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The Evaluation of a Soft Skills Curriculum in Athletic Training Education: A Mixed Methods Study

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The Evaluation of a Soft Skills Curriculum in Athletic Training Education:

A Mixed Methods Study

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By

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Dedication

"The future belongs to those who believe in the beauty of their dreams."
-Eleanor Roosevelt

This dissertation is dedicated to my daughter Charlotte. I have always dreamed of becoming a Mom as well as an educator. I have always believed that we can find a balance between work and home, and I wanted to inspire others through my actions of academic achievement and commitment to family.

When I started this journey, you, this research endeavor, and my doctoral degree were just a dream. During this journey I have learned to always stay true to my core values, which has helped my research passion flourish. I will constantly remember my doctoral journey and inspire students that I mentor to pursue their dreams and believe in their research passion, just like my mentors have done for me. I have also learned that education, scholarship, and leadership is not a destination, but rather a lifelong process and a commitment made through perseverance, effort, and most importantly a growth mind set. Charlotte, I hope that my actions inspire you more than my words and encourage you to follow your own dreams with your future endeavors.

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Abstract

Athletic Training Education Competencies (2011) include exhibiting empathy and compassion as foundational behaviors of practice. Despite evidence supporting the importance of compassionate care, there is currently evidence to suggest that healthcare is experiencing a compassion crisis (Patel et al., 2019). The purpose of this study was to investigate the ways pre-professional athletic training students' transfer knowledge from a soft skills curriculum to clinical practice. This study utilized an explanatory sequential mixed method design with a preliminary quantitative input (Morgan, 2014). Phase 1 of the study includes participants (n=19) enrolled in a pre-professional AT course. The quantitative questionnaires utilized are; the Jefferson Empathy Scale-HPS (Fields, 2011) and the Compassion Scale (Pommier & Neff, 2019). A repeated measures ANOVA calculated the students' empathy and compassion composite at three timepoints. The results revealed statistical significance within the students' development of empathy and the compassion construct of kindness.

Phase 2 included the same participants, now entry-level master students, in an AT program. Participants completed bi-weekly reflection logs describing empathy and compassion occurrence during their clinical experience. Reflection logs were coded with a constant comparative analysis. The embedded Phase 2 included four (n=4) semi-structured interviews. The results revealed that students applied empathy by connecting with their patients through lived experiences and the ability to stay out of judgement when listening to patients. The students described using compassion by reassuring their patients that they were not going to endure their injury alone and that a support system is in place.

Keywords: soft skills curriculum, empathy and compassion, athletic training education.

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Chapter 1: Introduction

A primary responsibility of healthcare educators is to teach healthcare students soft and hard skills to ensure that they become competent and caring healthcare professionals. Within the health science sector, students typically develop hard skills during their graduate programs or in the latter years of their academic endeavors. The primary focus of healthcare graduate programs is placed on hard skills such as students' abilities to perform pathological evaluations, diagnose, and treat medical conditions. However, healthcare providers and students need to remember that behind every medical evaluation, diagnosis, and treatment there is a very important component, the patient. As Holmboe (2016) eloquently stated, "Medicine is first and foremost a human endeavor" (p. 276). The concept of patient-centered care is a critical curricular component in healthcare. Interacting with a patient and viewing them holistically as a person requires soft skill development. Depending on the professional field, the definition of soft skills varies. In healthcare, soft skills include abilities such as ethics, attitudes, interpersonal abilities, communication, and lifelong learning (Joubert et al., 2006). According to Klaus and colleagues (2007), "Soft skills are defined as personal, social, communication, and self-management behaviors" (p.18). Ultimately, soft skills in a clinical context comprised of "doing the right thing at the right time, and doing it nicely" (Joubert et al., 2006, p. 29). Pre-professional students should have the opportunity to learn and practice soft skills to build foundational behaviors of professional practice prior to clinical experience and the development of hard skills.

Healthcare providers utilize soft skills on a daily basis to treat their patients with quality patient-centered, compassionate care, and emphasize the patient as their top priority of care. Soft skill development is valued across many healthcare fields. For example, the American Physical Therapy Association outlines several soft skill competencies: accountability, integrity,

compassion/caring, altruism, communication, and cultural competence (American Physical Therapy Association, 2019). Similarly, the Athletic Training Education Competencies (2011) include foundational behaviors of professional practice. The subcategory of professionalism states that athletic trainers advocate for the profession, demonstrate honesty and integrity, exhibit compassion and empathy, and express effective interpersonal communication skills (National Athletic Trainers' Association, 2011). This athletic training education competency mirrors the constructs incorporated in the definition of soft skills; ethics, attitudes, interpersonal abilities, communication, and being a lifelong learner (Joubert et al., 2006). Healthcare educators cannot forget to teach the art of soft skills involved with being a healthcare professional within the students' curriculum. Many health care professions emphasize soft skill development among their students because healthcare organizations have noticed soft skill deficiencies in qualified applicants (Bertram, 2018). To mitigate deficiency of soft skills among future healthcare providers, healthcare education programs can provide the opportunity for students to practice and demonstrate soft skills within their respective curriculum.

Rationale and Significance

While soft skills encompass a combination of people skills, social skills, communication skills, character or personality traits, attitudes, career attributes, social intelligence, and emotional intelligence quotients, this study will focus on the specific soft skills associated with emotional intelligence. Emotional intelligence is "the ability to monitor one's own and other's feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and actions" (Salovey & Mayer, 1990, p.189). This study will place emphasis on the competency of foundational behaviors for athletic training education including exhibiting empathy and compassion. Patel (2019) defined empathy as the ability to sense, feel, and

understand another's emotions. While acting with compassion is an emotional response to another's pain or suffering involving an authentic desire to help (Patel, 2019). Both empathy and compassion are essential soft skills for healthcare providers to employ during patient care.

Scholars in the field of neurobiology reveal that empathy needs to occur first to spur compassion. Emphasizing the importance of soft skill training by first focusing on understanding the patient's emotions (empathy) and then act with helping behaviors towards patients (compassion) (Patel et al, 2019). Despite abundant quantitative evidence supporting the importance of compassionate patient care, there is currently evidence to suggest that healthcare is experiencing a compassion crisis (i.e., an absence of – or inconsistency in – compassionate patient care), in which healthcare providers miss the majority of opportunities to show compassion and build a therapeutic relationship (Patel et al., 2019). Historically healthcare providers primarily focus on narrow biomedical inquiry and diagnosis explanations to their patient rather than delivering care with patient participation and involvement, therapeutic relationship building, and placing the patient at the center of the care.

Most importantly, empathy and compassion are concepts that healthcare educators can teach, and students can learn (Patel, 2019; Richardson, 2015). Currently, neither educators, clinicians, nor researchers developed a standard evidence-based curriculum to teach empathy and compassion to healthcare professionals. Therefore, healthcare educators need to fill this void with empathy and compassion training during medical education programs and continued education platforms. Thus, this study evaluates components of a soft skills curriculum and observes how students transfer soft skills to their clinical experiences.

Purpose of Study

The purpose of this study was to investigate the ways in which pre-professional athletic training students' transfer knowledge from a soft skills curriculum during a didactic pre-professional course to clinical practice during their clinical experience. This study utilized a pragmatic worldview and a mixed method research design (Creswell, 2018). Specifically, this study uses an explanatory sequential mixed method design with a preliminary quantitative input (quan → QUAL [qual]) (Morgan, 2014).

Problem Statement

Professional values such as care, communication, commitment, integrity, and knowledge are foundational for leadership development in healthcare professions (Raab et al., 2011). Athletic Training Education Competencies include foundational behaviors of professional practice. The subcategory of professionalism includes advocacy for the profession, demonstrating honesty and integrity, exhibiting compassion and empathy, and expressing effective interpersonal communication skills (National Athletic Trainers' Association, 2011). Athletic training educators are responsible for teaching professional values to the young professionals preparing to enter the field. Peer and Schlaback (2009) stated, "Professional values are powerful. They are standards that shape and motivate consistent patterns of behaviors, decisions, and practice and are shared by all members of the professional group" (p. 38). Researchers surveyed athletic trainers on the most important professional values and found the top three professional values included honesty/truth, respect, and accountability (Peer & Schlabak, 2009). Athletic trainers cherish the professional values of honesty, respect, and accountability. By teaching soft skills surrounding these professional values, young professionals can embrace the same core values. Raab and colleagues (2011) studied the characterizations of a

quality, certified athletic trainer. The open-ended interviews resulted in five constructs that quality athletic trainers have in common: care, communication, commitment, integrity, and knowledge (Raab et al., 2011). The researchers classified four out of the five constructs as soft skills, care, communication, commitment, and integrity. Their study emphasizes the importance of learning and practicing soft skills within AT education can improve the standard of healthcare while building relatable and meaningful relationships with patients. Therefore, entry-level AT students who demonstrate commitment and dedication to developing these characteristics become quality ATs (Raab, 2011).

In 2019, Davlin-Pater and Rosencrum published the first soft-skills curriculum for pre-professional athletic training students. Their educational technique was unique and emphasized the value of teaching pre-professional athletic training students' soft skills prior to beginning their clinical experiences and patient interactions. The reason for teaching a soft skills curriculum to pre-professional students is twofold. First, professional socialization and soft skill development could begin prior to patient care. Second, soft skills are the foundation in preparing students for their clinical experience. Teaching the proposed curriculum in athletic training education creates a solid foundation for students to transition to their professional education and prepare the students for patient centered interactions. The researchers published this soft skills curriculum as an educational technique providing other AT educators with a framework to incorporate into their curriculum. However, the researchers proposed that future research is needed to evaluate their educational technique. In a response to Davlin-Pater and Rosencrum's call for future research, this study builds upon their educational technique by exploring ways in which pre-professional athletic training students develop empathy and compassion during didactic instruction as well as how students transfer these soft skills into their clinical practice.

Research Questions

       The primary research question for this study was: *In what ways can knowledge from a soft skills curriculum during a didactic pre-professional course be transferred to clinical practice during an athletic training student's clinical experience?* To best answer the primary research question, I utilized a mixed methods research methodology. The quantitative data provided information regarding the empathy and compassion portions of the soft skills curriculum. Specifically, the quantitative data resulted in two composite scores one for empathy and one for compassion. The study participants will complete the surveys at three time points throughout the semester. To fully answer the primary research question, I used qualitative data to capture the athletic training student's perspective. Each study participant shared the ways in which they use soft skills during their clinical experience in written reflection logs. Together the quantitative and qualitative data answered the primary research question of this study.

       The secondary research questions for this study were written to reflect the quantitative strand, the qualitative strand, and were ordered to match the proposed mixed methods design (Creswell, 2018).

Phase 1 quantitative research questions included: (quan → QUAL [qual])

    1. How is a pre-professional soft skills curriculum associated with students' development of empathy?

    2. How is a pre-professional soft skills curriculum associated with students' development of compassion?

Phase 2 qualitative research questions included: (quan → QUAL [qual])

    1. In what ways do athletic training students perceive they transferred soft skills into clinical practice?

Embedded qualitative research questions included: (quan→ QUAL [qual]):

1. How do athletic training students describe their emotional response to utilizing soft skills during clinical practice?

2. In what ways are the development of soft skills associated with athletic training students' subjective well-being?

Quantitative and qualitative data provided a unique perspective of students' ability to learn empathy and compassion and their perception of transferring soft skills into their clinical practice.

Rationale for Mixed Methods Research

For healthcare providers, understanding the patient's perspective through an empathic and compassionate approach can be valuable. Often, intervention studies utilize a quantitative approach to provide evidence to support the interventions outcome measurements (Patel, 2019). However, when evaluating soft skills and how they transfer to clinical practice healthcare providers will have different lived experiences. The lived experience can vary based upon the healthcare provider's role in the healthcare system, their patients, and many other variables. For this reason, a mixed methods approach of integrating the self-reported quantitative intervention outcomes with the participants' perception of application of the soft skills holds value. This study utilized an explanatory sequential mixed method research design. According to Creswell (2018):

Integration in my explanatory sequential design will consist of explaining the survey results with qualitative interviews, connecting the quantitative results with the qualitative data collection, displaying the results that link the survey results with the qualitative research questions, and interpreting the results to help explain the survey results with information from participants who can best reflect on the survey results. (p. 298)

Mixed methods methodology added insight of a practical nature to this study. Students learn a soft-skills curriculum and throughout the semester the students used validated quantitative surveys to self-report their levels of empathy and compassion. Once the students transitioned to their clinical experience, the qualitative component of the study added the students' voices and experience helping to understand what knowledge participants' transfer from the classroom to clinical practice through a case study design. Therefore, the report of the quantitative results followed by the qualitative results will lead to insight about how the quantitative personal perceptions help explain the quantitative results (Creswell, 2018). Lastly, the embedded qualitative portion in this sequential mixed method design completed the triangulation. Triangulation occured between students' quantitative data, coding of clinical reflection logs, and interviews conducted with purposeful sampling of participants. According to Creswell (2018), triangulation seeks convergence and corroboration by comparing findings from qualitative data with the quantitative results.

Survey Design

This study included participant demographics and two quantitative self-reported questionnaires. The quantitative self-reported questionnaires used were the Jefferson Scale of Empathy (JSE) questionnaire to measure empathy and the Compassion Sale (CS) to measure compassion. I administered surveys at three timepoints: (a) timepoint 1- at the beginning of the academic semester (pre-curriculum intervention), (b) timepoint 2- during the curricular intervention (after the empathy and compassion lessons), and (c) timepoint 3- post curriculum intervention (at the end of the academic semester). After timepoint 3, the participants answered two additional questions regarding the frequency that they projected to utilize soft skills during their clinical experience and to quantify how important they thought soft skills to be

during a patient interaction. The follow up questions at timepoint 3 served as a prior quantitative criterion to help select the participants for semi-structured interviews during the embedded portion of Phase 2.

Jefferson Scale of Empathy (JSE). For researchers, the JSE is the most commonly utilized and psychometrically validated healthcare empathy scale (Hojat, 2016; Pate et al., 2019). Patel and colleagues (2019) conducted a systematic review of empathy and compassion training for medical residents. In their systematic review, 72% of the studies utilized the Jefferson Scale of Empathy (JSE). Since then, Hojat has created various versions of the scale for researchers' specific needs. This study utilized the 20-item Health Professions Student (JSE HPS-version) questionnaire to best sample the athletic training pre-professional student population. In this tool each question item is answered on a 7-point Likert scale with selection options from strongly disagree (1) to strongly agree (7) and can be completed in less than 10 minutes (Fields et al., 2011). Additionally, seven of the twenty questions are negatively worded to ensure survey compliance. The possible range of survey scores is 20-140, with a higher total score meaning the student has more empathetic behavior tendencies during patient care (Fields et al., 2011). The design intention behind the JSE- HPS- version was to develop a survey that researchers could utilize for interprofessional purposes. Therefore, questions addressed the participant as a healthcare provider rather than a dentist, for example. The JSE-HPS is transferable across healthcare professions, however, to date the athletic training profession is not represented among JSE data.

Compassion Scale (CS). Pommier and Neff (2019) developed scales for both self-compassion and compassion. A 16 item self-reported scale with strong psychometric properties on compassion will be utilized to collect the participants' perception of their own compassion

(Pommier et al., 2019). The 16 items are reported on a 5-point Likert scale ranging from 1 (Almost Never) to 5 (Almost Always). The higher the score that the participant received, ranging from 16-80, the more compassionate the participant. The CS defines compassion as a felt response to suffering that involves caring and an authentic desire to ease distress (Goetz et al., 2010). Compassion is emotionally responding, cognitively understanding, and paying attention to another's suffering (Pommier et al., 2019). The CS uses a Buddhist perspective as a framework, meaning the survey questions are derived from the philosophy that compassionate action is mindfully engaging with another's suffering, experiencing a kind response to their distress, and recognizing human interconnection with others that leads to a genuine desire to alleviate suffering (Feldman, 1995; Jinpa, 2015). Compassion for others includes the constructs of kindness, common humanity, and mindfulness. Each survey statement fits into a respective construct of compassion. A potential limitation could be that the scholars who designed the CS were for the general population. However, given the definition of compassion used and the Buddhist philosophy of acting with kindness and mindfulness to connect with another person to alleviate their suffering is similar to the altruistic behaviors that are valued in healthcare. As of 2019, the CS is the only self-reported measure of compassion that is consistent with a Buddhist perspective (Pommier et al., 2019). According to Patel and colleagues' (2019) systematic review on empathy and compassion training in healthcare, third party observers recorded outcome measures of compassion or incorporated a new self-reported measurement tool. Therefore, the CS is a viable option as a self-reported compassion survey for healthcare education, especially given the psychometric strength of the CS.

Case Study Design

For the qualitative portion (Phase 2) of this study, I utilized a case study research design. Yin (2018) defined case study research as an empirical method that "investigates a contemporary phenomenon (the case) in depth and within its real-world context, especially when the boundaries between phenomenon and content may not be clearly evident" (p. 15). Case study methodology supports research questions that seek to answer the how and why of a social phenomenon. For example, in this study I sought to answer how athletic training students perceive their transference of soft skills into their clinical practice. A case study research design allows researchers to gather "in-depth" and personal social phenomenon descriptions from their lived experiences. I will be asking athletic training students to describe their emotional response to using soft skills and their subjective well-being. For this research study, a single case study design with an embedded unit of analysis will serve to best answer the proposed research questions.

Single-Case (Embedded) Design. This research design utilizes a single-case (embedded) design, also referred to as a type 2 design (Yin, 2018). The single-case study (embedded) design for this study is illustrated in Figure 1.

Figure 1

Single-Case Study (Embedded) Design Description

Single-Case Design (Type 2)

Context: AT Students and Patient Interactions

Case: One MSAT Cohort
Demonstrating Soft Skills During
Their First Clinical Experience

Embedded Unit
Of Analysis 1:
Clinical
Reflection Log

Embedded Unit
Of Analysis 2:
Semi-Structured
Interview
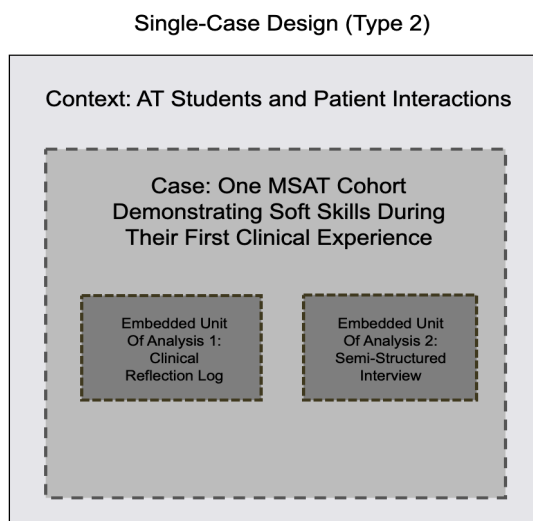
Note. As referenced by Yin (2018), Figure 1 illustrates the single-case study (embedded design). The components of the single-case study (embedded) design that I used for this study included the context of the case, athletic training students and their patient interactions, and the case as one first year cohort of Master's of Science in athletic training (MSAT) students at a university in the mid-Atlantic region of the United States, and how they describe utilizing soft skills during their first clinical experience. There were also two embedded subunits of analysis in this case, clinical reflection logs and purposefully selected, semi-structured interviews. All 19 study participants completed the clinical reflection logs and were analyzed with a constant comparative method to evaluate common themes. I conducted semi-structured interviews created descriptive narratives from four participants who self-report most frequently utilizing empathy and compassion during patient interactions. This purposeful semi-structured interview sampling highlighted the students' experiences of practicing patient-centered care with empathy and compassion. Studying the four students' clinical experiences and interactions helped explain how

these students transferred the skills that they learned during the didactic soft-skills curriculum into their clinical practice.

Significance of Study

This study focused on the development of soft skills, specifically empathy and compassion, in relation to patient care among athletic training students. Many researchers in healthcare have studied the relationship between empathy and compassion during patient care, yet currently no research exists which investigates the relationship between empathy and compassion during patient care among athletic training education and athletic training clinical experiences. This study aimed to fill a gap in the literature by investigating the ways in which a didactic soft skill curriculum taught pre-professional athletic training students behavioral tendencies associated with empathy and compassion. Ultimately, the study explored the phenomena of athletic training students applying empathy and compassion during patient interactions at their clinical experiences. The findings from this study have the potential to encourage athletic training education programs to incorporate soft skills as part of their curriculums.

This study focused on a paradigm shift towards implementing the biopsychosocial model and patient-centered care during therapeutic interactions. Cultivating a shift towards the biopsychosocial model is critical because, researchers have found that when healthcare providers practice patient-centered care clinical outcomes are improved, quality of care is elevated, and patient satisfaction increases while healthcare costs and health disparities decrease (Little et al., 2001; Mead. & Bower, 2002; Oates et al., 2000). When healthcare providers practice patient-centered care with soft skills like empathy and compassion there are physiological and psychological benefits. Researchers have established that empathetic communication and

compassionate care during a patient interaction improves patient-reported outcomes, activates

the patient's parasympathetic nervous system, promotes healing from trauma, builds trust,

establishes hope, and decreases anxiety, depression, and hostility among patients (LaMonica,

1987; Zachariae et al., 2003). To promote soft skills implementation, healthcare education

programs in the UK are emphasizing the value of emotional intelligence throughout curriculums

(Cherry et al., 2014). While physicians are engaging in empathy and compassion curriculums

during their medical schooling in the United State, the training is not occurring in all allied

healthcare profession (Patel, 2019). Despite empathy and compassion being professional

foundations for athletic training, empathy and compassion curricula have not been taught or

studied within the athletic training education.

Limitations

Every research study presents potential limitations or ethical concerns. For this proposed

study, there are four ethical considerations that I will discuss. The first ethical concern was my

level of involvement with the compassion and empathy curriculum. Second, the study

participants were students in the athletic training education program where I am employed.

Additionally, there was a chance that I could be a participant's clinical preceptor. The third

challenge was associated with the research design. Within the study, I plan to capture semi-

structured interviews with four students. Four students were selected through established

preliminary quantitative input that maximizes their voices captured during this portion of data

collection. Specifically, I interviewed the four students who self-reported using empathy and

compassion most often during their clinical education. Therefore, during the interviews there was

the potential of only capturing a homogeneous sample of empathy and compassion levels and

clinical utilization of the soft skills. Finally, challenges existed with collecting data in a healthcare setting during a pandemic.

Primary Investigators' Curricular Involvement

As the primary investigator, I was intimately involved with the data collection in this study. I also was a guest lecturer during the participants' soft skills curriculum. The participants, enrolled in the Capstone in Sports Medicine course, completed a soft-skills curriculum. The curricular framework that was implemented was inspired by Davlin-Pater and Rosencrum's (2019) educational technique in the *Athletic Training Education Journal* about teaching soft-skills to pre-professional athletic training students. The course instructor, a faculty member in the Department of Sports Medicine, and I, modified Davlin-Pater and Rosencrum's soft-skills curriculum framework for the Capstone in Sports Medicine course. One of the most robust changes was adding the topics of empathy and compassion. Together we collaborated to add empathy and compassion because these topics aligned with the athletic training education competencies (National Athletic Trainers' Association, 2011). As a result, I created the empathy and compassion modules for the course. The students learned about empathy and compassion in a hybrid format. The students completed online modules with Ted talks, podcasts, and lectures that I selected. Followed by an in-person lecture where the primary investigator facilitated an interactive presentation practicing the skills and concepts taught during the online module. The ethical consideration in this instance is the fact that the primary investigator was the one creating the content presented to the participants. Whereas if I used a standardized published curriculum to teach empathy and compassion to the participants there would be minimal bias. Since this type of curriculum did not yet exist in the allied healthcare field of athletic training, creating a curriculum was essential.

Addressing the Primary Investigators' Curricular Involvement. Since there is no current evidence-based curriculum for teaching athletic training students about empathy and compassion during patient care, I completed a literature search to appraise the best available literature. In an attempt to mitigate bias, I derived content from multiple interprofessional sources to create the empathy and compassion portions of the curriculum. Additionally, the core concepts used to create the content came from a systematic review, where Patel et al. (2019) included 52 studies on different empathy and compassion educational curriculums taught to physicians or medical students. Additionally, the primary investigator incorporated concepts from the nursing, neuroscience, and positive psychology literature (Bertram, et al., 2018; Lown, 2016; Richardson, et al., 2015; Seligman, et al., 2009). Therefore, the primary investigator attempted to eliminate bias in the creation of the empathy and compassion curricular content by utilizing an interprofessional perspective and the best available evidence.

Power Dynamic Between the Participants and the Primary Investigator

The participant sample utilized in this research study is a cohort of athletic training students attending the University where I am an instructor for their athletic training education program and an athletic trainer and preceptor for their clinical experiences. I recognized that in this position I held power and privilege.

The qualitative data collected during the reflection logs is an activity that is completed for class and graded by the course instructor. As the primary investigator, I only asked for permission to review the results. Therefore, I had no power over the students' grades in the course or for the assignment. Lastly, while there was a chance that I could be a participant's preceptor, this was not the case. However, is it had occurred, I would have conducted my clinical

practice as usual and let the student share their voice based upon their clinical experiences and clinical encounters.

Homogeneous Semi-Structured Interview Sample

During the embedded Phase 2 of the research study, I selected four participants to complete semi-structured interviews. The purpose of the interviews was to capture the ways in which students transferred the pre-professional didactic soft skills curriculum, specifically the topics of empathy and compassion, into their clinical practice. In using this method, I created a homogeneous sample for the semi-structured interview. The reason for selecting the 4 students who self-reported most frequently using empathy and compassion was to help answer the how portion of my research question. I wanted to understand from an exemplary case of students who were using empathy and compassion and how they perceived implementing these skills during their patient interactions (Creswell, 2018).

Addressing a Homogeneous Semi-Structured Interview Sample. The research design utilized was an explanatory sequential mixed method design with a preliminary quantitative input (Morgan, 2014). The student interview selection criteria included students who reported an increase in biweekly utilization of both empathy and compassion during the quantitative portion of the reflection log data collection. If more than four students had showed an increased in utilization of empathy and compassion, then the students with the highest self-reported empathy and compassion from the week 15 survey during Spring 2020 semester would have been selected for the interview process. The purpose of this selection criteria was to hear the voices of participants who have increased their use of empathy and compassion during their clinical experience. Additionally, by interviewing this selective group of students they will help answer the original research question and purpose of the study, in what ways does knowledge from a

soft skills curriculum during a didactic pre-professional course transfer to clinical practice during athletic training students' clinical experience? Hearing this specific group of students' voices aids future research and development of a pre-professional soft skills curriculum.

Collecting Data During a Global Pandemic

The final study limitation was regarding the global pandemic. In this research study, I was presented with the hardship of collecting data in a healthcare environment during a pandemic. This created new challenges, barriers, and opportunities.

Collecting Data During a Global Pandemic. During this time of uncertainty, I recognized the important research opportunity to capture the students' experiences of trying to learn and provide athletic training healthcare services for patients during a pandemic. Each student faced different challenges based upon their clinical site. While the majority of participants were placed at local high schools, some participants were completing their clinical experience at sports medicine clinics, or collegiate settings. While some clinical sites were still practicing telehealth, others returned to "normal" sport participation, some will participated in non-competitive athletic seasons, and some students had virtual clinical experiences led by their preceptors. Each student's clinical experience was dependent on the clinical site's regulations and guidelines that they decide to implement. The pandemic was a fluid situation, participants may have started the semester with one mode of clinical instruction and been forced to transition to another because of state regulations, school district decisions, conference decisions, and the health and safety precautions of the pandemic. With, capturing all participants' perspectives in a reflection log question was important during this unique time. The reflection log question addressing the global pandemic was, "To answer this question, reflect on your current clinical experiences. Given the pandemic, in what ways has your ability to provide patient- centered care been influenced?" I

intentionally wrote the question with a neutral tone to try and not lead the students in a positive or negative direction because this is a unique opportunity to research and learn from the students' clinical experiences.

Definition of Terms

Below I list the definition of terms frequently implemented throughout this research study.

Athletic Training (AT) - According to the National Athletic Trainers' Association (NATA), athletic training is an allied healthcare profession recognized by the American Medical Association (AMA), Health Resources Services Administration (HRSA) and the Department of Health and Human Services (HHS). The profession encompasses five domains of clinical practice: (a) injury and illness prevention, (b) examination and diagnosis of orthopedic pathologies, (c) immediate and emergency care, (d) treatment and rehabilitation of emergent, acute or chronic injuries, and (e) organizational and professional health and well-being (National Athletic Trainers' Association, 2020).

Athletic Training Student - Is a student enrolled in a graduate program accredited by the Commission on Accreditation of Athletic Training Education (CAATE). Once the athletic training student completes a CAATE accredited program, the student is eligible to take their national Board of Certification (BOC) exam.

Biopsychosocial Model - The biopsychosocial is a holistic approach to patient healthcare which includes all aspects of the human experience, emphasizing the psychological, environmental, and biomedical aspects of health (Engle, 1979).

Clinical Experience - Standard 18 of the 2020 CAATE standards state that an athletic training clinical experience provides students with opportunity to engage with patients.

Clinical experiences prepare AT students for contemporary clinical practice with patients who have a variety of health conditions. AT students can fulfil their clinical experience in traditional or emerging AT settings (CAATE Professional Standards, 2020).

Compassion - an emotional response to another's pain or suffering involving an authentic desire to help (Patel, 2019).

Empathy - the ability to sense, feel, and understand another's emotions (Patel, 2019). Wiseman (1996) suggested that there are four active components to achieve empathy; perspective taking, staying out of judgment, recognizing emotion, and communication. Empathy is distinguished from sympathy. Sympathy is defined as an emotional reaction of pity toward the misfortune of another (Sinclair et al., 2017).

Patient - Patients are the people that athletic trainers provide healthcare services to. The patient population for athletic trainers is mostly the physically active population. However, this is not limited to athletes, student athletes, or youth athletes. For example, athletic trainers treat patients that are industrial workers, occupational workers, military members, astronauts, and performers. The patient population treated by athletic trainers is vast.

Patient-Centered Care - O'Connell (2008) defined patient-centered care as, "A system of delivery of care to patients that incorporates both the lived experiences of illness (values) and the scientific knowledge (facts) in every aspect of health care while respecting the patient's right to self-determination based on mutual trust, understanding, and sharing of knowledge" (p.138).

Preceptor- According to the AT Strategic Alliance, "a preceptor supervises and engages students in clinical education" (Higgins, 2020). This term was previously identified as approved clinical instructor (ACI).

