

Challenges for Newly Credentialed Athletic Trainers During Their Transition to Practice

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Context: Understanding the challenges faced by newly credentialed athletic trainers (ATs) as they transition into clinical practice could assist employers and professional programs in developing initiatives to enhance this transition.

Objective: To explore the challenges faced by newly credentialed ATs during their transition from student to autonomous practitioner.

Design: Qualitative study.

Setting: Individual phone interviews.

Patients or Other Participants: A total of 34 ATs certified between January and September 2013 participated in this study (18 women, 16 men; age = 24 ± 2 years; work settings = college, secondary school, clinic, and other). Data saturation guided the number of participants.

Data Collection and Analysis: An interview guide was used. All interviews were recorded and transcribed verbatim. Data were analyzed via phenomenologic reduction, with data coded for common themes and subthemes. Trustworthiness was established via intercoder reliability, member checks, and peer review.

Results: Initially, participants had difficulty making decisions independently. However, making decisions and receiving positive feedback helped them develop confidence. Communication with coaches and parents was challenging, especially for those in the secondary school setting. Participants also experienced role ambiguity, as they were unsure of basic organizational and administrative structures and expectations. Mentor inaccessibility was the final challenge described by respondents. In particular, those in the secondary school setting and with part-time employment felt they did not have a supervisor or mentor whom they could contact for support and guidance.

Conclusions: Professional programs should educate students on potential challenges to help them understand what they might encounter during the transition to clinical practice. Employers should provide clear expectations and job descriptions to alleviate some of the stress and role ambiguity. If a mentor is not provided by the employer, the newly credentialed AT should seek one to assist during the transition.

Key Words: role ambiguity, decision making, communication

Key Points

- During their transition to practice, newly credentialed athletic trainers faced challenges in making decisions, developing confidence, role ambiguity, communication, and mentor accessibility.
- Employers should expect new employees to encounter challenges and assist by providing proper orientation and mentorship, especially during the first year of the transition.
- The challenges newly credentialed athletic trainers described were consistent with those experienced by other new health care providers, such as physicians and nurses.

The initial transition into clinical practice as a newly credentialed health care provider is a stressful time and has been referred to as the *shock of clinical practice*.^{1,2} The shock and stress attributed to this transition process are often due to the assimilation into a new environment and the individual's expectations of that environment.³ For nurses, the first 6 to 9 months are their most vulnerable in regard to medical errors, job dissatisfaction, and work stress.⁴ Questions surrounding the readiness of the newly credentialed athletic trainer (AT) have attracted heightened interest in recent years.^{5,6}

Transitioning into practice is a dynamic process whereby a person undergoes a transformation, which results in the opportunity to redefine and develop one's identity and assimilate into a new role.³ During this time, health care providers have faced many challenges, including job stress,

lack of knowledge and confidence, heavy workloads, too little support, inadequate time-management skills, inadequate critical thinking, and conflict.^{7–10} Challenges in communication, time management, and the expectations of residency directors affected internal medicine interns.¹¹ The transition process for the AT often accompanies a period of uncertainty, and as such, the AT must overcome the attendant challenges and obstacles.¹²

The transition can be both exciting and challenging and must be examined¹³ so that we can determine the need for support and socialization into the role. However, very little is known about the challenges faced by newly credentialed ATs during this transition process. Presently, in the athletic training literature, authors have examined 1 specific practice setting, such as the secondary school¹⁴ or collegiate¹⁵ setting. Thus, our purpose was to gain a

heterogeneous understanding of newly credentialed ATs' transition into practice. We wanted to understand the challenges they faced as they were acutely transitioning into their first full-time position. Our study was founded on the following research question: What challenges would be described by newly credentialed ATs as they transitioned into their first full-time position?

METHODS

We wanted to explore the challenges newly credentialed ATs may face as they transitioned into clinical practice for the first time. The framework of phenomenology allowed us to explore the common experiences of our participants as they acclimated to the role of AT and were expected to practice independently for the first time.¹⁶ A phenomenologic approach allows the researcher to develop a greater understanding of the common experiences of a particular group.¹⁷

Participant Information and Recruitment Strategies

We purposefully recruited ATs who had passed the Board of Certification examination between January and September 2013 and reported being employed as an AT part time or full time. This timeframe was chosen because the transition begins during the first weeks of employment and continues through the first year.^{2,5,11} The timeframe allowed us to capture individuals in the beginning to the middle of the first year of their transition who had 3 to 6 months of job experience. Our inclusion criteria and timeframe for certification were resolute,¹⁶ as the transition process has been described as beginning immediately after acceptance of a position and continuing through the first year of clinical practice.^{18,19} We gained access to participants from a larger study^{20,21} in which newly credentialed ATs completed a survey regarding their orientation and transition-into-practice experiences. At the end, the online survey solicited volunteers for a phone interview, and those who were interested were contacted directly by a researcher (S.E.W. or A.B.T.) for a semistructured interview. Our sample consisted of 34 ATs (18 women, 16 men; age = 24 ± 2 years). We provide individual participant demographic data in Table 1. Participants represented graduate assistant (n = 14), staff (n = 9), intern (n = 5), as needed (PRN; n = 4), and head (n = 2) ATs. After our 15th interview, we reached data saturation¹⁶ but continued data collection as the interviews had been previously scheduled.

