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Research Article

Perception of Education Interventions Used During the Pandemic Clinical Interruption in Athletic Training Education

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Abstract

Clinical experiences are imperative but can be limited in providing students with a full spectrum of experiences; this was especially true when clinical experiences were interrupted during the pandemic. The sudden interruption of in-person clinical opportunities prompted programs to incorporate alternative educational interventions to support continued skill development. This study examined which alternative clinical education interventions were implemented during the interruption and explored students' perceptions of their effectiveness compared to traditional clinical experiences. This cross-sectional study surveyed final-year athletic training students in accredited U.S. programs who experienced pandemic-related clinical disruptions and were preparing for the Board of Certification (BOC) exam. Students responded to surveys about the alternative interventions, clinical skill perceptions, and prior traditional experiences. Data from five intervention groups were analyzed to assess the relationship between BOC performance and the national three-year first-time pass rate. Students who received an intervention during the clinical interruption reported significantly more positive perceptions than those who did not ($F[4,93] = 4.42$, $p = .003$, $\eta^2 = .16$). All intervention groups had higher BOC pass rates than the national three-year average. These findings suggest that alternative interventions can support clinical education and encourage clinical skill development without negatively affecting performance or perceptions.

Keywords: clinical education, clinical experience, COVID-19, athletic training, simulation

Introduction

Athletic training students rely on clinical experiences to develop knowledge, skills, and clinical abilities. Education programs use in-person, hands-on clinical experiences early in athletic training education as a primary clinical education instructional tool to develop students into future athletic trainers (Craig, 2003). Other methods, such as simulation, standardized patients, mock scenarios, and recently, telehealth visits, have been utilized as supplemental interventions in areas students might not have direct exposure through clinical experiences (Armstrong et al., 2018; Armstrong & Jarriel, 2015; Gardiner et al., 2018; Serwe et al., 2020; Winkelman et al., 2020). Current research is examining whether these methods are sufficient to meet the educational outcomes for which they are intended. Some of these educational methods had to be adopted and then implemented as a primary intervention when in-person clinical experiences were interrupted during the COVID-19 pandemic.

When educational reforms are needed, they occur best in a real-world setting, especially since adapting to change is imperative to stay current and competitive. The process of making change within education takes time, whereas unplanned, quick changes can lead to failure (Kotter, 2012). Due to local regulations and student safety issues related to the pandemic, some athletic training programs were forced to discontinue clinical experiences and rapidly filled the void with alternative educational changes. Some programs implemented interventions with which they may have had little experience, had to learn to facilitate them properly using technology, and had to determine what worked best for their students, given the available resources.

Objectives

Exploring how educational programs adjusted during the pandemic can provide insight into which primary interventions were used and whether clinical development continued. The purpose of this study was to determine which alternative educational interventions were used in clinical education during the pandemic interruption and whether these changes were perceived to continue student development compared to traditional clinical experiences.

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Research Questions

The research questions for this study were:
1. What alternative clinical education interventions were used during the pandemic interruption?
2. How did students perceive their impact on clinical skill development compared to traditional in-person experiences?

Methodology

Design

To explore the impact of alternative clinical education strategies during pandemic-related interruptions, this cross-sectional study distributed a quantitative survey to active Commission on Accreditation of Athletic Training Education (CAATE) professional programs across the United States, which were passed along to students who met the inclusion criteria.

Participants

Final-year athletic training students enrolled in CAATE-accredited programs who experienced a disruption with in-person clinical experiences and were preparing for the Board of Certification (BOC) exam were surveyed. Recruitment began after the host institution's institutional review board approved, and a purposeful sampling procedure was used. At the time of this study, there were 387 CAATE-accredited athletic training programs in the United States (Commission for the Accreditation of Athletic Training Education, 2019). Clinical Education Coordinators (CECs) from CAATE-accredited athletic training programs were contacted via email and asked to forward the survey to students in their final year of the academic program. Inclusion criteria included students who had prior in-person traditional clinical experiences, were affected by a clinical interruption, and were planning to take the BOC exam during the data collection period.