Summary

Research supports the use of empathy and compassion during patient interactions to help build therapeutic relationships and provide patients with positive psychological and physiological outcomes (LaMonica, 1987; Little et al., 2001; Mead & Bower, 2002; Oates et al., 2000, Patel, 2019; Zachariae et al., 2003). Despite this evidence, researchers have not studied the application of empathy and compassion during patient-centered care in the field of athletic training. Davlin-Pater and Rosencrum (2019) proposed a pre-professional athletic training soft skills curriculum. Their curriculum serves as a framework for the curricular component of this study. This study followed an explanatory sequential mixed method design with a preliminary quantitative input (quan → QUAL [qual]) (Morgan, 2014). Specifically, Phase 1 of the study included two quantitative surveys (self-reported empathy and compassion) during the soft skills didactic instruction. Then, Phase 2 of the study will be commenced when the participants began their clinical education experience. I collected qualitative data through a single-case study (embedded) design by analyzing the participants' biweekly clinical reflection logs and conducting semi-structured interviews. In the next chapter, I will review the relevant literature and reveal the theoretical framework that shaped this study.

Chapter 2: Review of Literature

In healthcare there are two schools of thought for providing care, the dualist-reductionist biomedical model or the systematist biopsychosocial model (Engel, 1979). Healthcare providers who practice the biomedical model view health as an absence of illness, disease, injury, pain, or defect with the goal to treat the physiological cause of the pathology (Annandale, 1998; Fielding et al., 2010; Yuill et al., 2010). The primary focus of the biomedical model is to treat the disease independent of the person affected. Opposing the biomedical model, Engle (1980) stated that "the biopsychosocial model is a scientific model constructed to take into account the missing dimensions of the biomedical model" (p. 535). While implementing the biopsychosocial model, the healthcare provider commits to providing patient-centered care with the person as the primary frame of reference (Engle, 1979). The biopsychosocial model is a holistic approach which includes all aspects of the human experience, emphasizing the psychological, environmental, and biomedical aspects of health. In the following sections, I will explore the contrasting healthcare philosophies of the biomedical model and the biopsychosocial model. Additionally, I will discuss the value of patient-centered care, the application of empathy and compassion in healthcare, and educational approaches to incorporating the biopsychosocial model with social and emotional learning into healthcare education curriculums.

Biomedical Model

The biomedical model is an ideology that has dominated western medicine for centuries. Rasmussen (1975) traced the philosophic origins of the biomedical model back centuries to when religious leaders finally allowed physicians to learn from human cadavers. The caveat of allowing physicians to learn from cadavers was that the physicians needed to take a dualist approach and separate the cadaver's body from their mind, soul, morals, and emotions. This

philosophy of separation of mind and body in medicine is what shaped the traditional biomedical model that many healthcare providers practice today.

During a patient assessment, the biomedical model focuses on objective findings that healthcare providers view as the root cause of the pathology or disease. In order to stay objective with their diagnosis, physicians will intellectualize emotions (Cherry et al., 2014). Therefore, to cure the patient, the healthcare provider addresses the objective findings with medical interventions such as pharmaceuticals or surgery. Researchers have reported that health insurance and pharmaceutical companies have reinforced the use of the biomedical model as the primary philosophy of healthcare providers (Fielding et al., 2010; Yuill et al., 2010). The biomedical model ignores the intimate and complex relationships that exist between the mind and body and its environment, belief systems, socioeconomic status, and cultural conditions. In this model, the healthcare provider treats the disease, injury, or aliment separate from the person affected by the condition. To put it simply, a healthcare provider evaluates a condition then delivers a diagnosis to the patient and from the patient's perspective, they receive a generic prescription to treat the cellular root of the pathology. Delivering the news of a disease with the intention to only treat the pathology is the cause and effect reductionist nature of the biomedical model.

The biomedical model is a dualistic-reductionist lens that allows the healthcare provider to simplify the complexities of human beings who are suffering from medical hardships. The biomedical model fails to recognize the concept of care necessary in healthcare (Mali, 2018). However, the biopsychosocial model is an alternative model that places emphasis on relationships, the human experience, and patient-centered care.

Biopsychosocial Model

As an expansion to the biomedical model, George Engle, a clinical psychiatrist, proposed the biopsychosocial model in 1977 with the intention to integrate the psychological and the environmental portions of health into healthcare practice (Ogden, 2012). This model embraces the complexities of human beings and looks beyond disease as solely a somatic problem. This way of thinking is challenging, but rewarding, and requires a thought process based on systems theory. Engle (1980) explained, "Nothing exists in isolation. Whether a cell or a person, every system is influenced by the configuration of the systems of which each is a part, that is by its environment" (p. 537). Viewing health through the lens of a continuum of natural systems allows practitioners to respect the ongoing progressive sequences of intra and inter-systematic interactions with multilevel feedback arrangements (Engle, 1979). The model can be intimidating for healthcare providers because it removes the reductionist principle of cause and effect and requires an investment of time and emotion. Historically healthcare providers have prioritized the biomedical portion of health because healthcare educators have scarcely taught or practiced a biopsychosocial philosophy.

Engle (1980) emphasized that the biopsychosocial model still incorporates the biology aspect of disease, injury, and illness. The model serves as an opportunity for healthcare providers to empower their patients, build relationships, and recognize how the complexities that society, behavioral, emotional, cultural, and mental aspects contribute to health. With that being said, when an acute medical emergency occurs, the differences between the two models vanish and the healthcare provider will clinically manage the case following the best evidence-based practice guidelines. Thus, the difference lies in the philosophical foundation of each model, specifically where the healthcare provider places the patient in the process of healing from their

suffering (Engle, 1979). In the biopsychosocial model, the person is the primary frame of reference, considering the patients' core values, beliefs, morals, and entire personality. This perspective is critical in providing patient-centered care.

Patient-Centered Care

When healthcare providers implement the biopsychosocial philosophy during patient care, the interaction is referred to as patient-centered care. O'Connell (2008) defined patient-centered care as "a system of delivery of care to patients that incorporates both the lived experiences of illness (values) and the scientific knowledge (facts) in every aspect of health care while respecting the patient's right to self-determination based on mutual trust, understanding, and sharing of knowledge" (p.138). Patient-centered care is a combination of quality clinical care and interpersonal care. Quality clinical care includes provider knowledge and interpersonal care incorporates soft skills such as the value of communication and a relationship of shared decision making between the practitioner and patient (Hipra et al, 2020). Hipra and colleagues (2020) conducted a study asking the question, what matters most to patients? In their sample of patients, they reported that healthcare provider humanistic qualities and willingness to utilize shared decision-making models mattered most to patients when selecting their healthcare provider (Hipra et al., 2020). Patient-centered care does not only validate a patient's preference but can also provide positive outcomes for the healthcare professional. Researchers have concluded that practicing healthcare with a patient-centered care focus has the potential to improve clinical outcomes, quality of care provided, and patient satisfaction while decreasing healthcare costs, and health disparities (Little et al., 2001; Mead. & Bower, 2002; Oates et al., 2000). Research has validated the importance of patient-centered care. Next, educators

incorporate ways to teach patient-centered care as standard practice to future healthcare providers within their medical curriculums.

Empathy and Compassion in Healthcare

Patel and colleagues (2019) published a systematic review of curricula for empathy and compassion training in medical education. The purpose of the systematic review was to evaluate the literature on empathy and compassion training to determine the specific skills and behaviors and which methods of training are most effective. Ultimately, the systematic review led to results that will best help inform the development of evidence-based curriculums for empathy and compassion training within healthcare education. Currently, in the literature there is no standard evidence-based curriculum training developed to teach empathy and compassion for future healthcare professionals. There is an urgent need to fill this void so educators can implement this type of training during medical education programs and continued education platforms. Out of the 52 studies included in Patel and colleagues (2019) systematic review, most of the training interventions included aspiring physicians or physicians completing their residency programs engaging in empathy and compassion training. However, the systematic review showed that athletic training students and sports medicine professionals did not receive empathy and compassion education. These results demonstrate that healthcare providers can learn empathy and compassion through training interventions. Recognizing that we can learn empathy and compassion over time is important because the literature has shown that empathy and compassion declines during medical school and residency training. The researchers suggest that the trend of empathy and compassion decreasing with years of experience in healthcare may be a common trend among all healthcare disciplines (Patel et al., 2019).

The training interventions the Patel and colleagues analyzed shared common skills and behaviors in the patient's perception of healthcare providers' empathy and compassion. The skills and behaviors included: (a) taking time to listen and build awareness of the patients' emotions, (b) sitting versus standing during a medical consultation, detecting the patients facial expressions and nonverbal cues of emotion, (c) recognizing and responding to opportunities for compassion, (d) employing non-verbal communication of caring, (e) incorporating statements of support, (f) being present for the patient, and (g) reinforcing that they are not going through their current medical treatment alone (Patel, 2019). Learning how to practice empathy and compassion is important for healthcare professionals because of how their patients' benefit from such practice, but also for the wellbeing of the healthcare provider themselves.

In order to apply empathy and compassion, healthcare providers must agree upon definitions for understanding and application of the constructs. Empathy is the ability to sense, feel, and understand another's emotions (Patel, 2019). Wiseman (1996), a nursing scholar, shared the four qualities of empathy to help build the initial steps of a therapeutic relationship; perspective taking, staying out of judgment, recognizing emotion, and communication. On the other hand, compassion is an emotional response to another's pain or suffering involving an authentic desire to help (Patel, 2019). Both empathy and compassion are constructs that are essential soft skills during the care of patients. Empathy is required to spur compassion; therefore, empathy must be taught first. Training programs within this domain should first focus on understanding the patient's emotions (empathy) and then acting with helping behaviors towards our patients (compassion) (Lown, 2016).

Neurobiologists have studied this order of empathy and compassion application; fMRI studies have found that when a person experiences empathy, the pain centers of the brain are

activated. The existence of mirror neurons and the way they work in everyday life has countless implications (Lamm 2011; Lown, 2016). In the doctor (physician)-patient relationship, empathy is an extremely delicate issue: on one hand there is the needs of the patient, who may be scared and require reassurance while on the other side the physician, needs to be careful not to get too involved in the patient's suffering in order not to lose clearness of mind. Emotion during a patient interaction is a delicate balance, creating medial humanities where art and medicine intertwined. Traditionally, the physician solves the problem because they choose to bypass empathy and adopt a detached approach. This approach often leaves the patient perceiving the physician as cold and cynical. This attitude is understandable, as the discovery of mirror neurons allows us to realize that when we observe another person in pain, pain also arises within ourselves, and for a doctor who spends their entire day with patients this would be unbearable. This is the pain-empathy network which involves the anterior insula and medial and anterior cingulate cortex- activated when observing others fear, happiness, disgust, or anxiety through our brain's limbic system and amygdala. This neural pathway is active when we directly experience pain or observe another person suffering (Lamm 2011; Lown, 2016).

However, there is an antidote to empathy, compassion. When a person focuses on compassion, the reward pathways become active. Researchers conducting neuroimaging studies have shown that compassionate activation is associated with reward pathway activation. Endogenous reward areas and dopamine-related reward processing areas were more active in a physician's brain when they self-reported that they were actively relieving a patient's suffering (Lamm 2011; Lown, 2016). This neurobiological explanation helps reinforce the importance of first utilizing empathy during a patient interaction then concluding the interaction with compassion. The analogy by Trzeciak & Mazzarelli (2019) reinforces this concept: empathy is a

one-way street, traffic only moves in one direction and compassion is a two-way street with traffic traveling in both directions. To further explain, empathy is like a one-way street running toward the health care provider: detecting, processing, understanding and even feeling the incoming emotional cues from the patient. Compassion, on the other hand, is a street that runs in the other direction. Compassion is a responsive action toward the one who is suffering. In summary, empathy can be a one-way street, but compassion must be a two-way street. Application of this analogy helps the healthcare provider activate the reward pathway of their brain.

Utilizing empathy and compassion during clinical practice have shown numerous positive clinical outcomes. DiMatteo and colleagues' (1993) research revealed that empathetic patient communication and interaction resulted in increased patient compliance. Patient compliance is an essential aspect of all healthcare services, especially athletic training. Additionally, Zachariae and colleagues (2003) discovered that empathetic patient communication increased patient satisfaction, which as a result influences patient reported outcomes. During a clinical outcome study, researchers found that a nurse's empathetic engagement in patient care was predictive of reduced anxiety, depression, and hostility in cancer patients (LaMonica, 1987). Trzeciak and Mazzerelli (2019) shared the physiological and psychological health benefits of compassion: (a) less sedatives administered by anesthesiologists during surgery, (b) lower blood pressure, (c) activation of the parasympathetic nervous system, (d) prompting healing from trauma, (e) reduction in back pain, (f) trust building behaviors, and (g) cultivating hope.

Ideally healthcare providers would treat every patient with compassionate care. However, for healthcare providers to effectively build a therapeutic relationship with empathy and compassion, they need to first practice self-compassion and focus on their own well-being. Self-

compassion is a key construct within the field of self-care. Self-compassion is relating to oneself with compassion by actively encouraging the expression of warmth, concern, and caring toward the self (Neff, 2003a, 2003b). The literature suggests that to optimize compassion during patient interaction, the healthcare provider must first practice self-compassion on an interpersonal level (Trzeciak & Mazzerelli, 2019). Yet, healthcare providers face barriers to engaging in compassionate patient-centered care because of burnout and occupational stress. To combat these barriers, researchers have placed their focus on the need to improve healthcare provider well-being. If healthcare providers can improve their well-being then research suggests that the result is compassionate care towards others, such as their patients (Boelliinghaus et al., 2014; Olson & Kemper, 2014; Raab, 2014). Overall, there is evidence to support the effects of compassion on provider well-being, employee engagement, and organization performance. (Boelliinghaus et al., 2014; Olson & Kemper, 2014; Raab, 2014). In addition to the soft skill curriculum including empathy and compassion, educators must also teach future healthcare professionals (HCP) well-being strategies and self-compassion.

Within the literature, researchers utilized a mixed methods approach for two empathy and compassion studies. Bray and colleagues (2014) wanted to report "health professionals and pre-registration students' understanding of compassion with a focus on the perceived role of education in fostering compassionate practice" (Bray et al., 2014, p. 481). This study focused on exploring the perceptions of current healthcare providers and students' perceptions of compassion. Interestingly, both groups had similar views on compassion. The mixed method design of this study allowed participants to voice their lived experience on the topic of compassion in healthcare. For example, the topic of compassion being an innate or taught skill came up during the interview process. As a heavily researched topic, it was interesting because

the participants' data in this study was conflicting with the current body of literature. The study participants also discussed teaching compassion during healthcare professional's education. The participants provided examples of pedagogical strategies that they thought would be successful to conquer the endeavor of teaching compassion. The findings in this study are important to note when moving toward the development of a soft skills curriculum.

Fitzgerald (2014) and colleagues implemented a pilot program called CARE to teach empathy and compassion to healthcare providers in Scotland. This mixed method study utilized the qualitative semi-structured interviews to hear the participants voices to make the training program better. The CARE pilot study supports the utility of implementing the CARE approach as a generic learning tool for healthcare systems in Scotland. The authors concluded, "Together, the CARE Approach and CARE Measurement may offer a feasible way to monitor and/or improve the effectiveness of national policy directives aimed at driving up the quality of the human aspect of healthcare" (Fitzgerald, et al., 2014, p. 6). NHS Education for Scotland funded this study, making Scotland one of the first countries to recommend that all healthcare professionals place empathy and compassion at the heart of healthcare policy. Additionally, this study included five different healthcare facilities of interdisciplinary medical teams, various geographic settings, and differing socioeconomic areas. Also, the CARE program is a training that can be taught to various healthcare professionals or employees that work within the healthcare system but are not classified as medical staff. The participant sample is unique because in the literature most training programs are for the healthcare professionals (e.g. nurses, physicians).

Pedagogical Approaches to Soft Skills in Healthcare Education Curriculums

The eyes of healthcare education leaders are starting to accept the value of incorporating emotional intelligence frameworks into curriculums. Curriculums may vary based upon the specific healthcare profession. However, therapeutic relationships and commitment to emotional competence to foster patient-centered care in healthcare is essential.

The American College of Surgeons now regularly incorporates courses on emotional intelligence into their curriculum. While medical schools in the UK require students to learn and complete an evaluation on doctor patient communication skills (Cherry et al., 2014). A structured framework from The Consortium for Research on Emotional Intelligence Organizations offers EI competence model programs with competence charts to help educators guide learning and assess students' abilities to incorporate EI into their simulated patient interactions. This resource has been helpful to medical schools in the United Kingdom that teach students EI within their curriculum and evaluate students on their EI competencies during objective structured clinical examinations (OSCE) (Cherry et al., 2014). OSCE exams are a frequent assessment tool that educators utilize in healthcare education as a platform to assess students' EI competencies such as self-confidence, empathy, adaptability, communication, conflict management, and teamwork. Farmer (2015) declared, "In today's world of team training, team science, and interprofessional education, the importance of these soft skills cannot be understated" (p. 207).

This paradigm shift has started to occur within nursing education. Freshwater and Stickley (2004) noted, "Rather than an addendum to the nursing curricula, emotional intelligence needs to be placed firmly at the core" (p.96). In fact, nursing education programs are teaching

emotional intelligence, humanitarian values, and soft skills within their curriculum. The field of nursing describes that essential interpersonal constructs are vital foundations for being a successful nurse. Bertram (2018) shared that when student nurses and registered nurses use emotional intelligence, awareness, and empathy to guide their clinical decision making it results in better nurse performance. Another reason that many healthcare professions should emphasize soft skill development among their students is because healthcare organizations have noticed soft skill deficiencies in qualified applicants (Bertram, 2018). Therefore, healthcare education programs should best prepare their students for employment by practicing and demonstrating soft skills within their respective curriculum.

Soft Skills in an Athletic Training (AT) Education Curriculum

Davlin-Pater and Rosencrum (2019) were the first scholars to publish a curriculum promoting soft skill development in pre-professional AT students. The scholars designed the curriculum for pre-professional AT students prior to beginning their clinical experiences and patient interactions. The reason for this decision is twofold. First, professional socialization and soft skill development should begin prior to patient care. Second, soft skills are foundational in preparing students for their clinical experience. Therefore, teaching the proposed curriculum in AT education creates a solid foundation for students to transition to their professional education and prepare patient-centered interactions. The topics covered in the soft skills curriculum include: (a) masters of time and energy, (b) listen and lead, (c) knowledge and curiosity, (d) decisive and confident, (e) dependability and responsibility, (f) positive attitude and perseverance, (g) prepared and adaptable, (h) growth mindset and action oriented, (i) observant and exact, (j) good character and trustworthy, and (k) giver and takers (Davlin-Pater & Rosencrum 2019, p. 75). The researchers provided a curricular framework for other AT

education programs to promote a paradigm shift towards a biopsychosocial model of healthcare delivery while prioritizing patients as the central focus for care.

A paradigm shift to utilizing the biopsychosocial model during therapeutic care is the future direction of healthcare education. In order to cultivate change, healthcare educators need to incorporate the biopsychosocial philosophy into their curriculum. As Engle (1979) eloquently stated:

> Educators for the health professions are confronted with choices that could have momentous significance for the future of healthcare. Educators can continue to try to force medicine into the Procrustean Bed of the biomedical model, with all divisiveness and fragmentation encouraged by its inherent reductionism and dualism, or they can consider a more comprehensive model that emphasizes psychosocial skills based on a systems approach, with its potential to enhance collaboration, communication, and complementarity among the various health professions and enhance the general level of competence of each. That choice and opportunity is especially crucial for those just beginning their education, because how health science and healthcare evolve in the future is to a large degree determined by the approach health profession educators take in training fledgling providers-to-be (p. 165).

Students place trust in their educational leaders to teach them the skills needed to be successful providers. When the research is significant stating that patient-centered care improves clinical outcomes, quality of care provided, and patient satisfaction while decreasing healthcare costs and health disparities, they are outcome measures that we cannot ignore in our educational approach to teaching patient care (Little et al., 2001; Mead & Bower, 2002; Oates et al., 2000).

Summary

In conclusion, it is imperative for healthcare educators to make the paradigm shift toward incorporating the biopsychosocial model into clinical practice. This philosophy serves to integrate biomedicine, psychology, and social domains and embraces human connection, human complexities, and the uniqueness of the patient (Engle, 1979). When we intentionally place the patient at the heart of healthcare then we are advancing our medical practice through patient-centered care. Healthcare education curriculums have begun to recognize the value of patient-centered care. Physician training programs, surgical residencies, and nursing education programs are a few of the healthcare organizations who have prioritized teaching emotional intelligence competencies within their curriculums. Recently, Davlin-Pater and Rosencrum (2019) created a framework for athletic training educators to emphasize soft-skills within their curriculum. This framework is an appropriate starting place for AT educators to build the philosophical biopsychosocial foundation into the curriculum and prioritize patient-centered care.

Theoretical Framework for a Soft Skills Curriculum in Athletic Training Education

During a patient interaction, it is essential that a healthcare provider establishes a therapeutic alliance. According to Linsley & Carroll (2012), "A therapeutic alliance is a collaborative relationship between client and practitioner based on trust and respect" (p. 45). The process of achieving a therapeutic alliance, also referred to as a therapeutic relationship, is complex and requires multiple components, which I will expand upon in the following section. Therefore, models and theories help to create pedagogical strategies to develop healthcare providers' soft skills which are essential in developing therapeutic relationships.

This study utilizes Muetzel's model to acquire materials for healthcare students to learn how to build therapeutic relationships with empathy and compassion (Richardson et al.,

2015). Muetzel (1988) suggested that the patient and practitioner build a therapeutic relationship from the concepts of partnership, professional intimacy, and reciprocity. The model emphasizes that both the patient and practitioner benefit from the relationship built.

For a healthcare provider to be effective in establishing a therapeutic relationship they need to prioritize their own well-being. Seligman's Theory of Well-Being includes five constructs: positive emotion, engagement, relationships, meaning, and achievement (Seligman, 2009). If clinicians do not know how to cultivate their own well-being, then they will not be able to build holistic relationships and share these foundational constructs with their patients. McMahon (1986) posited that a therapeutic relationship should not only provide for the whole patient but also the whole healthcare provider. In addition to establishing well-being, healthcare providers need to practice self-awareness of emotions.

Goleman (1998) defined emotional intelligence (EI) as the ability to recognize, understand, and manage our own emotions as well as recognize, understand, and influence the emotions of others. Healthcare providers need to learn EI in order to recognize their personal and patients' emotional needs. EI determines healthcare providers' potential for learning practical skills and is based on five elements: self-awareness, motivation, self-regulation, empathy, and adeptness in relationships (Goleman, 1998). To achieve a common goal, empathy between the patient and the healthcare provider is critical. When the healthcare provider practices empathy, the patient feels and expresses emotions while the practitioner is sensing and absorbing the patient's emotions.

The next step towards achieving a therapeutic relationship is action, the practitioner must act with compassion towards the patient to achieve a common goal. The Action Phase Model of Compassion is when healthcare providers express a desire to help with compassion then act with

helping behaviors to achieve goals in partnership with their patients (Poulin, 2017). This portion

of the therapeutic relationship displays reciprocity, the practitioner and the patient have invested

in each other to achieve common goals. This study's theoretical framework is four-fold. Figure 2

illustrates how healthcare providers construct a therapeutic relationship from the theory of well-

being, emotional intelligence, and an action phase model of compassion.

Figure 2

Theoretical Framework for a Soft Skills Curriculum in Athletic Training Education
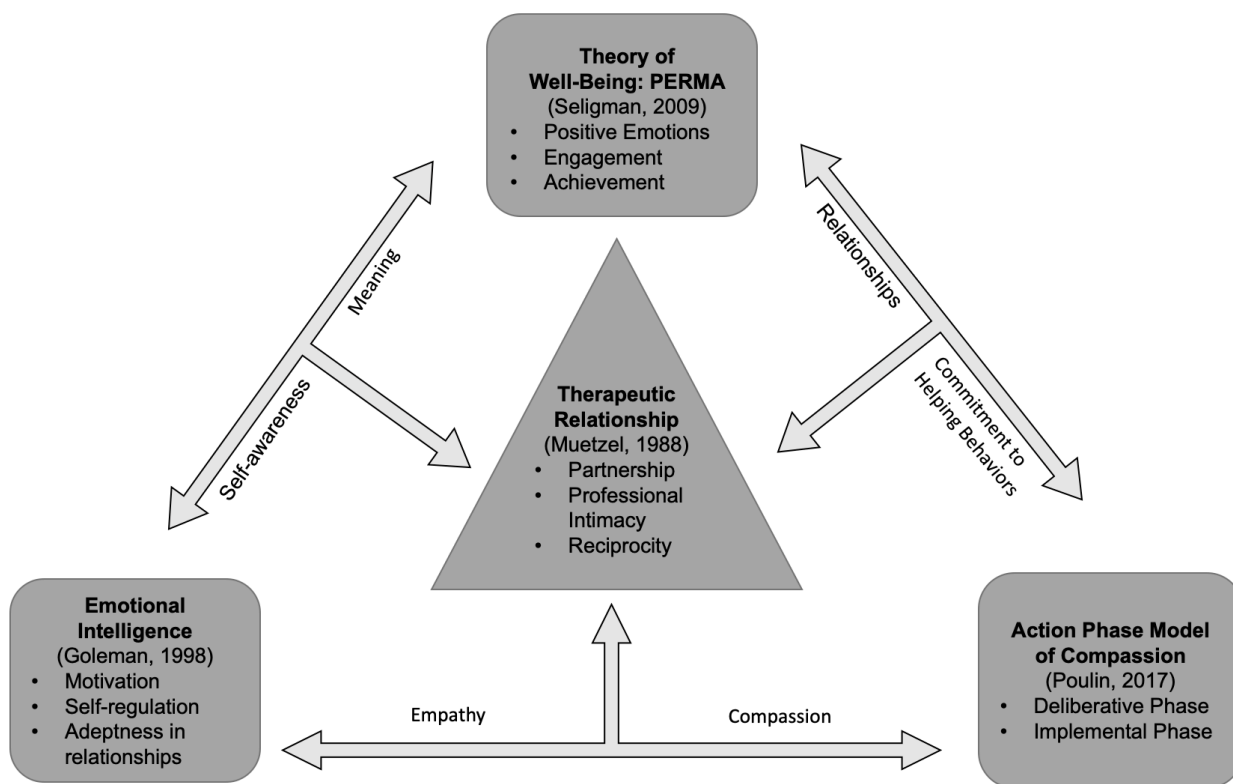
Note. Figure 1 Illustrates the connection between the theory of well-being, emotional
intelligence, and the action phase model of compassion to build a therapeutic relationship.

The following sections discuss how the theory of well-being, emotional intelligence, and an

action phase model of compassion interact to build a therapeutic relationship.

The Muetzel Model of Therapeutic Relationships

Derived from the nursing literature, the Muetzel Model of Therapeutic Relationships consists of three overlapping constructs; partnership, professional intimacy, and reciprocity (Muetzel, 1988). Muetzel (1988) described *partnership* as a working association between two parties towards a common goal. Partnership imperative to acknowledge that a power dynamic may be present between the parties in a therapeutic relationship because through an established partnership both parties' benefit. Researchers find partnership to be universally important and associated with other concepts such as collaboration, trust, mutuality, respect, understanding, shared decision making and empowerment (Richardson et al., 2015).

Muetzel (1988) defined professional intimacy as "a closeness at physical, psychological, and spiritual levels which suggests a sense of communion between persons that is meaningful and valuing to and of those concerned" (p. 98). Muetzel incorporated professional intimacy from Maslow's research cultivating a sense of belonging and altruism. Research captures intimacy within the concepts such as nurse presence, providing comfort, empathy, and compassion (Richardson et al., 2015). Patients want their healthcare provider to relate to them and get to know them as a person, Muetzel (1988) describes professional intimacy as, "the human-to-human interaction, a mutually significant experience- a recipe for authenticity leading to self-actualization for both, in accordance with the meeting of personal philosophies" (p.98). Creating a relationship helps the practitioner avoid defining patients by their illness, disease, or pathology and promotes seeing the whole person.

Reciprocity establishes that relationships are a two-way street. The patient receives support and care though a therapeutic relationship. While a healthcare provider also receives

benefits of a therapeutic relationship (Muetzel, 1988). For example, treating patients with empathy and compassion can enhance the clinician's well-being (Trzeciak & Mazzarelli, 2019). Muetzel created this model because she recognized that therapeutic relationships have an enormous potential for healing. The model is fluid because each practitioner and patient hold varying moral philosophies and different world views. Mill (1962) stated, "Human nature is not a machine to be built after a model and set to do exactly the work prescribed for it, but a tree which requires to grow and develop on all sides according to the tendency of the inward forces which make it a living thing" (p. 96). The goal of a therapeutic relationship is to provide an environment that is emotionally as well as physically secure for both the practitioner and patient to heal together (Muetzel, 1988).

Theory of Well-Being

Martin Seligman's Theory of Well-Being - PERMA model consists of the five building blocks: positive emotion, engagement, relationships, meaning, and achievement (Seligman, 2009). Together these constructs build the theory of well-being. Each construct is equally important in establishing well-being. However, the theoretical framework for this study will specifically focus on relationships and meaning as they relate to building a therapeutic relationship.

According to Seligman (2009), positive relationships are an essential element of well-being is positive relationships. The theoretical framework for this study emphasizes the importance of relationships when practitioners and patients interact, as human beings strive to establish satisfying relationships. Bowlby (1982) explained that from a human biology perspective, human beings desire to create affectionate relationships with each other. Muetzel (1988) also emphasized that humans build relationships through partnership, professional

intimacy, and reciprocity. This connection shows that having mutually-satisfying, positive relationships between practitioners and patients is an essential aspect of well-being.

The fourth pillar of well-being is meaning. Seligman (2012) defined meaning as having a sense of purpose derived from something viewed as larger than the self. A central value to healthcare is the desire to help and finding meaning in this course of action. Muetzel (1988) noted, "when practitioners and patients are not merely in association but rather in a relationship whose nature is holistic and therapeutic a confrontation and a sharing of meaning will occur in which both have the power to influence change and are vulnerable to change" (p. 97). The theory of well-being is an essential educational component when teaching future clinicians how to build positive patient relationships with emotional intelligence and compassion. As previously mentioned, relationships should not only cater to the patient but the clinician too. If clinicians do not know how to cultivate their own well-being they cannot achieve, partnership, professional intimacy, and reciprocity to establish a meaningful relationship.

