Perceived Challenges of Clinical Immersion in Professional Master's Programs: A Report from the Athletic Training Clinical Education Network

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Context: A clinical immersive experience is a new requirement within the clinical education standards as outlined by the Commission on Accreditation of Athletic Training Education.

Objective: Determine athletic training program administrators' perceptions of challenges facing athletic training programs as they implement immersive clinical experiences during clinical education.

Design: Sequential mixed methods.

Setting: Commission on Accreditation of Athletic Training Education athletic training programs.

Patients or Other Participants: Twenty-four administrators (7 male, 17 female) from 24 institutions with undergraduate and professional master's programs (1 undergraduate, 12 professional master's, and 4 offering both undergraduate and master's programs) responded to the survey, which was Phase 1 of the study. Seventeen of those who previously completed the Phase 1 survey volunteered to participate in Phase 2 of one-on-one, semistructured phone interviews (4 clinical education coordinators, 12 program directors, 1 department chair).

Data Collection: Phase 1: 24 participants completed an online survey. Phase 2: 17 of the 24 respondents participated in a one-on-one, semistructured phone interview. Quantitative data collected in Phase 1 were analyzed by calculating means and frequencies, and in Phase 2, a general inductive approach was used to evaluate qualitative raw data from the interviews. Researcher triangulation and peer review were completed for credibility.

Results: The 3 subthemes that emerged specific to administrators' perceived challenges regarding immersive clinical experiences for students were (1) isolation, (2) financial burden, and (3) time engaged in learning. The 3 main subthemes that emerged specific to the administrators' perceived challenges regarding immersive clinical experience for programs were (1) lack of a definition of the experience, (2) scheduling, and (3) preceptor involvement.

Conclusions: Program administrators continue to seek clarity on when and how immersive clinical experiences should be implemented. These challenges, if not addressed, could influence buy-in from the faculty and preceptors, and affect the success of the student.

Key Words: Transition to practice, educational practices

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KEY POINTS

- Students identified several perceived challenges, including feeling isolated from their peers, increased financial burden due to traveling to an immersive site without opportunities to earn money, and a feeling of counting hours, rather than experiencing learning.
- Program administrators identified scheduling challenges with immersive experiences, as well as trying to create quality-learning experiences during clinical immersion due to balancing downtime and engaged learning time.
- Challenges with implementing clinical immersion were identified as a clear definition was not yet developed by the Commission on Accreditation of Athletic Training Education standards.

INTRODUCTION

The importance of clinical education in the development of a credentialed athletic trainer is well understood, as it is viewed as the platform whereby the student becomes ready to practice independently.[1–3] Many factors existed regarding the decision to move to a master's-level degree program; one reason was the increase in time available for students to engage in clinical education due to the reduction in nonprofessional degree requirements.[3] Meaningful clinical education experiences, which support student development and prepare them for clinical practice, have been noted previously as an advantage of the professional master's model of education.[4,5] Moreover, program administrators of professional master's programs feel the curriculum allows for a variety of experiences, and in some cases those above and beyond undergraduate-level clinical education experiences.[4]

Many versions of "immersive clinical experience" in regard to terminology are used in discussions of this topic, including, but not limited to, *immersive experience*, *immersive clinical education experience*, *clinical immersive education experience*, *clinical immersive education*, and *immersive clinical experience*. For purposes of our research, we will align our terminology with the Commission on Accreditation of Athletic Training Education (CAATE) 2020 Standards[6] and therefore will proceed with "immersive clinical experience" as the terminology to reference CAATE-defined Standard 16: "practice-intensive experience that allows the student to experience the totality of care provided by athletic trainers."[6(p3)]

The concept of an immersive clinical experience is one of the aforementioned clinical education experiences that can be seen as above and beyond an undergraduate-level experience. At least 1 immersive clinical experience is now a required component of the clinical education experience for the professional master's student in athletic training.[6] Other health care education programs[7] such as nursing,[8] physical therapy,[9] and occupational therapy[10] offer a similar clinical education component, to allow for a total experience in patient care. As detailed by the new standards established by the CAATE, the expectation for an immersive clinical experience is to expose the athletic training student to the full-time experiences of an athletic trainer. More precisely, an immersive clinical experience encompasses a "practice-intensive experience that allows the student to experience the totality of care provided by athletic trainers."[6(p3)] Currently, the parameters of immersive clinical experience are bound only by a minimum of a 4-week period of time.[10]