Tool

A survey was created for this study, and before distribution, a pilot survey was sent to a purposive sample. The pilot study results were analyzed to ensure reliability and validity. Pilot participants completed the survey twice, at least two weeks apart, to determine the tool's reliability. A Pearson's correlation was completed using the raw scores for both attempts for each participant. All data that fell within two standard deviations from the mean were included in the calculation of the mean of *R*. The survey had a reliability (r = .74). It was created to collect data on the types of alternative interventions used, students' perceptions of their clinical skill development, and their prior experiences with traditional clinical experiences.

The initial section of the survey included an informed consent statement with a yes/no question. The survey included a demographic section with inclusion criteria to confirm that students were in their last year of the program, were planning to take the BOC exam, and had experienced a clinical experience interruption. If the student did not meet the criteria based on their answers, the survey data were excluded from the study analysis.

The second section included questions that allowed subjects to select the types of interventions used during the clinical experience interruption. The selection of interventions enabled analysis of individual survey data across various groups. The groups were separated by the interventions the students selected. The intervention options were: (a) in-person standardized patient; (b) virtual standardized patient; (c) participating as a standardized patient; (d) written clinical cases or case studies; (e) virtual simulations; (f) in-person simulations; (g) virtual telehealth or telemedicine visits with a preceptor and patient; (h) case journaling; or (i) no interventions were used. Following the selection of the interventions, the subjects responded using a five-point Likert scale (1- strongly agree, 2 - agree, 3 - neither agree nor disagree, 4 - disagree, 5 - strongly disagree) to several statements about their perceptions of the interventions, their clinical skills, and in-person clinical experiences, as shown in the Annexure. To end the survey, the students were asked if they would participate in a follow-up final survey that they would receive after the BOC testing cycle to report their performance data (pass/fail).

Procedures

The survey was created in Qualtrics (Provo, UT) and distributed via an embedded link in a recruitment email sent to a distribution list obtained through a CAATE request. Contacts used as a part of the pilot process were removed prior to distribution. The survey was open for four weeks, with reminder emails sent once per week to encourage participation. Once the student survey timeline had expired and responses were collected, the composite scores for each statement were calculated based on the scale ratings. Differences were statistically analyzed by comparing participants' responses grouped by the interventions used during the clinical experience interruption and those used in traditional clinical experiences. Students who agreed to receive the follow-up survey in the initial survey were contacted to complete it after the BOC testing period ended.

Analytic Strategy

There were 147 total survey responses from student participants. Responses to 28 surveys did not meet the inclusion criteria. Of the remaining 119 responses, 12 were not fully completed and were removed from the data analysis. The remaining 107 responses were analyzed and represented all NATA districts across the United States.

The survey questions were grouped into topic categories. The categories for the survey were: (a) the perception of interventions used during the clinical interruption; (b) the student's perception of their clinical skills; and (c) the perception of traditional clinical experiences. The raw scores on the five-point Likert scale for each participant were summed to analyze the data. Multiple repeated-measures analysis of variance (ANOVA) tests were conducted to analyze the data to determine if any differences existed between the perception scores for each statement category from the surveys within each intervention group, including the group that did not receive an intervention. When significant differences were found between the groups, a post hoc Tukey's test was conducted to determine which groups differed.

The students were also asked to participate in a follow-up survey to inquire about their performance on the athletic training BOC exam. The follow-up survey included inquiries asking if the student passed, did not pass, or did not take the exam during the testing cycle. Of the 107 complete responses, 96 consented to participate in the follow-up survey. The 96 students were contacted after the April/May 2021 testing cycle results were released. Of the 96 that were contacted, 82 responded. All response data from the 82 follow-up surveys were included for analysis. The data were analyzed to determine the one-year pass/fail rate of the participating students affected by the clinical interruption. The pass/fail rate was then compared with the national three-year average first-time pass rate on the BOC exam, excluding students affected by a clinical experience interruption. A chi-squared test was conducted to determine whether there was a relationship between students' exam performance and the national three-year first-time pass rate.

Limitions

Recruitment for this study depended on CECs sharing participation information with their students, which may have limited involvement since not all CECs chose to participate. The recruitment letter and survey were distributed electronically, but email filters may have prevented some CECs and students from receiving them. Additionally, in an electronic survey format, the level of honesty cannot be guaranteed. Students were asked in the survey whether they would participate in a follow-up survey, but not all respondents agreed, and those who did did not respond when contacted for the follow-up. Despite agreeing to participate, students may not have participated due to their exam results. Even though the response rate was high, even more responses could have influenced the data. The study, however, had adequate survey responses that represented all the NATA districts.

