summary, Athletic Therapy is an underutilized health care service. It is in a position to make a significant difference in reducing health care costs by keeping people happier, healthier, with more mobility and in their own homes longer. It is clearly in the public interest to reduce the overall cost of health care by making greater use of Athletic Therapy services.



Athletic Therapists at Major Games

History

Since the 1950s Athletic Trainers have been working with professional sports teams, particularly the Canadian Football League, to provide medical care to athletes. The starting point of the development of sports medicine in Canada is widely recognized to be a result of the lack of medical care available to Canadian athletes in comparison to other countries at the 1968 Olympics (Safai, 2007). As interest grew, Athletic Therapists were sought after to be a part of the health care team for such Major Games as the Olympics and the Pan American games. Jamie Laws, an Athletic Therapist who was a member of the first official health care team at the 1976 Montréal Olympics recalls "We were sought after because of our high qualifications and because we had real experience dealing with competitive athletes at a high level of competition" (Laws, 2013).

In 1971 a medical team of doctors, Athletic Therapists and physiotherapists was formed to travel to the Pan American Games in Columbia with the Canadian athletes. Laws remembers that,

A number of people including Gord Mackie of the Winnipeg Blue Bombers Football Club and Mert Prophet of the Toronto Argonauts Football Club went as part of the Canadian Medical Team. They really distinguished themselves in terms of their ability to treat the athletes and provide care for them (Laws, 2013).

Laws believes, due to the fact that these early Athletic Therapists provided such exceptional care for the athletes, that they solidified a position for Athletic Therapists to be members of future Major Games health care teams (2013).

In 1976, Canada hosted the Summer Olympics in Montréal. As the games neared, there were questions surrounding what Canada would do as the host country to provide medical services.

One of the giants at the time in the sports medicine community was Dr. Ted Percy, an orthopaedic surgeon in Montréal. He was a member of the Canadian Olympic Association and had been one of the team doctors for the Canadian Olympic team for many years. He was very keen on Athletic Therapists and felt we had shown our skills and certainly wanted us to be involved (Laws, 2013).

Laws knew that physiotherapists also wanted to be involved and they had a lot of backing from doctors partly because they worked in hospital environments and were used to regularly working with medical doctors. Thus, for these games, the therapy services were divided up between Athletic Therapists and physiotherapists. Laws (2013) recalls that,

It was acknowledged that Athletic Therapists had far more knowledge of dealing with injuries on the field and so it was the case that more Athletic Therapists were assigned to the competition venues and more of the physiotherapists were assigned to the clinical venues in the polyclinic at the Olympic Village (Laws, 2013).

The 1976 Montréal Olympics were the first time skilled sports physicians, sports physiotherapists and Athletic Therapists all worked together in large numbers and in a central location. It was to become the framework for the composition of teams as we now know it (Safai, 2007). A parallel process occurred at the Paralympic Games held



in Toronto in 1976 under the direction of Dr. Robert Jackson, team orthopaedic surgeon for the Toronto Argonauts Football Club. He recognized the value of Athletic Therapy in sport and ensured Athletic Therapists were part of the host medical team for the games. Athletic Therapists have played an important role with athletes with physical disabilities ever since.

As a result of the poor health care provided by the host country at the 1968 Olympics, in 1976, the Sport Medicine Council of Canada was created by the federal government with the Canadian Athletic Therapists Association being recognized as one of the three key decision-making professional organizations (Safai, 2007). Fully funded by Sport Canada, one of its mandates was to create a selection process for all Major Games comprised of Certified Athletic Therapists from the CATA; sport physiotherapists from Sport Physiotherapy Canada (SPC); and sports medicine diploma physicians from the Canadian Academy of Sport Medicine (CASM). Major Games were defined as: Olympics, Paralympics, Pan American, Commonwealth, Francophone, World University (FISU) and Canada Games.

The Sports Medicine and Science Council of Canada (SMSCC) as it had become to be known with the inclusion of the Canadian Association of Sport Science, grew to become a world leader in the field of sport medicine and, before its demise in the late 1990s, developed initiatives that earned it a reputation as the 'gold standard anywhere in the world' (Safai, 2007).