Data-Collection Procedures

After institutional review board approval was obtained, we began recruitment. As previously described, participants were recruited from a larger study,²¹ and those who provided e-mail addresses were contacted directly by a researcher (S.E.W. or A.B.T.) to coordinate an interview time. The semistructured interview guide (Appendix) was developed for this project; it provided a structured platform for each interview but allowed for flexibility to dialogue with the participants and gain more information when necessary. The interview guide was based on the literature specifically examining the transition into practice.^{15,22} Three experts in athletic training education reviewed the guide for content, bias, and clarity. Grammatical edits were

made, and we piloted the instrument with 2 ATs who met our inclusion criteria. We did not include the pilot data but did incorporate the feedback from the pilot study into the final version of the instrument. All participants consented verbally, and each interview lasted approximately 35 minutes and was transcribed verbatim.

Data-Analysis and Data-Credibility Strategies

Data were analyzed via phenomenologic reduction and were continually evaluated as they were collected.^{16,23} After data collection, to gain a sense of the data and identified concepts regarding the participants' transition into practice, 2 researchers (S.E.W., A.B.T.) independently read the transcripts. Concepts were organized into significant statements or codes. Emergent codes were organized into themes, which were used to develop a description of the transition-into-practice process for newly credentialed ATs.

Three strategies were used to establish credibility of the data: (1) intercoder reliability, (2) member checks, and (3) peer review. For intercoder reliability,²⁴ 2 members of the research team (S.E.W., A.B.T.) independently coded the data and then compared findings and came to agreement before sharing the results with the peer reviewer. The researchers were congruent with respect to all content; therefore, negotiations addressed the names of codes and themes but not content. For member checking, we e-mailed all participants their transcripts and asked them to review these for accuracy. Replies were received from 15 participants, and no changes were needed. The peer review was provided by an athletic training researcher who is an expert in qualitative research. The purpose of our study, research questions, data-analysis procedures, a few of the uncoded transcripts, and the codebook and themes were supplied. The peer reviewer confirmed coherence between the themes and the transcripts and the placement and logical organization of meaningful pieces of data into themes.²⁵

RESULTS

Our data revealed 5 themes related to challenges endured during the transition: (1) decision making, (2) developing confidence, (3) role ambiguity, (4) communication, and (5) mentor accessibility.

Decision Making

Making the final decision regarding medical care for the first time was a challenge for newly credentialed practitioners. As students, they made medical care decisions with support and feedback from their preceptors, which buffered them from full autonomy. Suzanne shared, "when something happens, I'm looking over my shoulder to where is the athletic trainer, [and] so [I now realize] that I'm that person. I guess that would be the main thing [challenge]." Pamela (junior college), Mike (National Collegiate Athletics Association [NCAA] Division III [DIII]), and Jane (youth, secondary, and university/college), similarly realized that they were now the ATs, the ones who needed to make the decision on medical care. Mike (NCAA DIII) stated:

Table 1. Participant Demographics

Participant Pseudonym	Gender	Type of Professional Program	Work Setting	National Athletic Trainers' Association District	Job Title
Andrea	Female	Baccalaureate	NCAA Division III	4	Graduate assistant ^a
Carmen	Female	Baccalaureate	NCAA Division III	2	Graduate assistant ^b
Francesca	Female	Baccalaureate	Secondary school	5	AT PRN
Gale	Male	Baccalaureate	Secondary school	3	Staff AT
Galina	Female	Baccalaureate	Performing arts	4	Graduate assistant ^b
George	Male	Baccalaureate	NCAA Division III	4	Graduate assistant ^b
Gretchen	Female	Baccalaureate	NCAA Division III	3	Graduate assistant ^b
Hank	Male	Baccalaureate	NCAA Division I	2	Graduate assistant ^b
Huell	Male	Baccalaureate	NCAA Division I	10	Graduate assistant ^a
Jack	Male	Baccalaureate	Secondary school	3	Staff AT
Jane	Female	Baccalaureate	Youth, secondary, and university/college	4	AT PRN
Janice	Female	Baccalaureate	NCAA Division II	3	Staff AT
Jesse	Male	Master's	Secondary school	8	Head AT
Kaylee	Female	Baccalaureate	National Association of Intercollegiate Athletics	7	Staff AT
Leanne	Female	Baccalaureate	Secondary school	4	Intern
Lydia	Female	Master's	Secondary school/clinic/hospital	4	Staff AT
Marie	Female	Baccalaureate	Secondary school/clinic/hospital	3	AT PRN
Matt	Male	Baccalaureate	Secondary school	5	Graduate assistant ^a
Mike	Male	Baccalaureate	NCAA Division III	2	Graduate assistant ^b
Pamela	Female	Baccalaureate	Junior college	6	Graduate assistant ^a
Pete	Male	Baccalaureate	Secondary school	6	Graduate assistant ^b
Saul	Male	Baccalaureate	Secondary school	4	Graduate assistant ^b
Skyler	Female	Master's	Youth, secondary, and university/college	9	Intern
Sophia	Female	Baccalaureate	Secondary school/clinic/hospital	5	Staff AT
Steven	Male	Master's	Professional sports	2	Intern
Suzanne	Female	Baccalaureate	NCAA Division III	2	Graduate assistant ^a
Tasha	Female	Master's	NCAA Division II	4	Intern
Ted	Male	Baccalaureate	NCAA Division I	9	Graduate assistant ^a
Tiffany	Female	Master's	NCAA Division III	2	Staff AT
Todd	Male	Baccalaureate	Secondary school	8	Head AT
Tyris	Male	Baccalaureate	Health/fitness industry	4	AT PRN
Victor	Male	Baccalaureate	NCAA Division III	4	Intern
Walter	Male	Baccalaureate	Secondary school	2	Staff AT
Wendy	Female	Master's	NCAA Division II	3	Staff AT

Abbreviations: AT, athletic trainer; NCAA, National Collegiate Athletic Association; PRN, as needed.

