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ORIGINAL RESEARCH

Athletic Trainers' Motivations for and Satisfaction with Transition to the Physician Practice Setting

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Context: An increasing number of athletic trainers (ATs) are transitioning from traditional settings, such as secondary schools, colleges, universities, and professional sports, to physician practice. Although research suggests ATs may be changing settings in search of better working conditions, little is known about their motivations for and satisfaction with the setting transition.

Objective: To explore ATs' motivations for and satisfaction with transition to the physician practice setting.

Design: Qualitative study.

Patients or Other Participants: Eleven certified ATs (6 women, 5 men; age = 38.5 ± 10.0 years) who transitioned from a traditional setting (secondary school, collegiate, or professional) to a physician practice setting were recruited through convenience sampling.

Data Collection and Analysis: Semistructured interviews were conducted via Zoom and transcribed for analysis. Data were analyzed by a team of 3 researchers using the consensual qualitative research approach to identify key themes across participants.

Results: Three key themes emerged from the data: (1) considerations for physician practice, (2) tasks performed and skills gained, and (3) transition experience. Participants emphasized achieving a better work-life balance, having a consistent schedule, and working with a diverse patient population as key motivators for transition to the physician practice setting. Athletic trainers also reported acquiring new clinical skills in physician practice, such as assisting in surgery and suture removal, as well as new administrative skills related to workers' compensation and insurance. Experiences with transition to physician practice varied among participants, with some finding the transition smooth due to supportive collaboration and effective onboarding, and others facing challenges such as limited opportunities for career advancement.

Conclusions: The transition to physician practice settings offers ATs a chance to achieve better work-life balance and gain new skills, but it also presents challenges, including limited upward mobility. Understanding these factors is crucial for both ATs considering this transition and the health care systems employing them.

Key Words: Hospital/clinic, career transition, work-life balance

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KEY POINTS

- Primary motivations for transition to the physician practice included achieving better work-life balance and a consistent schedule in addition to gaining exposure to a broader patient population.
- Transition to physician practice allowed athletic trainers to expand their knowledge and skill set in both clinical and nonclinical, administrative tasks.
- The upward mobility and long-term career advancement opportunities may be limited for athletic trainers in physician practice roles.

INTRODUCTION

Historically, athletic trainers (ATs) have been employed in colleges or universities, secondary schools, or professional sports settings, providing direct patient care for athletes of the teams involved. However, alternative settings such as physician practice have emerged as a growing option for employment. Athletic trainers in physician practice (ATPPs) function in a health care capacity like nurses, physician assistants, physical therapists, and other clinical personnel.[1] Knowledge and skills possessed by ATs can be easily translated into the physician practice setting. Athletic trainers in physician practice can use their skill set to fulfill responsibilities such as patient triage, injury assessment and evaluation, patient education, brace fitting, ordering diagnostic testing, outlining postoperative rehabilitation, and clinic management and administration.[2] Athletic trainers can competently fulfill these requirements while also learning new knowledge and skills working under the direction of or in collaboration with a physician.

An increasing number of ATs are transitioning into nontraditional settings such as physician practice; therefore, the reasoning behind this switch needs to be examined.[3,4] Research has shown that factors that motivate changes in practice setting include improving personal well-being, mental health, and burnout, in addition to exploring different career pathways.[4,5] Personal well-being entails positive evaluations of one's life, a sense of continual growth, a sense of meaning of life, quality relations, ability to manage life, and a sense of determination in oneself.[5] Consequently, overall personal well-being directly affects one's mental health and the burnout one experiences from one's job. Research has shown ATs in traditional secondary school or collegiate settings may experience low mental health levels and burnout.[3,6–8]