Because an immersive clinical experience is a relatively new component of the athletic training curriculum, very little is understood about immersion itself, as well as the possible challenges that may occur when it is implemented into the curriculum. Therefore, the purpose of this study was to understand athletic training program administrators' perceptions of challenges that face professional master's athletic training programs as they deliver immersive clinical experiences.

METHODS

Research Design

We used a sequential mixed-methods approach[11,12] to investigate the challenges associated with delivery of a clinical immersive experience in professional master's programs in athletic training. The demographic survey in Phase 1 allowed for the development of a descriptive landscape of the professional master's program. This helped to quantify information regarding the overall program makeup, as well as to gather more nominal data on the program itself. A general inductive approach was used to guide the Phase 2 qualitative research design and qualitative data collection, and to analyze the qualitative data.[13] A general inductive approach was chosen as the qualitative tradition to guide the study in that it values the core meanings relevant to the research objectives, identifies themes most relevant to the research objectives, and allows for a description of the most prevalent themes that emerged from the data.[13] The main purpose of the general inductive approach is to "allow research findings to emerge from the frequent, dominant, or significant themes inherent in raw data, without the restraints imposed by structured methodologies."[13(p238)] Using qualitative methods in Phase 2 for the semistructured, one-on-one phone interviews allowed researchers to better understand the lived experiences of the participants and how those experiences gave meaning to the topic of interest, in this case, professional master's program administrators' perceived challenges pertaining to immersive clinical experiences.[14–16] Once researchers understood those experiences, they could derive themes from among the data through the coding process. Coding in the general inductive approach allows for the researchers to begin with the initial reading of raw data and systematically narrow down the focus of the data by identifying specific segments related to the research objectives,

Table 1. Descriptive Information for Survey Respondents

Characteristic	Mean ± SD	No. of Respondents (n = 24)
Sex		
Female		17
Male		7
Age	44 ± 7	24
Years certified by BOC	22 ± 7	24
Years in PD/CEC role	13 ± 6	24
Credits required for graduation	69 ± 22	24
Enrolled students	23 ± 20	24
Clinical semesters	5 ± 1	24
Total semesters	6 ± 1	24
% BOC pass rate (first time)[a]	97 ± 4	22
Core faculty	4 ± 2	24
Associate faculty	2 ± 1	24
Adjunct faculty[a]	2 ± 2	23
Number of clinical experiences[a]	9 ± 3	22
Minimum hours of clinical per rotation[a]	150 ± 80	23
Maximum hours of clinical per rotation[a]	336 ± 117	23
Immersion offered		
Yes		17
No		6
Degree offered		
PM		15
Both BS and PM		9
School type		
Private		8
Public		15
Out-of-state clinical experiences offered		
Yes		12
No		11

Abbreviations: BOC, Board of Certification; BS, bachelor of science; CEC, clinical education coordinator; PD, program director; PM, professional master's.

[a] Data not available for all 24 participants: some respondents did not answer all questions.

Table 2. Program Demographics for Phone Interview Participants

Characteristic	No. of Respondents (n = 17)
Position	
PD	12
CEC	4
Department chair	1
Level	
BS	1
PM	12
Both	4
Immersion offered	
Yes	13
No	4
Carnegie classification	
R1	3
R2	4
R3	1
M1	4
M2	1
M3	1
Baccalaureate colleges: arts and sciences focus	2
Baccalaureate colleges: diverse fields	1

Abbreviations: BS, bachelor of science; CEC, clinical education coordinator; M1, larger master's program; M2, medium master's program; M3, smaller master's program; PD, program director; PM, professional master's; R1, very high research activity; R2, high research activity; R3, doctoral/professional university.

creating categories, and grouping like categories together to finally create a model that encompasses the key themes that emerged from the interviews.[13,17]