Selection Process

Athletic Therapists consider it a privilege to be selected to represent Canada and serve on the Canadian Performance Enhancement Team (PET) at national and international Games. Many Certified Athletic Therapists aspire to be selected to a PET and work diligently to expand their skills and knowledge base. For the 2012 London Olympic Games for example, the CATA received 94 applications from Certified Athletic Therapists to be selected to the PET (CATA, 2014).

Until the early 2000s, the medical team was comprised of the expert group selected core medical team and a few NSO dedicated health care providers (e.g., athletics, figure skating, swimming). The core medical team was composed primarily of sport medicine physicians, Certified Athletic Therapists and sport physiotherapists, with the occasional selection of a nurse depending on the game's needs and budget. Due to athlete requests over the years, other health care specialists have been added such as massage therapists, chiropractors, sport psychology consultants, sport scientists and dieticians. Often, the PET might total 20 people or more for larger games such as Olympics. Bruce Marshall, the Chair of the CATA High Performance Providers Committee (HPPC), says that prior to the year 2000, selection of team members for the core medical team was done by the Presidents of the SPC and CATA with the games franchise holder (e.g., Canadian Olympic Committee). Their chosen method was to compare each group's number one choice, choose a therapist, then move on to their number two choice, the losing number one therapist now being out of the running. This was deemed unfair because it left a number of highly qualified Athletic Therapists and sport physiotherapists off Games teams, which wasn't in the best interest of the athletes (Marshall, 2013).

In the early 2000s a new and more effective selection process was put in place and remains in place today. Marshall believes that the CATA has the strictest guidelines with respect to Major Games selection. The two in four rule will



only allow a CATA member to apply and be selected to two Major Games in a four year period. The only exceptions to the rule are the Olympic Games or being selected as a Chief Therapist (Marshall, 2013).

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When choosing the core team in the past, there was always an attempt to create as well-rounded a medical team as possible to provide the most benefit to the athletes Marshall says. Apart from the balance between SPC and CATA, there was a great deal of effort involved in making sure there was English and French represented, males and females, level of experience, geographical location and varying skills such as emergency care, acupuncture and manual therapy. To that end, the HPPC encourages CATA members applying for Major Games to continually update their skills and volunteer on national and provincial committees and at varying levels of sporting events in order to better their chances of being selected for a Games team.

Certified Athletic Therapist vs Sport Physiotherapist

Today, both Certified Athletic Therapists and sport physiotherapists are selected by NSO's to all Major Games Performance Enhancement Teams. In order to qualify for selection to a PET, CATA applicants must be Certified Athletic Therapists. In order for physiotherapists to be selected to a Major Games, they must gain extra knowledge and experience working specifically with athletes. To address this, Sport Physiotherapy Canada was created in 1972 as a subsection of the Canadian Physiotherapy Association where they developed two levels of sports certification: Certificate and Diploma. It is at the Diploma level where physiotherapists are allowed to call themselves "Sport Physiotherapists" and from where selection is made for Major Games (Sports Physiotherapy Canada, 2009a; Sports Physiotherapy Canada, 2009b) (See Table 3 below).



	ATHLETIC THERAPIST	SPORT PHYSIOTHERAPIST (CERTIFICATE)	SPORT PHYSIOTHERAPIST (DIPLOMA)	SPORT MEDICINE PHYSICIAN
Formal Education	Degree from a CATA accredited institution	Degree in Physiotherapy	Degree in Physiotherapy plus Sport Physiotherapy Certificate	Medical degree and licence to practise medicine in Canada
Emergency Care Certification	First Responder, Emergency Medical Responder, or equivalent	First Responder	First Responder	N/A
Practicum Hours	1200 hrs. (600 field/600 clinic) under a Supervisory Athletic Therapist	200 hrs. (75 with a contact sport) reviewed by an SPC approved mentor	200 hrs. reviewed by an SPC approved mentor	A. 2 years of medical practice; 1 provincial, or national sport medicine conference; 50 hours of team/sport/event coverage OR
				B. Fellow of the Royal College of Physicians and Surgeons or College of Family Physicians of Canada;
				Completed a one- year Sport Medicine fellowship with 50 hours of team/sport/event coverage.
Recommendation needed from:	Supervisory Athletic Therapist	SPC Mentor	SPC Mentor	CASEM Dip. Sport Medicine physician