In traditional athletic settings, ATs play a crucial role in providing direct patient care to athletes while also serving as the medical liaison among athletes, coaches, administration, and other sport league personnel.[9] The high expectations of and obligations to these various parties can predispose ATs to significant workplace stress, leading to role strain.[8,9] Role strain, defined as the subjective state of emotional arousal in response to external conditions of social stress, has been linked to reduced productivity, decreased job satisfaction, and an increased likelihood of considering leaving a job or career.[9] Previous research indicates nearly 50% of ATs in the college/university setting experience moderate to high levels of role strain,[6] and this role strain correlates with increased job dissatisfaction and a higher intention to leave their employment.[10] Similarly, nearly 54% of ATs working in professional sports settings report experiencing moderate to high levels of role strain.[9,10] This strain often stems from role overload, in which fulfilling role obligations becomes challenging due to excessive, complex, or time-consuming expectations, as well as interrole conflict, in which the demands of multiple roles clash.[9] This pressure can lead to increased occupational engagement, characterized by a strong dedication to one's occupation.[8] However, this dedication may come at a cost, resulting in emotional exhaustion, depersonalization, and burnout.[6] Long work hours, significant time commitments, weekend responsibilities, and high expectations from invested parties negatively impact the personal well-being of ATs, making it challenging to maintain a healthy work-life balance.[6] As a result, research has shown that ATs in traditional athletic settings are more likely to prefer being at home than at work, experience feelings of guilt for leaving work for family obligations, and even neglect family due to work commitments.[7,10]

The physician practice setting offers ATs an alternative employment setting with regular hours and competitive pay,[3] which can lead to improved job satisfaction and better rates of long-term retention in the profession.[11] However, it is important to note that many ATs may have specifically chosen a career path in athletic training, as opposed to other health professions, because it enables them to remain in athletics and support their own athletic identities.[12] Furthermore, many ATs are intrinsically motivated by and receive job and career satisfaction from the rewarding experience of interacting with athletes and witnessing their recovery from injury.[12] However, the roles and responsibilities of ATPPs differ significantly from those in the traditional athletic setting.[2] Athletic trainers in physician practice often engage with diverse populations, including geriatric, pediatric, chronic pain, and postsurgical patients, and thus they may not have the opportunity to be directly involved with sport or the rehabilitation and return to play of the athlete.[13]

Given the recent shift of ATs to the physician practice setting, it is timely and important to assess the motivations behind migration to the physician practice setting and the overall satisfaction of ATPPs with practice setting change. Therefore, the purpose of this study was to explore the experiences of ATs who transitioned from a traditional athletic setting (eg, secondary school, college/university, or professional sport) to physician practice and provide specific insight into their motivations for making the switch in addition to their satisfaction with the transition.

MATERIALS AND METHODS

Study Design

This study was guided using a consensual qualitative research (CQR) approach. The CQR method has been used widely to

Table 1. Participant Demographics

Pseudonym	Age, y	Years in Traditional Setting	Years in PP	Residency Trained
Pam	32	5	7	Yes
Jim	40	10–19	3	No
Meredith	40	10–19	1	Yes
Angela	26	3	2	Yes
Dwight	52	5	10–19	Yes
Darrell	44	10–19	2	Yes
Kelly	26	3	1	No
Erin	31	4	3	No
Michael	31	3	4	No
Jan	53	20–29	10–19	No
Kevin	49	10–19	9	No

Abbreviation: PP, physician practice,

study the subjective attitudes, beliefs, and experiences of participants and has been used in prior studies of career development.[14] We selected the CQR tradition to inquire into ATs' reasons for moving to the physician practice setting and their overall satisfaction with the transition. This research study was classified as exempt by the Institutional Review Board at [XXXXA.T. Still University].

Participants

Eleven certified ATs (6 women, 5 men; age = 38.5 ± 10.0 years) volunteered to participate in this study and were recruited by convenience sampling in addition to a social media flyer posted on LinkedIn. Demographics of the participants are shown in Table 1. Inclusion criteria for this study included the following: active Board of Certification certification and/or state licensure (or equivalent), full-time employment experience in the traditional setting (professional, collegiate, secondary school) for at least 3 years, and subsequent full-time employment experience in the physician practice setting for at least 1 year. The exclusion criteria included inactive or no Board of Certification certification and/or licensure (or equivalent), not having worked full-time in the traditional setting for at least 3 years, and not having transitioned to working as full-time in the physician practice setting for 1 year. To establish data saturation, we aimed to interview 12 participants. All participants consented to participation through completion of the demographic survey as well as verbally during the interview.