Participants and Sampling

Phase 1. Twenty-four athletic training program administrators, from 24 athletic training programs of both professional master's and undergraduate levels (7 males, 17 females) responded to Phase 1 of the study, an online Qualtrics survey (Provo, UT). The initial email invitation to complete the survey was sent to program directors of athletic training programs who were found on the CAATE Web site to be active and in good standing and whose programs offered a master's in athletic training at the time of data collection. Through snowball sampling we obtained contact information of other administrators such as clinical education coordinators and department chairs of both professional master's and undergraduate programs. Accounting for the additional potential participants acquired through snowball sampling, as well as the initial pool of program directors obtained from the CAATE Web site, a total of 74 emails were distributed. Twenty-four of the 74 surveys were completed, yielding a 32% response rate to the survey. Table 1 presents demographic information of those who completed Phase 1.

Phase 2. At the conclusion of Phase 1 data collection, all 24 administrators who completed the survey were asked if they were interested in participating in a follow-up interview, and if so, their contact information was requested. Seventeen athletic training faculty (4 clinical education coordinators, 12 program directors, 1 department chair) from 17 different athletic training programs (1 undergraduate, 12 professional master's, and 4 programs offering both undergraduate and professional master's simultaneously) indicated their willingness to participate in one-on-one phone interviews. Table 2 presents the individual program data, and Table 3 presents individual participant information. We reached data saturation at 17.

Data Collection Procedures

We followed a sequential design with 2 phases. Phase 1 collected quantifiable information about the athletic training

Table 3. Individual Participant Demographics

Respondent	Position	Level	Immersion Offered	Carnegie Classification
Andrew	CEC	PM	No	R3
Bridget	PD	PM	Yes	R1
Caroline	CEC	PM	Yes	R2
Danielle	PD	BS and PM	Yes	R1
Eric	CEC	PM	No	R2
Frank	PD	BS and PM	No	M1
Grace	PD	PM	Yes	Baccalaureate colleges: diverse fields
Hannah	CEC	PM	Yes	M1
Isabel	CEC	BS	Yes	M1
Jason	PD	PM	Yes	Baccalaureate colleges: arts and sciences focus
Kala	PD	PM	Yes	R1
Landon	PD	PM	Yes	M3
Melanie	PD	PM	Yes	R2
Nick	PD	PM	Yes	R2

Abbreviations: BS, bachelor of science; CEC, clinical education coordinator; M1, larger master's program; M2, medium master's program; M3, smaller master's program; PD, program director; PM, professional master's; R1, very high research activity; R2, high research activity; R3, doctoral/professional university.

programs, the administrator, and any offered immersive clinical experiences. Phase 2 included a semistructured one-on-one phone interview that incorporated questions pertaining to the immersive clinical experience, particular to its delivery, outcomes, and its criteria. We created 2 instruments for each phase of data collection. The development of each instrument was guided by the purpose of the study and any literature that was currently available on immersive clinical experiences. Phase 1 questions were closed-ended and focused on program demographics as well as the clinical education experiences of the programs. Phase 2 questions were open-ended and were used during the one-on-one phone interviews. The Phase 2 questions focused on organization and delivery of clinical education as well as the concept and delivery of immersive clinical experiences in athletic training.

One researcher developed the instruments, followed by 3 additional athletic training educators with program administrative experience who reviewed them for relevance and clarity. Once agreement was reached on the structure of the instruments and Institutional Review Board approval was gained, data collection began. In Phase 1, after the initial email was distributed, subsequent reminder emails were sent at the 1- and 3-week marks (postdistribution date) to those who had not yet responded, requesting survey completion. In Phase 2, one-on-one phone interviews followed a semistructured format using the instrument developed for Phase 2. The semistructured, one-on-one phone interviews were digitally recorded using a handheld digital recorder. The recordings were transcribed by a professional transcription company (Connecticut Secretary, Brandford, CT). The transcripts were deidentified, and participants were assigned a pseudonym to ensure confidentially of the participant.