Emotional Intelligence (EI)

From a historical perspective, EI came into the spotlight in the 1900s and within the last 30 years EI has received a great deal of attention. Psychologists John Mayer and Peter Salavoy introduced the original concept of EI to academia. They defined EI as "an individual's ability to monitor his/her own and others' emotions, discriminate between the positive and negative effects of emotions and use emotional information to guide his/her thought and actions" (Akerjordet & Severinsson, 2008, p.1406). Eight years later Goleman expanded Mayer and Salavoy's EI definition and connected emotional intelligence to learning. Goleman (1998) claimed that EI determines our potential for learning practical skills and is based on five elements: self-awareness, motivation, self-regulation, empathy, and adeptness in relationships. Goleman's

framework reflects EI as a social skill. Therefore, professional students like nurses and other healthcare professions can utilize Goleman's model to learn how to implement EI during therapeutic interactions. The literature has suggested that development of EI within clinical nursing is a valuable skill (Akerjordet & Severinsson, 2008). Specifically, EI can lead to self-awareness, greater adaptability, improved relationships, the ability to empathize, and productive communication (Freshwater & Stickley, 2004; Tischler et al., 2002). Each of these outcomes are essential to building a strong therapeutic relationship between a patient and a clinician.

Action Phase Model of Compassion

Poulin (2017) created the action phase model of compassion based upon mindset theory and the action-phase model of goal pursuit. According to Poulin (2017), the purpose of this model is express the effects of compassion and helping behaviors on well-being for both the practitioner and patient. Goetz and colleagues (2010) defined compassion as "the feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help" (p.649). The action phase model of compassion incorporated two phases. The first phase is the deliberative phase when the person feels compassion which results in a desire to help the other person who is suffering. The second phase is the implementation phase when the person shifts from a desire to help to a commitment of helping behaviors to alleviate another person's suffering. When a person chooses to express compassion through helping behaviors favorable outcomes for health and well-being occur (Poulin, 2017). When learning how to build a therapeutic relationship this model emphasizes the value of action and moving beyond simply a desire to help the patient that is suffering.

In summary, building a therapeutic relationship is complex and requires multiple components. Built on Muetzel's Model a practitioner and patient must achieve partnership,

professional intimacy, and reciprocity in order to establish a therapeutic relationship. This study utilizes three additional theories to explain the intricacies of achieving a therapeutic relationship. First, the practitioner needs to engage in their own well-being in order to build meaningful positive relationships with their patients. Once a state of well-being is accomplished healthcare providers need to learn about emotional intelligence. Emotional intelligence is building self-awareness of the practitioner's personal emotions as well as practicing empathy towards a patient's suffering. After a practitioner senses a desire to help, they will act with compassion and commit to helping behaviors to achieve a common goal of alleviating the patients suffering as shared in the action phase model of compassion. Establishing a helping relationship based on trust and respect not only supports the patient, but also provides the practitioner with a sense of meaning. Clinically, this fluid process takes practice and patience to implement. Theoretically, the combination of these three theories establish a framework for a therapeutic relationship to flourish.

Summary

In conclusion, as healthcare educators, making the paradigm shift towards incorporating the biopsychosocial model into our clinical practice is imperative. This philosophy serves to integrate biomedicine, psychology, and social domains (Engle, 1979). The biopsychosocial model embraces human connection, human complexities, and the uniqueness of the patient. When we intentionally place the patient at the heart of healthcare then we are advancing our medical practice through patient-centered care. Healthcare education curriculums have begun to recognize the value of patient-centered care. Physician training programs, surgical residencies, and nursing education programs are a few of the healthcare organizations who have prioritized teaching emotional intelligence competencies within their curriculums. Recently, Davlin-Pater

and Rosencrum (2019) have created a framework for athletic training educators to emphasize soft-skills within their curriculum. This framework is an excellent starting place for AT educators to build the philosophical biopsychosocial foundation into the curriculum and prioritize patient-centered care. The next chapter will describe the methodology utilized during this study. Specifically, in Chapter III, I will discuss the research participants, the study's setting, the quantitative and qualitative instruments, and the research procedures implemented to complete the data analysis.

Chapter 3: Methods

This study utilized an explanatory sequential mixed method research design. According to Creswell (2018), "Integration in explanatory sequential design will consist of explaining the survey results with qualitative interviews, connecting the quantitative results with the qualitative data collection, displaying the results that link the survey results with the qualitative research questions, and interpreting the results to help explain the survey results with information from participants who can best reflect on the survey results" (p. 298). Specifically, the research study consisted of quantitative surveys followed by a qualitative single case study embedded research design. Students were taught a soft-skills curriculum and throughout the semester the students used quantitative surveys to self-report their levels of empathy and compassion. Once the students transitioned to clinical practice, the students' voices and experiences were highlighted through the qualitative component of the study, providing an understanding of the knowledge that the students transferred from the classroom to clinical practice. Therefore, the results led to insight about how the qualitative lived experiences help explain the quantitative results (Creswell, 2018). Lastly, the embedded qualitative portion in this sequential mixed method design completed the triangulation between the students' quantitative data, coding of clinical reflection logs, and semi-structured interviews with purposeful sampling of participants. Triangulation establishes convergence and corroboration by comparing findings from qualitative data with the quantitative results (Creswell, 2018).

This study used an explanatory sequential mixed method design with a preliminary quantitative input (quan→ QUAL [qual]) (Morgan, 2014). According to Creswell (2015), a sequential mixed method design consists of first gathering quantitative data and then gathering qualitative data to help explain or elaborate on the quantitative results. Researchers use an

explanatory sequential case variant when the researcher places priority on the second qualitative phase instead of the initial quantitative phase (Creswell & Plano-Clark, 2017). Specifically, the study design is a preliminary quantitative input, meaning the quantitative data results allow me to purposefully select the embedded qualitative interview participants (Creswell, 2018). I completed this research study in three phases:

> *Phase One:* quantitative survey design
>
> *Phase Two:* case study research design with a constant comparative analysis
>
> *Phase Two Embedded:* semi-structured qualitative interviews with participants selected
>
> from Phase One quantitative criteria.

The timeline applied for this study is depicted in Figure 3.

Figure 3

Study Timeline
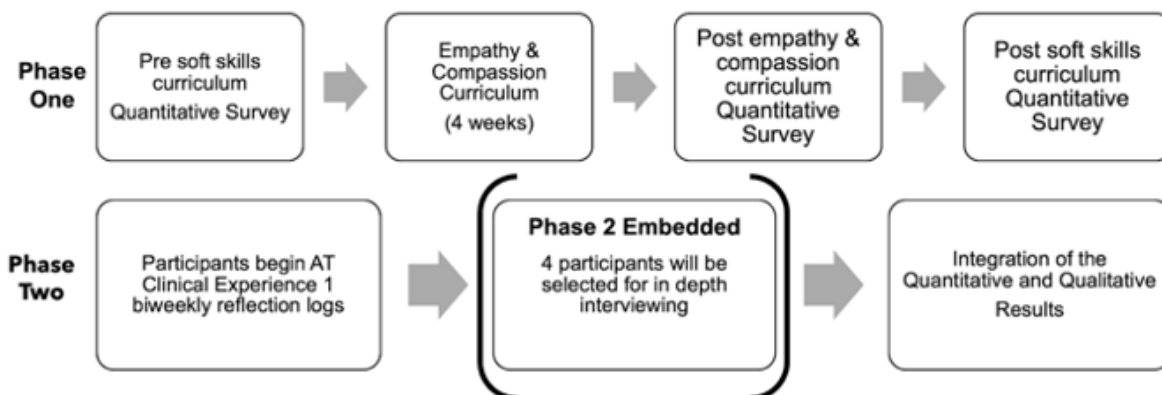
Note. Figure 3 describes the timeline for this study's procedures.

Phase 1

Phase 1 of the research study included two quantitative, self-reported questionnaires: one to measure empathy and one to measure compassion. I administered the Jefferson Empathy Scale for Health Professions Students (JSE-HPS) survey (Appendix A) and a Compassion Scale (CS)

(Appendix B) to the participants. I selected the two surveys with the intention to analyze the participants' perceptions of their own empathy and compassion. The participants completed both surveys at three different time points: (1) before the soft skills curriculum, (2) after the empathy and compassion curriculum, and (3) after the soft skills curriculum.

Empathy and Compassion Curriculum

The participants completed a 4-week empathy and compassion curriculum. The didactic lessons consisted of asynchronous online learning modules and synchronous sessions. According to Patel (2019), empathy is required to spur compassion; thus, I taught the empathy curriculum first.

Empathy Curriculum. The students began with the online asynchronous module which allowed the students the opportunity to explore the content at their own pace prior to attending the synchronous class. The objectives for the empathy curriculum were for students to be able to: (a) define empathy within the context of a therapeutic relationship, (b) understand and implement evidence-based practice (EBP) strategies to create an empathetic patient interaction, (c) recognize the importance of well-being for healthcare professionals, and (d) reflect on empathetic interactions within the healthcare system. Students were assigned learning activities and completed them in a sequential order. To guide students' thinking and help them stay organized during the module, they completed a guided worksheet, which was a document with eight thought-provoking questions throughout the module (Appendix C). First, the students watched a pre-recorded lecture that I created. Next, the students viewed a YouTube video, *Brene Brown: The Definition of Empathy* (Brown, 2013). Then, the students watched a video from the Cleveland Clinic, *Empathy: The Human Connection to Patient Care* (Cleveland Clinic, 2013). Finally, the students ended the online module by completing a researched gratitude practice

(Seligman et al., 2009). The instructions stated that the students submit their guided worksheet prior to our synchronous class.

The synchronous class began by discussing the students' answers to the first two questions on the guided worksheet: (1) Prior to learning about empathy and completing the module, how would you define empathy? (2) Reflect on a time when you were treated with empathy and treated with a lack of empathy? How did you feel? What do you specifically remember about these two events? After a brief discussion, we completed an information recall and reviewed the EBP steps of an empathic engagement which include various clinical skills and behaviors such as: (a) sitting versus standing, (b) detecting patients facial expressions and nonverbal cues of emotion, (c) recognizing and responding to opportunities for compassion, (d) employing non-verbal communication of caring, (e) incorporating statements of support, (f) being present, assuring the patient of a true focus, and (g) reinforcing that they are not going through their current medical treatment alone (Patel, 2019). Then, we practiced implementing the four qualities of empathy, perspective taking, staying out of judgement, recognizing emotion and communication, by applying them to a clinical scenario (Wiseman, 1996). I presented a vignette to the students in small groups where they critically applied the four qualities of empathy to a healthcare scenario. The synchronous session concluded with a one-minute quick write reflection where the students reflected on a topic from the empathy lessons (asynchronous and synchronous) that they envisioned utilizing in their future clinical practice. A visual representation of the empathy curriculum is displayed in Table 1.

Compassion Curriculum. Similar to the empathy lessons, the students first completed an asynchronous online compassion module followed by a synchronous compassion class. The objectives for the compassion lessons were to be able to: (a) define compassion within the

context of a therapeutic relationship, (b) describe the core elements of self-compassion, (c)

understand the antidote to compassion fatigue and burnout for healthcare providers, (d) explore

various ways to implement compassion during a patient interaction, and (e) practice utilizing

empathy and compassion during a mock patient interaction. The students completed a guided

worksheet assignment that connected to the online module material by promoting self-reflection

and critical thinking (Appendix D). The students completed six learning activities. First, the

students watched a pre-recorded lecture that I created using the available evidence to support the

use of compassion and self-compassion within healthcare. Then, the students watched three

supplemental YouTube videos: (1) *Compassion in Healthcare* (Dignity Health, 2015), (2) *How*

40 Seconds of Compassion Could Save a Life (Trzeciak, 2018), and (3) *'Cane Talks: Ask the*

Right Questions- What Athletic Trainers Can Teach Us About Healthcare (Harriell, 2020). Then

the students listened to a podcast by Keltner (2019), *The Science of Happiness*, *Does your*

Doctor Listen to you? Finally, the online module concluded with the same *three good things*

gratitude practice (Seligman et al., 2009).

I began the synchronous compassion lesson with an information recall, where the

students discussed the differences between empathy and compassion. Then, we reflected on the

ticket in assignment, the students shared values and barriers to self-compassion, we discussed

clinical take home messages from Dr. Trzeciak's Ted Talk, brainstormed ways to implement Dr.

Harriell's three important clinical questions, and shared any information that the students found

to be pertinent to their lives or clinical practice. Next, we completed Neff and Germer's (2018)

self-compassion exercise, *how do you treat a friend?* After that, we examined how to apply

compassionate interactions. Compassionate interactions included: helping behaviors,

concentration and acknowledging, research and respond, and paraphrasing (Patel, 2019). The last

activity was a clinical application, the students created a vignette and acted out a clinical scenario with a fishbowl exercise. The students were in groups of three, one student was the patient, one student was the clinician, and one student was the observer. The observer used The Schwartz Center Compassion Scale (2015) to provide their peers with feedback. After the role plays, we debriefed as a class, the students described how the exercise went for their group, identified what went well, declared ways to improve during future patient interactions, and stated their clinical take home message. A visual representation of the compassion curriculum is depicted in Table 1. The synchronous compassion concluded with the students completing the Timepoint 2 quantitative surveys.

Table 1

Empathy and Compassion Curriculum

Topic	Focus	Activities			
Empathy	The ability to sense, feel, and understand another's emotions.	Watch: (1) *Brene Brown: The Definition of Empathy* (Brown, 2013) (2) *Empathy: The Human Connection to Patient Care* (Cleveland Clinic, 2013)	Discuss: (1) Reflect on a time when you were treated with empathy and treated with a lack of empathy? How did you feel? What do you specifically remember about these two events?	Activity: Use the four qualities of empathy to apply to a clinical case: 1.) perspective taking, 2.) staying out of judgement 3.) recognizing emotion 4.) communication (Wiseman, 1996)	
Compassion	An emotional response to another's pain or suffering involving an authentic desire to help.	Watch: (1) *Compassion in Healthcare* (Dignity Health, 2015) (2) *How 40 seconds of compassion could save a life* (Trzeciak, 2018) (3) *Ask the right questions- what athletic trainers can teach us about healthcare* (Harriell, 2020)	Listen: (1) *The Science of Happiness*, *Does your Doctor Listen to you?* (Keltner, 2019) Discussion: What were your "AH-HA" moments after watching the videos and listening to the podcast?	Activities: (1) Self compassion exercise (2) Fishbowl exercise	Follow-up: (1) Describe how this exercise went for you. What went well? (2) What are you looking to improve upon during future patient interactions? (3) What was your take home message?

Note. Table 1 shows an organized format of the Empathy and Compassion curriculum.

Phase 2

Phase 2 initiated the qualitative data collection. The participants completed a total of 6 bi-weekly reflection logs. The reflection logs consist of multiple open-ended questions asking about the students' understanding of empathy and compassion and their lived experience of how they implement empathy and compassion during their semester-long clinical experience. The reflection logs were coded with a constant-comparative method (Glaser & Strauss, 1967). The specific approach to coding data includes open coding, axial coding, and selective coding. Southern and Devlin (2010) suggested that the inductive approach of grounded theory is an accessible method for bridging the gap between theory and practice. Therefore, constant-comparative coding characteristic to grounded theory methodology is appropriate when studying how concepts from a didactic curriculum are applied to clinical practice.

Embedded Phase Two

The Embedded Phase Two expanded the qualitative portion of the study. This qualitative strand consists of four purposefully selected in-depth, semi-structured interviews. I selected four participants based upon their quantitative survey results and the quantitative question asked on the participants reflection logs. Specifically, interview selection criteria included students who reported an increase in biweekly utilization of both empathy and compassion during the quantitative portion of the reflection log, the participants with the highest median values completed the semi-structured interviews. The purpose of this selection criteria is to magnify the voices of participants who have increased their use of empathy and compassion during their clinical experience. Using the specified selection criteria will help answer the original research question and purpose of the study, *In what ways does knowledge from a soft skills curriculum during a didactic pre-professional course transfer to clinical practice during athletic training*

students' clinical experience? I conducted the semi-structured interviews with a guided protocol (Appendix E). I voice recorded the interviews, transcribed the recording, and analyzed the data for codes using a constant-comparative approach. After the four participants were interviewed and the interviews were transcribed, member checking occurred to establish credibility and trustworthiness. For this study member checking included emailing the transcribed interviews to the research participants and allowing them to review the document and request necessary changes within one week of receiving the transcription. Qualitative researchers use member checking as a technique that allows the participant to verify that they have accurately shared information from their perspective. The process of member checking is similar to inter-rater reliability and supports the integrity of the data (Lichtman, 2013).

Participants

Phase One of the study included upper-level undergraduate students (n=19) enrolled in a pre-professional Capstone in Sports Medicine course at a University in the mid-Atlantic region (Spring 2020). This purposeful sampling is appropriate selection choice because all students enrolled in this capstone course completed a soft-skills curriculum (Davlin-Pater & Rosencrum, 2019), I asked participants for their consent to access outcome measurements (quantitative survey data) that the students completed during the course curriculum. Additionally, the participants were asked to complete demographic questions, as shown in Table 2.

Table 2

Demographics of Participants

Question	Response Options
Please record your participant identification number.	Identification protection of participants- numeric value response
What is your current age?	Numeric value response
To which gender identity do you most identify?	Male, Female, Transgender Male, Transgender Female, Gender Variant/Nonconforming, Other
Mentoring is a relationship between two people with the goal of professional and personal development. The "mentor" is usually an experienced individual who shares knowledge, experience, and advice with a less experienced person, or "mentee." Based upon this description, do you currently feel like you have a professional mentor?	Yes, No, Unsure
At which time point are you completing this Survey?	1- End of Survey 2- End of Survey 3- Time point three follow up questions

Note. This table describes the demographic questions that the study participants answered

prior to completing the qualitative survey tools.

The questions were completed three times, prior to each survey administration time point. The

same research participants (n=19) comprised the study sample for Phase Two which occurred

during the Fall 2020 semester. The sample of students transitioned to entry level master

professional students enrolled in a Commission on Accreditation of Athletic Training (CAATE)

athletic training education program (ATEP). The students are registered in AT Clinical

Experience 1 and will complete their first clinical experience during the Fall 2020 semester.

Students who are enrolled in AT Clinical Experience 1 without completing the Sports Medicine

Capstone course in Spring 2020 will not be eligible for study participation. The participants were

the same students from Phase 1 (n=19), no attrition occurred during data collection.

Procedures

Figure 4 illustrates the procedures and phases of this explanatory sequential mixed-

method design with a preliminary quantitative input (quan→ QUAL [qual]) research study.

Figure 4

Study Procedures Diagram

Quantitative Data Collection	Quantitative Data Analysis	Qualitative Data Collection / Qualitative Data Analysis	Case Selection: Interview Protocol	[Qualitative Data] Collection / [Qualitative Data] Analysis	Integration of the Quantitative and Qualitative Results
Repeated measures empathy and compassion surveys (N=19)	ANOVAs for composite scores, t-tests for Likert scales, SPSS	Thematic coding of reflection logs (n=19)	Purposefully selecting 4 participants that report using empathy and compassion skills clinically and high self reported empathy and compassion	Individual in person in depth interview with interview protocol	Interpretation and explanation of quantitative and qualitative results
Numeric data	Descriptive Statistics, composite scores overtime	Codes and themes Similar and different themes and categories	Cases (n=4) Semi-structured interview	Text data (interview transcripts)	Discussion, Implications, and Future research

Note. The procedural diagram consists of three rows, row one indicates the phase of the study, row two describes the procedure and data analysis, and row three identifies the research product.

Phase One of the research study began in Spring 2020 (1/21/2020-5/4/2020) with upper division

students enrolled in the course, Capstone in Sports Medicine, who were engaged in a soft-skills

curriculum (Davlin-Pater & Rosencrum, 2019). In addition to being the primary researcher, I had

the opportunity to teach the empathy and compassion portion of the course. At three points

during the semester (week 1, week 5, and week 15), I administered the Qualtrics quantitative

empathy and compassion surveys (Appendix A and B) to the students. The Qualtrics quantitative

empathy and compassion surveys allowed the students to know their baseline scores and if their

empathy and compassion measures changed throughout the curriculum. Participation in the

course curriculum was mandatory. The students provided informed consent for the researchers to

have access to the Qualtrics quantitative survey results. In total, the quantitative surveys took

approximately 15-20 minutes for the students to complete at each indicated time point. The

participants completed two surveys: The Jefferson Empathy Scale Health Professional Student

Version (Fields, 2011) (Appendix A) and the Compassion Scale (Pommier & Neff, 2019)

(Appendix B). Specifically, I administered the surveys at three timepoints, pre-curriculum

content (week 1), post empathy/compassion curriculum (week 5), and post course soft-skills

curricular content (week 15). As shown in Table 3, additional quantitative questions were added

to the week 15 survey.

Table 3

Timepoint 3 Follow Up Questions

Question	Response Options (Sliding Scale 1-100)
1. Please rate how frequently you project to utilize the respective soft skill during your future clinical experience.	Almost Never, Rarely, Sometimes, Often, Almost Always
2. Please quantify how important you think soft skills are during a patient interaction.	Not Important at All, Low Importance, Slightly Important, Neutral, Moderately, Very Important, Extremely Important

Note. Table 3 shows the two follow up questions that participants answered after completing the quantitative surveys at time point 3.

These two questions aided in the preliminary quantitative input for the embedded qualitative portion of this study. When the students completed the surveys at time point 3, this indicated the end of Phase One, quantitative data collection.

Phase Two incorporated a single case study embedded research design. The study participants completed six reflection logs every two weeks throughout the course of the Fall 2021 semester. I wrote the questions with the intention that the students would reflect on events that happened at their clinical experiences within the previous two weeks (see Table 4).

Table 4

Reflection Log Questions

Question

---

1. Empathy is defined by Patel (2019) as, the ability to sense, feel, and understand another's emotions. Given that definition, describe one or more times when you demonstrated empathy during the past two weeks of your clinical experience.

---

2. Compassion is defined as an emotional response to another's pain or suffering involving an authentic desire to help (Patel, 2019). Given that definition, describe one or more times when you demonstrated compassion during the past two weeks of your clinical experience.

---

3. Given the pandemic, in what ways has your ability to provide patient-centered care been influenced in the last two weeks?

---

4. Please describe your own well-being in the past two weeks.

---

5. Describe the ways in which your own well-being has influenced your ability to exhibit soft skills and provide patient-centered care in the last two weeks of your clinical experience.

---

6. How frequently did you utilize the soft skills of empathy and compassion in the last two weeks?
1: Never: I do not use empathy and/or compassion during patient interactions
2: Rarely: I use empathy and/or compassion during patient interactions monthly
3: Sometimes: I use empathy and/or compassion during patient interactions weekly
4: Often: I use empathy and/or compassion during patient interactions daily
5: Always: I use empathy and/or compassion during every patient interaction

---

Note. Table 4 explains the reflection log questions that the participants completed bi-weekly during the Fall 2020 semester.

After the students completed the reflections logs throughout the course of their semester,

I analyzed the qualitative data with a constant comparative method to interpret the results. Glaser

(1965) described four stages of the constant comparative method: (1) comparing incidents

applicable to each category, (2) integrating categories and their properties, (3) delimiting the

theory, and (4) writing the theory. This study will implement the first two stages of the constant

comparative method to draw conclusions and answer the research question, *In what ways do*

athletic training students perceive they transferred soft skills into clinical practice? A computer-assisted qualitative data analysis software (CAQDAS), Dedoose, was used for open, axial, and selective coding.

The embedded portion of Phase Two consists of four semi-structured interviews. The student interview selection criteria included students who reported an increase in biweekly utilization of both empathy and compassion during the quantitative portion of the reflection log. If more than four students showed increased median utilization of empathy and compassion, then the students with the highest self-reported empathy and compassion mean from the week 15 survey during Spring semester were selected for the interview process. The four participants answered open ended questions during a 30-45-minute virtual interview recorded on Zoom. See Appendix B to view the semi-structured interview protocol. I transcribed and coded the interviews using a CAQDAS, specifically the Dedoose software. The discovered data codes and themes answered the two additional research questions: (1) *How do athletic training students describe their emotional response to utilizing soft skills during clinical practice?* and (2) *In what ways are the development of soft skills associated with athletic training students' subjective well-being?*

Data Triangulation

Data triangulation occurs when researchers use multiple methods or data sources in qualitative data research to develop a comprehensive understanding of a phenomenon (Patton, 1999). By evaluating multiple methods of data collection about the same phenomena the researchers validate their data results. This study uses method triangulation and according to Polit and Beck (2012), "Method triangulation involved the use of multiple methods of data collection about the same phenomenon" (p. 545). For this study on implementing soft skills into

clinical practice, I used three sources of data including: (a) quantitative surveys over the course of a semester, (b) reflection logs with five writing prompts, and (c) semi-structured interviews. Data triangulation provides a broader understanding of the phenomenon of interest and supports data validation (Carter, 2014).

Description of the Setting

The site selection is based upon a purposeful and convenience sample. The study takes place at one University in the mid-Atlantic region that has a 3+2 Professional Athletic Training Education program. The field of athletic training has recently switched the level of degree necessary to sit for one's board of certification (BOC) exam to become a certified athletic trainer to a Masters of Athletic Training degree. Therefore, four different types of athletic training education programs are now available: (1) Bachelors in Athletic Training (phased out by 2022), (2) Masters in Athletic Training (2 year program), (3) 3+2 Athletic Training program (3 years for a BS and 2 years for a MS in AT), and (4) Post-professional Masters in Athletic Training program (these students are already certified athletic trainers furthering their education after earning a BS degree). Studying students in a 3+2 AT program provides the opportunity to investigate the purpose of the study: *Can soft skills be taught to pre-professional students then transferred to clinical practice as professional students during their master's program?*

Instrumentation

Compassion and empathy training programs tend to focus on quantitative outcome measures (Patel et al., 2019). This study implements a mixed-methods research design to assess quantitative program outcomes and qualitatively capture the ways in which students perceive implementing soft-skills during their patient encounters at their first clinical experience. Therefore, I implemented three instruments throughout the course of this study. Phase One

included survey data collection, Phase Two captured the participants' experiences through reflection logs, and the Embedded Phase Two consisted of four semi-structured interviews.

Surveys

The study participants completed two surveys at three different time points during the Spring 2020 semester. Students completed the Jefferson Scale of Empathy-Student Version (JSE-SV) and the Compassion Scale (CS). The JSE-SV is an interdisciplinary instrument used to measure empathy in the context of health professions education and patient care (Hojat et al., 2018). Pommier and colleagues (2019) developed the CS from Neff's theoretical model of self-compassion and Buddhist philosophical tradition. The CS measures compassion as a compassionate or uncompassionate response to others in the context of emotional responding, cognitive understanding, and paying attention to suffering (Pommier et al., 2019). In using both surveys, I was able to produce composite scores for the students' empathy and compassion levels and compare their scores over the course of the semester using repeated measures ANOVA statistical analysis.

Jefferson Scale of Empathy-Health Professions Student Version (JSE-HPS-version). The American Board of Internal Medicine (1983) recommended that humanistic qualities, such as empathy, are taught and assessed during physician education. However, empathy is a valuable skill for all healthcare professionals, not just physicians, because Hojat and colleagues (2014) identified empathy as a predictor of clinical competence and positive patient reported outcomes. Therefore, empathy is a professional skill value among healthcare professionals. The developer of the JSE-HPS (2016) noted that "empathy in patient care is a predominantly cognitive attribute that involves understanding of pain and suffering of the patient, combined with a capacity to communicate this understanding, and the intention to help" (Hojat, 2016). The JSE-HPS version

consists of 20 items, each answered on a 7-point Likert scale (strongly agree = 7, strongly

disagree = 1). Out of the 20 items, 10 are negatively worded requiring reverse coding for scoring.

Participant scores can range from 20 to 140. Ultimately, a higher composite score means that the

participant has more of an orientation or behavioral tendency toward empathic engagement in

patient care (Hojat et al., 2002). A letter of permission to use the JSE-HPS in this study is shared

in Appendix F.

Compassion Scale (CS). According to Feldman (1995), "Compassion is an outgrowth of

wisdom that entails mindfully engaging with another's suffering, experiencing a kind response to

their distress, and recognizing human interconnection with others that leads to a genuine desire

to alleviate suffering" (p. 1). Although the instrument developers designed the CS to be

administered to the general population given this definition of compassion, the survey is

applicable to healthcare providers and healthcare students. The researchers focused on

compassion as "being more focused on others' general life suffering" (Pommier et al., 2019, p.

2). Given this insight, Pommier and colleagues described an application of compassion that

encompasses the biopsychosocial model, viewing the patient at the center of care and focusing

on their psychological, emotional, social, and physiological health and well-being.

The CS is a 16-item survey that participants answer using a 5-point Likert scale (1 = Almost

Never to 5 = Almost Always). The directions on the survey instrument reminded participants to

answer the questions according to what really reflects their lived experiences rather than what

they think their experience should entail. Notably, the survey has four items that are negatively

worded, requiring reverse coding. To compute a total compassion score, the researcher takes a

grand total of all items yielding a compassion composite score. The scores can range from 16-80.

The CS includes coding themes that are reflective of specific survey items: kindness, common

humanity, and mindfulness. This helps the measurement of compassion stay true to Buddhist philosophical traditions and Neff's theoretical model of self-compassion.

Reflection Logs

The reflection log data is coded using a constant comparative method. Two steps took place during the coding process: (1) comparing incidents applicable to each category and (2) integrating categories and their properties (Glaser, 1965). First, I analyzed the data by coding each incident in the data in as many categories of analysis as possible. Glaser (1965) explained the defining rule of constant comparative method is that "while coding an incident for a category, compare it with the previous incidents coded in the same category" (p. 439). Then, I used the coding to integrate categories and their properties, essentially, comparing the coding with incident to incident to see how themes emerged.

Interviews

Four students participated in semi-structured interviews. The interviews were conducted over Zoom, audio recorded, transcribed, coded, and member checked. The interviewees met the predetermined selection criteria, the interviewees self-reported an increase application of empathy and compassion during their biweekly reflection logs. During the interview, I followed the semi-structured interview protocol (Appendix E). The participants' narratives provide an in-depth understanding of how they transferred didactic instruction into their clinical experiences. The interview data promotes an understanding of the participants' lived experiences told from their perspective.

Analysis and Coding Procedures

For this study, I analyzed quantitative data and interpreted qualitative data. During Phase One the quantitative data collection I used Statistical Package of Social Sciences, Version 24

(SPSS) to run a repeated measure ANOVA to analyze the survey data. During Phase Two for the case study embedded research I used Dedoose to apply a constant comparative method (Glaser, 1965) to analyze the qualitative data.

Quantitative Data

I collected data from the Jefferson Scale of Empathy-Student Version (JSE-SV) (Hojat et al., 2018) and the Compassion Scale (CS) (Pommier et al., 2019). Researchers created the JSE-SV specifically for the healthcare student population, while the CS was created for a general population. During Phase One of the study, the students completed the surveys at three time points: (1) the beginning of the Capstone in Sports Medicine Course, (2) after the empathy and compassion lessons, and (3) at the end of the Capstone in Sports Medicine Course. I used SPSS to perform a repeated measures ANOVA test with two composite scores (empathy and compassion), as well repeated measures analyses for individual survey questions. The ANOVA analysis measured change over time during the students' semester long learning of soft skills in their Sports Medicine Capstone course. Therefore, during this longitudinal data collection, it was appropriate to implement an ANOVA to compare three means with a post hoc to determine where the difference is during multiple comparisons.