Instrumentation and Procedures

The research team (A.G.G., N.A.H, C.W.B) sent recruitment emails to a convenience sample of ATPPs in January 2024. Additionally, participants were recruited through publishing of an infographic on the primary author's (A.G.G.) LinkedIn page that included study details, participant expectations, and a link to a demographic survey. The demographic survey included the following information to assess for inclusion criteria and previous occupational involvement: consent to research, active athletic training certification, current employment in physician practice, age, state of practice, highest degree obtained, traditional setting experience, cumulative years in traditional setting, specialty of physician practice setting in which they had experience, cumulative years in physician practice, successful completion of a Commission on Accreditation of Athletic Training Education–accredited residency program, and how prepared the individual felt transitioning into physician practice.

At the end of the demographic survey, participants were asked to provide their email address, allowing the primary researcher (A.G.G.) to confirm their consent and schedule interviews. The interview guide was initially created by the primary researcher (A.G.G.) who had experience in both the traditional and physician practice settings. This guide was then reviewed by the remainder of the research team before finalization of questions. Subsequently, the interview guide was emailed to 2 external individuals to assess for face and content validity, leading to the modification of 3 questions and the correction of a grammatical error.

The final semistructured interview guide consisted of 5 main questions, with additional probing questions to be used if needed to capture further detail during the participant interviews (Table 2). Before data collection, the primary investigator (A.G.G.) participated in pilot testing with 1 AT meeting the study inclusion criteria. After pilot testing, no additional modifications were made to the interview guide. Data from the pilot test were not included in the final analysis.

Interviews were conducted via Zoom and transcribed by Zoom, Zoom Communications, Inc. The primary investigator (A.G.G.) compared all transcripts with the interview recording and made modifications to reflect accuracy as necessary. Member checking was performed by sharing transcripts with participants to ensure accuracy and alignment with their experiences. Participants were given 1 week to suggest any necessary corrections. Data collection concluded once all interview transcripts were verified by participants. The research continued until data saturation was achieved on the 11th interview, when no new themes or insights emerged from the participants' responses.

Data Analysis

Data obtained from the open-ended questions during the interview were analyzed using the CQR method. Qualitative data analysis involved 3 main phases: determining domains, identifying the core concepts of participant responses, and connecting core concepts across the participants. To ensure trustworthiness through multiple perspectives, a 3-person

Table 2. Interview Guide

1. Please discuss your motivation for transitioning to the physician practice setting.
   a. Identify which professional factors, if any, compelled your transition to the physician practice setting.
   b. Identify which personal factors, if any, compelled your transition to the physician practice setting.
   c. If you had to choose, what is the one dominating factor that was most influential on your decision to transition to the physician practice setting?
2. Please tell us about your transition to the physician practice setting.
   a. How did your education and previous clinical experience help prepare you for working as an athletic trainer in physician practice?
   b. Upon entry to the setting, how prepared did you feel to work as an athletic trainer in physician practice?
   c. What challenges did you encounter while transitioning to the physician practice setting?
3. Please tell us about your transition to the physician practice setting.
   a. How did your education and previous clinical experience help prepare you for working as an athletic trainer in physician practice?
   b. Upon entry to the setting, how prepared did you feel to work as an athletic trainer in physician practice?
   c. What challenges did you encounter while transitioning to the physician practice setting?
4. Please describe your satisfaction with transition to the physician practice setting.
   a. How does this satisfaction affect your overall career satisfaction.
   b. How do you anticipate your satisfaction to affect your longevity in the athletic training profession?
5. What advice would you offer to athletic trainers considering transition to the physician practice setting?

research team was used (A.G.G., N.A.H., C.W.B). First, each team member individually coded 3 randomized interviews into categories to create their own codebook. The team then met via Zoom to discuss similarities in categories. Next, 1 member (A.G.G.) coded the remaining 8 interviews and sent the coded responses to the other 2 members (N.A.H., C.W.B.) who met to discuss codes. All themes were then finalized by all 3 team members to create a finalized codebook.