Data Analysis and Credibility

All demographic data collected in Phase 1 were analyzed by calculating means and frequencies. A general inductive approach[11] guided the analyses of the qualitative data in

Phase 2. To start, 2 reviewers read individual participant transcripts to capture a more holistic understanding of the clinical immersive experience offered by the program. With each subsequent read of the individual transcripts, reoccurring ideas or themes were recorded and then compared with the other participants' transcripts. The commonalities were labeled accordingly, and then compressed and grouped together. Raw data were extracted after the coding process was done, and only those codes with a majority (75%) of participant responses were included in the final presentation of the data.

Two specific credibility strategies were used: (1) researcher triangulation and (2) peer review.[11,12] It is important to also recognize that the data collected in Phase 1 provided context to the findings collected in Phase 2 (methodological triangulation). Researcher triangulation encompassed (1) review of the survey used in Phase 1 and (2) review of interview protocols used in Phase 2. This was done before data collection and completed by experts (n = 5) in the field. Coding of the interview transcripts was done independently by 2 researchers. The 2 researchers, before comparing codes and final presentation of the data, analyzed the data separately. Upon completing the coding process, they shared their coded transcripts and operational definitions supported by quotes from the transcripts. Then, they shared their agreed-upon findings with 2 peers for completion of a peer review. The peer review was completed by sharing 2 coded transcripts and 2 uncoded transcripts, along with operational definitions and additional raw data extracted from the interviews. The peer reviewers confirmed the coding analyses completed in the multiple analyst triangulation process.

RESULTS

Challenges faced by athletic training programs that offer clinical immersion are focused on the student as well as the program implementing it. Two main themes were deduced from the data: perceptions from administrators regarding

challenges for the student and challenges for programs. The three subthemes that emerged specific to clinical immersion challenges for students, as perceived by program administrators, were (1) isolation, (2) financial burden, and (3) time engaged in learning.

Challenges for Students

Isolation. Isolation occurred for the athletic training students while they were completing immersive clinical rotations that were off-campus. Participants discussed that students described feeling isolated from peers, program faculty, and the campus. As Isabel described from feedback she received from her students regarding the immersive experience:

A lot of students have been telling us, especially the last two years, is that [distance immersive clinical experiences] are lonely. [Students] are used to having their friends around them, either athletic training friends, or other friends at school. Then they go to a place that's out of state and they don't have somebody there that they can talk to.

The location of the clinical immersion experience was the primary facilitator with regard to the feelings of isolation. Attempts by faculty to create connectivity through asynchronous communication did not ease the isolation. As Melanie described,

Being away from their peers for us is a challenge because we try to do one-on-one [immersive clinical experience] sites. So being away from their peers and faculty that have been their security blanket can be a challenge. So, while we're still here communicating electronically, it is a lot different than face-to-face. When we have them that first year, we see them literally every day on campus. So that's a big shift for them. Some of our students handle that well, and some don't handle it so well.

Some participants discussed the importance of traditional classroom experiences, as they believed that these provided tangible benefits to learning. Danielle stated, "I'm also a little worried about students being disconnected from each other because I think that group learning is pretty powerful." The previous data in this study described isolation from peers and faculty, which was perceived to affect the multifaceted educational experiences in which they can participate.

Financial Burden. Clinical immersive experiences have the potential to distance the student from the campus. The student's not being on or near the campus was perceived to create financial concerns for the professional master's student. Our participants were concerned about financial expectations related to transportation to the clinical sites, and how the student could balance cost-of-living expenses as a graduate student. Andrew shared his concern regarding the challenges facing his students:

[Immersive clinical experiences] will limit the [athletic training] students' ability to have an outside job. We have quite a few nontraditional students so that could be a limitation for them [when trying to meet the expectations of the program].

Jason also spoke about financial challenges as they related to short-term clinical immersion experiences. Jason said,

Getting graduate students to buy into the idea of investing in their clinical education is a challenge. Spending the money to go off-campus to a distant site where they're going to get the [immersive clinical experience] they want, obviously, that costs money. If you're only there for eight weeks, you have to get there, you have to find short-term housing. Graduate students are paying their own way to school, and they're much more financially conscious [than undergraduate students].