Results

The five interventions that had the most common responses were used to determine the groups. The five intervention groups were: (a) virtual standardized patients; (b) being a standardized patient; (c) virtual simulation; (d) written cases; and (e) no intervention. Of the 107 completed surveys, 98 of the respondents selected at least one of the most common interventions. The remaining nine respondents selected only interventions that were not included in the analysis. To determine whether perceptions of interventions implemented during the pandemic clinical interruption differed from those of the traditional clinical education method, a one-way ANOVA was conducted to assess whether there was a significant difference in perception scores across the five intervention groups. A series of nine positive statements about the interventions used during the clinical interruption, as shown in Annexure, were analyzed. The raw scores were summed to determine the means (See Table 1). The mean scores for each group were virtual standardized patient (M = 28.79), being a standardized patient (M = 27.93), virtual simulation (M = 28.30), written cases (M = 27.84), and no intervention (M = 34.62). The alpha level of significance was set at .05. A one-way ANOVA was conducted to examine differences in perception scores across the five intervention groups. Because participants were originally eligible to contribute data to multiple intervention groups, a random subsample was created, with each participant included in only one group, to meet the assumption of independence.

Table 1
Mean Perception Scores of Clinical Education Interventions by Group

Group	*n*	*M*
Virtual SP	29	28.79
Being a SP	14	27.93
Virtual Sim	23	28.30
Written case	19	27.84
No intervention	13	34.62

Note. N = 98. Lower scores indicate more favorable perceptions (1 = *strongly agree*, 5 = *strongly disagree*).

The analysis revealed a statistically significant effect of intervention group on perception scores (F[4, 93] = 4.42, p = .003, η^2 = .16), indicating a moderate effect size. Post hoc comparisons using Tukey's honestly significant difference (HSD) test revealed that the no-intervention group (M = 34.62, SD = 6.46) reported significantly higher (i.e., less favorable) perception scores than all intervention groups (p < .01). No statistically significant differences were observed among the intervention groups (p > .05). These findings suggest that participation in any intervention was associated with more favorable perceptions compared to no intervention, while no specific intervention type was perceived as more effective than another.

Table 2
One-Way ANOVA Summary for Perception Scores Across Intervention Groups

Source of variation	SS	*df*	MS	*F*	*p*
Between groups	461.84	4	115.46	4.42	.003
Within groups	2432.16	93	26.15		
Total	2894.00				

The average mean scores for the intervention groups, except for the no intervention group, were (M = 28.22). The means were grouped because they were found to be similar in the ANOVA compared to the no-intervention group, as indicated by Tukey's post hoc testing. Dividing the mean score by the number of questions indicated the average score for the four groups on each question (M = 3.13). The mean score signified that responses fell just past '3 - neither agree or disagree' with a slight disagreement response level on the five-point Likert scale. The no-intervention group had a mean score of (M = 34.62). The no intervention group mean score was divided by the number of questions in the positive statements about the interventions used category; the average was (M = 3.84), moving closer to the disagree levels of the five-point Likert scale.

Table 3
Mean Preference Scores for Traditional In-Person Clinical Experiences by Group

Group	*n*	*M*
Virtual SP	45	1.22
Being SP	30	1.27
Virtual Sim	51	1.16
Written case	59	1.29
No intervention	15	1.13

Note. N = 98. Scores range from 1 (strongly agree) to 5 (strongly disagree).

Another single-factor ANOVA was conducted to determine whether there were differences in response scores for the traditional clinical education method question category. This category only had one statement to which the participant could respond. The statement was, "In-person clinical experiences are a better way to learn clinical skills for me." The same five intervention group scores were analyzed, with the following results: virtual standardized patient (M = 1.22), being a standardized patient (M = 1.27), virtual simulation (M = 1.16), written cases (M = 1.29), and no intervention (M = 1.13). The mean scores for each group were also analyzed. There were no statistical differences within the means, indicating that students felt the same about the traditional clinical education methods shown in Table 4, F(4,195) = 0.49, p = .74). The average of the mean scores across all groups was M = 1.21, with a '1' on the Likert scale indicating that the student strongly agrees with the statement. Regardless of the intervention group, all students preferred in-person clinical experiences for learning clinical skills.