The primary investigator (A.G.G.) coded responses for each open-ended section (clinical experience and education, reason for transition, self-efficacy and preparedness, and overall satisfaction) into keywords. Next, the primary investigator (A.G.G.) analyzed the data for repeat keywords; then, commonalities of keywords were organized into phrases based on each section. Once all responses were reflected by at least 1 phrase created, data analysis commenced. The researcher counted how many responses related to each phrase and calculated the percentage of responses that correlated with each phrase.

RESULTS

Overall, 11 participants both completed the demographic survey and followed through with the interview process. Table 1 outlines the demographic responses from participants included in this study who completed both the demographic survey and the interview. The 3 themes that emerged from this research were (1) considerations for physician practice, (2) tasks performed and skills gained, and (3) transition experience.

Considerations for Physician Practice

Most participants expressed a desire to transition to the physician practice setting to achieve work-life balance or a more reliable schedule. Ninety-one percent (n = 10 of 11) of participants discussed either work-life balance or reliable schedule as a positive consideration toward the transition. This included being able to engage in personal activities, time with family, getting weekends off, and ease of using paid time off. Angela commented,

> *I felt pretty stressed on missing family and friends' life events. So, knowing that I can take a day of PTO [paid time off] and not be super stressed about having someone cover or not being allowed to do that, I think that's probably just having an overall better quality of life, work-life balance.*

Another participant, Meredith, mentioned, "The biggest thing for me is my work-life balance is so much better now, and I have so much more control of my own life and my own schedule." Two participants reported how the typical 9-to-5 work schedule associated with the physician practice setting illustrated this work-life balance. In conjunction, reduced burnout and stress were other positive benefits of the physician practice setting. Although this attested to a better work-life balance and reliable schedule, participants also noted additional sources contributing to a decrease in burnout and stress. Pam expressed, "The clinic was less stressful. You know, being on the sideline, the football games, it was fine, but my head was on a constant swivel when it came to football or wrestling." Darrell also remarked,

> *I was able to be home in the evenings and my weekends were open. I could do more things. So, that is the benefit. That really was worth leaving the college setting. The stress, the travel, the nights, the weekends, holidays."*

The third category of considerations for physician practice included being able to treat patients across the lifespan. This term was operationally defined as pediatric, adult, and elderly patients with varying ages and complexities. Erin stated, "You do not learn about things that affect a population over the age of 25," illustrating a consideration for the contrast from the traditional young, athletic patient. Additionally, Jim commented,

> *In our entry-level education, often we probably learn only top one-third of the disease spectrum because we work on athletic*

populations maybe from the ages of 13 to 24. We do not necessarily get a ton of exposure in pediatrics or in older populations where problems like arthritis are more a problem that we see. So, those are not things we are exposed to too much. So again, an appreciation for that as well in this setting. It was very impactful.

Lastly, all participants commented on the consideration for physician practice to affect growth and trajectory in terms of personal goals or advancement. Participants' responses reflected either a positive or negative viewpoint regarding this thematic category in the context of the physician practice setting. Positive growth and trajectory through this transition included furthering education and gaining new skill sets. Jim commented,

The main points of distinction honestly were involved around the emphasis on the utilization of imaging techniques within clinical practice like X-ray or MRI [magnetic resonance imaging] in developing a base level of skill in not only understanding the nature of those studies, but also getting a base level of exposure and knowledge to essentially recognize normal anatomy from pathologic anatomy and certain pathologies such as arthritis, labral tears, ACL [anterior cruciate ligament] ruptures. So, I was able to expand my skill set in that way.

In conjunction, Erin commented,

I feel like a lot of times in the secondary school setting, I was doing a majority of the teaching. Obviously, you learn plenty of things with kids and the trends, but I wanted to learn a little bit more about the medical side of things and kids cannot really teach you that.