Qualitative Data

I collected the qualitative data during Phase Two of the research study. Phase Two consisted of a single case study design with two embedded units of analysis (Yin, 2018). The two embedded units of analysis were the participants' biweekly reflection logs and semi-structured interviews. Both units of analysis were examined using the constant-comparative method. The constant comparative method is native to grounded theory research developed by Glaser and Strauss. Tesch (1990) further described constant compassion analysis:

The main intellectual tool is comparison. The method of comparing and contrasting is used for practically all intellectual tasks during analysis: forming categories, establishing the boundaries of the categories, assigning the segments to categories, summarizing the content of each category, finding negative evidence, etc, The goal is to discern conceptual similarities, to refine the discriminative power of categories, and to discover patterns (p. 96).

The coding process involved first and second cycle coding. First cycle coding is used to initially summarize segments of data (Miles et al., 2014). Specifically, I used in vivo coding as the first cycle coding technique. In vivo coding includes statements captured from the participants' words. Therefore, in vivo coding prioritizes and honors the participants' voices (Miles et al., 2014). Second cycle coding groups the first cycle codes into themes and sub themes. The categories and themes are used to answer the qualitative research questions: (1) In what ways do athletic training students perceive they transferred soft skills into clinical practice? (2) In what ways are the development of soft skills associated with athletic training students' subjective well-being? (3) How do athletic training students describe their emotional response to utilizing soft skills during clinical practice? During second cycle coding, I evaluated the data for phrases or statements that answered the specific research questions and organized them into subcategories until I reached saturation. Charmaz (2001) described coding as "the critical link between data collection and their explanation of meaning. In qualitative data analysis, a code is a researcher-generated construct that symbolizes and thus attributes interpreted meaning to each individual datum for later purposes of pattern detection, categorization, theory building, and other analytic processes" (p. 3-4). According to Miles and colleagues (2014), the second cycle coding benefits are fourfold for the data analysis, as it: (1) condenses large amounts of data into

smaller number of analytic units, (2) gets the researcher into analysis during data collection, (3) helps the researcher elaborate a cognitive map-an evolving, more integrated schema for understanding local incidents and interactions, and (4) lays the groundwork for cross-case or within case analysis by surfacing common themes and directional processes. I inductively coded the data to allow the themes and subthemes emerge from the participants' perspectives of applying soft skills during clinical practice, the current global pandemic and how it impacts their ability to apply patient-centered care, their perceived subjective wellbeing, and their emotional response to implementing soft skills during their clinical experiences.

Threats to Validity and Reliability

The following section will identify researcher's bias, acknowledge my research positionality, and potential ethical considerations. I disclose threats to reliability, such as the instrumentation used to collect data. Then, I address the internal validity of the research study by disclosing confounding factors such as the current global pandemic and how this environment potentially impacted the research participants responses. Next, I discuss the purposeful sampling bias of a homogeneous sample for semi-structured interview participant selection and how this decision could impact the external validity of the research study. Finally, I recognize the generalizability of the following research study and how the findings can contribute to athletic training and other healthcare fields.

Researcher's Bias

The researcher's bias that is present in this study is examined through various lenses, positionality, and potential ethical issues. My positionality as a researcher is balanced; however, my positionality was not always like this; I had to discover my own epistemology. At the beginning of my research endeavor I had a postpositivist mentality. I thought that if a variable

was not quantitatively measured, then it was not worth studying. As I continued my research journey, I started to recognize the value of qualitative research and the sincere importance of building a partnership with participants to highlight their voices. Additionally, I started to develop an interest in constructs like trust, relationships, empathy, and compassion - constructs that are difficult to measure statistically. The idea of multiple realities and multiple perspectives excites me and I believe the idea of improving patient clinician relationships through quantitative findings while qualitatively reporting the voices of the people involved holds significant value.

My own axiology of being a teacher and clinician creates my pragmatic worldview. My study design targets students' didactic course work and building soft skills then seeing if they can apply those skills to their clinical practice. However, the dynamic of being the research participants' professor in their athletic training education program presents bias. As a result of being the participants' course instructor, the participants may view me as an outsider in a position of authority or power. Therefore, they may feel pressure to answer survey questions, complete reflection log prompts, or answer interview questions in a particular way, thinking that they need to provide the correct answer to support me in my data collection. I proactively attempted to correct this potential ethical concern by using participant identification numbers and ensure them that I was not the professor grading their assignments. The students were aware that their data would be collected by using participant identification numbers to ensure that their responses were not connected with their name to protect their identity and to allow them to honestly report their lived experiences without fear or judgement or academic penalty.

Reliability

Reflection logs were one of the qualitative instruments that I used to collect data for this study. Participants completed biweekly reflection logs during one academic semester. Each

reflection log consisted of the same six questions and each participant was responsible for completing the reflection log based upon their clinical experiences through the two weeks. However, the students' self-perceptions create the concern of interrater reliability. Interrater reliability measures the degree of agreement between people assigned to the same instrumentation. In this study, only the student completed the reflection based on their perception and application of soft skills during patient interactions. The methodology to understand the phenomena of AT students' application of soft skills during patient interaction could be strengthened if their preceptor or a research observer also analyzed the interaction. The introduction of interobservers should be considered for future research studies, however, in this research study the research questions were written to understand the student's perceptions. I would like to mention that the students' perceptions are subjective and therefore opinions and views of the phenomena will naturally differ. To best mitigate the concern of the subjective nature of the reflection log instrumentation, I have clearly defined the research questions of this study to focus on the students perceived experience and triangulation of data from multiple instrumentation (surveys, reflection logs, and semi-structured interviews).

Internal Validity

Within this research study, I recognized three threats to internal validity: (1) a confounding factor, (2) instrumentation, and (3) social interactions.

Confounding Factor. The confounding factor presented during this study was a global pandemic. The COVID-19 global pandemic forced the institution where data was collected to move to remote instruction to mitigate the spread of the respiratory virus. With the transition to remote instruction, the University also cancelled intercollegiate athletics for the semester. This decision forced the clinical coordinator to pivot to find clinical sites for the master's in athletic

training students (the participants of this study). Many of the students were able to complete in-person clinical experiences at local high schools, sports medicine clinics, or at surrounding universities who were still participating in athletic seasons. However, this certainly posed limitations such as periods of quarantine for potential COVID-19 exposures, telehealth consultations, limited time during patient interactions, and non-competitive athletic seasons minimizing the students' exposure to orthopedic injury. Additionally, students were required to engage in virtual clinical experiences to supplement the minimal hours of in person clinical regarding COVID-19 restrictions. Therefore, students' answers during reflection logs and semi-structured interviews may have been impacted by uncontrollable variables in relation to COVID-19. To achieve transparency and acknowledge the current global conditions, additional questions about the pandemic and patient-centered care were added to both the biweekly reflection logs and semi-structured interviews.

Instrumentation. The second threat to the internal validity of this study was instrumentation, specifically the CS. Pommier and Neff (2019) developed the CS and created the survey for the general population, not specifically for a healthcare population. According to the researchers, "The CS was operationalized as experiencing kindness, a sense of common humanity, mindfulness, and lessened indifference toward the suffering of others" (p. 1). I utilized teachings from Neff's self-compassion research during the compassion curriculum, to help the students formalize themselves with the language and terms of the CS, However, future research should establish a compassion evaluation for healthcare students, similar to the JSE-HPS-version where the language is consistent with patient interactions.

Social Interactions. Lastly, social interactions posed a threat to the internal validity of the study. The participants of this study are a cohort of 19 athletic training students at one

University. The participants were all committed to a 3+2 master's in athletic training program. The participants have attended school together for three years and now are in the first year of their master's program. Therefore, the students have created social connections and relationships. Many of the participants live together, attend clinical together, and are in all the same academic courses. Their close relationship has the potential to influence the outcome of their reflection logs if they have conversations about the assignment.

External Validity

External validity refers to the way in which results of a study can be generalized to other situations or groups. The research study that I conducted poses two threats to external validity, sampling bias and the Hawthorne effect. First, the sample used from this study included one cohort of 19 3+2 Master's of Science in Athletic Training (MS AT) students who were native to the university where the study was being conducted. The students who participated in the study all completed their Bachelor's degree in Sports Medicine studies at the same institution. However, the entire cohort of MS AT students included 25 students. The additional 6 students are post-baccalaureate students who earned their Bachelor's degree from a different institution or a different area of study. Although the six students completed the biweekly reflection logs as a course requirement, they could not be included in the study because they did not complete the soft skills curriculum prior to beginning their clinical experiences.

Second, the sample of students selected for the semi-structured interviews was purposefully a homogeneous sample. The four students were selected by self-identification of using soft skills most frequently during their clinical experiences. On their biweekly reflection logs, the sixth question that the students answered was a quantitative question (Table 3), the students who self-reported the highest median values were selected to complete the semi-

structured interview. For this study, I selected students to interview after completion of three reflection logs, after six weeks of their clinical experience. If there was a tie, then I evaluated the students quantitative survey results and the student with the highest reported composite scores for empathy and compassion at Timepoint 3 was selected for the interview. I recognize that this is a homogeneous sample and acknowledge that there is value in random selection or a heterogeneous sample selection. However, given the specific research questions and the internal validity threats of the pandemic, I decided that a homogenous sample would best serve this research study because I wanted to understand from an exemplary case of students who were using empathy and compassion and how they perceived implementing these skills during their patient interactions. Creswell (2018) explains that a homogenous sample answers the "how" portion of research questions. Specifically, the phase two embedded portion of the study sought out to answer the following research questions: (1) *How do athletic training students describe their emotional response to utilizing soft skills during clinical practice?* (2) *In what ways are the development of soft skills associated with athletic training students' subjective well-being?* Also, given the confounded factors like the global pandemic, some students were forced to quarantine, had delayed starts for their in-person clinicals, or were only completing virtual clinical interactions, making random selection an unviable option for this study. Therefore, to answer the two research questions, it was necessary to further investigate students who perceived using the soft skills most frequently during their patient interactions. Additionally, because of the given timeframe for data collection and analysis, the four semi-structured interview participants were selected after completing three of their six reflection logs. Therefore, students could have had more robust clinical experiences and opportunities towards the end of their clinical experience but did not qualify for the selective criteria for the semi-structured interviews. To mitigate this

limitation, all students' reflection log data is analyzed and valued; I never eliminated a reflection log response with the intention of capturing the student's soft skills application and development throughout an entire semester long clinical experience.

The next threat that I would like to acknowledge to the external validity of the study is the Hawthorne effect. The Hawthorne effect is the ways in which research participants change their behavior because they know that they are being researched. In this case, the students knew that I taught portions of the soft skills curriculum and that I was evaluating their levels of empathy and compassion over time. Even though the survey directions specifically state to answer the questions on how you currently feel and not how you think you should feel there can still be subjectivity within the students' responses. Additionally, the reflection log questions were consistent, and the students completed them every two weeks during the semester. Therefore, the student knew that they will be asked about empathy and compassion during their patient interactions so they may have become consciously aware of this during their clinical experiences and tried use those soft skills to have something to write about in their reflection logs. However, the reflection logs are still a chance for the students to self-reflect on their experiences and share their voice whether or not they are consciously utilizing their soft skills in their clinical setting.

Generalizability

Although the findings from this study cannot be generalized to all athletic training students. The results present insightful information for athletic training and other healthcare education programs. Specifically, the findings will help educators make informed decisions on when to introduce soft skills into the curriculum. Additionally, the finding will allow healthcare educators to understand the ways in which students perceive soft skill application during therapeutic interactions. Understanding and emphasizing the value of soft skills of future

healthcare providers is critical because healthcare organizations have identified soft skill deficiencies in qualified applicants (Bertram, 2018). In order to mitigate the deficiency in soft skills among future healthcare providers, healthcare education programs can provide the opportunity for students to practice and demonstrate soft skills within their respective curriculum. The results of this study support the ways in which educators can successfully teach and enhance healthcare students soft skills application during clinical practice. Additionally, the study will provide awareness surrounding the connection between students' well-being and their ability to provide patient-centered care. This finding is impactful for all healthcare education programs because the results of the study will allow educators to begin to understand the connection between clinician well-being, emotional intelligence, and how therapeutic relationships are successfully established. The research findings are critical to understand as healthcare transitions to an environment where telemedicine and telehealth is prominent and when human connection, relationships, and patient- centered care is essential during therapeutic interactions.

Limitations of Methodology

The research design that I selected for this study is an explanatory sequential mixed method design with a preliminary quantitative input (quan→ QUAL [qual]) (Morgan, 2014). The selected research design emphasizes the qualitative data collection. Therefore, the sample size selected for this study was purposeful and chosen to represent the lived experiences of one cohort of MS in AT students at one university, who completed their undergraduate degree at the same university as part of an accelerated 3+2 MS in AT program. The study that I conducted is not generalizable to the entire population of MS in AT students because this study only focused on 19 students' perceptions, knowledge, and application of skills. The sample size selected for

this study is an adequate selection for a prioritized qualitative mixed methods study with a case

study research design. Vasileiou and colleagues (2018) stated that in healthcare

research, "Qualitative samples are purposive, that is, selected by virtue of their capacity to

provide richly- textured information, relevant to the phenomenon under investigation… recent

research demonstrates the greater efficiency of purposive sampling compared to random

sampling in qualitative studies, supporting related assertions long put forth by qualitative

methodologists" (p. 2). Ultimately, researchers are suggesting that the small sample size in order

to support the in-depth nature of case-oriented analysis is a fundamental mode of inquiry for

qualitative dominant studies.

Informed Consent and Protection of Human Subjects

I received approval to complete this study through my university's Institutional Review

Board (IRB) (Appendix G). Prior to beginning data collection, I met with the participants during

their Capstone in Sports Medicine course, where I discussed the project overview. Specifically,

we discussed the purpose of the study, the commitment required to be a participant of the study,

how I protect their privacy, and who to contact in case of a research related concern. All

participants signed the informed consent form prior to beginning data collection (Appendix H).

The participants' identities were protected by using individual identification codes. As a result of

the global pandemic, an IRB revision was submitted in June 2020 to include the required

revision to the application to include no in-person data collection. Therefore, I conducted the

semi-structured interviews over Zoom rather than in person. Additionally, three questions were

added to the reflection logs to reflect the students' clinical experiences and patient encounters

while providing healthcare during a global pandemic. The additional questions were: (1) Given

the pandemic, in what ways has your ability to provide patient-centered care been influenced in

the last two weeks?, (2) Please describe your own well-being in the past two weeks, and (3)

Describe the ways in which your own well-being has influenced your ability to exhibit soft skills

and provide patient-centered care in the last two weeks of your clinical experience. The

participants signed a revised informed consent (Appendix G) prior to Phase 2 data collection.

Summary

Chapter III provided an overview of the methodology used in this study. This research

study used an explanatory sequential mixed method design with a preliminary quantitative input

(quan→ QUAL [qual]) (Morgan, 2014). The data collection took place over the course of two

academic semesters and included 19 pre-professional athletic training students who transitioned

to entry level masters athletic training students during the duration of the study. Data was

collected for this study in two phases. During Phase One the research participants completed a

soft skills curriculum where they were taught empathy and compassion curriculums and

completed two quantitative surveys (JSE-HPS and CS) at three time points during the semester.

Phase Two of the research study began once the students transitioned to completing their clinical

experiences. The participants completed six bi-weekly reflection logs during the semester, and I

coded the qualitative data with a constant comparative methodology. Finally, the Phase Two

Embedded portion of the research study included semi-structured interviews with the research

participants who reported the most frequent utilization of empathy and compassion during

their clinical experiences. I then discussed the threats to validity and reliability. I specifically

emphasized threats such as the instrumentation used to collect data, confounding factors such as

collecting data during a global pandemic, and the purposeful sampling bias of a homogeneous

sample for semi-structured interview participant selection. Despite the threats to validity and

reliability, this study presents useful research to emphasize the value of teaching pre-professional

athletic training students' soft skills to enhance their delivery of patient-centered care during

their clinical practice. In Chapter IV, I will discuss the results of the data collection, beginning

with the results of Phase 1, the quantitative portion of the study, and then analyzing the

qualitative data in Phase 2 and Phase 2 Embedded.

Chapter 4: Results

This chapter provides an in-depth analysis of the mixed-methods study addressing the question, *In what ways can knowledge from a soft skills curriculum during a didactic pre-professional course be transferred to clinical practice during an athletic training student's clinical experience?* The data was collected in two phases: Phase 1 (quantitative data) and Phase 2 (qualitative data). Specifically, the research study consists of quantitative surveys followed by a qualitative single case study embedded research design. Given that the phases of the study are important for interpretive purposes, in this chapter I will present the results in a parallel format to the research study design.

Phase 1 of the research study reflects the ways in which a pre-professional soft skills curriculum is associated with students' abilities to develop empathy and compassion. The 19 research participants completed the Jefferson Scale of Empathy (JSE- HPS) questionnaire to measure empathy and the Compassion Scale (CS) to measure compassion at three different time points throughout the course of the academic semester: (a) Timepoint 1 - at the beginning of the academic semester (pre-curriculum intervention), (b) Timepoint 2 - during the curricular intervention (after the empathy and compassion lessons), and (c) Timepoint 3 - post curriculum intervention (at the end of the academic semester). Using repeated measures ANOVA statistical analysis, I compared each participant's empathy and composite scores over the course of the semester. This analysis allowed me to answer the two secondary research questions explored through the quantitative portion of the study:

(1) How is a pre-professional soft skills curriculum associated with students' development of empathy?

(2) How is a pre-professional soft skills curriculum associated with students' development of compassion?

Phase 2 of the research study fulfills the qualitative data collection. During Phase 2, the 19 research participants from Phase 1 of the study had transitioned from pre-professional Bachelors of Science in Sports Medicine Studies students to entry-level Masters of Athletic Training students, where they began their clinical experiences. The research participants completed six biweekly reflection logs through the course of the semester to reflect upon the ways in which they implemented soft skills during their patient interactions. As part of Phase 2 of this study, I answered the following secondary research questions:

1. In what ways do athletic training students perceive they transferred soft skills into clinical practice?

2. In what ways are the development of soft skills associated with athletic training students' subjective well-being?

I implemented constant comparative methodology to analyze the qualitative data. Specifically, I used first and second cycle coding to allow the themes and subthemes to emerge inductively from the participants' perspectives of how they applied soft skills during clinical practice, the current global pandemic and its impact on their ability to apply patient-centered care, their perceived subjective wellbeing, and their emotional response to implementing soft skills during their clinical experiences.

The Embedded Phase 2 of the study answered the following secondary research questions:

(1) How do athletic training students describe their emotional response to utilizing soft skills during clinical practice?

(2) In what ways are the development of soft skills associated with athletic training students' subjective well-being?

The Embedded Phase 2 consisted of four semi-structured interviews conducted over Zoom. I selected participants for semi-structured interviews based upon their self-report of using soft skills during their clinical practice. The students who reported the highest median score and highest mean empathy and compassion composite scores from Phase 1 were selected for the semi-structured interview. I used this selection criteria to account for the confounding factor of the global pandemic. For example, many participants were required to quarantine which resulted in missed clinical experience and patient interactions. By implementing a median rather than a mean calculation for frequency of soft skill utilization this allowed students who may have had to quarantine for two weeks to still be selected if they reported using soft skills while permitted at their clinical site. I used the same constant comparative analysis to discover themes and subthemes to best understand the phenomena of how students transfer knowledge from a soft skills curriculum during a didactic pre-professional course to clinical practice. In this chapter, I will describe the quantitative data collected through the JSE-HPS and CS and the qualitative reflection logs and semi-structured interviews.

Quantitative Results

The quantitative portion of my research study sought to investigate how a pre-professional soft skills curriculum was associated with students' development of empathy and compassion. The JSE-HPS and CS (Hojat, 2016; Pommier et al., 2019) provided data for my quantitative research results. During Phase 1 of this research study, participants completed the two surveys at three timepoints in an academic semester while students completed a soft-skills curriculum.

Research Participant Demographics and Background

The research participants completed demographic and background information prior to completing their surveys. The demographic data collected included age, gender, professional mentorship, and projections of future soft skills application. Participants completed demographic information at Timepoint 1, which was in addition to the professional mentorship data, collected at all three timepoints (See Table 5).

Table 5

Participant Demographics

Age (mean)	20.4 (0.5)		
Gender			
Identifies as Male	3 (15.8%)		
Identifies as Female	16 (84.2%)		
Professional Mentor			
Timepoint 1	Yes 10 (52%)	No 5 (26.3%)	Unsure 4 (21.1%)
Timepoint 2	Yes 9 (47.4%)	No 8 (42.1%)	Unsure 2 (10.5%)
Timepoint 3	Yes 13 (68.4%)	No 4 (21.1%)	Unsure 2 (10.5%)

Note. Table 5 displays the research participants' demographic information; age, gender, and perception of having a professional mentor.

On average, research participants were 20.37 years old (SD = 0.456). All of the research participants were in their final semester of their three-year undergraduate degree before matriculating to the two-year Master's in Athletic Training program. The students in this cohort predominantly identified as female (84.2%), while fewer students in the cohort identified as male (15.8%).

An important aspect of soft skill development and professional socialization is the role of mentorship. The research participants were asked to answer the following question at each data collection timepoint:

Mentoring is a relationship between two people with the goal of professional and personal development. The "mentor" is usually an experienced individual who shares knowledge, experience, and advice with a less experienced person, or "mentee". Based upon this description do you currently feel like you have a professional mentor?

Table 5 shows that at the beginning of the semester, 52% of students selected *yes* while 47.4% students selected *no* or *unsure*. Then at the end of the semester (Timepoint 3), 68.4% of students selected *yes* while 31.6% of students selected *no* or *unsure*. This data was collected prior to students engaging with clinical experiences when they are assigned to preceptors in the field of athletic training. The process of mentoring fosters benefits in terms of successful education and implementation of clinical skills. Without properly established mentorship students may not be in a conducive environment to observe soft skills necessary for the healthcare field.

When the research participants completed their final survey at the end of the course (Timepoint 3), the survey included three additional questions that addressed projections of soft skill application during their future clinical practice. The students respond to the following prompts on a sliding scale from 1-100:

(1) Please rate how frequently you project to utilize empathy during your future clinical experience?

(2) Please rate how frequently you project to utilize compassion during your future clinical experience?

(3) Please quantify how important you think soft skills are during a patient interaction.

Table 6 shows the results of the students' projections of how frequently they planned to use soft skills at their future clinical experience and how much they value soft skills during patient interactions.

Table 6

Student Projections of Future Soft Skill Clinical Application at Timepoint 3

	Mean	SD
Empathy during clinical experience	90.000	6.515
Compassion during clinical experience	91.840	6.049
Importance of soft skills during a patient interaction	95.840	5.550

Note. At Timepoint 3, the participants were asked to project how often they would use both empathy and compassion during their future clinical experience and how important they perceived soft skills to be during a patient interaction. The participants selected their answers on a sliding scale from 0-100.

Students projected to use empathy (M=90.000, SD= 6.515) less frequently compared to

compassion (M=91.840, SD= 6.049). However, the average student response for the importance

of how important soft skill application is during a patient interaction was 95.840 (SD= 5.550),

student responses ranged from (85-100). Therefore, after the students completed a soft skills

curriculum, they reported to that they would likely utilize empathy and compassion during their

clinical experiences. Ultimately, the students' results revealed that they viewed soft skills as an

important aspect of patient interactions.

Student Empathy and Compassion Development During an Academic Semester

The 19 research participants completed both the JSE-HPS and CS at three timepoints

over the duration of an academic semester. I used the statistical analysis of a one-way repeated

measures ANOVA to determine if the three groups' means were different over time with the

same participants in each group. Girden (1992) suggested that a one-way repeated measures

ANOVA should be used when participants have been measured over multiple time points to see

if any changes have occurred usually during an intervention, in this case throughout a soft skills

curriculum intervention. When using repeated measures ANOVA statistical analysis three assumptions need to be met to reduce the risk of type 1 error: (1) no significant outliers, (2) the distribution of the dependent variable in the two or more related groups are normally distributed and (3) sphericity. All three assumptions were met for the quantitative data in this study. The empathy and compassion composite scores and repeated measures ANOVA statistics are displayed in Table 7 and Table 8.

Table 7

Empathy and Compassion Composite Descriptive Statistics

		Mean	SD
Empathy (JSE- HPS)	Timepoint 1	108.579	11.437
	Timepoint 2	119.895	9.231
	Timepoint 3	117.158	9.167
Compassion (CS)	Timepoint 1	60.263	3.694
	Timepoint 2	60.894	4.618
	Timepoint 3	62.052	4.527

Note. The JSE-HPS is a 20-item survey reported on a 7-point Likert scale, participant scores can range from 20-140. The CS is a 16-item survey reported on a 5-point Likert scale, participant scores can range from 16-80.

Prior to the soft skills curriculum (Timepoint 1), the research participants had an average self-reported empathy level of 108.579 (SD = 11.437) and compassion level of 60.263 (SD = 3.694); during the soft skills curriculum after the empathy and compassion curriculum the research participants had an average self-reported empathy level of 119.895 (SD = 9.231) and compassion level of 60.894 (SD= 4.618); and after the conclusion of the soft skills curriculum at the end of the academic semester the research participants self-reported empathy level slightly decreased to 117.158 (SD = 9.167), and compassion slightly increased to 62.052 (SD = 4.527).

Table 8

Repeated Measure ANOVA Statistics

Within Subjects Effect	*df*	Mean Square	F	*p*
Empathy	2	662.263	20.375	.000***
Compassion	2	15.649	1.394	.261
Compassion Construct- Mindfulness	1	.421	.716	.408
Compassion Construct- Kindness	1	5.921	5.737	.028*
Compassion Construct – Common Humanity	1	1.684	1.422	.249

Note. *Statistically significant at *p*<.05, ***Statistically significant at *p*<.001

Data analysis revealed a statistically significant difference in the research participants'
reported empathy levels on the JSE-HPS over the course of the semester $F(2)= 20.38$, $p=.000$.
Mauchly's Test of Sphericity indicated that the assumption of sphericity had not been violated,
$x^2 (2) = 1.952$, $p= .377$. Data analysis did not reveal a statistically significant difference in the
research participants' reported compassion levels on the CS over the course of the semester
$F(2)= 1.39$, $p=.261$. Mauchly's Test of Sphericity indicated that the assumption of sphericity had
not been violated , $x^2 (2) = 1.076$, $p= .584$. However, the CS is divided into three constructs of
compassion; mindfulness, kindness, and common humanity (Pommier, et al., 2019). A repeated
measures ANOVA statistical analysis conducted for the CS constructs the data analysis revealed
statistical significance for the kindness construct over the course of the semester $F(1)= 5.74$, $p=$
.028. Although, the data analysis revealed no statistical significance for mindfulness ($F(1)= .72$,
$p=.408$) or common humanity ($F(1)=1.42$, $p=.249$).

Qualitative Results- Transferring Soft Skills into Clinical Practice

The qualitative portion of my research study investigated the ways in which AT students perceived they transferred soft skills into clinical practice. In the field of healthcare, providers utilize soft skills on a daily basis to treat their patients with quality patient-centered, compassionate care, and emphasize the patient as their top priority of care. Specifically, soft skills include abilities such as ethics, attitudes, interpersonal abilities, communication, and lifelong learning (Joubert et al., 2006). According to Klaus and colleagues (2007), "Soft skills are defined as personal, social, communication, and self-management behaviors" (p.18). Through reflection logs and semi-structured interviews, the research participants shared how they perceived applying soft skills during their semester long clinical experience. Both units of analysis were examined using the constant-comparative method. The coding process included first and second cycle coding. I began coding by examining all of the data categorized into each specific research question. Then, I used first cycle coding to summarize segments of data (Miles et al., 2014). As a result, the data was first separated into two major themes: (a) empathy, defined as the ability to sense, feel, and understand another's emotions and (b) compassion, defined as an emotional response to another's pain and suffering with an authentic desire to help (Patel, 2019). Then, I used second cycle coding to group the first cycle codes into multiple subthemes. According to Miles and colleagues (2014), second cycle coding lays the groundwork for within case analysis by surfacing common themes. The themes that emerged from the participants' six reflection log entries and semi-structured interviews included: (a) relating to patients through personal experiences, (b) staying out of judgement, and (c) demonstrating helping behaviors.

Perceived Application of Soft Skills

Table 4 displays all the research questions that the participants were prompted to answer regarding their application of soft skills during their clinical experience. The first two questions included:

(1) empathy is defined by Patel (2019) as, the ability to sense, feel, and understand another's emotions. Given that definition, describe one or more times when you demonstrated empathy during the past two weeks of your clinical experience and (2) compassion is defined as an emotional response to another's pain or suffering involving an authentic desire to help (Patel, 2019). Given that definition describe one or more times when you demonstrated compassion during the past two weeks of your clinical experience.

Based upon participant answers, subthemes of empathy and compassion emerged from that data. Since neurobiology reveals that empathy needs to occur first in order to spur compassion, soft skill training should initially focus on understanding the patient's emotions (empathy) and then act with helping behaviors towards patients (compassion) (Patel et al., 2019). Therefore, I taught the soft skill curriculum in this specific order and will display the corresponding data analysis in a parallel manner. The following subthemes emerged regarding how the research participants described exhibiting empathy: (a) relating to their patients through personal experience and (b) staying out of judgement. Subsequently, the subthemes of the ways in which the students implemented compassion included: (a) demonstration of helping behaviors, (b) reassurance, and (c) plan of action.