Membership	Member in good standing of CATA and provincial chapter	Member in good standing of CPA and SPC	Member in good standing of CPA and SPC	Member in good standing of CASEM
Written Examination	3 hr. multiple choice	2 hr. multiple choice	2 hr. multiple choice	See below:
Practical Examination	1, 90 min. Field station; 1, 90 min. Clinical station	Oral/practical OSCE style with questions; 3 stations; 105 minutes	Oral/practical OSCE style with questions; 3 stations; 105 minutes	6 hr. exam; 20 OSCE style stations with some multiple choice and short answer written questions
Maintenance	Yes	Yes	Yes	Yes
Title	Certified Athletic Therapist (CAT(C))	Physiotherapist	Sport Physiotherapist	Diploma in Sport Medicine (Dip. Sport Med.)

Table 3. Credential process for Athletic Therapists, Sport Physiotherapists (Certificate and Diploma) and Canadian Academy of Sports Medicine physicians.

Challenges and the Future of Major Games Selection

Marshall (2013) believes a major challenge is that since 2002 the CATA has lost ground as a provider group as a result of not having a strong voice on the national stage. During the days of the SMSCC, there was significant funding through Sport Canada to set up offices in Ottawa for all three expert groups, pay for administrative costs and initiate sports medicine education programs. All three groups were strong and growing in influence in Canada. Once the SMSCC was dissolved, the CATA moved to Calgary, but CASEM and SPC chose to continue to share an office in Ottawa. This close association between these two provider groups has created a very strong bond (Safai, 2007) causing a greater challenge to have the CATA's voice heard. This is a barrier for Athletic Therapists to be treated as an equal provider.

A second challenge is that there are fewer opportunities to be selected to the core medical team. In the past, the PET was comprised of the core medical team and one or two dedicated therapists brought along by the NSOs. The core medical team was made up of six or eight therapists who worked closely together to provide health care for the athletes and accompanying Games' team staff. Now with Sport Canada funding going directly to the NSOs, most sports teams are bringing to Major Games their own dedicated health care professionals who often work with the team throughout the year. This is the best scenario for the athlete because it provides them with continuity of care and builds a strong level of trust among the health care team, the athlete and the coaching staff. As a result



however, this means that, due to the diminishment in size of the core medical team, there are fewer opportunities to be selected to Major Games unless the therapist works specifically with a national team.

This leads directly to the next challenge of becoming a dedicated national team therapist. Presently, few Athletic Therapists are dedicated to work with winter national teams (Marshall, 2013). It may be the case that Athletic Therapists are busy, particularly those working in private practise settings, and are finding it increasingly difficult to sacrifice the time and money to travel with a team. As a result, when it comes to Athletic Therapy representation at winter games such as the Olympics, the CATA is not as well-represented as sport physiotherapists. This has led to greater encouragement by the CATA to have its membership work directly with national teams in order to gain greater professional recognition among the NSO's, as well as to increase Athletic Therapy's representation at winter Major Games.

There is a perception among CATA members that there is a greater challenge for Athletic Therapists to be selected to Major Games than for sport physiotherapists. Marshall (2013) says that Athletic Therapists have fared well in being selected to Major Games, noting that at the selection meetings, a balance is always sought between selecting Athletic Therapists and sport physiotherapists, alternating selection of Chief Therapist between the two groups (Marshall, 2013). CATA records kept for the 36 years between 1976 and 2009 support Marshall's statement, showing that in almost every year, and on 33 occasions, an Athletic Therapist has represented Canada as Chief Therapist (See Chart 2 below).