Frank identified increased financial challenges due to clinical immersion in addition to an already costly tuition. Repayment of potential student loans on an average athletic trainer's salary was posed as a secondary area of concern.

Our essential challenge as a private institution, that charges 56 000 dollars a year for full room and board tuition, is developing and maintaining a master's program that allows us to be competitive and marketable for students given that added burden of cost [of potential distance immersive clinical experiences] as well as considering the current salary data for athletic training as professionals.

Our participants described concerns of balancing cost of living and the investment on the part of students that it can take to complete these immersive experiences, as this can limit their ability to manage a part-time job and clinical education.

Time Engaged in Learning. Time when people were not engaged in learning activities was viewed as a challenge by our participants, as they described a clinical environment that was lacking volume or consistency in learning opportunities. Eric described his apprehension about time for learning, a lens that focused on the quality of learning versus time engaged in learning:

I'm a big fan of quality of hours, not quantity of hours. A lot of the [immersive clinical experience] is being there all day long. Even if [the athletes] are not working out, even if teams are there but not [practicing], you're still there immersed in it. And I think that requirement sets students up for an idea that they have to be in the training facility all day long. I don't know if that's the correct setup.

Lack of directed and structured clinical experiences was thought to contribute to burnout specific to the immersive setting. For example, Kala stated, "If it's just counting hours, then you're going to have downtime and wasted time. That could lead to burnout in the students."

Challenges Programmatically

The three main subthemes that emerged specific to clinical immersion challenges for programs were (1) lack of a definition of the experience, (2) scheduling, and (3) preceptor involvement.

Lack of a Definition. Despite the new CAATE requirement to include a clinical immersion experience, our participants struggled with the lack of clarity and lack of a true definition. Without a definition at the time of data collection, our participants shared concerns and frustrations regarding development of an experience that meets the expectations associated with the new standard. Caroline's reflections demonstrate this trepidation, as she shared,

I think one of the biggest struggles we [athletic training faculty] are having right now, especially with the new

CAATE [standards] coming out requiring an [immersive clinical experience] in the [athletic training] program at some point, is there is no clear definition. We haven't had an established definition given to us. It is something that's really open to interpretation.

Eric posed questions, before the release of the CAATE 2020 Standards,[6] searching for clarification on the immersive clinical experience and the impact it can have on developing a curriculum for his students.

Are you [CAATE] saying that students can't have any didactic course work? Can we do a hybrid where they do online courses? What does that mean? Can you do an [immersive clinical experience] where you're at a site for a week, and then you do didactic for a week or however they want?

Eric continued to express his confusion and desire for more information, stating:

What do they [CAATE] mean by [immersive clinical experience]? How are they defining [immersive clinical experience]? I'd be willing to seriously consider and implement it if they [CAATE] allow for flexibility and autonomy with the institutions. I don't want it blowing up my entire clinical model and my entire clinical program just to appease one [CAATE] standard of [immersive clinical experiences].

Our participants reported that a clear definition of clinical immersion, along with more structured guidelines, would help mitigate the challenges for creation and implementation of the experience.

Scheduling. Many participants shared challenges surrounding issues of scheduling immersive experiences in relation to balancing other academic requirements or components of the curriculum. Eric described the challenges related to fitting in all of the academic requirements while still needing to make room within the curriculum for a clinically immersive experience. He said,

We have four semesters. Now how do we incorporate immersive experiences? How do I move all my stuff around? And we're a pretty well-established clinical program. My curriculum's been set. We've been doing this curriculum for over ten years.

Bridget voiced concerns of scheduling clinical immersion experiences from the perspective of academic faculty buy-in and opposition to an abbreviated academic allowance of time for education.

Scheduling is one of the things that has been a little difficult in terms of getting faculty buy-in. Our students have four [immersive clinical experiences] in the program. The first three (fall-spring-fall) they do a one-week immersion in each, wherever they happen to be placed for that semester. Then they have one six-week immersion at the end of their last semester. That compresses everything [didactically] into the first nine weeks of the semester instead of the entire fifteen-week semester. We've had a lot of resistance from faculty in terms of teaching everything in a nine-week period versus the whole semester.