^a Graduate assistant in a nonpostprofessional program.

^b Graduate assistant in a postprofessional program.

The learning curve of trusting your gut [was concerning]. In my undergrad [studies], I would perform the rehab protocol or the treatment or evaluation, and it would be smooth, easy, because I had someone [my preceptor] in the back [ground] saying, “Hey, you did the right thing. Maybe you want to include this in your documentation, but otherwise, you did a great job,” but when you’re on your own, you basically do the same thing.

Participants described one of their challenges as believing in themselves when making decisions, as it was the first time without intervention from another AT who in the end was the liable, responsible party. Making decisions was described as “frightening” and at times “overwhelming,” as they realized that it was now their responsibility and they were credentialed to make those decisions. When asked about the transition from student to graduate assistant, Carmen, working in the NCAA DIII, commented:

I think a lot of it was just the unknown, and it was the first time I was going to be making decisions. I had a great experience at my undergrad, I was able to work closely with athletes and with other [athletic trainers],

but there was still someone else making the ultimate decision.

She elaborated on how decision making was the most challenging aspect of her transition:

I would have to say it’s the decision making, being in charge, not that I don’t enjoy that role, it’s just that it’s a little bit of a reality check. It’s a little more frightening that I’m the one making the decisions. [In undergraduate], there was always someone over my shoulder, and you know, even though it seemed annoying at the time, it was like a security blanket. There was always someone [preceptor] watching to make sure I was not causing harm to anyone. I still have a security blanket with 2 head [athletic trainers] here who have a lot of experience. When it comes down to it, it’s just me in here for many hours, and I still have to make those decision. Ultimately, I am responsible for the welfare of those people.

Galina, who treated patients in the performing arts setting, noted that 1 of her preceptors validated her

decisions during her professional preparation, which resulted in her now having difficulty making decisions:

I wasn't quite prepared for making decisions and not having anyone there beside me to say, "Yes or no, that's the right decision." I worked my senior sport at [college] for men's soccer, but of course, there was a preceptor there with me. So no matter what situation we were faced with, she was always there to say, "Yes or no, this is the right decision. You are implementing the correct treatment."

For Kaylee, working in the National Association of Intercollegiate Athletics setting, decision making was a challenge but in a positive way:

The biggest thing was having the power to make all my own decisions because [my preceptor] told us initially, even while he was there [with our respective sport], unless we came to him with a question, we were the end all, be all.

Participants described the decision-making process as a challenge they needed to face and overcome as they transitioned. Fundamentally, the challenge was that they no longer had the crutch of being a student and relying on validation and support regarding clinical decision making from more experienced ATs who served as resources.

Developing Confidence

The second challenge identified was confidence. Participants described developing confidence in themselves when providing patient care and continuing to work as an AT, a progression that was not immediate. A period of uncertainty occurred, especially concerning their abilities and skills. Mike, a graduate assistant in the NCAA DIII, felt that trusting himself was difficult, even though he knew he was prepared:

It's "just trust your gut." I feel like I go through the motions, and at the end, I second-guess myself. So I feel like that was kind of the hardest thing to gain that confidence. You spent 2 years training for this; you know what you're doing.

Tyris (health and fitness industry) felt similarly:

I think the hardest thing is the confidence. Trying to span that gap between you're a student in May and then you graduate and all of a sudden, come the end of May, you're working at a high school or working as a physician extender, and all of a sudden, you have to actually apply this. You actually have to do all this and document it, and with insurance, and so all of this, it's almost like you have to jump into being so sure of yourself that that confidence, transition, is a big leap to take.

Participants reported gaining confidence as they performed more duties in their new role. Gretchen, a graduate assistant in the NCAA DIII, explained, "Gaining the confidence as a certified athletic trainer was really difficult

at first, but the more I did [my job], the more confident I became in my decisions." Jane (youth, secondary, and university or college) expressed the same feeling as she engaged in her role:

Just working more is pretty much the main thing. Just getting out there and doing more and having more experience and also having injuries that I haven't worked on for a while, just because I knew that I knew because I had had a lot of experience with them. So that was a big thing.

Pamela, who was a graduate assistant at a junior college, had a comparable experience:

The first time I had an athlete pass out on me, at first, it was like, "Crap," but as I went through it and slowed down my thinking, I was fine. I handled the situation really well, but then the second time that happened, I went into it so much more confident and so much more prepared, and even with different injuries, like acute injuries on the field, or whatever, like the more times they would happen, the better I feel about it.

The development of confidence was based primarily on role engagement but also on receiving positive feedback and affirmation regarding proper patient care. Galina (performing arts) remarked:

I think that having moments where I'm right has helped me develop that confidence. Just being able to make a decision and kind of go out on a limb and for my treatment or for my diagnosis to be accurate, I think that has really impacted my confidence. There have been a lot of situations that I've faced so far where I have questioned my clinical diagnosis, but there haven't really been any moments where I've been really wrong. So I think that's definitely helped my confidence.

George (NCAA DIII) felt that positive feedback from his physician affected his confidence levels:

I would tell a physician [my opinion], and the physician totally agrees upon their evaluation from x-rays and their general opinion on what was going on, and I've been right on. That was nice and really boosted my confidence.