Other participants mentioned a lack of growth in this setting for ATs. Jan stated, "I am bored. I am not challenged. There is really a problem with positions like this, there is not upward mobility." Angela expressed, "I feel like sometimes the physician practice does not use athletic trainers as much as they can in certain aspects. I think there are certain things that we would be able to help the doctors with."

Tasks Performed and Skills Gained

Tasks performed and skills gained encompassed clinical and nonclinical tasks. Clinical tasks included tasks involving direct patient care and involvement in a patient's treatment. Multiple participants listed tasks such as taking a history, reconciling medications, suture removal, and assisting with in-clinic procedures such as injections. Jim expressed the following in regard to his duties,

I do a review of systems, take a history and then go through an exam. When the exam is complete, we would walk out and present the case to the provider and then we would actually go in together to see the patient.

Other participants, such as Angela, mentioned hands-on tasks stating,

I basically do kind of a quick HPI [history of present illness] like a subjective portion of like a SOAP [Subjective, Objective, Assessment, and Plan] note, suture removal, staple removal, cast removal. We will help put on splints and put DME [durable medical equipment] braces on.

Dwight and Michael discussed clinical tasks within the operating room for ATs in the physician setting. Dwight commented, "Basically, I am a surgical first assist. I assist in surgery and then close incision, splint them, position them." In conjunction, Michael commented,

I am in the OR [operating room] being able to scrub and assist in surgery as needed, utilize the scope that my doctor needs, as well as wound closure and suturing skills are definitely vastly improved and something different than I did before.

Nonclinical tasks included administrative roles and tasks that did not involve direct patient care. This included rooming the patient, phone calls, entering orders, and paperwork for workers' compensation and Family and Medical Leave Act patients. Erin discussed,

I would room the patient, I would get all the preauthorizations for any sort of procedures or imaging done. I did a lot of answering phone calls and delivering results for patients. I filled out all the workers comp information that we needed or getting a note to somebody for a school or work. Basically, I kept the office clean and tidy, kept inventory of all the supplies, and I also communicated with our DME rep and made sure that we maintained that inventory as well.

Furthermore, participants mentioned nonclinical roles in the aspect of a traditional ATs coming into a nontraditional role. Michael commented, "A skill set of having to work with insurance and authorization is needed to navigate that field, which is kind of the hardest part of our job."

Transition Experience

Transition experience encompassed collaboration and onboarding, salary and compensation considerations, prior experience, and emotions experienced. Collaboration and onboarding involved experiences with personnel available to help, peer resources, and onboarding during the transition. Multiple participants mentioned mentorship through coworkers including physicians and other ATs in similar positions. Erin remarked, "Going into it, it was really helpful to have connections with other people that were athletic trainers that were familiar." Positive and negative viewpoints were apparent for mentorship and onboarding through physicians. Kevin commented:

The primary care physician sports medicine doctor that I worked for, he was very in tune with athletic trainers. You know, he allowed us to wear white lab coats, and he wanted us to be a high level of a physician extender. So, it was a great opportunity.

In conjunction, Dwight brought light to a positive experience: "The biggest thing is the relationship I have with the orthopaedic surgeon. It was his first job out of residency fellowship, and it has been an awesome fit. We have a great working relationship." To the contrary, Pam mentioned, "I think each provider is unique. You have to get to know them, their likes and dislikes." Similarly, Darrell stated, "The challenge is the personalities of the physicians. There are a lot of personalities with the doctors you are working with."

Salary and compensation considerations referred to differences or similarities in pay or benefits from the transition

from a traditional setting to a physician practice setting. Forty-five percent of participants (n = 5 of 11) referred to salary and compensation. Angela remarked, "I am very happy. The pay is not what I would like it to be, but I am living at home kind of saving all my money in that aspect." To the contrary, Erin mentioned, "They increased our pay a little bit, so it was a pretty big jump from the secondary school to the physician practice." To add to this comment in terms of the traditional setting, "I just, you know, the money was not good enough."