Andrew echoed Bridget's thoughts about time restrictions in the classroom by stating, "I think our issue, right now, is finding the structure to best do [immersive clinical experienc-es] with only having the five semesters. It limits our time in the classroom."

The main concern for scheduling the immersive clinical experience centered on the need to condense the academic calendar to allow for immersive clinical experiences within the program's schedule.

Preceptor Involvement. Specific to the immersive clinical experience, a concern that surfaced was program administrators' perceptions of the extent to which a preceptor is engaged with the student. This included the additional workload that comes along with providing a clinical placement for an immersive clinical experience. Danielle acknowledged the preceptors' need for occasional alone time, which can be difficult to manage as an immersive clinical experience preceptor. She shared,

Some of the preceptors don't want the students around that much. And I can appreciate that too, especially if you are a solo provider somewhere you may not want this person in your space all the time.

Some preceptors in immersive clinical experience settings may feel as though they are always on and need to educate or entertain students even during downtime. Isabel stated,

The student is always there. The preceptors don't have any downtime. If they just need to write notes, or if they need to deal with insurance, or even if they need to deal with something personal while they're at work, the student is always there. I know some preceptors sometimes feel like they need to entertain the student and have something for the student to do all the time. That can be a little overwhelming for some of the preceptors.

Grace reiterated Isabel's thoughts by stating, "Sometimes you just want to be able to sit there, watch practice, and not have to entertain somebody, teach them, or answer questions." Furthermore, Eric explained:

It's one thing to design learning opportunities and teachable moments for a student when you know you're going to see them for three or four hours. But what do you do when you have them for eight hours a day? You run out of things to teach them. You run out of activities. You can only do so many quizzes and ask so many questions, et cetera. So, there is a little bit of baby-sitting effect. I use that term not to be derogatory, but the preceptors feel like they're always on, like they're always having to develop something.

These data supported the preceptor involvement theme through the descriptions of the preceptor's need for alone time as well as preceptors potentially feeling overwhelmed by constantly developing learning opportunities, even during slower periods in the immersive clinical experience.

DISCUSSION

Millennial students want a team-oriented approach to learning, and therefore opportunities to learn in a collaborative setting with their peers is desired.[18,19] One challenge identified by our participants was the idea of isolation, with the students not surrounded by their peers or program faculty, during the clinical immersive experience. Programs may use technology, as millennials are savvy in this respect,[18] to help provide an interactive learning experience by incorporating an

online component into the immersive experience. The asynchronous communication can promote engagement among the faculty and students despite a lack of physical presence. The concept of isolation was perceived by the program administrators, not the students themselves. Gaining the perspective of the student will be helpful in understanding whether this is a challenge that needs to be addressed.

Negative financial implications have been discussed as a concern for the transition to a graduate degree.[20] A challenge to graduate athletic training students could be balancing costs associated with daily living and clinical education requirements,[20] such as distance clinical immersion placements, without the flexibility to have a job for supplemental income. There is no empirical evidence in the field of athletic training regarding the implications of graduate-level education on concerns related to tuition costs and debt after graduation. Evidence in physical therapy suggests that doctor of physical therapy students do have student debt issues, as they use student loans as a means to support their education and cost of daily living while enrolled in school.[21]

The importance of clinical education is unopposed[1] in athletic training, and the value perceived by students with respect to its positive impact on their professional development suggests the need for quality experiences in clinical education. Despite some reports that clinical education is perceived to be a benefit of the graduate-level model,[22] there has been some trepidation about the quality of the clinical education experience.[20] Our participants shared concerns with quality of clinical education hours, particularly related to time spent unengaged despite being physically present. The concerns raised by our participants parallel the previous concerns raised by Berry and peers,[23] which focused on time spent in clinical education in which students may be waiting to act or learn (ie, downtime).[23] Program administrators should reflect on the patient volume at identified immersive clinical experience sites as one consideration to attempt to reduce the amount of excess downtime. Additionally, quality preceptor training can help prepare preceptors for the challenges that may arise when hosting a student completing a clinically immersive education experience.