Jack (secondary school) concurred, "It would give me more confidence I'm doing a satisfactory job. I get positive feedback, like a lot, which is great." Tyris (health and fitness industry) felt his confidence improved when his athletes returned with other injuries:

I think doing it and getting it right [improved my confidence]. Having athletes want to come back to me, and just me, to work with me, knowing they trust me and that I'm the one they want to come to if something goes wrong, which tells me that I'm doing it right, that positive feedback from them and then from having an evaluation and sending it off and saying, "I'm pretty sure your foot is broken. You need to get an x-ray," and then having them come back, and I was right. So to have that

feedback saying you were right and what you feel is what your intuition is telling you is right, that has been just phenomenal for me in building my confidence up.

Role Ambiguity

The third challenge that emerged was role ambiguity. Participants were uncertain about policies for general referrals to physicians, concussion, and how to organize their time among treatments, administrative duties, and being present at practices. Role ambiguity also occurred because participants were not clear on what was expected of them in their role. Although they felt that expectations were clear during professional preparation, their new roles were often unclear, especially in the high school setting. Some respondents did not feel they understood certain aspects of their role, especially pertaining to documentation or developing emergency action plans. Part of this role ambiguity appeared to be due to the lack of orientation as participants entered their roles. We present a list of these challenges with supporting quotes (Table 2).

Communication

Two subthemes described communication challenges: communication with (1) coaches and (2) parents. Participants felt ill prepared to manage communication with coaches and parents, as they believed they had limited chances to do so before transitioning into practice. They also struggled when choosing among the different methods of communication (text, e-mail, in person) depending on the situation and each individual's communication style.

Coaches. Participants reported feeling unprepared to communicate with coaches during their professional training. Struggles communicating with coaches about patient care, practice scheduling, and resolving conflict were common. Pamela (junior college) described her thoughts on communication and how she believed it was a challenge for her:

I think a lot of it is just having open communication with the coaches and with my head athletic trainer. I had a couple situations where an athlete had told the coach something different than I had said, and he hadn't been participating, and then I had heard about it. So then I had to go approach the coach about it, and for me, that was a really stressful situation because I had never really had to deal with confronting a coach as a student.

Sophia (secondary school, clinic, or hospital), like Pamela (junior college), experienced difficulties communicating with coaches:

For me, to meet the new coaches and the new athletes, I'm still trying to get used to that. I need to remind them every now and then and even ask, "Hey, did anything happen today when I wasn't there?" and I know I have to send reminders to some of them because a lot of them will forget [to tell me about injuries that occurred].

Identifying their struggles to communicate with coaches also revealed a desire to have more educational experiences

before transitioning as a way to prepare for this aspect of their role. Mike (NCAA DIII) wanted the chance to practice his communication skills:

Not every coach is the same, and you kind of get a broad general view of coaches and what they're going to act like, but I feel like it [communication skills] could use more development, but that just may be my personality coming out, but it's through learning through the fire and learn[ing] how to adjust how I speak.

Participants were acutely aware that real-time experience was necessary for skill development and confidence. Wendy, who worked in the NCAA Division II, illustrated the need for actual experience as part of the developmental process and readiness to transition into clinical practice:

With the coaches, you don't really prepare [for communication] too much with coaches until you're certified. So in talking with the coaches, sometimes they [coaches] force the athletes to be ready to play before they're ready, which is hard to say no [to] sometimes, or to say, "Listen, you didn't give me 48 hours for this practice ahead of time, and therefore I cannot cover it. I can't be there." Saying no, that's been hard.

All participants struggled to communicate effectively with their coaching staff, regardless of their setting.

Parents. Participants in the secondary school setting also reported that communication with parents was challenging because they had rarely communicated with them during their professional preparation. Marie articulated this idea:

So a lot, most of the parents have been pretty cooperative, but some of them, you know, kind of tell their students and athletes like different things or try to persuade them against me, and I never, even though in college we worked with mostly college athletes, but we did go to the high schools, and I just never had to have that interaction with a parent or dealing with the direct paperwork.

As Francesca noted, 1 aspect of communicating with parents was calming them after their child was hurt:

I've had a couple of parents get very worked up and overwhelmed by the fact that their child got hurt. It's hard to get them to calm down enough to get them to appreciate the situation is not as bad as it seems because it sometimes seems like I'm kind of on my own, making it up as I go along, as it comes to kind of calming a situation down and getting people to take a deep breath and appreciate that something's not that horrible.

Participants described challenges regarding the parent's knowledge base; that is, many parents knew either too much or too little about the injuries and conditions. Therefore, difficulties resulted from trying to communicate effectively about the condition itself as well as the treatment and management of the condition, including referrals and return to play. Saul highlighted this aspect of communication:

Table 2. Role Ambiguity Antecedents

Policies and Procedures

“What kind of injuries happens at the [recreational] sports? I don’t have any injury report forms, so the only thing I fill out, not like a [subjective, objective, assessment, and plan] note, it’s like a generic injury report, so that was challenging. How specific do I need to get with this? Then I asked, what type of supplies do you use? Do I need to get specific tape or regular tape? How do I go about this if one has an injury and then they told me to send the student to the center if you don’t know? So it was a lot of questions.” – Andrea (National Collegiate Athletic Association [NCAA] Division III)

“Well, one, I had a student-athlete who had the first concussion that I’ve dealt with. During the concussion, my protocol to get them back to play, I wasn’t sure if I needed to talk to their doctor and if I could get a verbal or for him to start returning to contact or if he needed to go see the doctor again to get cleared.” – Walter (secondary school)

Work Hours

“Well, 1 example is, how do I structure my hours? I didn’t really know how to go about doing treatment hours, and I didn’t really know what I could and couldn’t do as far as cell phone use because I went from being a student and not being allowed to be on my phone to being allowed to be on my phone because that’s how we communicate. Some questions were about dealing with certain athletes because I didn’t know them.” – Tasha (NCAA Division II)