YEAR	EVENT/LOCATION	CHIEF THERAPIST	ASSISTANT CHIEF THERAPIST
2012	Summer Olympic London Games		Sam Gibbs
2010	Winter Olympic Vancouver Games	Raymonde Fortin	
	Commonwealth Delhi Games	Isabel Grondin	
2009	FISU Serbia Games	Andrea Prieur	
	Francophone Lebanon Games	Deborah Skelton	
2008	Summer Olympic Beijing Games	Steve King	Mario Mercier
2007	FISU Thailand Games	Tracy Meloche	
2004	Summer Olympic Athens Games	Cindy Hughes	
2003	Pan American Dominican Republic	John Boulay	
	Games		
2002	Winter Olympic Salt Lake City	Cindy Hughes	
	Games		
2000	Summer Olympic Sydney Games	Glen Bergeron	Jim MacLeod
		Mario Mercier	
1999	FISU Spain Games	Cindy Hughes	
	Pan American Winnipeg Games –	Glen Bergeron	
	host medical		
1998	Winter Olympic Nagano Games	Dale Butterwick	
1997	Francophone Madagascar Games	John Boulay	



1996	Summer Olympic Atlanta Games	Dave Campbell	
	Paralympic Atlanta Games	Wendy Hampson	
1995	FISU Japan Games	Glen Bergeron	
1994	Winter Olympic Norway Games	Lynn Bookalam	
1993	FISU Summer Buffalo Games	Guntis Obravscos	
1992	Summer Olympic Barcelona Games	Jim McLeod	
1990	Commonwealth Victoria Games	Garry Lapinski (was CATA at the time)	
1988	Winter Olympic Calgary Games Winter Olympic Calgary Games - host medical	Dexter Nelson Dale Butterwick	
1986	Commonwealth Scotland Games	Dale Butterwick	
1984	Summer Los Angeles Olympics Winter Sarajevo Olympics	Clyde Smith (was CATA at the time) Brian Gastaldi (was CATA at the	
		time)	
1983	FISU Edmonton Games FISU Edmonton Games – Host medical	Doug Freer Ray Kelly/David Magee	
1979	Pan American Puerto Rico Games	Doug Freer	
1976	Summer Olympic Montréal Games	Clyde Smith (was	
	Summer Olympic Montréal Games –	CATA at the time)	
	Host Medical	John Perry	

Table 4. CATA High Performance Providers Committee CATA Chief Therapists at Major Games 1976-2012

In an effort to improve the opportunities available for Athletic Therapists to travel to Major Games, the CATA and the HPPC are working on several fronts. The CATA's 2013 strategic plan states that it plans to continue to raise Athletic Therapists' profile among key influencers such as Games' Franchise Holders. In turn, the HPPC actively encourages the membership to gain more experience by volunteering with local, provincial, national and international events and obtaining more professional skills in order to increase their likelihood of being selected. As well, the HPPC continues to maintain the visibility of Athletic Therapy at the national level by attending conferences such as SPIN (Sport Innovation Summit) organized by the Canadian Olympic Committee's Own the Podium. This is an important conference as it brings together Canada's top sports scientists, coaches, high performance directors, practitioners and support service providers giving the CATA a critical opportunity to network and actively participate in planning meetings (CATA, 2014).