Relate to Patients Through Personal Experiences. When students shared their experience of applying empathy, they commonly mentioned relating to their patient through their own

personal experience. For example, Participant 14 shared that they could empathize with their

patients because they, too, have wanted to participate in sport, but the pain from their injury was

debilitating and caused them to not be able to participate. Additionally, participants described

connecting with their patients through self-reflection of their own lived experiences which

allowed them to be more understanding of their patients' feelings. Participant 11 shared, "I

understand exactly how that [having medial tibial stress syndrome (MTSS)] feels because I had

the same issue when I was younger. I was right by my patients' [sic] side making sure that they

knew I understood their emotions." Notably, the students were able to recognize the emotions of

their patients and create an environment where they appeared comfortable. For instance,

Participant 5 shared that a mother and daughter showed up to the athletic training facility to

explain why they did not have their insurance paperwork complete by the due date for Fall sport

participation. The participant described how the parent and student athlete were uncomfortable

about delaying the administrative process necessary for sport participation. Participant 5 shared

their connection with their patient stating, "I knew where they were coming from. I have been in

similar situations and didn't want the athlete to feel embarrassed." The connection that the

participants were able to call upon from their own lived experiences allowed them to exercise

empathy for their patients. An emerging theme from the empathy data included placing

themselves in their "patients' shoes". When athletic training students were unable to relate to

their patients through their own past experiences, they mentioned that they would try to shift

their perspective by placing themselves into their patient's shoes. Participants described shifting

their perspective to their patient's lens in multiple clinical scenarios. The clinical scenarios

included: (a) conducting orthopedic evaluations, specifically when it was the patient's first time

experiencing an injury, (b) recognizing that rehabilitation exercises are challenging so making

adjustments in order for the patient to feel confident, and (c) understanding and validating student athletes' emotions when they are not able to participate in important competition. The athletic training students used the strategy of shifting perspectives to effectively sense, feel, and understand their patients' emotions.

Staying out of Judgement. Within the nursing education literature, Wiseman (1996) described four qualities of empathy: perspective taking, staying out of judgement, recognizing emotion, and communication. The data that emerged from the students' reflection logs echoed the empathetic quality of staying out of judgement. Wiseman (1996) described staying out of judgement as not making comments that infer patients' emotions or responses were invalid or wrong. Participants described staying out of judgement during their reflection log responses, "I will be there as ears to listen and never to judge, I want to create a comfortable space with my patients" (Participant 4). Participants described the importance of listening to their patients' stories without being judgmental or jumping to conclusions. A few of the participants even disclosed learning ample information from their patients' perspectives. For example, two participants were at the same clinical site and reflected on the same patient's story. They shared that their patient was epileptic. One day, their patient experienced her 58th epileptic episode. The athletic training students made an avid effort to support her, listen while she explained what happens during an episode, learn how they could best help her during a future episode, and try to understand how she wanted her medical condition to be managed (Participants 10 and 18). In addition to listening to patients' perspectives, students also wrote about the importance of recognizing the validity of their patients' feelings, allowing patients to process emotions, and further questioning their patients to understand the full story to prevent making assumptions. For example, Participant 16 shared an experience where they went to help an injured athlete from the

opposing team with their preceptor and quickly realized that the athlete did not speak English. The participant described recognizing the athlete's fear and understanding how important nonverbal communication and staying out of judgement is when managing the athlete's pain and injury. After the participants used empathy to sense, feel, and understand their patients' emotions, they transitioned to applying compassion techniques: (a) demonstration of helping behaviors, (b) plan of action, and (c) reassurance.

Demonstration of Helping Behaviors. Helping behaviors are an essential component of the Action Phase Model of Compassion. Compassion occurs when healthcare providers express a desire to help and then engage in helping behaviors to achieve goals in partnership with their patients (Poulin, 2017). Helping behaviors in a therapeutic relationship displays reciprocity, and includes a shared commitment between the practitioner and the patient to achieve common goals. The first way that the athletic training students described applying compassion during their patient interactions was by creating a plan of action.

Plan of Action. Another way the students' employed compassion was through creating plans of action, which included ensuring that the patient was comfortable with their therapeutic treatment plan, explaining the purpose behind their rehabilitation exercises, providing additional mental health resources and referrals, helping the patient schedule an appointment with a physician, and creating short term and long term goals with their patient (Participants 1, 4, 5, 6, 14) . In addition to creating a plan of action with their patients, the most common way that students described implementing helping behaviors was through reassurance.

Reassurance. The participants described frequently reassuring their patients and clearly comforting them that they were not going to go through their injury process alone. For example, Participant 7 shared, "We used compassion to calm him [the patient] down and make him

understand that everything is going to be OK." Similarly, participants explained that they did everything they could to ensure their patient was comfortable and clearly articulated that the sports medicine team was there to support them (Participants 6, 13, and 15). Additionally, students used the word "we" to connect with the patient. Participant 3 reported, "When I was managing the athlete with the lis franc injury, I was reassuring him that he would be OK and we would get through it together." The responses during the participants' reflection logs were evidence that they connected compassion with reassurance that everything will be adequate, calming their patient down, and ensuring them that they are not alone.

Curriculum to Clinical Practice

The purpose of this study was to investigate the ways in which pre-professional athletic training students' transfered knowledge from a soft skills curriculum to clinical practice during their clinical experience. The research participants described class activities and clinical experiences that resonated with them to help promote the application of soft skills during patient interactions. The subthemes that emerged from class activities included: (a) practice discussing emotions and (b) self-awareness. The sub-theme that emerged from clinical experience was mentorship. An overlapping sub-theme of both class activities and clinical experience was patient-centered care.

Practice Discussing Emotion. During the semi-structured interviews, three of the four interviewed participants mentioned how discussing emotions during class helped them transfer soft skills into their clinical practice. Throughout the soft skills curriculum the students learned strategies to paraphrase emotions and ask engaging questions to their patients. The students practiced emotional intelligence communication skills during small group activities. Participant 5 shared that discussing emotions during class was the first time she was exposed to emotional

intelligence. She perceived that the skills she developed positively impacted her ability to understand emotions:

> We did an activity where it was about compassion and it was when my friend first got diagnosed with cancer, and that was when the class was going on, too, so it really helped me. I forget what the lesson was exactly but we split into groups and we talked about being compassionate and... I talked about my friend. Before that I was always really bad at... not so much confronting people but...trying to help them through situations because it was hard for me to understand where they were coming from. So, after that activity it was really easy for me to...when my friend would talk to me... I was able to bring in those little skills that we learned and be able to understand better where she was coming from. (Participant 5, semi-structured interview)

This participant's insight showed the value of the small group activities and allowed her to build confidence when discussing emotions. Another participant shared that the workshops helped them understand themself and how they deal with emotions (Participant 9). The interactive lessons created a space where they could practice their unique style of empathy and compassion. Practicing and becoming comfortable with empathy and compassion is a crucial aspect of the curriculum because students can be taught soft skills strategies, but only through authentic practice can you identify how students will apply those skills during patient interactions.

Self-Awareness. The semi-structured interviews yielded an emerging theme of self-awareness, as two of the four participants highlighted the value of the Clifton Strengths Finder self-awareness lesson. Goleman's (1998) model of emotional intelligence determines our potential for learning practical skills and is based on five elements: self-awareness, motivation, self-regulation, empathy, and adeptness in relationships. Specifically, EI can lead to more

positive attitudes, greater adaptability, improved relationships, increased orientation towards positive values, the ability to empathize, and productive communication (Freshwater & Stickley, 2004; Tischler et al., 2002). One participant shared that if you are able to understand your own strengths and weaknesses, then you can help other people like your patients identify their strengths and weaknesses (Participant 19, semi-structured interview). Davlin-Pater and Rosencrum (2019) suggested during the soft skills curriculum, the students completed the Clifton Strengths Assessment. This tool identified the students top five strengths based on a series of questions that they answered. Once the students learned about their strengths a Strengthsfinder educator presented to the class and challenged them to build self-awareness surrounding their strengths. This activity clearly resonated with the students and helped them build self-awareness which resulted in a successful application of soft skills during clinical interactions.

Mentorship. During the semi-structured interviews, all four students described how mentorship was an essential component of how they learned how to apply soft skills during therapeutic relationships. According to social learning theory, behavior is learned before it is performed as students observe a role model exemplifying the desired behaviors then replicate their actions (Bandura, 1971). Participant 5 described how she watched her mentors and tried to replicate their actions. She discussed how her preceptors and professors were always supportive, comforting, and provided her with their full attention when she needed help. Specifically, she shared, "Their [my professors and preceptors'] actions translated to my clinical practice, I try to mimic what they've done or how they've handled our situations, especially with COVID [sic]. My preceptors and professors are so helpful, whenever someone tries to talk to me I have our professors in my head and I ask, 'Would they handle it this way?' So I try to handle it that way" (Semi-structured interview 5). Similarly, Participant 17 noted how helpful her sports medicine

professors had been with their response to COVID-19 and the global pandemic. She described

that when she was personally ill with COVID-19, her professors did everything in their ability to

check on her and support her. Then, she continued, mentioning how observing her role models'

caring actions inspires her to be the best clinician to her ability (Participant 17). Participant 19's

interview concurred with the ideas raised in the interviews of her peers, as she shared that

observing the sports medicine staff as an example has a lot to do with how she treats her patients,

as she wants to mirror their high standard of patient-centered care. Participant 9 described that

her preceptor, who she views as a mentor, creates an environment of trust and light heartedness

where the student athletes know that they have a support system behind them regardless of the

obstacles that they could face while recovering from their injury. Ultimately, all four participants

agreed that mentorship is an essential part of helping them apply soft skills to their clinical

practice. Just the reverse, mentors must recognize that students are observing and mirroring their

behaviors.

Patient-Centered Care. A common theme discussed during the semi-structured interviews

was patient-centered care. The students mentioned how patient-centered care was a common

theme integrated throughout both their sports medicine curriculum and their clinical experiences.

Participant 19 noted that the emphasis of patient-centered care began during their first year of

undergraduate education in their Introduction to Sports Medicine class. Based upon what she

learned in class and then later saw at her clinical site, she was able to recognize the value of

getting to know her patient's background because understanding how her patients interpreted

medicine because their worldview can affect how they view healthcare providers. However,

Participant 17 specifically discussed the soft skills curriculum, mentioning that the modules

emphasized the importance of treating a patient as a person rather than discussing them as their

illness or injury. The same participant also shared how asking a patient the right questions is a critical part of patient-centered care. She specifically cited Harriell's three principal clinical questions: (1) What matters to you the most? (2) Have we addressed all your concerns? (3) Is there anything you want to share with me that I did not ask? These three questions provide the opportunity for patients to voice their concerns and allows the clinician to become an advocate for them and their healthcare needs (Harriell, 2020).

Specifically, O'Connell (2008) defined patient-centered care as, "A system of delivery of care to patients that incorporates both the lived experiences of illness (values) and the scientific knowledge (facts) in every aspect of healthcare while respecting the patient's right to self-determination based on mutual trust, understanding, and sharing of knowledge" (p.138). Participant 5 shared that when they are interacting with a patient, they constantly remind themself to place their patient's emotions into perspective. The athletic training student makes sure that she understands her athlete's point of view and why they feel particular emotions. She attributed the emotional awareness that she developed to the soft skills curriculum, and perceived the soft skills curriculum made a difference in her ability to establish trusting relationships with her patients. Similarly, Participant 9 described how the soft skills curriculum opened her eyes to the value of patient-centered care:

> I feel like I'm more aware of the soft skills that we learned being at clinical because we weren't necessarily in clinical when we learned them. Being an athletic training student we learn a lot of the anatomy portions and injury portions of it all. So, hearing a different side to patient care, the empathy and compassion, it puts into perspective for me that we are going to use it [soft skills] and it's not just about, 'Oh let me help you and fix you'. It's asking, 'What else is going on in your life? How are you feeling about this injury? What

are your goals at the end of this?' Returning to play is not just like a clear end goal for

everyone, so it made me more aware...I feel (semi-structured interview).

In this quote, the research participant is describing how they are engaging in a biopsychosocial

model of healthcare. While implementing the biopsychosocial model, the healthcare provider

committed to providing patient-centered care with the person as the primary frame of reference

(Engle, 1979). The biopsychosocial model is a holistic approach which includes all aspects of the

human experience, emphasizing the psychological, environmental, and biomedical aspects of

health. The student clearly reflects on the importance of hard skills throughout the curriculum,

(e.g. students' abilities to perform pathological evaluations, diagnose, and treat medical

conditions) in conjunction with soft skills (e.g. a combination of people skills, communication

skills, and emotional intelligence).

Patient-Centered Care During a Pandemic

Given the unique nature of being a healthcare student during a global pandemic, the

research participants were asked to reflect on their semester-long clinical experiences in their

reflection logs. The specific bi-weekly prompt that the students answered was: *Given the*

pandemic, in what ways has your ability to provide patient-centered care been influenced in the

last two weeks? The subthemes that emerged from the students' answers included: (a) challenges,

(b) policy changes, and (c) altruism.

Challenges. Being a healthcare student during a global pandemic certainly created

unprecedented challenges. Participants shared challenges that ranged from creating more home

exercise programs rather than directly supervising rehabilitation to the emotional taxing aspect of

the pandemic. Students were prohibited from their clinical sites periodically as a result of local

COVID-19 outbreaks, and with marginal sport participants and minimal time to interact with

patients, they found it difficult to create a rapport with their patients. Since the healthcare students had limited time with their patients, soft skills were critical for them to implement during their patient interactions to help establish therapeutic relationships. Participant 16 wrote in their reflection log, "It is clear some of them [patients] really just need a hug or a one-on-one conversation, and I cannot give that to them. I think a lot of people are lonely, fearful...and not being able to interact like I want is prohibiting me from giving them what they need." The challenge Participant 16 presented certainly raises emotional concern, emphasizing why soft skills are a critical curriculum component to healthcare education programs.

The challenge that the research participants noted most frequently was regarding face masks. The students perceived that face masks made it challenging to communicate with their patients and they needed to rely more heavily on understanding body language as nonverbal communication. Additionally, students described not being able to recognize their patients while wearing a mask which made it difficult for them to provide proper patient-centered care. Wearing face masks while interacting with patients was a new policy that the students needed to adjust to during their clinical experience. However, the implementation of policies that made wearing face masks mandatory may call for healthcare providers to become more proficient in recognizing emotion through body language and storytelling, is an aspect of Wiseman's (1996) qualities of empathy.

Policy Changes. Policy changes occurred regularly during the students' Fall 2020 clinical experience. The policy changes forced the students to practice adaptability and attempt to see the positive aspects of the policy changes. Participant 18 described, "Being a student during a pandemic has made me more adaptable for the future, no doubt about it." The positive policy change that the participants reflected on most frequently was the clinician to patient ratio. Social

distancing of six feet apart required athletic training facilities to limit the amount of patients present in the healthcare facility at a time. The change in the clinician to patient ratio was is described by Participant 5, "Due to the pandemic I feel as though we are able to give better patient-centered care than before (from what I can imagine). Many of these are one-on-one sessions and there is more time to get to know the athlete as an individual and how these injuries are affecting their lives." The insight that Participant 5 provided mirrored the prospective numerous participants shared. Patients receiving one-on-one attention from their athletic trainer because of scheduled appointment times is a positive policy change that was established because of the global pandemic. Allowing fewer patients in the athletic training room minimized chaos and promoted a structured healthcare environment where patients received undivided attention from their provider.

Altruism. According to Raab and colleagues (2011), quality athletic trainers demonstrate the ability to care, show commitment and integrity, value professional knowledge, and communicate effectively with others. Quality athletic trainers also display altruism. Altruism is, "motivation that is other-directed and aims to increase or benefit another individual's well-being" (Burks & Kobus, 2012, p. 318). The participants reflected on how the pandemic has taught them to be more understanding when interacting with their patients in order to provide patient-centered care (Participant 1). The pandemic magnifies that each person faces challenges and struggles in their personal life and as healthcare providers it is critical to be respectful of those areas of their lives. Participant 19 shared, "We are all in this together and everyone's situation is different, so it's even more important to be considerate and kind in your care for others." Altruism is taking action through helping behaviors to positively benefit the patient.

The shift towards telemedicine could be a difficult transition for both patients and practitioners. Participant 5 discussed how during telemedicine; healthcare providers need to focus on making their patients feel comfortable when interacting on virtual platforms like Zoom. The role of healthcare providers is to still provide patients with undivided attention, establishing and achieving their goals, and connecting through establishing trusting relationships (Participant 5, semi-structured interview). Participant 17 added that despite providing healthcare during a pandemic athletic trainers and athletic training students can still deliver great patient-centered care by asking the right questions and treating the patient, not just their injury. Through altruism, the research participants captured the importance of providing care through a biopsychosocial lens.

Student's Subjective Well-Being and Emotional Response During Patient Care

Over the duration of the Fall 2020 semester, the research participants answered reflection log questions addressing their subjective well-being. The prompts that the students answered biweekly were: (1) *please describe your own well-being in the past two weeks*, and (2) *describe the ways in which your own well-being has influenced your ability to exhibit soft skills and provide patient-centered care in the last two weeks of your clinical experience.* The prompts allowed students to reflect on their emotions over the last two weeks and how their emotions have influenced their ability to apply soft skills during therapeutic relationships, ultimately answering the following research questions:

(1) *In what ways are the development of soft skills associated with AT students' subjective well-being?*

(2) *How do AT students describe their emotional response to utilizing soft skills during clinical practice?*

After completing first and second cycle coding with a constant comparative analysis, the data inductively produced themes and subthemes to answer both research questions. When evaluating the students' subjective well-being three emotion categorization themes emerged from the data: (a) negative, (b) neutral, and (c) positive.

Then, to address the second research question regarding students' emotional response to utilizing soft skills during clinical practice, a similar pattern developed from the data. The emotional response to utilizing soft skills during clinical practice that students described were: (a) personal barriers that negatively impacted their ability to build therapeutic relationships, (b) flip the switch, a phenomenon where despite poor self-reported well-being, the students were able to apply effective soft skills during their clinical patient interactions, and (c) their own positive emotions that influence therapeutic relationships. The following sections will explore the research participants' well-being and their emotional response as they cultivate therapeutic relationships during their clinical experience.

Subjective Well-Being

Each research participant completed six reflection logs throughout the Fall 2020 semester. In this semester, the participants completed their first semester as Masters students and their first clinical experiences. Certainly, this semester is viewed as a transition period for the students as they step into the clinical responsibilities and core curriculum of an entry level Masters in Athletic Training program. With this in mind, the students were asked to describe their own well-being every two weeks during the semester. The students' perception of their own well-being is displayed in Figure 5.

Figure 5

Students' Perceptions of Their Own Well-Being Throughout an Academic Semester

Note. Figure 5 is a text cloud that represents how the research participants described their own well-being throughout an academic semester. The size of each word represents the frequency of word choice during the participant's reflection log entries.

Similar to Brackett's (2019) text cloud aesthetics on how students and educators describe their daily emotions across the United States, I used a text cloud to represent the frequency of the students' word choices. The larger the word, the more frequently the students used that specific word to describe their well-being in their reflection log response. In totality, the students completed 114 reflection logs and their answers fell along a large spectrum from negative to positive responses throughout the semester.

Negative Emotions. The negative emotions that the students reported included: stressed, overwhelmed, frustrated, anxious, upset, and poor mental health. The students most frequently reported stressed as the status of their well-being, 42 reflection log entries. The reasons for the student's elevated stress levels were multifaceted and included poor time management skills,

quarantine and COVID-19 exposures, academic classes, and aspects of the students' personal lives. For instance, Participant 14 described feeling increasingly stressed because of her two jobs, class, and clinical responsibilities. Managing a busy schedule with increased responsibilities was challenging for the students and impeded their abilities to establish daily routines that included essential self-care elements such as enough sleep and meal preparation. Others described the desperate need to establish a routine that consists of self-care. Participant 8 stated, "My well-being is definitely in the trash right now. Virtual clinical has been extremely overwhelming, considering all of our classes and having in person clinical too. I wish I had downtime for self-care, but I truly can't find a single hour in the day just for me which is exhausting." In addition to being exhausted trying to balance school, clinical, and personal responsibilities the students of the Fall 2020 semester had to endure the stress of living in a global pandemic.

The confounding factor of the global pandemic added additional stress to the students' lives. Students shared the hardships of quarantine and COVID-19 exposures, and there were periods of isolation as well as fear and guilt of potentially exposing their friends, family, or roommates to the virus. Students who became ill during the semester completed classes virtually while their peers still attended in-person classes, adding additional stress to their lives. Participant 4 disclosed that they were stressed as a result of being ill many times throughout the semester, falling behind with clinical hours, and feeling isolated while she attended classes online and the rest of her classmates completed in-person classes. Overall, the students' stress levels seemed to rise as the end of the semester and finals week approached. A consensus from the students was that the semester left them stressed, irritable, and drained. They recognized that the end of a semester is a challenge; however, the circumstances presented this semester maximized the stress that they endured.

Neutral Emotions. Again, the circumstance of the global pandemic created an unpredictable semester. Students learned how to adjust to changes which they viewed as a positive, however the whirlwind of not knowing what the next day would bring created a stressful environment for them. The academic workload, virtual clinical experience, and COVID-19 procedures seemed to produce the most stress for the students. Although, the students described their in person clinical as their "happy place" (Participant 13 and 17). Likewise, Participant 9 stated, "I have been incredibly stressed for COVID reasons and the workload we have currently. However, I am still excited about how much I am learning and the clinical experiences I am getting." By the end of the semester, students shared that they were sad for their clinical experience to come to an end. Ultimately, the semester created "ups and downs" in the students' lives, as they endured exciting weeks where they built upon their clinical skills and there were weeks that they described as emotionally taxing and draining. Participant 18 emphasizes this theme:

> It [the semester] has its ups and downs. I feel as though some days I am as high as the clouds when I am going to school, clinical, the gym, and staying on top of my nutrition. On the other hand some days getting out of bed in the morning is harder than ever and finding the motivation to complete tasks is difficult. I have a lot on my plate with finances, relationships, job, health, and well-being, and it is hard to balance. I am putting 100% of my efforts into school and clinical and my studying habits and I do not have anything left for the rest of the things I love. (Participant 18, Reflection Log)

The semester created an environment where the students practiced their own time-management skills and work-life balance strategies.

Positive Emotions. The students reported positive emotions of feeling "good", "energized", "fantastic", and "phenomenal" throughout the semester. "Good" was the most frequently reported positive emotion, totaling 16 times. Thematically, the students seemed to report their well-being as "good" when they gave themselves permission to take a break. Participant 5 mentions, "My well-being has been good. Coming home and having a break was much needed." Overall, the students described less stress when they were able to dedicate time spent with family to rest and rejuvenate (Participants 8, 11, 17, and 18).

Emotional Response During Therapeutic Relationships

During a patient interaction, healthcare providers strive to create a therapeutic alliance, also referred to as a therapeutic relationship. Muetzel (1988) suggested that the patient and practitioner build a therapeutic relationship from the concepts of partnership, professional intimacy, and reciprocity. The model emphasizes that both the patient and practitioner benefit from the relationship built. In order for healthcare providers to constructively build therapeutic relationships, both the patient and provider need to focus on their own well-being and self-awareness of emotions. The following sections describe the ways in which athletic training students describe their emotional response to utilizing soft skills during clinical practice. The data reveals three distinct student reactions, describing their emotions and how they were able to engage with their patients. The themes that emerged from the data were: (a) personal barriers that impact therapeutic relationships, (b) "flip the switch", and (c) positive emotions that influence therapeutic relationships. Along the spectrum of responses, a second cycle coding revealed subthemes for each theme. The personal barriers that impacted their ability to establish therapeutic relationships included (a) stress and (b) being overwhelmed. When students described the phenomena of "flipping the switch" recognizing that despite their own current state

of well-being they needed to prioritize patient care and soft skills the subthemes of (a) helping others and (b) kindness emerged. Lastly, when students described experiencing positive emotions during their therapeutic relationship the subthemes of (a) reciprocity and (b) partnership surfaced.

Personal Barriers that Impact Therapeutic Relationships. During first cycle coding for the final research question, *How do AT students describe their emotional response to utilizing soft skills during clinical practice?* The students revealed personal barriers that impacted their ability to establish therapeutic relationships. The two subthemes that emerged were (a) overwhelmed and (b) stressed. This data presents concern regarding the student's own well-being and self-care strategies. If clinicians do not know how to cultivate their own well-being, they cannot achieve partnership, professional intimacy, and reciprocity to establish a meaningful relationship.

Overwhelmed and Stressed. The research participants shared a common theme of being overwhelmed, which negatively impacted their ability to establish therapeutic relationships. The students alluded to their overwhelming feeling because of academic requirements, such as coursework and constantly trying to keep up with their "to-do-lists." Participant 6 described, " I feel that because I have been so overwhelmed or so busy it has been hard to absorb all the new information that I am getting in abundance everyday which makes it harder to have confidence in the skills that I am learning." Although Participant 6 did not describe that being overwhelmed impacted their patient care, if their confidence is low then their focus during patient interactions will be placed on hard skills rather than soft skills. For example, the student may be so focused on remembering how to perform the orthopedic special test that they forget to explain to the patient why they are performing this test and share the results of the test with the patient in a way that does not startle them. Students also described being so distracted by other responsibilities

that they could not focus on their patient or did not take the time to ask them questions because their minds were elsewhere (Participant 3 and 5).

Similar, to being in an overwhelmed state, the students described being stressed. The students shared that when they were more stressed they were able to notice that they used less empathy and compassion during their clinical interactions (Participant 4, 5, and 14). Participant 16 echoed how stress impacts patient care, "My own well-being has been absolutely taken away from my ability to care for others. I am riding the [struggle] bus this week and it is very hard for me to be my best, kindest, and most compassionate self when it feels like every aspect of my life is a stressor." The level of stress and distraction that the students described negatively impacted their ability as healthcare students to connect with and build a therapeutic relationship with their patients through trust and respect, which can leave the practitioner without a sense of meaning. However, despite describing a negative sense of well-being some students were still able to positively cultivate a therapeutic relationship with their patients through a phenomenon described as "flipping the switch."

Flip the Switch. During the semi-structured interviews, all four participants explained a phenomenon where despite their mood they recognized a sense of purpose to be fully present to help support their patient. Participant 19 was the first to name the term, "flip the switch":

> I feel like I'm a very introspective person just all the time. So, if I am in a dumpy mood, I am very aware that I'm in a dumpy mood… if I'm at my clinical site and I am evaluating someone you kind of flip that switch so you take on a different role. It's like setting whatever else aside, sometimes it's easier to just compartmentalize. It's kind of like customer service in my head… you can be grumpy and then as soon as you have a customer, you're like DING… customer service mode. It's similar in my head, as soon

as the patient is gone or I'm done providing care in that instance I can very easily go

back to my mood. I know how I would want to be treated and how I would want to be as

a clinician, so I think having that goal of who I want to be as an athletic trainer… that is

what reminds me to flip the switch. (Participant 19, Semi-Structured Interview)

Participant 5 agreed that when you are interacting with a patient, they deserve your full attention

despite your own feelings and mood. However, she also added that when she was engaging with

a patient and helping them overcome their hardships, the therapeutic relationship could actually

allow her to cognitively appraise her own mood and reduced her stress because she is able to put

her life into perspective comparatively. Although the theme of flipping the switch strongly

emerged from the semi-structured interview data, second cycle coding revealed subthemes of (a)

helping others and (b) kindness to determine students' motives for flipping the switch.

Helping Others and Kindness. Helping others is an essential element of healthcare. Some

practitioners and healthcare students may have even selected a career in medicine because they

wanted to help people get better when they were facing a time of difficulty. Compassion is a key

component to engage in helping others. According to Poulin (2017), the purpose of the action

phase model of compassion is to examine the effects of compassion and helping behaviors on

well-being for both the practitioner and patient. The research participants described their role as

athletic training students to be emotionally taxing, however when they interacted with their

patients and helped them get better, they described their clinical experience as engaging and

exciting (Participant 1, 14, and 19). Participant 11 described learning to leave their own personal

problems at the door to make sure that the athlete not only has their full attention, but they treat

their patients' holistically as a person rather than just their injury. Ultimately, when the students

engage in helping behaviors and know that they are making a difference to their patient they feel fulfilled and shift their perspective away from their own personal problems.

Another way that students shifted perspective from their own negative well-being to providing positive patient care was through kindness. Pommier and colleagues (2019) defined kindness as "being caring toward and concerned for others who are in pain, accompanied by the desire to support those in need" (p. 2). Participant 1 exemplified the definition of kindness by explaining how despite their own stress and anxiety they always treat their patients with kindness because everyone has struggles and challenges pertaining to their own life. If healthcare providers can be empathetic and compassionate towards their patients, then they can establish trust and build a true relationship. On the other end of the well-being spectrum, students wrote about how when they were in a good mood and considered their well-being to be positive, building therapeutic relationships came with ease.

Positive Emotions that Influence Therapeutic Relationships. As students experienced their own positive emotions, they could more effectively transfer these emotions to their therapeutic relationships. When the students described a positive state of well-being their underlying cause was being focused, fully rested, calm, and less stressed. Some students noticed how their own well-being created a difference in their patient care that they then began to make their own well-being a priority, "I have been making sure to take breaks and focus on me, my mental health, and well-being because I am of no use to my athletes if I am overwhelmed" (Participant 13 Reflection Log). Seligman (2009) is the developer of the Theory of Well-being-PERMA model, which consists of the five building blocks: positive emotion, engagement, relationships, meaning, and achievement. In their reflection logs, the students described similar constructs to the PERMA model of well-being through reciprocity and partnership.

Reciprocity and Partnership. Reciprocity establishes that relationships are a "two-way street" where the patient receives support and care though a therapeutic relationship. Likewise, a healthcare provider also receives benefits from a therapeutic relationship (Muetzel, 1988). The students recognized that when their well-being is good, they were more willing to invest in their patient's care. Participant 12 explained, "I am more focused and almost never tired anymore which allows me to have better conversation with patients while giving them the best possible care. When my headspace is clear I provide better patient-centered care." Likewise, other students mentioned how when they prioritize their own well-being, they are more confident in their skills and can help others with an open-minded approach (Participant 5 and 6). Simply put, when the athletic training students found themselves in a good mood, they were able to share that emotion with their patients and help them through a difficult time, such as recovering from an injury.

Partnership is another pillar of building therapeutic relationships. Muetzel (1988) described partnership as a working association between two parties towards a common goal. Participant 6 explained, "I think my soft skills have led my patient-centered care in the last couple of weeks. I have been leading with care and been trying to keep the holistic patient in mind as I ask them what their goals are and what they want to accomplish care wise in the athletic training facility." Goal setting is important for the athletic training students to complete with their patients to establish partnership. Untimely goal setting helps achieve accountability for the patient and also an agreement that they are not going through their injury recovery process alone. Another helpful aspect is when the partnership shows appreciation towards one another. For example, Participant 9 explained how they enjoyed seeing their patients' progress and get better. When the patients are appreciative of their clinicians, it helps create a sense of

achievement. Also, when the students prioritize their own well-being, they were able to successfully establish therapeutic relationships through reciprocity and partnership.

Summary

The research participants completed a soft-skills curriculum and clinical experiences that allowed them to develop empathy and compassion during their patient interactions as athletic training students. During Phase 1 of the research study, the students showed statistically significant development of empathy and the compassion construct of kindness. Throughout Phase 2 of the research study, the research participants described how they perceived their application of soft skills during their clinical experiences. Specifically, students connect the application of empathy to relating to their patients through shared personal experiences and staying out of judgement when interacting with patients. When the students described how they applied compassion, they focused on using reassurance to communicate with their patient that they were not going to progress through their injury journey alone.