Unclear Expectations

“It’s been weird because I’m used to what is expected of you at the college level, and now with the current situation is, at the high school and at the clinic, they really have no idea what to expect of me, which is a little weird because I’m used to meeting expectations and surpassing them, but when you don’t really have set expectations that you’re knowledgeable of, it makes it a lot harder to do that.” – Jack (secondary school)

Documenting Policies and Patient Care

“I think a lot of it is just the program planning. We glance over like how to design an emergency action plan [during professional preparation], but for me, it’s being thrown into a site that’s basically do whatever you want to do. There’s nothing really written down, so it’s an adjustment. Developing these programs on the fly, and what do you do when you have 3 athletes coming to you with the same pain? I had 2 new sports with athletes who had never played in college, so having to balance those things out.” – Mike (NCAA Division III)

“More of formal explanation of what’s required from my position for documentation, as well as what’s some of more explanation of what the procedures were. I was aware of the concussion-evaluation protocol and return-to-play protocols, but the forms for documentation for those were never explained to me or shown to me, really. I had to hear about that secondhand, as well as an orientation to more of exactly how to perform my marketing duties. I was given no training on that at all. They kind of just expect me to generate referrals, and I’m not exactly sure how to do that because I don’t know everything about what the hospital provides and how it can be beneficial. I’m in a low-income school and demographic, so most of the student-athletes don’t actually have health insurance, and their parents are not overly outgoing to seek medical services.” – Jack (secondary school)

Lack of Orientation

“I mentioned the whole learn-on-the-fly thing. When I was visiting here and talking with the staff athletic trainers that were here at the time, they said, “You’re going to be working a lot with insurance companies.” So that was something new to me, but at least I had been told about it prior to arriving here. Beyond that, it’s kind of been just learn as you go. Like I mentioned before with the like getting the exam set up, imaging appointments, getting medications from the pharmacy, who to call, where, in dealing with injury clinic forms, and things like that was all kind of just try to figure it out and not ask somebody. We didn’t have any formal training or anything like that with ‘if this happens, you’ll need to do this, and this is how you do it’ type of thing like that.” – Hank (NCAA Division I)

“I’ve still struggled in some situations because I felt like you [I] get yelled at because you [I] didn’t do it the right way, but when I don’t know what the right way is because I haven’t seen it or been given instructions, it becomes a little bit of an issue. It was, ‘Oh, he didn’t need to go there [certain physician practice].’ I spent a week out there. I had a kid who was having brachial plexus issues with numbness and burning down his arm, and so at the same time, it looked like he also had an [acromioclavicular] separation, so I sent him to whoever his mom wanted him to go, and they took him to the [emergency room], and when I told [my supervisor] she was like, ‘Well, that is something you shouldn’t do,’ but I had no idea where to send him! So that’s the kind of thing that I struggled with, that I just didn’t know in that situation, and I know what we were taught to do, but I had no idea doctorwise or the facility where to go to, and that’s where I really struggled and I still struggle now because we have 1 doctor they are pushing that we should use, but he’s not a foot specialist, and he’s not a hand specialist.” – Skyler (youth, secondary, and university/college)

I have a whole bunch of parents behind me, and I would think the parents would be the first person to back me up and say, “He can’t play,” but the parents say, “He’s fine. Just tape it up.” They truly believe that tape fixes almost everything. If tape doesn’t fix it, Tylenol will, and if that doesn’t fix it, ice will. If you use all 3 well, you’re surely not going to be able to fail. So having that mentality of “Who needs surgery?” having people constantly question, “Well, why do you do that? Well, it’s an obvious deformity.” If it’s not obvious, that’s a huge challenge.

Saul stated that communicating to parents at a level they would understand was also difficult. He knew the information but had trouble conveying injury severity to parents and grandparents:

The anatomy has almost become the easy part. I can tell you about the rectus femoris origin, insertion, innervation, action. That’s a true fact. I learned that, but trying to explain to someone you have a quad contusion to an 80-year-old grandparent and trying to get them to understand that, “I need you to go see someone because I’m concerned your 14-year-old may have myositis ossificans,” I can tell them that. I know what I’m talking about, but trying to get other people onboard, that’s a whole different ball game. I feel like I need to get another undergraduate degree in interpersonal communication because it is so challenging, and I feel like I’m talking to a brick wall sometimes. I’ll explain things as plainly as I possibly can, and I still hear, “I don’t really think he needs to go see anyone.” That’s challenging. I

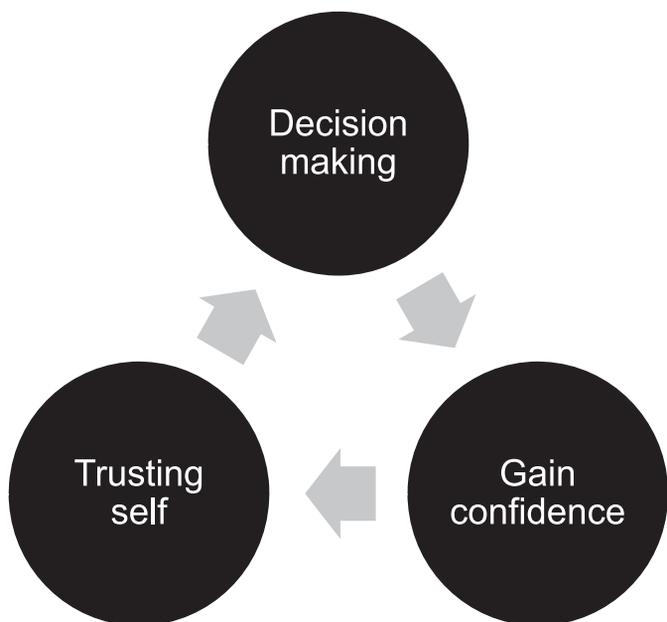


Figure. Challenges encountered by newly credentialed athletic trainers transitioning into clinical practice.

cannot talk to these people for more than a couple of hours without physically being exhausted. I come home every night being physically exhausted because I have to communicate like that every day. I have that struggle every day.