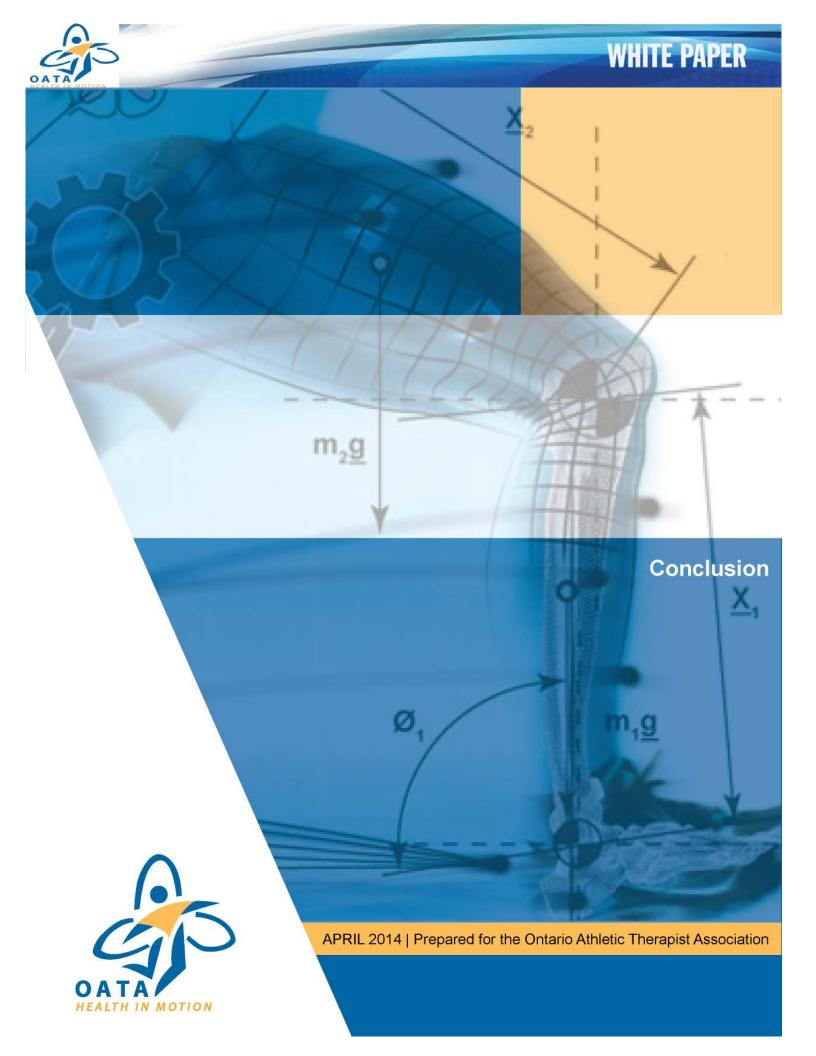
Marshall does not see the present system of selection changing in the future. The majority of therapists attending games will continue to be designated therapists with only a very few being selected to the core of the PET team. He says,



We are the most all round qualified people to be there. As long as we keep pushing to work with national teams and sacrifice the time to travel, we will continue to hold our ground in the sport medicine coverage in our country (2013).

Athletic Therapists have been involved with providing health care to high-level athletes at Major Games since before sports medicine became a recognized profession. Pioneering Athletic Therapists created a path for future Athletic Therapists by distinguishing themselves at Major Games as effective and sought-after providers of health care to athletes, officials and games' team members alike. Through Athletic Therapists' commitment to excellence, evidence-based therapeutic interventions and volunteerism, Athletic Therapists continue to be an essential component of performance enhancement teams at Major Games.

Athletic Therapists have been involved with providing health care to high-level athletes at Major Games since before sports medicine became a recognized profession. Pioneering Athletic Therapists created a path for future Athletic Therapists by distinguishing themselves at Major Games as effective and sought-after providers of health care to athletes, officials and games' team members alike.





Conclusion

The profession of Athletic Therapy has a rich, colourful and accomplished history in Ontario. Athletic Therapy has grown and developed in the province from the first Canadian Athletic Therapists Association's Annual General Meeting in 1966, of ten members, to a current OATA membership in 2014 of more than 700. In a relatively short period of time the profession has expanded from a focus on high-level athlete healthcare to include the average physically active citizen of Ontario.

Certified Athletic Therapists have the knowledge and skills to assist in the achievement of the goals of Ontario's Action Plan for Health Care. The citizens of Ontario would benefit from an Athletic Therapists' focus on a safe return to physical activity through comprehensive rehabilitation programs.

The CATA and OATA recognize the need to meet stringent requirements to be recognized as a legitimate healthcare profession. The hallmarks of any healthcare profession include a quality educational program, a discerning professional certification examination and continuing professional education. The CATA and OATA have enshrined these requirements in their organizational structures, thus ensuring that Certified Athletic Therapists meet these rigorous standards of a health care professional.

The CATA and OATA are the associations for the provincial and national self-regulating healthcare professions. These associations have the dual role of advocacy for the Athletic Therapy profession and governance of the profession in the public interest. In the province of Ontario, the OATA is seeking government legislation for a health regulatory College for Athletic Therapy.