Students also explained the most dominant class activities and clinical experiences that helped them transfer soft skills into their clinical practice. The class activities included emotional intelligence activities such as, practicing discussing emotion and building self-awareness. The clinical experience that helped students develop soft skills was mentorship from Sports Medicine professors and athletic training clinical preceptors. Lastly, the students described an overarching theme of the emphasis placed on patient-centered care in their curriculum and during their clinical experiences to help them implement soft skills during therapeutic relationships.

Next, the confounding factor of the COVID-19 global pandemic did not drastically impact the student's abilities to provide patient-centered care during their clinical experiences. The barrier that the students most frequently identified was the use of masks. The students

described how masks made it difficult for them to recognize their patient's non-verbal communication cues. However, a positive change that was established in regard to the pandemic was how the athletic training facilities needed to schedule patient appointments to comply with social distancing policies. Appointment scheduling promoted a culture where clinicians and patients engaged without distractions that traditionally occur with a vast amount of people moving through an athletic training facility.

Finally, my data results revealed that the student's subjective well-being mirrored their emotional response to utilizing soft skills during clinical practice. When students described a negative sense of personal well-being, they experienced burdens that negatively impacted their ability to build therapeutic relationships. Students also described neutral well-being which resulted in a phenomenon called "flip the switch," where despite mediocre well-being, the students were able to direct all their energy and attention to their patient care. Lastly, when students reported positive well-being, then they were able to transfer their position emotions into their therapeutic relationships. In Chapter V, I will discuss the application of the theoretical framework to the findings and how the results from this study confirm, contradict, or extend the existing literature. In addition I will make recommendations for educational implications and provide directions for future research.

Chapter 5: Discussion

Through this study, I investigated the ways in which pre-professional athletic training students transferred knowledge from a soft skills curriculum to their patient care during their first clinical experience. I implemented a mixed methods research approach to integrate self-reported surveys (i.e., the Jefferson Scale of Empathy Health Professions Student version (JES-HPS) and the Compassion Scale (CS)) with a case study design composed of participant reflection log entries and embedded semi-structured interviews. There were statistically significant differences during the didactic soft skills curriculum within the students' development of empathy and the compassion construct of kindness. The students' qualitative data results revealed the ways in which they perceived applying their soft skills during their patient interactions. Particularly, students reported the ability to: (a) apply empathy by connecting with their patients through shared lived experiences and (b) stay out of judgement when listening to their patients. Additionally, the students described using compassion to reassure their patients that they were not going to endure their injury alone and that they would have a support system in place during their recovery process.

Based upon the findings from this study, I recommend athletic training programs, as well as other healthcare education programs, to include soft skill applications within their curriculums to support the development of patient-centered care and therapeutic relationships. The results of this study revealed that exposure to a soft skills curriculum can enhance students' empathy and compassion allowing them to transfer these particular soft skills into their clinical practice and patient interactions. In the remainder of this chapter, I will (a) describe the application of the study's theoretical framework, (b) discuss the results of the study, (c) acknowledge limitations, (d) provide implications for educators and healthcare providers, and (e) propose areas for future research.

Summary of the Study

The purpose of this study was to investigate the ways in which pre-professional athletic training students' transferred knowledge from a soft skills curriculum during a didactic pre-professional course to clinical practice during their clinical experience. I used an explanatory sequential mixed method design with a preliminary quantitative input (quan → QUAL [qual]) to collect data (Morgan, 2014). I wrote the secondary research questions for this study to reflect the quantitative and qualitative portions of the mixed methods research design (Creswell, 2018). Phase 1 quantitative research questions (quan → QUAL [qual]) included:

1. How is a pre-professional soft skills curriculum associated with students' development of empathy?

2. How is a pre-professional soft skills curriculum associated with students' development of compassion?

Phase 2 qualitative research questions (quan → QUAL [qual]) included:

1. In what ways do athletic training students perceive they transferred soft skills into clinical practice?

2. In what ways are the development of soft skills associated with athletic training students' subjective well-being?

Phase 2 Embedded qualitative research questions (quan→ QUAL[qual]) included:

1. How do athletic training students describe their emotional response to utilizing soft skills during clinical practice?

2. In what ways are the development of soft skills associated with athletic training students' subjective well-being?

Phase 1 of the research study included purposeful sampling of 19 upper-level undergraduate students enrolled in a pre-professional soft skills curricular course. The research participants completed the JES-HPS and the CS at three timepoints throughout the academic semester. During Phase 2 of the research study, the research participants began their first clinical experience and completed bi-weekly reflection logs. After completing three of the six reflection logs, four students were purposefully selected to participate in semi-structured interviews. For the quantitative portion of the study, I analyzed the JES-HPS and CS composite score data with a repeated measure ANOVA to observe the difference of three group means over the course of the semester. Then, for the qualitative data, I used a constant comparative analysis to complete first and second cycle coding to inductively produce themes and sub-themes to answer the study's relevant research questions. Finally, I integrated the quantitative and qualitative results to answer the respective research questions.

The theoretical underpinnings of this study included: (a) Muetzel Model of Therapeutic Relationships, (B) Theory of Well-being: PERMA, (c) Emotional Intelligence, and (d) Action Phase Model of Compassion. For the discussion of this research study, I will: (a) portray the ways in which the results pertain to the theoretical framework and (b) discuss how the results from this study confirm, contradict, and extend the existing literature.

Application of Theoretical Framework to Findings

In Chapter II, I presented a theoretical framework for this study consisting of four theories. At the center of the theoretical framework is Muetzel's Model of Therapeutic Relationships. According to Muetzel (1988), a patient and healthcare provider interaction needs to consist of partnership, professional intimacy, and reciprocity in order to establish a therapeutic relationship. However, there are additional aspects from the healthcare provider and the patient

perspective that help cultivate a therapeutic relationship. In order to achieve a therapeutic relationship, this study utilized three additional theories to explain the intricacies of achieving a therapeutic relationship. First, the healthcare provider needs to establish their own well-being prior to creating therapeutic relationships with their patients. The concept of prioritizing the provider's well-being comes from the PERMA Model of Well-Being (Seligman, 2009). Prioritizing practitioner well-being includes establishing their own positive emotions, engagement, relationships, meaning, and achievement then they can begin to cultivate self-awareness to implement emotional intelligence (EI) into their clinical practice. Thus, EI can lead to self-awareness, greater adaptability, improved relationships, the ability to empathize, and productive communication (Freshwater & Stickley, 2004; Tischler et al., 2002). Remember Patel's (2019) definition of empathy, the ability to sense, feel, and understand another's emotions. The outcomes of EI align with the definition of empathy, insinuating that EI is a critical component in healthcare provider's ability to exercise empathy towards their patients. Then, after a practitioner understands their patients' emotions, they transition to the Action Phase Model of Compassion (Poulin, 2017). In this phase, the practitioner decides to emotionally respond to their patients' pain or suffering with an authentic desire to help (Patel, 2019). Thus, the healthcare provider commits to employing helping behaviors to achieve a common goal with their patient as described in the action phase model of compassion. In summary, establishing a helping relationship based on trust and respect not only supports the patient, but also provides the practitioner with a sense of purpose.

The Muetzel Model of Therapeutic Relationships

The Muetzel Model of Therapeutic Relationships consists of three components: partnership, professional intimacy, and reciprocity (Muetzel, 1988). Figure 6 displays the

connection between, security, communication, and vulnerability, three components which I use

to connect Muetzel's Model to the results of this study.

Figure 6

The Muetzel Model of Therapeutic Relationships with Research Findings
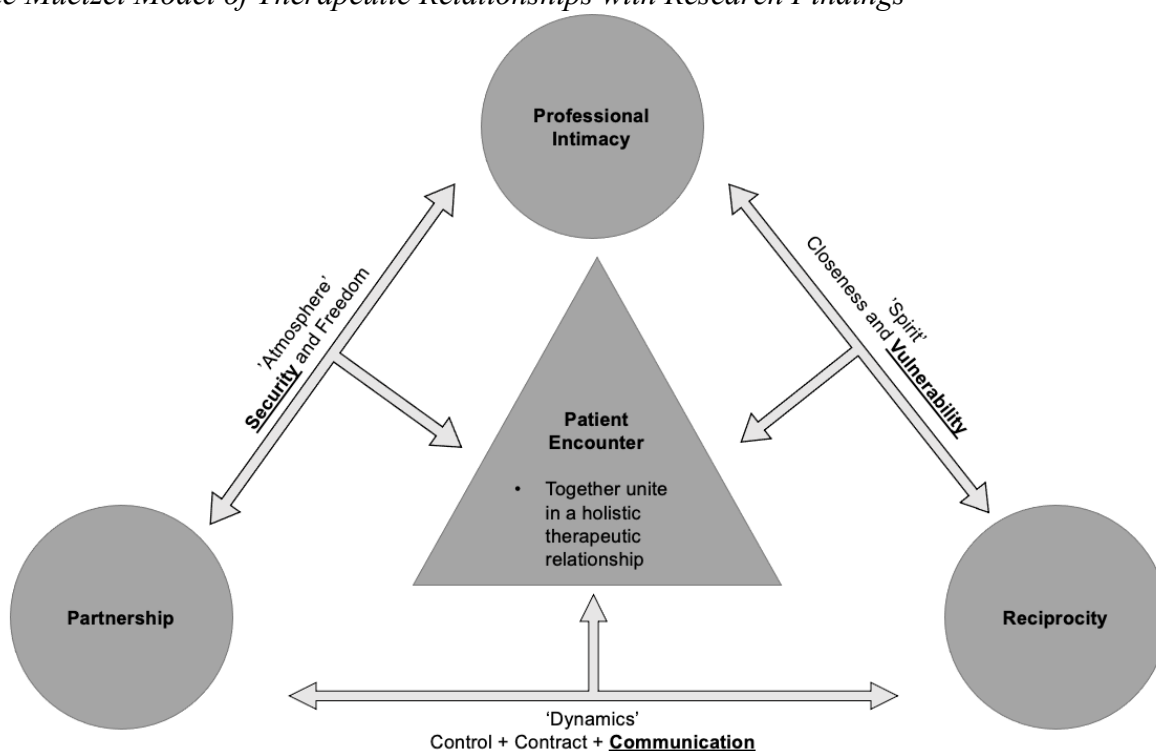
Note. Figure 6 provides a visual representation of Muetzel's Model of Therapeutic Relationships in conjunction with the results of this research study.

Partnership and Professional Intimacy. According to Muetzel (1988), partnership and

professional intimacy creates the atmosphere of security and freedom during a patient encounter.

Carkhuff and Benzon (1982) elaborated on the atmosphere of security, noting that it includes the

following factors: (a) increased awareness, (b) recognition of similarity, (c) core conditions

perceived (empathy, warmth, and genuineness), (d) expressiveness, (e) open communication, and

(f) relatability. Thus, the healthcare provider cultivates a secure environment with their patient

through both emotional and physical support. Similar to Carkhuff and Benzon's security factors,

the research participants in this study described their ability to apply empathy within their patient

interactions by relating to their patients through personal experience. The students created an atmosphere where their patients perceived safety through validation of their emotional and physical state by relating to their current situation.

      Partnership and Reciprocity. In Figure 6, partnership and reciprocity connect to create the dynamics of a patient encounter. This length of Muetzel's Model establishes the constructs of control, contract, and communication. In this study, the research participants described how they perceived to apply empathy during their clinical interactions. In addition to relating to their patients through personal experience, the participants also noted that they stayed out of judgement when interacting with patients. The students described listening to their patients' stories in order to understand their patients' perspectives regarding their injuries (Participant 10, 13, 15, 18). After listening, the students described that they would continue their interaction with helping behaviors. Through these actions, the research participants provided their patients with reassurance by hearing their concerns, checking for confirmation of understanding, and then affirming that there was a support system in place to help them navigate their injury process. According to Muetzel (1988), partnership and reciprocity building is "information thus converted and comprehended then needs checked against that intended, so that understanding is a process of evolution, rather than an escalation and subsequent collapse of assumptions" (p. 106). The students in this research study demonstrate effective communication strategies with their patients through open-ended questions, affirmations, reflections, and summary of what the patient is sharing.

      Reciprocity and Professional Intimacy. Reciprocity and professional intimacy establish the spirit of the therapeutic relationship through closeness and vulnerability. Practitioners establish reciprocity and professional intimacy by committing to being fully present during

patient interactions and expressing an authentic desire to help the patient in need. Muetzel (1988) explained, "The being there for another is required at this level of relationship, where shared tears and tissues are in themselves meaningful and meet suffering in a place which is, in the first instance quite inaccessible to techniques and technologies" (p.109). The emotional aspect of a therapeutic relationship requires humanness resulting in vulnerability. Viscott (1976) explained that when healthcare providers cannot express vulnerability, they also lack sensitivity. With a lack of sensitivity, the practitioner cannot effectively respond to their patients' emotions because they have a deficiency in understanding their own feelings. In this study, when students described class activities from the soft skills curriculum that resonated with them to help promote the application of soft skills during patient interactions, they focused their attention on the areas of practice discussing emotions and self-awareness. The class activities help students learn the humanistic quality of vulnerability needed to cultivate a therapeutic relationship (Goleman, 1998; Muetzel, 1988; Neff & Germer, 2018).

Ultimately, the three components of a therapeutic relationship - partnership, professional intimacy, and reciprocity - collide to create dimensions of security, communication, and vulnerability that establish a positive patient encounter. The results of this research study align with the dimensions of Meutzel's Model of therapeutic relationships. Students create an atmosphere of security for their patients by relating and recognizing similarities between the patient and themself. The research participants dynamically communicated with their patients by listening to their patients in a non-judgmental manner and checking for understanding through the demonstration of helping behaviors. Lastly, the students learned how to establish the humanistic quality of vulnerability through their soft skills curriculum by practicing discussing emotions and building their own emotional self-awareness. Together the dimensions of security,

communication, and vulnerability unite the practitioner and patient in a holistic therapeutic relationship.

Theory of Well-Being

Seligman's PERMA Theory of Well-Being consists of the five building blocks: positive emotion, engagement, relationships, meaning, and achievement (Seligman, 2009). Together, these constructs build the theory of well-being. In this study, the research participants described their own well-being every two weeks over the course of an academic semester. The students self-reported well-being varied between positive, neutral, and negative emotions of well-being. In addition to reflecting upon their own well-being, students described their emotional response to utilizing soft skills during clinical practice. Again, the students' responses varied, ranging from how their own positive emotions of helping others and kindness which positively influences therapeutic relationships, to a neutral response of "flip the switch" (i.e., a phenomenon where despite a student's mood, they were able to be fully engaged when interacting with patients), or personal barriers such as being overwhelmed and stressed that inhibit their ability to establish a therapeutic relationship. The research participants' responses confirmed the importance of their own well-being in establishing effective therapeutic relationships with their patients.

Emotional Intelligence

Goleman's (1998) framework for Emotional Intelligence (EI) described EI as a social skill set. EI determines our potential for learning practical skills and is based on five elements: self-awareness, motivation, self-regulation, empathy, and adeptness in relationships. The soft skills curriculum that the research participants completed during Phase 1 of the research study incorporated units of emotional intelligence, growth mindset, and mentoring. The course

instructor taught specific topics within each unit. Within the emotional intelligence unit, the topics of instruction included: (a) self-awareness- the power of habit, (b) self-awareness-identifying strengths, (c) empathy, and (d) compassion. Based upon what the research participants learned in the classroom, they described the practicing discussing emotions and self-awareness class activities as the most influenced in how they implemented soft skills into their clinical practice. Both discussing emotions and self-awareness connect with Goleman's (1998) emotional intelligence framework.

Action Phase Model of Compassion

The purpose of the Action Phase Model of Compassion is to express the effects of compassion and helping behaviors on well-being for both the practitioner and patient (Poulin, 2017). The action phase model of compassion incorporates two phases. The first phase is the deliberative phase when the person feels compassion which results in a desire to help the other person who is suffering, where the second phase is the implementation phase when the person shifts from a desire to help to a commitment of helping behaviors to alleviate another person's suffering. During this research study, the participants perceived applying compassion during their clinical interactions as helping behaviors, reassurance, and a plan of action. The students clearly progressed through both phases of the Action Phase Model of Compassion. In the deliberative phase, the students experienced an authentic desire to help their patients by conveying the aspiration to implement helping behaviors during their patient interactions. Then, the students transitioned to the implementation phase where they committed to applying helping behaviors. Specifically, in this study, the participants most frequently expressed helping behaviors as creating a plan of action with their patient. From an athletic training student's perspective, a plan of action could range from building a therapeutic rehabilitation plan, to

referrals with other healthcare providers, to creating goals with their patients. However, a key component of a compassionate plan of action included agreeance among both the patient and practitioner which in turn results in a therapeutic relationship built upon partnership and reciprocity.

In conclusion, the theoretical framework presented in Chapter II validates the results of this research study. In conjunction the Theory of Well-being, Emotional Intelligence, and the Action Phase Model of Compassion establish the foundation for a therapeutic relationship based upon Muetzel's Model. According to Muetzel (1988), therapeutic relationships form when clinicians and patients collaborate to create an atmosphere of safety, communication, and vulnerability. The research participants in this study described establishing therapeutic relationships by creating a secure space where they could relate to their patients through personal experiences, staying out of judgement and checking for understanding as communication strategies, and practicing vulnerability through self-awareness and discussing emotions. The results of this research study extended Muetzel's findings by revealing the ways in which athletic training students cultivated therapeutic relationships.

Discussion of Results

Healthcare professionals' responsibility for implementing a biopsychosocial model of healthcare where patient-centered care is a priority has increased in recent years (Coulter & Ellins, 2007; Hush et al., 2011). The biopsychosocial model is a holistic approach which includes all aspects of the human experience, emphasizing the psychological, environmental, and biomedical aspects of health, while patient-centered care is a combination of quality clinical care and interpersonal care. Specifically, quality clinical care includes provider knowledge and interpersonal care incorporates soft skills such as the value of communication and a relationship

of shared decision making between the practitioner and patient (Hipra et al, 2020). Griffiths and colleagues (2012) found that the primary requirements that patients' value when selecting a healthcare provider is their ability to care, display a professional attitude, create a non-judgemental environment, and prioritize patient-centered care. In the literature, common themes that characterize patient-centered care include patient participation and involvement, the relationship between the patient and the healthcare professional, and the way healthcare providers deliver care (Kitson et al, 2013). These findings support that soft skills are an essential component of providing patient-centered care.

Healthcare providers accept empathy and compassion as important components of professionalism and mutually beneficial attributes of the health provider-patient relationship across the health professions (Fields, 2011). Specifically, for athletic trainers, the soft skills of empathy and compassion are incorporated into the foundational behaviors of professional practice (National Athletic Trainers' Association, 2011). There are benefits to incorporating empathy and compassion into clinical practice for both the patient and healthcare provider. A few benefits to applying empathy and compassion in healthcare include: improved patient compliance (DiMatteo et al., 1993), more accurate prognosis (Dubnicki, 1977), increased patient satisfaction (Zachariae, 2003), activation of the parasympathetic nervous system (Trzeciak & Mazzarelli, 2019), and psychological health benefits of trust building and cultivating hope (Trzeciak & Mazzarelli, 2019). Optimally, healthcare providers would treat every patient with empathic and compassionate care. However, there are barriers such as burnout and occupational stress that healthcare providers face when providing care. To combat these barriers, a focus has been placed on the need to improve healthcare provider well-being. If healthcare providers' well-being can improve then researchers suggest the ability to provide empathic and compassionate

care towards their patients will improve as well (Raab, 2014; Olson & Kemper, 2014; Boelliinghaus et al., 2014). Therefore, healthcare educators should incorporate both soft skills such as empathy and compassion in the curriculum and ways to teach future healthcare providers well-being strategies and self-compassion.

Davlin-Pater and Rosencrum (2019) created a framework for athletic training educators to emphasize soft skills within their curriculum. This framework is an appropriate starting place for AT educators to build the philosophical biopsychosocial foundation into the curriculum and prioritize patient-centered care. In this section, I will explain the results of the data and the implications regarding the ways in which pre-professional athletic training students transfer knowledge from a soft skills curriculum into their clinical practice.

Soft Skills Curriculum Findings

As pre-professional students, the research participants engaged in a soft skills curriculum during Phase 1 of this research study. The participants completed the JES-HPS and the CS surveys at three different time points: (1) before the soft skills curriculum, (2) after the empathy and compassion curriculum, and (3) after the soft skills curriculum. The statistical analysis of a one-way repeated measures ANOVA determined a statistical significance in the research participants' reported empathy levels on the JES-HPS over the course of the semester $F(2)=$ 20.38, $p=.000$. However, the data analysis did not reveal statistical significance differences in the research participants' reported compassion levels on the CS over the course of the semester $F(2)=$ 1.39, $p=.261$. Pommier and colleagues (2019) created three constructs within the CS; mindfulness, kindness, and common humanity. A statistical analysis conducted for the CS constructs revealed statistical significance for the kindness construct over the course of the semester $F(1)=$ 5.74, $p=.028$.

During the soft-skills curriculum, over a four-week period, the students learned about empathy and compassion in healthcare. As displayed in Table 1, the empathy and lessons incorporated both asynchronous and synchronous activities. The empathy lesson focused on clinical skills and behaviors such as: (a) sitting versus standing, (b) detecting patients facial expressions and nonverbal cues of emotion, (c) recognizing and responding to opportunities for compassion, (d) employing non-verbal communication of caring, (e) incorporating statements of support, (f) being present, assuring the patient of a true focus, and (g) reinforcing that they are not going through their current medical treatment alone (Patel, 2019). The activities included in the lesson were role playing where students practiced applying Wiseman's (1996) four qualities of empathy: (a) perspective taking, (b) staying out of judgement, (c) recognizing emotion, and (d) communication. The activities presented and skills practiced in during class aligned with the JES-HPS survey tool. The JES-HPS was specifically developed for health profession students. A two-year longitudinal study examined the measurement properties of the Jefferson Scale of Physician Empathy (JSE) which was adapted for specific administration for health profession students (JSE- HPS) and investigated group differences of empathy scores in nursing programs (Fields, 2011). The internal consistency found from Field's (2011) study, assures the measurement properties of the JSE-HPS for use in diverse health profession students. To my knowledge, this study was the first to implement the JSE-HPS among athletic training students.

Unlike the JSE-HPS, the CS was created for the general population, rather than exclusively the healthcare community. The compassion lessons focused on self-compassion, communication tools, paraphrasing strategies, and vignette role playing with peer feedback. Although the students were exposed to Neff and Germer's (2018) self-compassion constructs which align with the CS survey, the curriculum did not incorporate specific lessons on common

humanity and mindfulness. Pommier and colleagues (2019) defined kindness as being caring toward and concerned for others who are in pain, accompanied by the desire to support those in need. Pommier et al.'s definition of kindness (2019) for the CS aligns with the definition of compassion utilized in this study. Patel (2019) defined compassion as an emotional response to another's pain or suffering involving an authentic desire to help. While common humanity involves two components, recognizing that all people experience hardships and a sense of connection to those who are suffering (Pommier et al., 2019). In this study, although the students engaged in role playing to simulate common humanity behaviors, they were given a standardized vignette and did not truly connect to someone who was suffering, as they would with an injured patient during their clinical experience. Lastly, Pommier and colleagues (2019) interpreted mindfulness as a type of balanced awareness that neither avoids or gets lost in others pain with the willingness to listen to and pay attention to others' when they are suffering. The soft skills curriculum did not include any form of mindfulness training; therefore, I did not anticipate statistical significance results for the mindfulness compassion construct. The curriculum that I taught focused on foundational and practical elements of empathy and compassion for healthcare students. In Patel and colleagues' (2019) systematic review, *Curricula for Empathy and Compassion Training in Medical Education: A Systematic Review,* 75% of the 52 included studies found that the tested curriculum improved physician empathy and/or compassion on at least one outcome measure which confirms the quantitative findings of this study.

Curriculum Activities and Clinical Experiences

During Embedded Phase 2 of this research study where I conducted the semi-structured interviews, the research participants described class activities and clinical experiences that

resonated with them to help promote the application of soft skills during patient

interactions. The class activities that helped the students apply soft skills during patient care

were practicing discussing emotion and building self-awareness. Both practice discussing

emotion and self-awareness are grounded in the theory and application of emotional intelligence

(EI). During the students clinical experience the predominant factor to help them transfer soft

skills to their clinical practice was mentorship. An overlapping concept established during both

class activities and clinical experience was patient-centered care.

Emotional Intelligence. The students disclosed that both practice discussing emotions and

self-awareness were important curricular components for their ability to implement soft skills

into their clinical practice. To practice discussing emotions, the students completed small group

activities where they practiced Wiseman's (1996) four qualities of empathy: perspective taking,

staying out of judgement, recognizing emotion, and communication. The theoretical

underpinnings of this class activity was established through the nursing literature. Currently,

healthcare providers are beginning to acknowledge the value of emotional intelligence for

clinical practice (Prado-Gasco et al., 2019; Sharp et al., 2019). However, the field of nursing

pioneered the paradigm shift towards integrating emotional intelligence into healthcare

educational curriculums (Freshwater & Stickley, 2004). Now other healthcare fields look to the

nursing literature as an example to implement and acquire the benefits of EI.

In order to build self-awareness, the students in this study completed the Clifton

Strengths Finder assessment, a tool which generates the individual's top five talents and provides

a detailed report. A guest lecturer then taught the students about becoming aware of how to

implement strengths to their full potential. The students also learned how personal strengths can

potentially hold people back in some circumstances. The students were challenged to critically

think about their strengths and how they implement them into their own life. Davlin-Pater and Rosencrum (2019) recommended implementing the Clifton Strengths Finder into a curriculum to promote soft skill development in pre-professional athletic training students. The researchers explained their justification for implementing the Clifton Strengths Finder program as "provid[ing] a framework for discussing individual difference, empathy, and communication. Along with learning to see themselves [the students] more clearly, they also learned how to see others more clearly through recognition of talents that may be the same or different from their own" (p. 76). EI provides healthcare teams with the ability to build self-awareness skills while understanding personal strengths, weaknesses, needs and desires (Sharp et al., 2019). Additionally, EI promotes self-regulation where healthcare providers wait and allow their emotions to settle before they act (Goleman, 1998).

The skills that EI promotes are essential for the development of a healthcare provider establishing therapeutic relationships. Additional benefits of EI include reducing stress and burnout, while increasing work satisfaction (Sharp et al., 2019). Freshwater and Stickley (2004) suggested that an EI healthcare curriculum should include the following components: reflective learning experiences, supportive supervision and mentorship, modeling, opportunities for working creatively with the areas and humanities, focus on developing self and dialogic relationships, developing empathy, and a commitment to emotional competency. Based upon both the findings of this research study and the nursing literature, I recommend that healthcare educators wanting to promote soft skill development within their curriculum implement foundational elements of emotional intelligence into their lessons in addition to activities such as discussing emotions and building self-awareness through the Clifton Strength Finder assessment (Freshwater & Stickley, 2004).

Mentorship. During the semi-structured interviews, the four research participants described mentorship as a critical component of how they learned to apply soft skills during patient interactions. The research participants most often described watching and mirroring their preceptors' or professors' actions. Within the athletic training literature, Mazerolle and colleagues (2016) described modeling as an important aspect of professional socialization for athletic training students. Specifically, the mentoring process allows the mentee to gain an appreciation of what is expected of them during patient interactions. According to Mazerolle et al. (2016), "Mentors help athletic training students develop as future clinical practitioners by not only allowing them to engage in the role, but also by providing them with chances to brainstorm, solve problems, and gain feedback on performance" (p.75). When athletic training students have a professional mentor, they can observe their behaviors, easily ask for feedback, and confidently develop their clinical soft skills.

Patient-Centered Care. The research participants attributed patient-centered care with the biopsychosocial model of healthcare. Specifically, the students shared how their curriculum prepared them for their clinical experience where they interact with patients through a holistic lens, always placing their patient at the center of care. In Kitson et al's (2012) literature review on the core elements of patient-centered care from a health policy, medicine, and nursing perspective, three core themes of patient-centered care emerged: (a) patient participation and involvement, (b) the relationship between the patient and the healthcare professional, and (c) the context of how healthcare professionals deliver care. The students in this study discussed patient-centered care to include: (a) respecting cultural competencies, (b) asking the patient the right open ended questions, and (c) using emotional intelligence to understand the patient's perspective. The students' interpretation of patient-centered care aligns with the first theme of

patient-centered care that Kitson and colleagues (2012) described in their research. The first theme of patient-centered care involves the patient participating in their care as a respected individual. The care plan created with the patient is based on their individual needs and addresses both physical and emotional needs (Kitson et al., 2012). When the students use their cultural competency training during patient interactions, they are respecting their patient as a person with individual needs. As a result, the students build the care plan based upon asking their patient what is most important to them, asking if they addressed all their patients concerns, and providing patients with the opportunity to share any additional information that they think is important. Lastly, the students applied emotional intelligence to understand the patient's perspective to address not only their physical needs but their emotional needs, too. Ultimately, the students in this research study concluded that their implementation of patient-centered care began with soft skills.

AT Students' Perceived Application of Soft Skills

The purpose of this research study was to investigate the ways in which pre-professional AT students' transfer knowledge from a soft skills curriculum during a didactic pre-professional course to clinical practice during their clinical experience. Figure 7 provides a visual representation of the research participants' perceptions as to how they applied soft skills during patient interactions at their first clinical experience.