Eighty-two percent of participants (n = 9 of 11) believed prior experience influenced their experience with the transition. One participant, Jim, commented on his experiences obtaining his doctor of athletic training (DAT) degree before this transition:

> *I completed my DAT before transitioning to that position. I do believe that my DAT was foundational in my relative success in that setting because I do feel like it gave me knowledge that allowed my peers to look up to me in certain situations and gave me advanced knowledge and gave me really the attitude and intention that I was a health care provider.*

Other participants noted their experiences with residency before the transition. Dwight commented,

> *The residency that I went through was huge and at least gave me a big step toward that when I got the position with the surgeon I work for. It was kind of a good springboard to get at least some understanding.*

In conjunction, Michael remarked:

> *I did do a residency program which prepared me for my position really well. It is definitely tailored to athletic trainers that are transitioning or wanting to transition in teaching a base of those skills to do that. I have a lot of peers now that did not do a residency program that came in after me. There is a level of time that you feel like you can pick up your job pretty quickly, and a lot of my peers that did not necessarily have those experiences. You can see it took them a lot longer to feel comfortable.*

Additionally, 36% of participants (n = 4 of 11) mentioned having prior experience with shadowing or clinical experiences or lack thereof in the physician practice. Jan commented, "When I graduated from college, my athletic training program was very focused on traditional, like these settings did not exist. So, that education piece just was not there." To the contrary, Angela remarked,

> *My senior year of school, I shadowed at the physician setting as like the physician extender position. Before you are jumping in, definitely try to shadow because I think that was a huge part for what has helped me and having realized what you want down the line.*

Emotions experienced encompassed emotions through transition and challenges faced. Emotions experienced were related to work-life balance and skill development. Jim commented,

> *I feel I was much more satisfied working in that [physician practice] setting because I felt like it made me more of a well-rounded provider. I have been an athletic trainer for 16 years, and I have definitely experienced burnout, but it is knowing that I have developed the skill set over time to be able to tackle any new setting or walk into a new setting and be able to make a difference. That level of satisfaction is what I learned in the position in the physician practice setting.*

Another participant, Michael, mentioned his experience as more nerve-racking:

> *I think that is just a nerve and nervousness of itself to not know what to expect. I felt that what I did was to know what you did not know and be able to identify quickly so that you can always constantly learn because that is the great part about this practice or transition. You are always learning something new. There is always a doctor to teach you something. There is always a nurse next to you to teach you something.*

In terms of challenges faced, participants noted some lack of knowledge that affected their transition into the physician practice. Erin remarked,

> *I had no idea what all it took to get imaging done and that is a huge part of orthopaedic work. X-rays do not need authorization, but a lot of doctors have specific[s] that they want with their imaging. There are different things I had no idea about. I did not know anything about CPT [Current Procedural Terminology] codes, the authorization process, and what insurance requires. I feel like as an undergrad, we were told we do not deal with insurance, but in the physicians practice setting, it is all about insurance.*

DISCUSSION

The experiences of ATPPs emphasized both positive and negative factors that should be considered by ATs when contemplating employment in the physician practice setting. Overall, a favorable transition to the physician practice setting was evident, with participants reporting benefits of the physician practice setting to include better hours, not having to take work home, having weekends off, and more support for taking paid time off. With these benefits, the physician practice setting may offer a significant opportunity to support motivations for switching settings by alleviating the common drivers of burnout experienced by ATs in traditional athletic settings. Athletic trainers often face long, irregular hours, high job demands, and the pressure to be constantly available, all of which contribute to elevated stress levels and burnout.[15] In contrast, the structured environment of a physician practice typically provides a consistent 8-hour schedule, allowing for more predictable and manageable work hours. This consistency appears not only to reduce the immediate stress of last-minute schedule changes but also to enable ATs to plan their personal lives more effectively, leading to a potential for improved work-life balance.[6]

Disengaging from one's role as an AT has been recommended as a strategy for promoting personal and professional rejuvenation.[16] This disengagement requires having regular available personal time (eg, breaks during the day, vacations, and days off) that can be used to engage in healthy lifestyle practices and toward the devotion of time and energy to nonwork roles.[16] The regular hours and weekends off provided by employment in the physician practice setting may function to

help ATs fully disengage from work during their time off and achieve mental and emotional recovery from work stressors.[16] Furthermore, the ability to take paid time off without the stress of finding coverage or the fear of returning to a backlog of work appears to further support improved well-being in ATPPs. We recommend that ATs contemplating employment in the physician practice setting consider how these factors may collectively contribute to a reduction in burnout by ensuring that employees have time for rest, personal interests, and social connections, all of which are essential for maintaining personal well-being.