Table 4
One-Way ANOVA Summary for Preference of Traditional Clinical Experiences Across Groups

Source of variation	SS	*df*	MS	*F*	*p*
Between groups	0.65	4	0.16	0.49	.74
Within groups	64.22	195	0.33		
Total	64.87	199			

Table 5
Post hoc Tukey's Test Results between Intervention Groups

Pair	Tukey HSD	
	p	inference
No Int vs. Virtual SP	.008	p < .05
No Int vs. Being a SP	.009	p < .05
No Int vs. Virtual Sim	.005	p < .05
No Int vs. Written Case	.004	p < .05
Virtual SP vs. Being a SP	.985	Not significant
Virtual SP vs. Virtual Sim	.997	Not significant
Virtual SP vs. Written Case	.970	Not significant
Being a SP vs. Virtual Sim	1.000	Not significant
Being a SP vs. Written Case	1.000	Not significant
Virtual Sim vs. Written Case	.998	Not significant

Note. Level of not significant = .05.

To determine if there was a difference in the first-time pass rate on the BOC exam for students impacted by the clinical experience disruption compared to the national previous three-year first-time pass rate, a chi-squared statistical analysis was conducted. The 2018-2020 national three-year aggregate first-time pass rate was 76% (Accreditation of Athletic Training Education, 2020). Of the students who responded to the follow-up survey (n = 83), 66 reported passing, 3 reported not passing, and 14 reported not taking the exam. The chi-squared analysis included only students who took the exam (n = 69), as shown in Table 5, and identified a significant difference between the observed and expected values chi-square (1, N = 69)= 14.61, p < .001. The results showed that the national average did not align with the students' results. Since the scores did not fit, it indicated that the student participants performed better than the three-year national average for students completing the exam without a clinical interruption.

Table 6
First Time BOC *Exam Results Compared to National Three-year Pass Rate*

Exam result	Observed	Expected
Passed	66	52.44
Did not pass	3	16.56
	$\chi^2 = 14.61$	p < .001

Note. Expected frequencies were based on a comparison pass rate of 76%. A chi-square goodness-of-fit test indicated that the observed outcomes differed significantly from the expected outcomes.

Discussion

The study examined perceptions of clinical education interventions implemented during the clinical experience interruption and whether these changes effectively continued student development compared with traditional clinical education methods. Through investigating the survey responses, four interventions (virtual standardized patients, being a standardized patient, virtual simulations, and written cases) were most prominently used.

The survey results showed that some athletic training programs did not use an intervention during the clinical experience interruption. The students in the no-intervention group did not have any clinical experiences or alternative interventions during the intervention. Students who received an intervention reported greater positive feelings about their clinical progress and the interventions than those who did not. No individual intervention stood out from the others, indicating that none increased positive perceptions more than the others. Despite the students' lack of preference among the four interventions, each was still viewed as more positive than no intervention. The mean response scores for the questions fell into the middle of the Likert scale, indicating they did not feel strongly either way about the interventions. The fact that an intervention was implemented during the clinical experience interruption increased students' positive perceptions of their ability to develop their clinical skills. Even though students perceived having an intervention more positively than not having one for enhancing clinical skills, all students significantly preferred in-person, hands-on, traditional clinical experiences as the preferred way to learn clinical skills. These findings suggest that traditional clinical education experiences remain the preferred way to learn clinical skills, despite exposure to alternative interventions, as previous research suggests (Armstrong et al., 2009, 2018; Burton et al., 2019; Mazerolle et al., 2012; Sims-Koenig et al., 2019).