Figure 7

AT Students' Perceptions of Applying Soft Skills during Patient Interactions
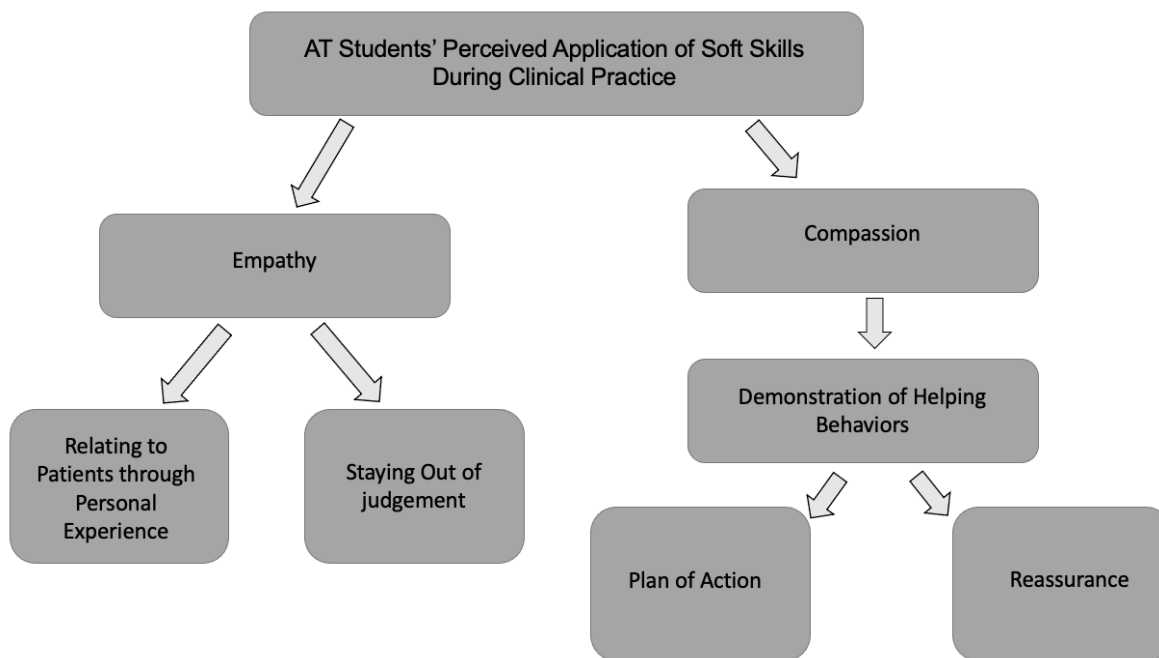
Note. Figure 7 portrays the ways in which the research participants of this study described applying soft skills to their patient encounters during their first clinical experience as AT students.

The research participants displayed empathy to their patients by relating to them through personal experiences and staying out of judgment. I propose that students in this research study easily connect to their patients through lived experiences because of their close proximity in age and their specific clinical assignment. The average age of students in this research study was 20.4 (SD=0.5) years old, which is close in proximity to the majority of their high school patients' ages. Additionally, this study took place during a global pandemic which resulted in challenges and hardships for clinical coordinators to place students at clinical assignments. Therefore, athletic training students most commonly completed their Fall 2020 clinical rotation at high school locations, with 14 out of the 19 of research participants placed at high schools for their clinical rotation. Given that the majority of the participants experienced high school in a

traditional setting, many of which also participated in high school sports, the participants easily connected with their high school patients through their personal lived experiences. However, during a semester without confounding factors like the global pandemic students were placed in an array of various clinical assignments. In addition to high school clinical assignments, clinical placements could include professional sports, collegiate sports, orthopedic practices, trade schools, performing arts, or industrial settings. Students' application of empathy during patient interactions would have to change if they were placed in a culturally-diverse or emerging clinical assignment because the AT students may not be able to apply empathy and build therapeutic relationships if they are not able to connect with their patient through their own lived experiences. According to the National Athletic Trainers' Association (2020), emerging settings are an area of growth within the field of athletic training. Emerging settings include healthcare administration, military, occupational health, performing arts, physician practice, and public safety. Evaluating how AT students implement empathy into their patient interactions within clinical placements of emerging settings yields the need for future research.

The students within this research study revealed that staying out of judgement is an important part of implementing empathy during patient encounters. As Wisemen (1996) described, staying out of judgment is one of the four qualities of empathy and it was a skill that the students practiced during their soft skills curriculum. Staying out of judgement is the ability for the healthcare provider to avoid comments that infer patients' emotions or responses were invalid or wrong. This study focused on the AT students' perception of empathy application. Interestingly, staying out of judgment extends the athletic training literature regarding the athlete's perception of how their athletic trainer applies empathy. In a qualitative study, David and Larson (2018) found five themes that athletes perceived to be critical during the patient-

clinician relationship. These themes include: advocacy, communication, approachability, access, and competence (David & Larson, 2018). The AT students' perceptions of empathy and staying out of judgment connects with the athletes' descriptions of empathy through advocacy, where an athlete in David and Larson's (2018) research stated that advocacy is "a fundamental part of a relationship just being heard and not feeling judged" (p. 11). When an athletic trainer portrays empathy through advocacy, communication, and approachability, they establish a therapeutic relationship which results in the delivery of patient-centered care.

The research participants displayed compassion to their patients by demonstrating helping behaviors, specifically creating a plan of action with their patient and reassurance. The students' perception of applying empathy strongly connected to the soft skills curriculum that they completed in Phase 1 of this research study. Patel's (2019) definition of compassion is implemented for this research study, an emotional response to another's pain or suffering involving an authentic desire to help. In the compassion lesson of the soft skills curriculum, Trzeciak and Mazzarelli's (2019) empathy and compassion analogy emphasized that empathy is like a one-way street running toward the health care provider: detecting, processing, understanding, and even feeling the incoming emotional cues from the patient. Compassion, on the other hand, is a street that runs in the other direction, a responsive action toward the one who is suffering. In short, empathy can be a one-way street while compassion cannot. This analogy emphasizes that compassion is associated with action. As a result, the AT students interpreted compassion as plans of actions. For example, ensuring that the patient was comfortable with their therapeutic treatment plan, explaining the purpose behind their rehabilitation exercises, providing additional mental health resources and referrals, helping the patient schedule an appointment with a physician, and creating short-term and long-term goals with their patient.

The students' interpretation of reassurance as a way to implement compassion was also derived from the soft skills curriculum that they completed prior to their clinical experience. Throughout the curriculum, the students learned an evidence-based approach to empathy and compassion engagement for healthcare providers. The clinical skills and behaviors included: (a) taking time to listen and build awareness of the patient's emotions, (b) sitting versus standing during a medical consultation, (c) detecting the patients facial expressions and nonverbal cues of emotion, (d) recognizing and responding to opportunities for compassion, (e) employing non-verbal communication of caring, (f) incorporating statements of support, (g) being present for your patient, and (h) reinforcing that they are not going through their current medical treatment alone (Patel, 2019). The last clinical skill and behavior of reinforcing to their patient that they are not going to progress through their medical treatment alone clearly resonated with the research participants in this study, since reassurance was a dominant theme among the students' perception of soft skills application. Additionally, the compassion application strategies that the students learned about during the soft skills curriculum were based upon the Schwartz Center Compassionate Scale (Lown et al., 2015). Lown and colleagues wrote the strategies from the patient's perspective including: (a) expressing sensitivity, caring and compassion for your situation, (b) striving to understand your emotional needs, (c) considering the effect of your illness on you and your family, (d) listening attentively to you, (e) conveying information in a way that is understandable, (f) gaining your trust, (g) involving you in decisions about your treatment, (h) comfortably discussing sensitive, emotional, or psychological issues, (i) treating you as a person not just as a disease, (j) showing respect for you and your family, (k) communicating test results in a timely sensitive manner, and (l) spending enough time with you (Lown et al., 2015). Although the results of this study did not specifically represent the

compassion strategies on the Schwartz Center Compassion Scale, future research provides the opportunity for scholars to use this scale across athletic training education curriculums during mock patient interactions, OSCE examinations, or for patients to complete after a healthcare interaction to gain their perspective of how the healthcare student applies compassion care.

Students' Subjective Well-Being and Emotional Response to Utilizing Soft Skills

Throughout Phase 2 of the research study, the research participants completed six reflection logs, every two weeks of the academic semester. All of the reflection log questions are displayed in Table 4. Specifically, two of the questions centered around the students' perceived well-being and the ways in which their well-being influenced their ability to exhibit patient-centered care.

1. *Please describe your own well-being in the past two weeks.*

2. *Describe the ways in which your own well-being has influenced your ability to exhibit soft skills and provide patient-centered care in the last two weeks of your clinical experience.*

Interestingly, the students subjective well-being mirrored their emotional response to utilizing soft skills during their clinical practice. Figure 8 is a visual representation of the students' reported well-being themes and the themes that emerged from the data describing their emotional response to using soft skills during patient encounters.

Figure 8

Students' Subjective Well-being and Emotional Response to Utilizing Soft Skills

Negative Emotions
"stressed", "overwhelmed", "frustrated", "anxious", "upset", and "poor mental health"

- Personal barriers that negatively impacted students' ability to build therapeutic relationships
- Stress
- Being Overwhelmed

Neutral Emotions
"tired", "emotional", "drained", and "chaotic"

- "Flip the Switch"
- Helping Others
- Kindness

Positive Emotions
"good", "energized", "fantastic", and "phenomenal"

- Positive emotions that influence therapeutic relationships
- Reciprocity
- Partnership

Note. The left side of Figure 8 displays themes that emerged from the data describing the research participants' self-reported well-being throughout the semester. The right side displays the themes and subthemes of the students' emotional response to using soft skills during patient-centered care.

During their reflection logs, the students most frequently reported the negative emotions of stress and being overwhelmed to describe their well-being. When the students described experiencing negative states of well-being, they portrayed their negative emotions as barriers to the ability to provide patient-centered care. In the nursing literature, Singh and colleagues (2018) reported that healthcare providers commonly associate personal challenges to applying compassion. Specifically, the challenges included the healthcare providers' attitudes and personal perspectives towards their patients. Contradicting the results of this study, the

participants in Singh et al.'s research specifically described the personal barriers to compassion implementation as egotistic caregiving and individual differences in healthcare providers' virtues.

Athletic training students who experienced neutral emotions still provided patient-centered care and established therapeutic relationships. Interestingly, the students described this phenomena as "flipping the switch" where despite their self reported well-being, the students were able to apply effective soft skills during their clinical patient interactions. The students used their self-awareness and self-regulation strategies to set aside their personal well-being to be fully present for their patients. The research participants described their role as athletic training students to be emotionally taxing, however when they interacted with their patients and helped them get better, they described their clinical experience as engaging and exciting. Ultimately, the students voiced that their desire to help others and provide positive patient care with kindness outweighed their own personal challenges when they were at their clinical experience.

Lastly, when students expressed a positive state of well-being, they could more effectively transfer positive emotions to their therapeutic relationships. Students prioritized their own well-being in order to feel focused, rested, calm, and less stressed when interacting with their patients. The positive emotions that they shared with their patients promoted reciprocity and partnership during their therapeutic relationship. Similarly, Singh and colleagues (2018) reported self-care, contemplative practices, and personal connection as facilitators of healthcare providers abilities to provide compassionate care. In order to best support their patients through compassionate patient-centered care, healthcare providers and healthcare students must prioritize self-awareness, self-regulation, and self-care strategies.

How the Global Pandemic Influenced Patient-Centered Care

I had the unique opportunity to collect data for this research study during a global pandemic. To incorporate the research participants' lived experiences of being healthcare students during a pandemic the students answered a prompt on their bi-weekly reflection log, *Given the pandemic, in what ways has your ability to provide patient-centered care been influenced in the last two weeks?* Ultimately, the students reported challenges, policy changes, and a sense of altruism that occurred throughout their first clinical experience.

The challenge that the research participants noted most frequently was regarding face masks. The students perceived that face masks made it challenging to communicate with their patients and they needed to rely more heavily on understanding body language as nonverbal communication. In David and Larson's (2018) research on athletic trainer empathy, patients reported communication as an essential part of patient-centered care. Specifically, nonverbal communication related to body language, presence, and attentiveness were important clinician actions from the patient's perspective (David & Larson, 2018). Given our current global environment, soft skill curriculums now need to place an emphasis on navigating communication through nonverbal communication cues when both the practitioner and patient are wearing face masks for their safety.

The COVID-19 pandemic and social distancing policies surprisingly created a positive change for athletic training facility culture. In athletic training facilities, patients traditionally come and go as they please with no appointment necessary. The unstructured schedule created a busy and overcrowded healthcare facility where providing a patient with one-on-one attention and support was rare. However, now patients are required to schedule appointments with their

athletic trainer prompting more one-on-one patient interactions, which results in promoting the implementation of soft skills and in enhancing patient-centered care (David & Larson, 2018).

Another positive attribute that the students observed while being a healthcare student during the pandemic was their altruistic ability. Altruism is "motivation that is other-directed and aims to increase or benefit another individual's well-being" (Burks & Kobus, 2012, p. 318). The students shared how the pandemic magnified individuals' personal hardships and encouraged healthcare providers to be respectful and cognizant of their patients' challenges. The pandemic created a difficult environment that we could all connect to because COVID-19 impacts everyone to some extent. Ultimately, the pandemic created a culture where soft skills are essential. The ability for healthcare providers to express empathy and compassion in conjunction with clinical competency facilitates therapeutic relationships which are necessary in a global environment where isolation and separation are regarded as the new normal.

Limitations

This study did have limitations that potentially impacted the data and results including: (a) researcher bias, (b) survey instrumentation, (c) sample size, and (d) generalizability. In the following section, I will describe the ways in which the limitations of this study may have impacted the results.

Research Bias

As I have previously disclosed, I hold a position of insider and outsider status to the research participants. My insider status exists because the students in this research study are comfortable with me. I am a professor within their academic program as well as a clinical preceptor. Some of the students may have viewed me as an outsider status because of my position of power. I was a guest lecturer who presented the empathy and compassion lessons as a

portion of the soft skills curriculum in. Phase 1 of the study. Therefore, the students may have answered their surveys in a particular way knowing that I would be collecting data specifically to the constructs of empathy and compassion. I tried to mitigate students' perceptions that they would be judged based upon their survey results or reflection log responses by protecting their identity. I used participant identification numbers throughout the entire study to ensure that their responses are not connected with their name to protect their identity and to allow them to honestly report their lived experiences without fear or judgement or academic penalty.

Survey Instrumentation

During Phase 1 of this research study, I used the JES-HPS and the CS surveys to assess the research participants' levels of empathy and compassion. The JES-HPS is an empathy survey specifically designed for healthcare professional students. Unlike the JES-HPS, the CS was developed for the general population and was created from Buddhist philosophy rather than from a healthcare perspective. Therefore, it is possible that students may not have recognized some terms used in the survey or may have had difficulty connecting with the questions from a healthcare perspective.

Sample Size and Demographics

The sample used from this study included one cohort of 19 3+2 Master's of Science in Athletic Training (MS AT) students who committed to completing both their undergraduate education and Masters degree at the University where the study was being conducted, meaning the students who participated in the study all completed their Bachelor's degree in Sports Medicine Studies at the same institution. The small sample size of 19 students makes the results difficult to generalize beyond this specific athletic training student population. Additionally, I made the purposeful decision to select a homogeneous sample for the semi-structured interviews.

Given the particular research questions and the confounding factor of the global pandemic, I decided that students who had reported the most frequent utilization of empathy and compassion during their clinical practice would be best suited to elaborate on how they implemented the soft skills into clinical practice. Purposely, by selecting students who most frequently reported using soft skills provided an exemplary model of how AT students perceive to implement soft skills into clinical practice.

Generalizability

Although the results of this study present insightful information for athletic training and other healthcare education programs, these findings cannot be generalized to all athletic training students as this study only examined one case of athletic training students at one University. To generalize the results, future research of other athletic training students is needed. However, the findings associated with the soft skills curriculum and application to clinical practice recognize the importance of teaching emotional intelligence and class activities such as discussion emotions and building self-awareness. In addition, the findings emphasized the importance of professional mentorship for athletic training students when delivering soft skills during patient interactions. Additionally, participants reported the importance of learning about patient-centered care across their curriculum and being able to practice implementing patient-centered care strategies at their clinical site. This finding is impactful for healthcare educators as they recognize which didactic techniques are successful for implementation of soft skills into clinical practice.

Implications for Educators

The results from this study support the necessity of including soft skills, specifically empathy and compassion, as intentional elements within an athletic training curriculum. Athletic

Training Education Competencies (2011) include foundational behaviors of professional practice. The subcategory of professionalism states that athletic trainers advocate for the profession, demonstrate honesty and integrity, exhibit compassion and empathy, and demonstrate effective interpersonal communication skills (National Athletic Trainers' Association, 2011). The soft skills curriculum taught in this study, provides evidence that healthcare students can develop empathy over the course of an academic semester. Additionally, this study focused on the ways in which athletic training students transferred their soft skills into their clinical practice. Therefore, when educators develop soft skills curriculums, they must provide opportunities for students to apply didactic soft skills to their clinical practice. Bertram (2018) emphasized the importance of healthcare students developing soft skills during their education because professionals in hiring positions have noticed soft skills deficiencies in qualified applicants.

The results from this study revealed that the curricular activities that predominantly helped the students transfer soft skills into clinical practice include practice discussing emotions and building self-awareness. Both discussing emotions and building self-awareness are rooted within the theoretical underpinnings of emotional intelligence (EI). Therefore, I would recommend educators purposefully incorporate emotional intelligence elements within soft skills curriculums for healthcare providers.

The results from this study also emphasized the importance of student well-being. I discovered that when students perceived their well-being as positive, they were then able to effectively engage with their patients and build therapeutic relationships with ease. However, if the students perceived their well-being to encompass negative emotions such as stress and feeling overwhelmed, then their abilities to create therapeutic relationships were hindered. Thus, explicitly incorporating well-being strategies throughout the curriculum promotes students'

abilities to build self-awareness and self-regulation which will help them as healthcare students and future healthcare professionals. Educators can foster well-being within curriculum from a programming standpoint, like in the Penn Resiliency Program PRP (Seligman, 2009), Learn to BREATH (Broderick & Metz, 2009), Strath Haven Positive Psychology Curriculum (Seligman, 2009) or through Mindfulness Based Stress Reduction (MBSR) (McConville, 2017; Holland, 2006; Kabat-Zinn, 2003). In contrast, educators can implement well-being in more subtle ways, starting class with a gratitude practice, adding mentorship opportunities for students and faculty, incorporating reflective writing, and experiential learning (Lyubomirsky & Layous, 2013; Riley, 2012; Salvin 2014; Seligman, 2009; Waters, 2014; Weeks, 2017). Keyes (2007) shared a surprising statistic noting that less than 20% of humans are manifesting the skills and knowledge to actively practice well-being in their daily lives. The research from this study emphasizes the importance of incorporating emotional intelligence and well-being strategies into healthcare curriculums in order for healthcare students to effectively establish therapeutic relationships with their patients.

Implications for Future Research

Future research efforts surrounding soft skills development within the field of athletic training have the ability to significantly expand in regards to the dearth of studies examining empathy and compassion. I suggest that future studies should examine the development of a compassion survey specifically established for healthcare professionals and healthcare professional students, exploring preceptors abilities to apply soft skills during clinical interactions, incorporating diverse clinical experiences and students ability to utilize soft skills, and lastly assessing students application of empathy and compassion during real time clinical encounters.

First, I recommend the development and validation of a compassion survey specifically developed for healthcare professionals and healthcare students. This study included the JES-HPS, specifically created for the field of healthcare while the CS, was developed for the general population. The CS survey certainly posed a threat to the internal validity of this study because the instrument was not consistent with healthcare examples and healthcare lexicon. The development of a compassion survey for healthcare providers would allow healthcare researchers consistency among their instrumentation when assessing empathy and compassion development.

Second, the results from this study revealed that mentorship was a critical component of the athletic training students' abilities to transfer soft skills into their clinical practice. To date, no studies have been published regarding preceptors' knowledge and application of soft skills into clinical practice. This gap in the literature, most likely presents itself because the accountability for healthcare providers to practice patient-centered care has increased within the last two decades (David & Larson, 2018). A paradigm shift towards the biopsychosocial model, patient-centered care, therapeutic relationships, and emotional intelligence is occurring within healthcare and healthcare education. However, preceptors who engage with athletic training students can range from veteran to newly certified clinicians. Therefore, future research should evaluate preceptors' knowledge of empathy and compassion supplemented with continued education opportunities on the topic because the results from this study publicized that mentorship and mirroring of preceptor's behaviors influenced the students' application of soft skills. Providing educational opportunities for preceptors to learn more about using empathy and compassion to cultivate therapeutic relationships may help healthcare overcome 'hidden curriculums' of uncaring attitudes and behaviors demonstrated by supervisors which reinforce uncompassionate care norms for students (Lown, 2016).

Next, regarding the confounding factor of the global pandemic, the clinical experiences for the students in this study consisted of a homogeneous sample of primarily high school clinical rotations. Interestingly, the research participants in this study most commonly reported applying empathy by relating to their patients through their own personal experiences. This finding raises the question of how athletic training students would apply empathy if they could not easily connect to their patient. Thus, this study should be replicated when students have the opportunity to partake in clinically-diverse healthcare experiences.

Last, this study assesses soft skills application during therapeutic interactions from the athletic training students' perspectives. Future studies should consider assessing athletic training soft skills application during standardized patient encounters such as an objective structured clinical examination (OSCE) or through researcher observations during live patient encounters in an athletic training facility. Having a healthcare professional assess athletic training students' soft skills application will help provide internal consistency for research results as well as an opportunity for feedback and growth for the athletic training student.

Summary

In summary, this study investigated the ways in which pre-professional athletic training students transferred knowledge from a soft skills curriculum to their patient care during their first clinical experience. The study consisted of two phases, Phase 1 included a soft skills curriculum where the research participants completed the JES-HPS and CS at three timepoints. The results revealed statistically significant results during the didactic soft skills curriculum regarding the students' development of empathy and the compassion construct of kindness.

Then, Phase 2 of the study incorporated bi-weekly reflection logs and semi-structured interviews while the students completed their clinical experience. The students' qualitative data

results revealed the ways in which they perceived applying soft skills during their patient interactions. The students reported the ability to apply empathy by connecting with their patients through shared lived experiences and the ability to stay out of judgement when listening to their patients. Additionally, the students described using compassion to reassure their patients that they were not going to endure their injury alone and that they would have a support system in place during their injury recovery process.

Based upon the results from this study and the current literature, I suggest that athletic training education programs intentionally incorporate soft skills, especially empathy and compassion, into their curriculums. Further curricular additions to support students' abilities to deliver patient-centered care and build therapeutic relationships include emotional intelligence education and well-being strategies.

Currently, there is a scarcity of research surrounding empathy and compassion within the athletic training literature. Therefore, there are abundant opportunities for future studies in this line of research. I suggest that future studies consider implementing a compassion survey specifically for healthcare professionals, continued education opportunities on empathy and compassion training for preceptors, diverse and emerging clinical experiences, and the standardization of observing students' soft skills during patient encounters. In conclusion, incorporating soft skills into athletic training curricula has the potential to improve students' application of empathy and compassion and improve therapeutic relationships during patient care.

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Appendix

Appendix A: Jefferson Scale of Empathy Health Professions Student version

With permission, the Jefferson Scale of Empathy Health Professions Student version was a survey implemented in this study. Additional information about the survey can be found at https://www.jefferson.edu/academics/colleges-schools-institutes/skmc/research/research-medical-education/jefferson-scale-of-empathy.html.

Appendix B: The Compassion Scale

The compassion scale was a survey implemented in this study. Additional information, including a PDF of the survey can be found at https://self-compassion.org/self-compassion-scales-for-researchers/.

Appendix C: Empathy Guided Worksheet Assignment for Asynchronous Empathy Module

Empathy: Guided Worksheet

Please complete the respective questions while following along with the online module in D2L. Remember to answer all questions with honesty and based upon your lived experiences, there is no need to google answers. Please bring or bring an electronic copy of this document to our F2F class on Thursday.

1.Prior to learning about empathy and completing the module, how would <u>you</u> define empathy?

2. Reflect on a time when you were treated with empathy and treated with a lack of empathy? How did you feel? What do you specifically remember about these two events?

3. After watching the power point lecture, in what ways do you think empathy can enhance a therapeutic relationship?

4. List the clinical skills and behaviors that are proven to help a clinician display empathy during a patient interaction.

5. From Brene Brown's video, *The Definition of Empathy*, please describe the difference between empathy and sympathy.

6. Also from the video mentioned above, list the four qualities of empathy based upon Theresa Wiseman's research.

7. Please reflect on the *Empathy: The Human Connection to Patient Care video*. How did this video make you feel? What is running through your mind after watching this video?

8. Please record your three good things here.

Appendix D: Compassion Guided Worksheet Assignment for Asynchronous Compassion Module

Compassion: Guided Worksheet

Please complete the respective questions while following along with the online module in D2L.

Please print and bring this document to our F2F class on Thursday.

1.Prior to learning about compassion and completing the module, how would <u>you</u> define compassion?

2. Record the antidote to "compassion" fatigue and/or burnout in Healthcare Professionals?

3. List the three core elements that create self-compassion? Think- how do you practice self-compassion? Do you feel like you face barriers to practicing self-compassion? If so, what are they?

4. Use the space below to take notes on Dr. Stephen Trzeciak's Ted Talk.

5. What three questions does Dr. Harriell suggest always asking your patient?

6. Record an "AH-HA" moment from, *Why the Future of Medicine is about Kindness and Compassion* or *The Greater Good Podcast Episode #51: Does your Doctor Listen to you?*

7. Please record your three good things here.

Appendix E: Semi-Structured Interview Guide

Semi-structured Interview Guide

Topic: Teaching empathy and compassion during a soft-skills curriculum to pre-professional AT

students and how the soft-skills are transferred to clinical practice during patient interaction.

> Research Question: In what ways can knowledge from a soft skills curriculum during a didactic pre-professional course be transferred to clinical practice during an athletic training student's clinical experience?

Interview Guide:

Question	Probe
1. Can you describe in your own words the definition of empathy?	
2. Can you describe in your own words the definition of compassion?	
3. Did SMD 450, specifically the lessons on compassion and empathy, influence you clinically?	If so, in what ways? If not, why do you think this was the case for you?
4. Talk to me about your clinical site. What does empathy and compassion look like at your clinical site?	Can you talk to me about a time when you demonstrated empathy/compassion at your clinical site?
	Can you talk to be about a time when you observed your preceptor demonstrate empathy/compassion at your clinical site?
5. Do you think your own well-being is associated with the delivery of compassion and empathetic patient-centered care? If so, how? If not, why not?	
6. Given the pandemic can you talk to me about providing patient-centered care during this time?	

Appendix F: Letter of Permission to utilize the JSE-HPS

Hello Emily,

Thank you for your interest in the Jefferson Scale of Empathy. We are glad that you're considering the JSE for your research project with athletic training students. The HPS-version would indeed be the one best suited for your study.

Although there is normally a charge for using the JSE, we sometimes make concessions for medical students if no funding is available or if there special circumstances concerning sample size or your funding status. In that case, permission might be granted to make copies of the scale, but you would have to do all data entry, scoring and other analyses yourself. We do not grant free use for multi-institutional or multi-year projects; or for multiple versions of the JSE. With permission of use, you will receive a PDF of the scale, the scoring algorithm and the User Guide.

If you would like to be considered for this, these conditions apply:

- Please send a brief description of your study including the expected number of participants, number of administrations of the survey, the institution from which they will be selected, and the duration of the study (approximate beginning and ending dates).

- Have your faculty sponsor send a brief email to confirm his/her sponsorship of your study and agreement to these conditions.

- If the scale is posted on a website, it needs to be a secure site with access by invitation only and it needs to be removed from the website promptly at the permission end date. E-mail may be used to distribute URL addresses to where the survey is hosted; however e-mailing the scale items to participants is not permitted.

- If making hard copies, you certify that only the authorized number of copies will be made.

- Please copy the scale exactly as it is. The text of the items, their order of appearance, instructions and response scale must remain unchanged and intact.

- Please include the following copyright on all administrations: © *Thomas Jefferson University, 2001. All rights reserved.*

  Jefferson, as the sole copyright holder, maintains the copyright for granting or declining permission for any additional use of any and all versions of the JSE

- Administrations are for a single not-for-profit project which includes participants from a single institution and lasts not more than 6 months.

- You agree to follow our scoring instructions, particularly on handling the missing data.

- Please do not share any part of the copyrighted files you receive with any person or entity except those directly involved in your project who agree to honor the copyright.

- If the results of this project will be published, include the names of all authors/investigators and send us a copy of any publication resulting from the study.

- TJU is the sole copyright holder of the JSE and its translated versions, thus reproducing the JSE in print, publications, or posting it on the web in its entirety is strictly forbidden without the permission of TJU. However, publishing up to 3 items is permissible for illustrative purposes.

Please consider these conditions to ensure that your project meets these criteria. If any condition cannot be met but you believe there are extenuating circumstances that warrant a waiver, please include that in your response. Once we have the information requested above, including your written agreement to each condition, we will consider your request to use the JSE for free or at a reduced rate.

I look forward to hearing from you.

Regards,

Shira Carroll

Appendix G: Institutional Review Board (IRB) Approval

WCU
WEST CHESTER
U N I V E R S I T Y

Office of Research and Sponsored Programs | West Chester University | Wayne Hall
West Chester, PA 19383 | 610-436-3557 | www.wcupa.edu

TO: Emily Duckett, Heather Schugar, Alison Gardiner
           Shires, & Jackie Hodes

FROM: Nicole M. Cattano, Ph.D.
           Co-Chair, WCU Institutional Review Board (IRB)

DATE: 6/28/2020

Protocol ID #
20200114A-R1

Project Title: The Evaluation of a Soft Skills Curriculum in Athletic Training Education - REVISION

Date of Approval for Revision/Amendment**: 6/28/2020

☒ **Expedited Approval**

The submitted amendment/revision to this previously approved expedited study does not elevate the study risk. As a result, the amendments are approved for implementation. Any revisions to this protocol that are needed will require approval by the WCU IRB. Upon completion of the project, you are expected to submit appropriate closure documentation. Please see www.wcupa.edu/research/irb.aspx for more information.

Any adverse reaction by a research subject is to be reported immediately through the Office of Research and Sponsored Programs via email at irb@wcupa.edu.

Signature:

Nicole M. Cattano

Co-Chair of WCU IRB

WCU Institutional Review Board (IRB)
IORG#: IORG0004242
IRB#: IRB00005030
FWA#: FWA00014155

Appendix H: Informed Consent

Project Title: Assessing a Soft Skills Curriculum in Pre-professional Athletic Training Students

Investigator(s): Emily Duckett; Heather Schugar

Project Overview:

Participation in this research project is voluntary and is being done by Emily Duckett as part of her Doctoral Dissertation to investigate in what ways knowledge from a soft skills curriculum during a didactic pre-professional course could be transferred to clinical practice during athletic training students' clinical experience. Your participation will take about 15-20 minutes to complete the questionnaires and reflection logs which will be class assignments, therefore we are requesting access to these materials. If selected it will take about 30-45 minutes to compete an interview virtually on Zoom. There is a minimal risk of students feeling anxious about participating in the interviews while sharing their experiences. Students may withdraw from participation at any time. There is the opportunity for participants to share their knowledge from a soft-skills curriculum, and this research will help Athletic Training Education Programs, cultivate a soft skills curriculum to comply with the foundational behaviors of professional practice including: advocacy for the profession, demonstrating honesty and integrity, exhibiting compassion and empathy, and demonstrating effective interpersonal communication skills.