The immersive clinical experience is described in the literature as "a practice-intensive experience that allows the student to experience the totality of care provided by the athletic trainer. Students must participate in the full-time, day-to-day and week-to-week role of an athletic trainer for a period of time identified by the program (but minimally one continuous 4-week period)."[4(p8)] Our participants, despite being aware of the standard, were concerned that it was nondescript and left more questions than answers. Other health care education programs such as nursing and physical therapy use clinical immersion as a transition to practice strategy, and often view it as a time when students are being socialized into their clinical role, with consistency and frequency.[24] Much as with the parameters, or the lack thereof, physical therapy (PT) and physician assistant (PA) programs have little data on the structure and efficacy of the clinical immersive experience. The concern regarding the expectations of and structure expected for an immersive experience highlight the need for continued research, as well as the need for programs that offer immersion currently to share their philosophies and design.

Although preceptors have yet to be studied, as a means to find how immersion would and can affect their roles as clinical supervisors and educators of the student, an assumption is made that immersion would be welcomed by the preceptors or at best accommodated by them as this becomes the new normal in clinical education. Therefore, programs should continue to support preceptors to help them manage the possible increase in workload and expectations, but also help educate them on their role in the immersive experience so as to reduce any uncertainty around their role in supervising the student.

Health care programs, such as PT and PA studies, include an immersive clinical experience while using an integrated clinical experience to supplement the specific foundational curriculum.[21,24–27] Nursing programs may use immersion throughout the curriculum to help support the development of a competent nurse, who will be ready to transition to clinical practice easily.[9,26–29] Empirical support for when immersive clinical experiences should be included in the curriculum is unavailable; however, as shared by our program administrators, trying to offer immersion while completing all foundational course work can be challenging. The challenge is rooted in completing all necessary didactic course work with clinical experiences in a timely fashion to allow for an immersive clinical experience at the conclusion of the curriculum, similar to the PT model. Continued research will be needed to better understand how to facilitate clinical immersion while complementing didactic work required for degree completion.

FUTURE DIRECTIONS AND LIMITATIONS

We collected our data before the decision to have an immersive clinical experience as a clinical education requirement of all professional master's programs. Although we collected data from predominantly professional master's programs, not all were requiring immersion at the time. We asked all participants to answer questions related to their perceptions of challenges specific to immersive clinical experiences within a professional master's athletic training program, even if their program did not offer an immersive clinical experience or was not a master's-level program. Although their responses were framed within a professional master's athletic training program offering an immersive clinical experiences mindset, a limitation could be that they did not have firsthand experience with these challenges. However, given that many of the perceived challenges of the immersive clinical experience discussed within this study are not exclusive to the professional master's level, nor are they all unique to the immersive clinical experience, we felt it was appropriate to include responses from all administrators. As more programs become accredited at the master's level, additional research should be gathered about the immersive clinical experience.

Our data share only the challenges as perceived by program administrators. Preceptors and students can have their own perceived challenges that may not represent what is viewed at the administrator level. A future study can include all stakeholders, including student and preceptor perceptions of immersive clinical experiences, as a way to present a more comprehensive impression, including potential burnout from either role as a result of the immersive clinical experience.

CONCLUSIONS

There are perceived challenges associated with delivering an immersive clinical experience. Some programs that offer immersion at off-campus locations may find that students feel isolated from one another as well as from program faculty. The financial strain that immersive clinical experiences can create was also a perceived challenge. Students must balance a full-time academic load while accruing costs associated with daily living and potential expenses associated with immersive clinical experiences. It is the perception of the interviewed program administrators that students will spend more time at an immersive clinical experience but may not spend quality time engaged in learning or skill application. Therefore, quality versus quantity of hours was voiced as an area of concern specific to the time spent in an immersive clinical experience. Additionally, due to the need of the preceptor to be engaged with the student during the daily routines throughout the immersive clinical experience, program administrators speculated that this increased demand for student supervision may affect the preceptor's ability to balance tasks typically completed without the student present, as in the traditional integrated model of clinical education.

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