Since the interventions were perceived more positively than not having an intervention, the suggestion could be made that alternative interventions, such as the four studied in this research, could be used to supplement clinical education to allow simulated practice and enhance learning, but not be used as a primary or only intervention due to students perceiving in-person traditional experiences positively. This suggestion is supported by previous research indicating that alternative interventions can enhance clinical skill development (Burton et al., 2019; Sims-Koenig et al., 2019; Walker et al., 2016). This study is unique because students experienced a true discontinuity in in-person clinical experiences due to pandemic restrictions. Previous research has not compared the different types of interventions in athletic training education, and more specifically, during the clinical experience interruption. This is the first study to identify alternative clinical interventions as a primary intervention for a defined period. Previous research has shown improvements in specific clinical skills, such as referral and psychosocial skills, but did not demonstrate improvements in communication with standardized patients (Walker et al., 2016). The use of standardized incognito patients has been found to increase students' confidence in clinical skills, clinical reasoning, and decision-making, but this study did not support this, as the student perception scores indicated only a slight disagreement (Burton et al., 2019).

The student participants' performance outcomes on the BOC exam significantly differed from the national three-year first-time pass rate. The students in this study performed significantly better than the national average despite the clinical interruption and despite students' neutral perceptions of the interventions. The fact that student participants outperformed the national average suggests that the interruption of clinical experiences, whether or not accompanied by alternative interventions, did not negatively affect performance. Student success was maintained regardless of the disruptions and changes in clinical education methods. Although this study found no significant differences between intervention groups regarding students' perceptions of their clinical skills, the response scores generally fell towards the middle of the Likert scale. Despite the neutral perception, students still performed well on the BOC exam. Showing that students' perceptions of their clinical readiness did not necessarily align with their actual performance outcomes. It should also be considered that this was a small select group of students completing the exam. Even with survey responses from all NATA districts, the data may still not have been entirely representative. Many factors may explain why the students did well, and it is likely multifactorial. These findings cannot be supported or discounted by previous research due to the lack of literature. Further research into some of the possible factors could be considered.

Future Research

The findings of this study provide a foundation for understanding student perceptions of interruptions to clinical experience in athletic training education, supported by broad national geographic representation. Although this study did not examine the duration of clinical experience interruptions, future research could consider this factor, as it may have affected how students perceived the intervention they received. Additionally, examining perceptions of clinical progress with alternative interventions, depending on the length of the interruption, could yield different outcomes. More research is needed to evaluate alternative clinical interventions as supplements to traditional education, to identify methods that may foster more positive student perceptions. This is particularly relevant given that students expressed neutral views toward the interventions used, highlighting the need for more targeted, evidence-based approaches to alternative clinical skill development.

Conclusion

The four most prominent student-reported interventions implemented during the clinical experience interruption identified in this study were: virtual standardized patients, being a standardized patient, virtual simulations, and written cases. Students did not perceive any of these interventions as better than the others and felt neutral about the interventions used. The fact that an intervention was implemented led students to perceive the intervention and their clinical skills significantly more positively than when no intervention was implemented. The clinical experience interruption did not seem to affect student performance, even if the students lacked an intervention or had an alternative intervention implemented.

This study's findings suggest that traditional clinical education experiences are the preferred way to learn clinical skills despite exposure to alternative interventions. While students did not strongly favor any specific alternative intervention, having an intervention during a clinical interruption was associated with more positive perceptions than not having one. Since students perceived all interventions neutrally and still preferred traditional hands-on experiences, educators should strategically integrate alternative interventions to enhance, rather than replace, traditional clinical experiences.

AI Use Statement

The author used Grammarly for grammar checking to improve sentence clarity. The author reviewed and edited the output and takes full responsibility for the final content.

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Annexure

Survey Category and Statements

Student perception of the interventions	1. The clinical experience interventions used during the clinical interruption helped me grow my skills. 2. The interventions gave me a similar experience to what an in-person clinical experience would have. 3. The clinical interventions gave me exposure to something new. 4. I feel I learned as much as I would have if I had in-person clinical experiences during the interruption. 5. I learned something new. 6. The intervention accelerated the development of my clinical skills. 7. I would like more exposure to interventions like these. 8. I would recommend these interventions in the future for athletic training education.
Student perception of the interventions	1. The confidence in my clinical skills grew during the clinical experience interruption. 2. I am prepared and ready to do independent clinical practice. 3. I feel confident in my growth as an athletic training student.
Perception of traditional experiences	1. In-person clinical experiences are a better way to learn clinical skills for me.