Furthermore, based on accounts of participants' experiences, we recommend that ATs considering employment in the physician practice setting take into account the differences in the roles and responsibilities of ATPPs. Most participants from this study referred to the ability to work with patients across the lifespan as a benefit that allowed them to develop new skills and adapt to a wide range of health care environments. However, many also acknowledged a lack of previous experience working with patients and conditions uncommon to the athlete or young adult population. The Commission on Accreditation of Athletic Training Education outlines Standards for Accreditation of Professional Athletic Training Programs as a mechanism for guiding education programs that prepare professional ATs.[17] Standard 17 states that a program's clinical education component includes clinical practice opportunities with various clinic/patient populations, including those with a diversity of age, sex, socioeconomic status, physical ability, and setting.[17] In conjunction with different populations, Standard 79 requires that athletic training students develop and implement strategies to mitigate the risk for long-term health conditions across the lifespan, including adrenal diseases, cardiovascular disease, diabetes, neurocognitive disease, obesity, and osteoarthritis.[17] Despite these standards, previous research has suggested that more than 80% of patient encounters recorded by athletic training students during their clinical experiences were gained in the collegiate or secondary school setting.[18] Thus, with physician practice becoming an increasingly attractive option for employment, athletic training programs should recognize how clinical experiences in the physician practice setting can help to fulfill these standards by subjecting students to patients in nonsport settings and across the lifespan, not only to support their future clinical practice but to provide students with exposure to employment opportunities that offer regular hours and reliable schedules.

Ensuring that students of professional athletic training programs have clinical experiences in physician practice is important, because unlike the relatively homogeneous population of patients in athletics, physician practice settings involve treating patients from diverse age groups, socioeconomic backgrounds, ethnicities, and health statuses. Thus, ATs must be prepared to manage a wider range of health conditions. Likewise, the communication strategies that work in a traditional athletic setting may not be as effective with a broader patient population. Thus, clinical experiences may help prepare future ATs to adapt their communications styles to patients with different health literacies and expectations of care. Last, but not least, transitioning to a physician practice setting may expose athletic training students to the realities of health disparities, in which patients may have unequal access to care or have different outcomes based on their social status.

In addition to the diversity in patient population, ATPPs noted significant differences in the daily roles and responsibilities of the AT. Unlike the traditional setting, ATPPs were responsible for clinical tasks including taking a history of present illness, reconciling medications, and direct patient care such as casting, fitting durable medical equipment, drawing injections, reading diagnostic images, instructing home exercise programs, and suture or staple removal. Additionally, ATPPs reported being responsible for nonclinical tasks like entering in orders, sending emails, telephone encounters, completing Family and Medical Leave Act and workers' compensation documentation, prepping patients' charts for clinic, performing inventory, and securing insurance authorization. This also includes use of the hospital or clinic's electronic medical record. Athletic trainers considering employment in physician practice should consider their knowledge of and desire to engage in these clinical and nonclinical tasks.

All participants with previous exposure to the physician practice setting, through either clinical experiences or residency training, indicated that their experience better prepared them for their role as an ATPP. Exposure to physician practice can include shadowing, clinical experiences, residency, or fellowship opportunities. In addition to increasing the opportunities for exposure to physician practice settings, we recommend an increase in the development of continuing education and professional development opportunities relevant to physician practice and patients across the lifespan, so that ATs looking to potentially migrate settings have a baseline understanding of the practice setting and the knowledge and skills needed to succeed as an ATPP.