Mentor accessibility

The final challenge was accessibility of an experienced individual or supervisor. Participants, especially in secondary school or part-time settings, felt they lacked a mentor or supervisor to contact in many situations, especially those related to patient care. Jane, who worked as needed in the collegiate, secondary school, and youth sport settings, felt she did not have access to a mentor or supervisor. When asked who she contacts when she is working, she responded, “No one. Like if I needed to get ice and I couldn’t find it, I would talk to the athletic director, and then that’s kind of really the only outlet of a person that I have to go to.” Jack, working in the secondary school setting, did not have another health care provider or a mentor to consult:

The athletic director has been helpful with some of the processes of going and interacting with some of the parents, but in terms of a health care situation or medical advice or reference, outside of my supervising physician, I don’t really have any other resources. My supervising physician is extremely busy, and it was kind of awkward how the hospital is set up. Our relationship, we were introduced, and it’s pretty obvious he didn’t have much interest in having an athletic trainer under him. He doesn’t have much free time to provide service or support to me. The athletic director is retiring next year, so it’s also become very obvious that he’s more focused on getting out of there than he is on doing other stuff.

Some participants who lacked mentorship spoke of wishing they did have someone in athletic training to contact for help as they believed it would be beneficial to them. Andrea, a graduate assistant in NCAA DIII, talked of needing this relationship, as she did not feel she had a mentor:

I was the only [athletic trainer at my setting]; no one really knew my position exactly. I wish I had the previous [athletic trainer] there to just shadow me a couple of days or for the week, show me what to do, what to take out to practice, where they practice, what they brought to practice, and what they brought to game, talk about specific injuries at different events, and show me the ropes a little bit. You can learn more hands on instead of reading a binder. If I would just have had some type of mentor, just even for a week to show me the ropes, I would have been a little more comfortable, just like the small questions athletic training wise. The supervisors do what they can, but they don’t know anything about athletic training, and I wish [I had] somebody specifically for athletic training questions.

Walter, an AT in the secondary school setting, felt he could reach out to his former classmates or a nearby AT but was concerned about not having anyone to directly supervise or mentor him:

It would be nice to work under an athletic trainer with more experience than me. I don’t think I’m going to have that option where I am now. I don’t know if the high school has the money to have 2 athletic trainers there, but that would definitely be helpful to have someone with more experience. I’m on my own. OK, I have a question about this now that I’m handling this on my own. Who do I talk to about that? I have a couple of people to talk to, so that’s been helpful, but it would be a lot more convenient and a lot more helpful to bounce every question I had off of an athletic trainer I work with, but that’s not the case right now.

DISCUSSION

Making Decisions and Developing Confidence

The 2 themes of making decisions and developing confidence were highly related because, initially, participants lacked confidence to make the decision; however, as they made more decisions, their confidence increased. Respondents reported being challenged by making decisions and trusting themselves (Figure). These decisions ranged from patient care, such as return to play, to balancing organizational duties and creating their own work schedules. Participants often felt unsure about their medical decisions and, when making them, had difficulty feeling confidence in them. For some, their preceptor had always been there to validate the decision or make the final decision (or both). Now newly credentialed and practicing autonomously, they were expected to make medical decisions. Making decisions and feeling confident appeared to depend on each other in that the more decisions that were made correctly, the more confident the participants felt. Difficulty making decisions was not surprising, as this has

been found among new nurses¹⁹ and new physicians²⁶ as well as ATs.^{27,28} Supervisors of graduate assistant ATs felt that new ATs struggled with making decisions and being confident in their skills and decisions²⁸; however, they believed that practice and more experience allowed the new ATs to gain confidence.

Confidence was gained over time by making decisions and receiving feedback, role engagement, and real-life experiences. Supervisors of newly credentialed graduate assistants believed that confidence should be further developed during professional preparation.^{28,29} Although ways to develop confidence during professional preparation exist, the “reality shock” of transitioning to practice and losing the safety net of preceptors who validated decisions can cause a crisis of confidence as one transitions into practice. Providing students with opportunities to practice skills, make decisions, and practice independently (under supervision) during professional preparation may facilitate decision making and confidence, but newly credentialed ATs still need support as they transition from having a safety net to being the ultimate decision maker. To address the challenges during the transition, authors^{19,30} have suggested that new nurses be placed in less complex decision-making situations and positions when first hired at their jobs. Inexperienced nurses will learn to think critically only when they are expected to do so, and placing them in clinical practice with a preceptor who coaches by asking questions and giving feedback has been proposed.³¹ Employers could gradually ease newly credentialed ATs into independent clinical practice during their first few weeks. This could improve their confidence, as they would be paired with an experienced AT to provide support and feedback.