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Appendices

1. National Athletic Therapy Month Poster

Rapid return to Control Rapid return to Control Rapid return to

If your injury affects:



Seeing a Certified Athletic Therapist, CAT(C), will help get you back to work and play.



www.athletictherapy.org

June is National Athletic Therapy Month



2. List of Acronyms

AGM - Annual General Meeting

AMA - American Medical Association

ATC - Athletic Trainer Certified (National Athletic Trainers Association Board of Certification) U.S.A

ATTH - Certificate in Athletic Therapy, York University

CAC - Coaching Association of Canada

CAIP - Canadian Athlete Insurance Plan

CASEM – Canadian Academy of Sport and Exercise Medicine (previously CASM - Canadian Academy of Sport Medicine)

CASS - Canadian Association of Sports Sciences

CATA – Canadian Athletic Therapists Association

CAT(C) – Certified Athletic Therapist (Canada)

CBoCAT – Canadian Board of Certification for Athletic Therapy

CF - Canadian Forces

CPA - Canadian Physiotherapy Association

CPR - Cardiopulmonary Resuscitation

CRC - Canadian Red Cross

DPA - Drugless Practitioners Act

EAP - Employee Assistance Program

ERC - Examination Review Committee

DART - Days Away/Restricted or Transfer Rate

Dip. AT&M – Diploma Athletic Training and Management, Sheridan College

Dip. SIM - Diploma Sports Injury Management, Sheridan College

HODC - Hockey Ontario Development Committee

HPPC - High Performance Providers Committee

HPRAC - Health Professions Regulatory Advisory Council



HTCP - Hockey Trainers Certification Program

LIMRA - Life Insurance and Market Research Association

LHIN - Local Health Integrated Network

MMA - Mixed Martial Arts

MSK - Musculoskeletal

MOHLTC - Ministry of Health and Long Term Care

mTBI - Mild Traumatic Brain Injury

NATA - National Athletic Trainers Association (American)

OATA - Ontario Athletic Therapists Association

OMHA - Ontario Minor Hockey Association

OPHEA – Ontario Physical and Health Education Association

OSHA - Occupational Safety and Health Administration

OSTA – Ontario Sports Therapists Association

OTC - Over the counter

PAC - Program Accreditation Committee, Canadian Athletic Therapists Association

RHPA - Regulated Health Professions Act

RMC - Royal Military College

SAO – Sport Alliance Ontario

SIPAC - Sports Injury Prevention and Care program

SMSCC – Sport Medicine and Science Council of Canada (previously known as SMCC - Sport Medicine Council of Canada)

SOAP - Subjective; Objective; Assessment; Plan

SPC - Sport Physiotherapy Canada

WADA - World Anti-Doping Agency

WFATT - World Federation of Athletic Trainers and Therapists

WSIB - Workers' Safety Insurance Board

WWE - World Wrestling Entertainment



3. OATA Past Presidents

Name	Date
Fred Dunbar	1974-1978
D. Tim Page	1978-1985
Chris Broadhurst	1985-1990
Marcia Franklyn	1990-1992
Karen Holland	1992-1994
Kathy Pye	1994-1997
Janice Holmes	1997-2001
Kelly Parr	2001-2005
Drew Laskoski	2005 to present



4. Ten Reasons Your School Needs an Athletic Trainer

- 1. A Certified Athletic Trainer is the number one healthcare provider trained and educated to work with athletes.
- 2. A Certified Athletic Trainer is trained to handle emergencies whether it's a broken arm, a neck injury, or cardiopulmonary. All athletic trainers are trained in life-saving skills such as CPR and AED use.
- 3. Athletic Trainers are one of the best-educated professionals to recognize and manage concussions.
- 4. Athletic Trainers are proactive and spend a lot of time trying to prevent injury.
- 5. Athletic Trainers have hundreds of hours of related experience before they ever step foot into a full-time job.
- 6. Athletic Trainers set aside the score and make decisions based on what is best for that student-athlete.
- 7. Athletic Trainers are nationally certified and regulated by most states.
- 8. Athletic Trainers are a team player; working in conjunction with other medical professionals and athletic personnel.
- 9. Athletic Trainers understand the drive for an athlete to compete and want to work to help that student-athlete to succeed!
- 10. Other schools have one; your school is creating a liability without one!

Every Athlete Deserves an Athletic Trainer.¹

¹ Retrieved from: http://mnhopper1s.wordpress.com/2011/08/08/ten-reasons-your-school-needs-an-athletic-trainer/