In addition to having previous experience, participants of this study reported that collaboration and onboarding occurring through helpful personnel, peer resources, and onboarding training often helped to ease the transition from traditional to physician practice settings. Previous research has shown that onboarding that includes individualized orientation training, reviewing of policy and procedures, meeting of staff and other vital personnel, a list of staff contact information, and other information regarding processes that the ATs may need to provide the best care possible for their patients enhances an individual's transition to practice.[19] Transition to practice in a new setting can be unsettling for both early professional and career-advancing ATs; however, to help ease role ambiguity, employers should provide orientation training specific to roles and responsibilities of the AT within the physician practice setting in which they are hired.[19] Employers of ATPPs should be cognizant of the need for supportive onboarding processes for ATs, especially those coming from traditional settings. Likewise, ATs pursuing employment in the physician practice setting should make it a point to inquire about the onboarding processes of the organization during the interview and hiring processes.

Lastly, growth and trajectory were emphasized as a major consideration for transitioning to the physician practice setting. In addition to improvements in work-life balance, many participants noted the ability to gain knowledge on the management of orthopaedic conditions in the general population as beneficial to their professional growth. Skill sets gained through the physician practice setting can help to establish the AT as a more well-rounded allied health professional. This addition of tools to the tool box can assist professionals in decision-making and treatment for patients. However,

although ATPPs attested to positive transition experiences due to decreased burnout, better work-life balance, and skill acquisition, they also noted a lack of opportunities for professional growth and upward career mobility. Physician practice settings typically have a more hierarchical structure, in which the top leadership positions are often held by physicians or administrative staff. This can limit opportunities for ATs to advance into leadership roles within the organization, especially compared with settings like collegiate or professional sports where ATs may perceive clearer pathways for promotion. Furthermore, participants noted that physician practices might have a fixed number of positions for ATs, which can result in a highly competitive environment for advanced roles or available promotions. With fewer positions available, ATs might find it challenging to advance within the same organization, leading to potential stagnation in their career progression. Moreover, this study suggests ATPPs may find their roles more narrowly defined, focusing primarily on patient care and education under the direction of a physician. This can limit opportunities for expanding their scope of practice that might be more available in other settings. More research is needed to determine if the limited scope and potential for growth can impact job satisfaction for ATPPs in the long term. Ultimately, ATs should consider how a role in a physician practice fits into their long-term career goals.

Limitations and Future Research

Several limitations may impact the generalizability and validity of the findings. First, because we used a convenience sample, the participants may not be representative of all ATPPs, which could limit the broader applicability of the results. Additionally, the small sample size may further restrict the generalizability of our findings, as it may not capture the full diversity of experiences within the ATPP population.

Attrition and scheduling availability also presented challenges. Some participants completed the demographic survey but did not provide an email for follow-up, and others provided an email but did not respond to interview scheduling requests. This reduced participation rate may have negatively impacted the study's overall outcomes. To mitigate this, we included a free text box at the end of the demographic survey and sent reminder emails 1 week after no response was received. Nonetheless, scheduling conflicts between the primary researcher and interviewees posed challenges, as coordinating mutually convenient times for interviews was difficult.

Another important consideration is the potential for bias introduced by researcher interpretations and interactions with participants. Participants may have provided socially desirable answers or withheld information they considered sensitive or negative toward the profession, which could have skewed this study's data. Future researchers could benefit from exploring different growth opportunities for ATs who may have used the transition to a physician practice setting to further their careers in athletic training.

CONCLUSIONS

Many ATs are motivated to migrate from the traditional setting to the physician practice setting to obtain better work-life balance. Overall, ATPPs are satisfied with the transition, based on benefits including better hours, a reliable schedule, support for taking paid time off, and skills gained related to exposure to patients across the lifespan. With these benefits, the physician practice setting may alleviate the common drivers of burnout experienced by ATs in traditional athletic settings and extend retention in the profession. However, this transition also presents challenges related to limited professional growth and career mobility. When considering employment in the physician practice setting, ATs should carefully evaluate how such a role fits within their overall career aspirations and consider the need for further education or experience to ease the setting transition and achieve their long-term career goals.

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