Feedback had a positive effect on developing confidence, and it was provided in many forms. Participants reported that feedback came from other health care providers, coaches, and patients themselves. Confirming opinions from other health care providers helped affirm to participants that their clinical judgements were accurate, which in turn elevated their level of confidence and trust in their abilities. Some nursing programs³² have begun using simulation in the final year to enhance communication and team-delegation skills. Feedback from this activity helped participants apply clinical decision-making principles, and the simulation was a stepping stone toward independent clinical practice.³² Decision making and critical thinking are important skills because programs cannot prepare students for every situation.³³

Role Ambiguity

Role ambiguity was a challenge reported by our participants as they struggled initially with gaining a full understanding of their responsibilities in their organizations. Ambiguity occurs when roles and responsibilities are vague or not clearly communicated.^{34–36} *Transition shock*³⁷ is a term often used to describe the initial stages of role adaptation and inductance for newly licensed nurses as they become assimilated into their new roles. Our results highlight this period of uncertainty, when the newly credentialed AT, much like the newly licensed nurse, is trying to create an identity and assimilate into the role he or she was hired to do. In some cases, our respondents had

feelings of ambiguity, as they were unaware of items, such as expectations for working hours or documentation procedures regarding patient care. On the organizational level, this speaks to a lack of organizational socialization, whereby the AT is given a formal induction to roles and responsibilities and organizational policies and expectations.¹⁴ On a personal level, it speaks to natural feelings of self-doubt, uncertainty, and shock.^{37,38}

Recent investigators²⁰ learned that 23.9% (76) of newly credentialed ATs had no formal orientation to their new position, whereas 25.2% (80) had an orientation that lasted less than 1 day, and 28.6% (91) had an orientation that lasted 1 to 2 days. Only 1.6% (5) received ongoing orientation for more than 6 months. These results and our current findings suggest that for a newly credentialed AT, a formal orientation to the setting or workplace can assist in reducing the unfamiliarity discussed by our participants. Orientation or onboarding is a key aspect of role adaptation and transition, as it provides structure and role understanding, thus limiting confusion and possibly ambiguity.^{12,39} For the newly credentialed AT transitioning into clinical practice for the first time, actively engaging in the onboarding process is important. Relying on past experiences as well as previous mentors can assist in the process, but participating in orientation sessions and asking questions about the organization are also helpful and necessary to reduce ambiguity.

Communication

Respondents reported difficulty communicating with coaches and, among those in the secondary school setting, communicating with parents. Previous authors^{27,28} found that employers felt new ATs had difficulty communicating with coaches, athletes, parents, and even peers. This difficulty included discussing misinformation communicated to the coach by athletes, being proactive in discussing player status, and informing a coach that a player was unable to participate. It is clear that before their employment, the newly credentialed ATs did not have many interactions with coaches in various scenarios, such as communicating player status and initiating difficult conversations. This skill may not be practiced often during students' clinical experiences because coaches may prefer to discuss the medical status of athletes with the AT rather than a student.

In regard to communicating with parents, the skills needed were mediation as well as patient and parental education. Because patients in the secondary school setting are minors, conversations with parents are important and necessary. Participants struggled to find the right wording and terminology (ie, nonmedical language, no jargon) to relate the injury or condition of the patient without alarming the parent. When discussing sensitive topics with patients and their families, new physicians and medical residents often use jargon⁴⁰ that may be too complex for them to comprehend. In addition, with the Internet and Web sites such as Web MD,⁴¹ medical information is readily available. Parents can learn about their child's injury but may not quite understand the specifics of their child's condition and may overestimate or underestimate the severity of the injury and the child's needs. Newly credentialed ATs clearly need stronger communication skills to accurately convey information to coaches and

parents. During professional education, students must have experiential learning opportunities regarding communication, as this is an integral part of the AT's role in health care. Communicating with coaches and parents is a new skill, and the opportunity to perform skills that are just beyond their level of competence is important for developing competence.⁴² Once employed, the new AT needs a mentor to discuss and strategize some of the conversations he or she will have with coaches and parents. Although some topics can be simulated during professional education, such as conflict resolution and delivering bad news, it is impossible to prepare a new AT for every future conversation with a coach or parent. We recommend that preceptors include students in their conversations with coaches and parents and discuss their communication strategies. Conversations could include how to introduce oneself, the proper timing of discussions with coaches regarding patient care, and the location of such conversations.

Mentor Accessibility

Participants wanted mentors, but those in settings where few or no other health care providers practiced, such as the secondary school setting, did not have mentors. Mentorship is a widely used mechanism for transitioning newly credentialed ATs^{14,15,21} and is well documented in the medical and nursing literature^{2,43} as a tactic for transitioning new health care professionals into clinical practice. For an individual in a new role, a mentor offers the chance to gain affirmation and feedback from someone who is experienced and knowledgeable.³⁹ In fact, mentors can help newcomers seeking organizational socialization,³⁹ as they provide role legitimation by demonstrating and modeling expected behaviors and actions as well as sharing their knowledge about the organization and its culture and climate.⁴⁴

Often, newly credentialed ATs seek positions that allow for mentorship,^{14,15,21} as they view it as a means of gaining autonomy and self-assurance while still being supported. However, our participants shared that the inaccessibility of a potential mentor was a challenge to overcome during their transition. Many barriers can affect⁴⁵ mentoring relationships, but fundamentally, without a mentor, no relationship can be formed. In the case of our participants, limited accessibility to a mentor was problematic for those in the secondary school setting. This finding was not surprising as secondary school ATs often practice in isolation or at best interact with other health care providers (physical therapist, team physician) on a restricted basis. Research³⁶ continues to support the concept of mentorship and the importance of organizations offering platforms to provide mentors for newly transitioning health care providers. Aside from a supervisor, who may provide some support in terms of policies and procedures, our participants who were employed in the secondary school setting did not have access to another health care provider for gaining legitimation, a critical part of role inductance and assimilation. We recommend that new ATs reach out to any local and state athletic training organizations to see if mentoring programs are available. We also suggest contacting previous preceptors and mentors. In addition, successful mentoring requires the institution (ie, employer) to facilitate an environment that allows it to occur, either

formally or informally.^{36,43} As described by our participants, this opportunity was not available to them because of a lack of resources, which was manifested by practicing in isolation or not having a formal mentoring program.

We know that the benefits of having a mentor are remarkable; therefore, we encourage newly credentialed ATs to seek one. Informal networks are common ways ATs in the secondary school setting navigate organizational socialization,⁴⁶ and in some cases, a team physician or nonmedical provider can serve as a mechanism for role transition and inductance.³⁸ Mentees who are described as successful are those who actively seek a mentor and the formation of a mentoring relationship.⁴³ Organizationally, we encourage employers to provide resources for the newly credentialed AT to gain mentorship; this may be stimulated by creating connections between in-house personnel or those in the community.

LIMITATIONS AND FUTURE RESEARCH

We explored only the first few months of the transition, which can last several months to a year or more. Our participants represented a variety of settings, which provided overall insight into transition-into-practice challenges, but certain challenges could differ based on the specific setting. Future researchers should investigate the experiences of those practicing in different settings, specifically newly credentialed ATs in the secondary school setting. Newly credentialed ATs from professional bachelor's and master's programs were interviewed. Future authors should focus on the experiences of those graduating from professional master's programs. Our results provide insight as to the challenges of the first few months of employment, yet those could change over the entire transition of 6 months or more, and we need to understand the challenges of the later phases. It is unclear how challenges during the transition affect patient care, and more work is needed to investigate the patient care provided during and through the transition into clinical practice.

RECOMMENDATIONS

Based on our findings, we have recommendations for newly credentialed ATs and their employers. For newly credentialed ATs, we advise seeking feedback from mentors. Mentors can share past experiences that relate to the current situation. Communication with mentors can be as frequent as needed, as a means to reduce the stress and uncertainty that accompany the initial role transition. Also, the full job description and duties of the position should be thoroughly reviewed. If the information is unclear, the newly credentialed AT should ask questions and inquire about a review period for ensuring role performance. If an orientation is offered, the newly credentialed AT should attend. All policies and procedures should be reviewed. Lastly, we advise newly credentialed ATs to seek feedback on role performance from all members of the workplace, as this can facilitate improvement and legitimation.

For organizations employing newly credentialed ATs, we recommend that they expect a lack of confidence and decision making during the first 6 months to a year during the transition. A job description with all duties and expectations, including the organizational hierarchy and resources for completion of job responsibilities, should be

provided. Initial and ongoing orientation for up to 1 year to review various policies and procedures of the organization and job duties is advised. Ongoing feedback regarding performance and assimilation into the workplace is also helpful. Finally, organizations employing newly credentialed ATs should establish mentoring programs.

CONCLUSIONS

Although newly credentialed ATs possess knowledge and skills when entering the workforce, what an individual already knows may represent only a portion of what he or she needs to perform effectively in his or her role in a new setting.⁴⁷ Knowing the challenges to be faced can empower the new AT to understand his or her feelings and deal with them more effectively. Much like nurses,⁴⁸ ATs are employed in diverse settings ranging from larger universities to secondary schools and even middle schools where the AT is the sole provider of care. Regardless, as a profession, we have a responsibility to prepare new employees entering the workforce with knowledge of what to expect during the transition into clinical practice and strategies to assist them during this time.

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Appendix. Interview Guide^a

1. Please describe your educational background (undergraduate or graduate professional program), when did you graduate, when did you pass the Board of Certification?
 2. Please describe your current position (title, patient care duties, part or full time, setting, other athletic trainers around), and how long you have been at that current position?
 3. Who is your direct supervisor (other athletic trainer, athletic director, clinic manager, etc)?
 4. Can you describe a typical day/the details of activities—hours, educational and clinical supervision, formal and informal education requirements and opportunities, preceptor responsibilities; other prompts—research meetings, audit, journal clubs)?
 5. What formal processes (eg, orientation, policy and procedure manual, mentor meetings) have helped you perform and understand your role?
 6. What are other ways you've been oriented to your role (meetings with coaches, administration, discussion with colleagues, etc)?
 7. Who do you often ask for help (day, night, circumstances)?
 8. Do you ever ask anybody else for help? How do you get help?
 9. Do you feel your supervisor(s) as well as other individuals (coworkers, coaches, administration) are available and open to various questions?
 10. Just thinking about yesterday morning/afternoon (for example), you'll have asked lots of people lots of questions—can you think of some examples of different types of questions to different people (patients, other professionals, doctors, cleaners, patients' relatives)?
 11. What else do you do when you're not sure about something?
 12. From whom do you learn from when you're on the job? What if no one is available?
 13. How would you describe your experiences of transitioning from a student to a full-time position as an athletic trainer?
 14. Describe any work-related tasks or responsibilities that have been required but you felt you were not prepared for? Why did you not feel prepared?
 15. Please describe any positive and negative interpersonal experiences you have had in the work setting (patients, coaches, peers, supervisors).
 16. What has been most difficult (eg, situations, experiences, personalities) in adapting to your new role?
 17. What additional information, skills do now wish you had learned prior to assuming your new role (water coverage, sport coverage/priorities, medical records storage and documenting, ordering x rays, etc)? Did your professional educational program present any transition to practice advice and/or preparation?
 18. Is there anything else you can tell me about your experiences and needs?
- ^a Reproduced in its original form.