The research project is being done by Emily Duckett as part of her Doctoral Dissertation to investigate the ways knowledge from a soft skills curriculum during a didactic pre-professional course could be transferred to clinical practice during athletic training students' clinical experience. If you would like to take part, West Chester University requires that you agree and sign this consent form.

You may ask Emily Duckett any questions to help you understand this study. If you don't want to be a part of this study, it won't affect any of your studies from the university. If you choose to be a part of this study, you have the right to change your mind and stop being a part of the study at any time.

1. What is the purpose of this study?

    o To investigate in what ways knowledge from a soft skills curriculum during a didactic pre-professional course could be transferred to clinical practice during athletic training students' clinical experience.

2. If you decide to be a part of this study, you will be asked to do the following:

    o Provide access to the questionnaires and reflection logs from your class assignments. You will not need to do anything to share these resources beyond providing your consent.

    o If selected, complete an interview that will take about 30-45 minutes of your time.

3. Are there any experimental medical treatments?

    o No

4. Is there any risk to me?

    o Possible risks or sources of discomfort include: students feeling anxious about participating in the interviews to share their experiences. Students may withdraw from participation at any time.

    o If you become upset and wish to speak with someone, you may speak with Emily Duckett or Heather Schugar.

    o If you experience discomfort, you have the right to withdraw at any time.

5. Is there any benefit to me?

- o Benefits to you may include: the opportunity to share your knowledge from a soft-skills curriculum.

- o Other benefits may include: a soft-skills curriculum development for Athletic Training Education Programs to comply with the foundational behaviors of professional practice including: advocacy for the profession, demonstrating honesty and integrity, exhibiting compassion and empathy, and demonstrating effective interpersonal communication skills.

6. How will you protect my privacy?

- o The interview session will be recorded on Zoom.

- o Your records will be private. Only Emily Duckett, Heather Schugar, and the IRB will have access to your name and responses.

- o Your name will not be used in any reports.

- o Records will be stored:
  - ▪ in a locked cabinet in ████████████████████ which will also be kept locked.
  - ▪ Password Protected File/Computer

- o Records will be destroyed three years after study completion

7. Do I get paid to take part in this study?

- o No

8. Who do I contact in case of research related injury?

- o For any questions with this study, contact:

- Primary Investigator: Emily Duckett at 610-436-3024 or

  educkett@wcupa.edu

- Faculty Sponsor: Heather Schugar at 610-738-0507 or

  hschugar@wcupa.edu

9. What will you do with my Identifiable Information/Biospecimens?

   o Not applicable.

For any questions about your rights in this research study, contact the ORSP at 610-436-3557.

I, _____ (your name), have read this form and I understand

the statements in this form. I know that if I am uncomfortable with this study, I can stop at any

time. I know that it is not possible to know all possible risks in a study, and I think that

reasonable safety measures have been taken to decrease any risk.

_____

Subject/Participant Signature   Date:_____

_____

Witness Signature   Date:_____

Appendix I: Semi-Structured Interview Transcripts
Participant ID: 5
Semi-Structured Interview
11/6/20

Duckett, Emily: Okay. So just to give you some background. My ultimate topic of this research study is teaching empathy and compassion during a soft skills curriculum. To pre-professional athletic training students, and then how those soft skills are transferred into clinical practice during your patient interactions. So, I have a series of six questions that I'm going to ask you today is that sound okay?

5: Yeah.

Duckett, Emily: Perfect. So the first question is, can you describe in your own words, the definition of empathy?

5: Okay, I do get empathy and compassion mixed up all the time, but when it comes to empathy. I think it's.. correct me if I'm wrong… I think that's the one where you can like feel what the other person's feeling like being able to understand where they stand and how they feel what the situation like their struggles and like not so much like feeling bad for them. But like being able to like put yourself in their shoes, like know what's going on as best as you can.

Duckett, Emily: Yeah, that's wonderful. So now I'm going to ask you a similar question, but could you describe compassion, the definition of compassion in your own words?

Castillo, Emily R.: Wait…empathy for yourself…. see, I don't…they're so similar to me and like it all goes back to me like before school starting not having empathy and compassion. So like when we took Allison's class, it was a lot of like not new information but that's why I struggle with it.

Duckett, Emily: That's perfectly okay. Just If you had to define compassion, say to a friend or a family member, somebody says, so what is compassion? What would you tell them?

5: Being compassionate… let me think. I want to say still being able to understand and like feel for someone like putting yourself in their shoes. I know I said that for empathy, but I don't know I do these reflection logs all the time for Alison and I'm always like, trying to separate the two. But for some reason, the two are very like similar to me.

Duckett, Emily: Yeah, and that is an absolute fine description. Good. Do not stress. Okay, so the next question is in Allison's class that you alluded to, specifically, the lessons that were taught on compassion and empathy, how do you feel like they have influenced you clinically?

5: I think it helped a lot, actually! Because like I said not that I'm not very compassionate and empathetic but like it's hard for me when people are going through something, especially if it's not like life or death kind of thing… like when it's not the biggest deal. It's hard for me to like feel bad because I grew up with such a mentality that it could always be worse so was my

problems like… I try not to stress over them when they're little things. So I don't understand. Sometimes when people stress over little things because I'm like, why are you stressed? Like it's not a big deal but like that class really opened my eyes to understand that some people. I'm sorry- there's background noise, the cars. And open my eyes to understand that it's okay for people to be stressed, with little things like everyone has their own look on situations and just because I'm not stressed about it, like it could be like really be affecting them. So like I've worked ever since class I've worked a lot more on like my compassion, like my empathy like when someone, even if it's not like clinically related like if someone's telling me that they feel certain way about something I always try to say like I don't fully understand where you're coming from, but can you explain to me, why you feel like that. And like, it helps a lot when they like talk it out because I'm like okay now I understand where you're coming from. And then trying to figure out a way to fix it. But when it comes to like my clinical and like how I put that into perspective, like I don't just brush it off… I try to make sure that I understand where the athletes are coming from and why they feel that way the feeling. So it's definitely like helped a like to open my eyes to look at the big picture, but also like the little details as to what's making them feel like that.

Duckett, Emily: Great. So you were talking about the course and how those lessons helped a lot and you specifically said, "can you explain to me", which is something that was practiced in class. Where there certain elements of those lessons that resonated with you or really helped the content stick?

5: Like activities that we did?

Duckett, Emily: Sure, or whatever stood out to you.

Castillo, Emily R.: Well, the thing that this more like personal not so much like the class, but we did an activity where we it was about compassion stuff and it was when my friend, I think you were there got first diagnosed cancer, and like that was when like the class was gone on too, so it really helped me. I forget what the lesson was exactly but we split into groups and we talked about like being compassionate stuff and like I talked about my friend, before that I was always really bad at like, not so much confronting people but like trying to help them through situations because it was hard for me to understand where they were coming from. So, like after that activity like it was really easy for me to like when my friend would talk to me like I was able to bring in those little skills that Alison taught us and like be able to like understand better where she was coming from. So from there I've been able to apply it more in like clinical and stuff.

Duckett, Emily: That's great. So it sounds like your ability to verbalize your own emotions and feelings and practice that with appear to make it personal resonated with you the most. Is that correct?

5: Yeah.

Duckett, Emily: Great. Alright, so the next question is going to be if you could talk to me about your clinical site. I know it's been unique this year. If you could describe maybe the uniqueness and then for you, what does empathy and compassion look like at your clinical site?

Castillo, Emily R.: So my clinical site is a lot of Telehealth and it's at West Chester. So it's a lot of Telehealth and also there's like two or three athletes that we see for a rehab in the ATR. When it comes to empathy and compassion applying it to those specific athletes… there's one athlete that like I had with my preceptor and she spoke a lot about how she has to be a caretaker for her Mom, even though she has an injury and it's not so much the injury but also like mental health. And how her mom, even though her mom's like a therapist, she like pushes on her that she's fine kind of thing… and she causes more stress. So like I was able to like be compassionate empathetic towards her, because the way she was talking and what she was saying I could like fully put myself in that situation in life.

Duckett, Emily: It froze. So.. I last thing I heard was, you could put yourself in her situation.

5: I can put myself in the situation, especially with her mom not being so compassionate towards her. My parents, I don't know if it's the Latino background, but my parents have the mentality it could always be worse… like, why are you stressing over it and like not the mental health like depression stuff isn't a thing, but they're like more like you can fix it if you want it to, like, If that makes sense. Like, they're not big on the whole, like, it's a thing. So like what she was talking about in our Mom like pushes her off… like I was able to like put myself in this situation like I understand like that your mom isn't like fully supportive. My parents were supportive, but like I can understand that your parents or your Mom is not like understanding where you're coming from. I was able to apply my skills there. Then for like other the other athletes aren't so much mental health, but other injuries. Like I know one girl she would always go running and loves to be outside and the fact that she can't do that anymore. Like, she's always stressed. Like me, I was an athlete all of high school and there was a time where I wasn't able, I had really bad shin splints, I had to go to doctor for stress fractures and like I wasn't able to participate. So like I understand where she's coming from with like missing out on stuff that you like enjoy doing.

Duckett, Emily: Absolutely, yeah, sounds like you're making a connection with a few of them. So you have a series of preceptor is that correct?

5: Yeah… there's multiple

Duckett, Emily: Has there been a time when you've observed one of those preceptors demonstrate empathy or compassion?

5: Yeah, so, a specific preceptor really stood out to me with that athlete, because when she was talking to her, she was so like comforting towards her. And she's like, we understand that you're going through this and she provided her resources. That was like I don't know, really big. She said that therapists right, now like some places, waive the fees because of COVID and all the situations that I didn't even know…the athlete really was like, oh, like I need to look into that. So when it comes to actually how the athlete felt she was just very - her body language, even those on Zoom was very like attentive and like she was nodding. And she was like, I understand, like, I know like I want to know more about like how you're feeling and like I want to know why you're feeling like that.

Duckett, Emily: Absolutely. So do you feel like after observing those skills that's something that will stick with you and your future clinical practice?

5: Yeah, because we talked about it a lot in class and we do little activities, but I've never seen it happen like in real life, and with an actual athlete that like doesn't see the background like practice of it. So it's like it made sense. It put everything together as to, like, why you guys say to do certain things. Because the way she like handled it you could tell it the athlete felt comfortable and like, that's why we practice it, how it is, but like after I saw it happen like now I know more of how to handle the situation better, especially with like the mental health aspect of it.

Duckett, Emily: Great. Perfect. So, next question. Do you feel like your own well-being, is associated with the delivery of compassion and empathetic patient care?

5: My own well-being, yes, but at the same time no because I would say yes, because there's days that I'm myself like I'm not myself like I've had a bad day and like sometimes I can see it translating into like my clinical like I won't be as …I won't pay attention to detail as well because I have my own things like on my head, but at the same time… no, because of an athlete like truly like speaks to me about something I can put my personal life aside and, like, make sure I can like give them my full attention.

Duckett, Emily: Yeah. So I'm really interested because this has been said very frequently, kind of like prioritizing, and somebody described it as like flipping a switch or I've heard it called like a boomerang effect, how would you describe that process of being there for your patience despite your own well-being… maybe not being 100%?

5: I think that flipping a switch is very accurate because like I said like, even though I have stuff going on like in the moment. In the moment you want to care and like give them your full attention. So you kind of forget about like what you're going through. And like sometimes it even puts my problems into perspective, because like they have a lot going on, and like I want to understand where they're coming from, I want to know what they're going through, and sometimes it even helps my situation because I'm like why am I, again, I could always be worse. Like, why am I stressing over that. So I would say it's like flipping a switch, because in the moment I'm able to give them my full attention and try to understand their situation and put my feelings aside from what I'm going through.

Duckett, Emily: Yeah, so that's a hard thing to do. The flipping of the switch... what in your, what promotes that action in your experiences or like, why do you want to go above and beyond to do that?

5: Why do I want to do that?

Duckett, Emily: Yeah.

5: I guess compassion and empathy it all goes back to that. I want to help people get better and I don't like seeing people struggle through things. So it's not even that I mean to do it, but like, it's

so easily like happens where they start talking to me about something and like we sit down and it's like… Okay, well, tell me more. So I don't know why I want to do it just happens.

Duckett, Emily: So it feels like a natural process?

5: Yeah, like I don't think about things when they're talking to me. It's not like I sit there and think, okay, I can't worry about my things right now. Like I just lock in right away to what they're saying and like forget about like pther things going on outside of that conversation.

Duckett, Emily: Do you feel like classes you've taken or preceptor or mentors, you've worked with have influenced that ability in you?

5: Yeah, I think it's a lot of the.. not so much the classes the content, but like the our preceptors and our professors like for example, our professor, whenever I tell her about anything going on with me she sits down and she's like, "oh my god, like, are you okay like talk to me." Or any of our professors like XX like she's so kind, whenever I talk to them…It's so comforting and I know that they're giving me their full attention. So that kind of translate to me like a clinical like I try to like mimic what they've done or how they've handled our situations, especially with COVID. Like, they've been so like helpful with all of that. So like whenever someone tries to talk to me. I like how our professors in my head it's like would they handle it this way? So I try to handle it that way.

Duckett, Emily: Wonderful. That was a great description. So the last question I have, which you just alluded to is given the pandemic, Can you talk to me about providing patient centered care during this time?

5: I think it's a little, not that it's harder, but like you have to pay a little bit more attention because before this happened like everyone like was going with like their own thing and doing their own thing and not worrying about little things. But now, like the pandemic has caused so much stress and anxiety that the things that people might not have cared about before my like it might be affecting them even more. I don't know if I answered your question.

Duckett, Emily: So you're talking about the pandemic and how it's influenced patient centered care. And you mentioned… an increase of stress and anxiety among patients do you feel like what you have learned has prepared you to handle these situate these heightened anxiety situations or what are some things that you feel like you need to learn to be able to manage them?

5: I don't know about what I need to learn, but I mean every situation is different and like no one could have seen this happen. So like when we learned about patient care and stuff. It was like basic patient care. But now I feel like we need to focus more on like making patients feel comfortable, especially with things like zoom. Making sure that they have your full attention that it's not just like in and out. Like, you want to take care of them and like if it takes this long, it takes that long. I feel like with the with zoom and doing everything online it doesn't feel as personal so when it comes to patient care you have to really focus on like making them feel comfortable and making them feel like you're there the same as you would have been in person.

And that's just something that like since I started school like that wasn't something we had to worry about, like, making sure that onlinethey understood that you were there for them. So maybe I mean virtual clinical has helped a lot. But, like, one thing that we could work on more is like making sure it feels as comfortable as it would have been like an office or something.

Duckett, Emily: Yeah. So what does patient centered care mean for you?

5: Focusing on the patient like making sure like you hit their goals and like you are able to like connect with them be comfortable enough like to, like, get back to the point where you're comfortable and like being able to obviously, go figure out what their injury or at what's going on, but like more than that to like create that relationship and being able to like comfortably like help them and make sure that they have that trust with you. Yeah.

Duckett, Emily: And how do you feel when you're able to implement patient centered care?

5: It feels good, because you want that connection with them, and like I feel like I'm able to like give them better care but like that goes back to like having that trust and having them be comfortable with you.

Duckett, Emily: Yeah. Wonderful. So I don't have any more questions. But do you have anything from this whole experience or anything that you'd like to add or share along these lines?

5: I don't think so. Did I answer all your questions?

Duckett, Emily: Yeah you did... you did a great job.

5: Okay. Yeah, I don't think I have any more questions. Perfect.

Participant ID: 9
Semi-Structured Interview
11/11/20

Duckett, Emily: All right. So to give you a background of what we'll be talking about today specifically my research topic is teaching empathy and compassion during a soft skills curriculum to preprofessional athletic training students. Then what I want to study are the ways in which you transfer those soft skills into your clinical experiences and your patient interactions. So I have a series of six questions to ask you today and we'll get started. The first one…this is not a quiz question… so don't panic. can you describe in your own words what empathy means to you?

9: I would say empathy means to me is… umm actively trying to understand what someone is going through and trying to use that knowledge to the best of your ability to help them through whatever they are going through.

Duckett, Emily: Great, and then on the flip side of that, could you describe what compassion means to you?

9: Umm similar, in a sense, but also like trying to like put yourself in their shoes and like, help them through that way.

Duckett, Emily: Perfect. Can you identify a difference between the two of them or do they feel very similar to you?

9: I always had a hard time differentiating them. They always felt very similar to me. I know they're obviously is a difference, but it's always been like very hard for me to differentiate like trying to like pinpoint like this is that, and this is that.

Duckett, Emily: Got it. So SMD 450 you were taught specifically two lessons on empathy and compassion. Can you share how they could have influenced you clinically?

9: Um, I feel like I'm more aware of the soft skills that we learned being and clinical because we weren't necessarily in clinical and we learn them. Being a student being athletic training student or learning a lot of like the anatomy portions and the injury portions of it all. So, hearing a different side to patient care- the empathy and compassion it put like it into perspective. For me, that we are going to use it and it's not just about "oh, let me help you fix you". Like what else is going on in your life? How are you feeling about this injury like what are your goals at the end of this? It's not just like a clear end goal for everyone, so like it made me more aware… I feel.

Duckett, Emily: Great. So you're describing kind of your sequence of your courses- within the curriculum. Do you feel like learning those soft skills was a good place like before starting your clinical and before your hard skills like your orthopedic exam or would you have liked to see it move somewhere else, like what would be most beneficial for you?

9: Umm… I find it difficult right now being in my like ortho class and trying to go through clinical and like not having the background knowledge. But that's, I feel like that's not like… I do have a preceptor that can help me walk through it, whereas the empathy and compassion like soft skills and other soft skills like that's not something that like your preceptor can teach you. It's something like you figure out through your time and like If you have a background of before, like you can build on that yourself. Whereas, like ortho you get taught something and then you have to remember it type of thing. And, like you, you can't really be taught that from someone like from your preceptor in a sense, like you tell you ask them about their feelings, but like the workshops that we did help you understand yourself like how you deal with emotions yourself. And how like you do with your own type of compassion and empathy like no one can tell you how to do that.

Duckett, Emily: I love that. So you mentioned the workshops was there specific lessons or specific like workshop sessions that resonated with you the most?

9: I like all my classes are running together, but the one that reach out to me. I remember like being like on your balcony and on your in the basement. Like, just like what really makes you feel on top of the world and want to like you notice like brings you down and I feel like if you

know your own strengths and weaknesses that can obviously help you like when you're speaking with others.

Duckett, Emily: So do you feel like it's fair to say then, like the balcony and basement were part of self-awareness and your strength finders So do you feel like you needed that self-awareness to then be able to help others clinically?

9: Yeah, I feel like you need to be aware because if you're not aware of yourself, how are you gonna be aware of other people and what they're feeling?

Duckett, Emily: Great point. So can you talk to me a little bit about your clinical site and where you are, things you're doing, and what empathy and compassion looks like at your clinical site?

9: So I'm at XX High School. I'm, I'm with two peers so it's nice having to others to like bounce ideas off of and just like go through it with. In the beginning, so it's been weird with COVID like I feel like I've been on and off for the whole time. But in the beginning. I mean, like, it was, it was relatively busy. We have a few kids that come in every day for rehab for different like surgeries, they went through. So they just have to have that continuous stuff. And then just like the acute stuff. Um, I've like.. we've started like build a relationship with some of those kids just because like we see them every day for the past three months, so like the regulars like "hey what's up" and all that stuff. Um, empathy and compassion I would say like It's more, I would say it's like more that and goal setting… the one kid his goal isn't to get back to football, it's about to get back to Spring season. So right now we're just figuring out what's best for him in the moment. As opposed to like trying to get him back. So I feel like it's just more like that stuff, I don't really feel like I deal with a lot of like emotional aspects with the kids just because they are high school. It's not so much like, oh, this is like a career ending injury like this is the end of the world type of thing. So not like a huge amount of that... but like I do still see it.

Duckett, Emily: So you mentioned that you have a patient whose goal isn't to get back to playing football but to get to the spring. How did you come to that conclusion, like what skills, did you use to be able to identify this person's goal?

9: Well, I feel like he kind of knew. So he had a whole medial side mess up of his knee. So that was fixed like a year ago and then he tore a bunch of stuff in his shoulder. So then he was just he's recovering from that and I'm pretty sure he's going to college for baseball. So like he still goes to football practice every single day… but like, it was clear to me include everyone else that like I think he understood that he was not going to be able to get back to football and even if he was it could have affected his baseball career, which was like the end goal for him.

Duckett, Emily: Got it. So can you talk to me about a time when you displayed empathy and compassion at clinical?

9: Umm…I'm trying to like differentiate between like trying to like be there and like calm someone down or like if that would be considered empathy.

Duckett, Emily: It's up to you... it's your definition of it.

9: Or the one of the biggest, moments at clinical that stood out to me, this was towards beginning, we were at football practice because they were the only ones left practicing. Freshman football was already done and then it was just JV and varsity finishing up. A kid, one of the freshman football players runs up and says, like this kid slipped and fell on his head and is in a lot of pain. So then we ended up cleaning up where we were. We drive over and this kid was in the most pain that I've ever seen in my entire life. As students we just kind of like stood there with him. Our preceptor just like making sure that there wasn't anything like exponentially wrong. That took a little while and then he went up to meet the Mom. So then it was just us three with him, and we just like talked him through it saying like "he was gonna be okay" like "you don't have to worry about anything except for getting better right now" because he was like really upset to like someone's going to get in trouble because there was a whole other thing that happened. Umm…and that he wasn't gonna be able to play football again. So then, like we just like tried to put ourselves in his position and like he's freaking out, like his head hurts so bad, he thinks he's not gonna play football. So we just talked him through it and said, "everything will be OK- you just have to take it one step at a time."

Duckett, Emily: Yeah, that's that sounds like an intense experience.

 9: Yeah, it was crazy.

Duckett, Emily: So you shared with me, your experience, have you ever watched your preceptor demonstrate empathy and compassion?

9: Um, I would say we have a another kid on the football team. He dislocated his shoulder, two weeks ago, during a game he's like the star player. And the kid was more so upset, he thought his season was over. And like my preceptor just tried to assure him like… It's not, we're going to figure it out. Don't work yourself up cheer on your team and get yourself together. And we'll figure it out, day by day. So I was like really cool to see like how he like redirected his mind completely, and was like, pull yourself together, it's not the end of the world, Like, we will get through this.

Duckett, Emily: And you view your preceptor as a mentor.

9: Yeah.

Duckett, Emily: So do you feel like actions that your preceptor takes you'll like. How do you feel like you'll be able to use them in your future career?

9: Um, well, first of all, it's insane to me because he knows every single athlete's name at the high school, which is like mind boggling to me. So that's one thing like I don't know if I'll ever be able to do. Just the way he interacts with them like they all know that that he's there for them. So like, it's very light hearted between him and the athletes and they all joke around constantly but like at the end of the day, like they know that he's going to help them no matter what and get them better. So just like that aspect of it like being so well trusted and not having everything so serious. I would say because in time, like I feel like things could be like super difficult if you're

worried like, you're not going to get better and he'll just be like, "Why are you upset right now like we're going to get through it". Like, I don't know, like, just relax.

Duckett, Emily: Love that. Okay. Two questions left. So do you think your own well being, is associated with the delivery of compassionate and empathetic patient centered care?

9: My own… What do you mean my own wellbeing?

Duckett, Emily: Yes, do you feel like your own wellbeing influences how you're able to provide patient centered care?

9: Umm yeah in a sense. I feel like when I feel like I individually separate like my own personal stuff with clinical just because I don't want my own things going on in my life to affect or determine the care that I give someone else. I feel like I'm pretty okay with separating that I mean, obviously, like you get stressed and, but I feel like I don't really allow myself being like stressed to affect how I'm empathetic and compassionate towards someone else.

Duckett, Emily: So how do you find that separation?

9: I think I just think about like if it were me in the in the other shoes… I wouldn't want someone taking their life out on me, so I wouldn't want to do that to them. Also like being at clinical and like helping people is kind of like it's a distraction from everything else because I feel like I'm not stressed about my life or like the school work I have to do. It's just like, I'm here, I'm learning, and I'm like helping so I feel like being a clinical is like an escape, not like an escape, more like a distraction.

Duckett, Emily: Yeah, so a lot of your peers that I've interviewed have kind of come to this conclusion of an analogy called flipping a switch. Like when they're at clinical like it switches and they become this professional to be able to provide the patient centered care. Does that resonate with you at all?

9: Yeah, absolutely because you too many other things to think about when you're at clinical that you can't dwell on, yeah that's the other thing like you can't think about the other thing that's happening outside of clinical because you have to focus on what you have to do and what you have, what you're learning, and at this point in this point in this point, so like there's no room to think about the other things that are going on. Yeah, it is like flipping a switch.

Duckett, Emily: So is it fair to say that clinic clinical sounds like a stress reliever for you rather than a stress inducer?

9: Yeah, I would say so. And then I get home at 7:30 and I'm like, wow, I have a lot of homework to do well but while I'm there… yeah, it's fine.

Duckett, Emily: And is that stress relieving environment created by you helping others, being with your preceptor learning, like, what, what makes it a stress reducing encironment?

9: There's a couple things I think it helps that I'm with XX and XX, because they're one of my closest friends and my preceptor is extremely helpful. Like I said, he's light hearted so that makes it easy. I like the aspect of helping people and like seeing people progress and get better and them being so appreciative of me, like when they're walking and they're like, "thank you so much, like I really do appreciate it", and I'm like, "well that's what I'm here for." Just like taking things that I learned in class and seeing it be put in place in clinical and then also like learning stuff at clinical that then I then I see in class. So that part is really cool like not just seeing it all on paper, seeing it in person. So it's just kind of like a bunch of things.

Duckett, Emily: Great. Alright, last question, given the pandemic can you talk to me about providing patient centered care during this time?

9: Um, I feel like it's all just weird times. I've noticed that in the AT room like it doesn't really seem like it that there's a pandemic going on, not in the sense of like it being unsafe.
But I feel like that's how it should be run anyway, like people shouldn't be on top of each other people shouldn't be running in and out because there's no way to get the correct form of care that way. There are four rooms, we wiped down everything after we use it, which I feel like should be done anyway. There's only allowed to be a certain couple people in the room. But other than that, like it's relatively like the same as it would be. It's just a little cleaner, which isn't a bad thing.

Duckett, Emily: Absolutely, and you identify such an important point of patient centered care is your patient volume. So that, that's very interesting. So those sound like pros actually. Are there any negatives or do you mostly view positives?

9: I say I mostly view positives, um, I haven't really noticed any negatives. Trying to think, I mean like during football games they have designated water people bring out water and they're not like. But that's nothing like significant at all. So like not really in that sense.

Duckett, Emily: Wonderful. So I finished all my questions. Is there anything you want to add about your experiences between learning soft skills, putting them into practice clinically or any last thoughts you want to share?

9: No. I'm pretty good.

Participant ID: 17
Semi-Structured Interview
11/9/20

Duckett, Emily: I'm just going to give you a little refresher on what the topic is and then we're going to have a conversation about it over a series of six questions.

17: Okay.

Duckett, Emily: All right, so the overall topic that I'm interested about is teaching empathy and compassion during a soft skills curriculum to preprofessional athletic training students and then

how they transfer those soft skills. Specifically, how you transfer those soft skills into your clinical practice during your patient interactions. So, I'd like to start off by asking you in your own words, if you could describe what empathy is for you?

17: Empathy is like being able to feel how someone else's feeling and being able to relate to them.

Duckett, Emily: Perfect. And then, could you describe compassion. What does compassion mean for you?

17: It's almost like the first step would be empathy, you're feeling how someone else's feeling, but then you're taking it like a step further and trying to help them or do something for them.

Duckett, Emily: Perfect. Did you feel like you knew these definitions prior to learning them in class, or do you feel like this content is sticking with you from class?

17: I think it's definitely sticking more from class because I feel like before I didn't really know the difference. Like, I knew empathy, compassion was like oh, you're helping someone, but I don't think I really understood that it's like putting yourself in someone else's shoes and like being able to feel how they feel. Just like the difference between the two. So I feel like the class like helped me like clarify specifically what each is, and how to use them.

Duckett, Emily: So then along the lines of your SMD 450 class…were are there specific elements of that class or specific lessons in that class that influenced you clinically?

17: Yeah because in clinical I know we talked about, like, three questions like to ask your patient during like a history because I know like histories are so structured like the MOI, why you're getting, like, the chief complaint all that. But now I asked, like, is there anything I didn't ask or is there any concerns that I missed that I didn't ask you that you want to bring up? So I always ask that, like at the end. Just like to make sure that I'm doing like patient centered or like just their goals like what specifically do you want out of your care? So I think that definitely helped. Um, it's not technically empathy or compassion. But just like the soft skills of, like, making sure that you're doing like patient centered care and not just like oh, your ankles injured. We're gonna fix your ankle like we're going to help you and like do everything that you want.

Duckett, Emily: That is really a great description. You talked a little bit about those three questions. So, you learned that from the modules that you completed. What's your patient response like when you ask those questions for them?

17: I feel like sometimes they're thrown off. They're almost like don't know how to respond because I feel like they don't get those questions a lot like sometimes they don't know what to say when I'm like, "Oh, is there anything I missed" because I feel like sometimes they think, oh, I think I'm missing something, but I was like, no, like, I want to know like if there's something specific that you want me to know that I didn't ask you. So I feel like I even have to like explain it to them, like why I'm asking them these questions. But it's been good outcomes because they would tell me stuff that about like how they're remote and that they're sad about school just like

other things in their life that could be influencing their injury. So I feel like that's super important too.

Duckett, Emily: Yeah. Do you feel like those elements help you be a better clinician?

17: Yeah, I definitely think so.

Duckett, Emily: Yeah, that's so interesting. Wonderful. So can you talk to me about your clinical site, a little bit. So this is your first clinical experience, which is, of course, unique, given our current environment, but what does empathy and compassion look like at your clinical site?

17: Yeah, I'm at a high school. I'm at XX high school. So it's like eight minutes away. And when I got there, they were remote but still doing sports so. For empathy, I feel like I already, like before the class, I'm just like an empathetic person because I feel like I get sympathy pain when someone else's hurt. I honestly feel like I can feel their pain… like my preceptor we had a fibula fracture and he was like down on the field, we were doing like an on the field eval and he was like palpating the fibula and I could tell he was in like so much pain. I was hurting for him, so I feel like naturally that was already my instinct. But then I take it like the second step to compassion like using my patient centered care. What can I do for you, how can I help? So I feel like that's how I used empathy and compassion clinically.

Duckett, Emily: Yeah, that's great. Um, so when you're saying you're hurting for him, or you're hurting for the patient. Can you talk to me a little bit more about that process? I think I'm specifically interested in, like, does that cause you to ruminate and bog your own self down or because you switch to that step two and apply compassion… what is that outcome of hurting for somebody?

Harris, Devin N.: Yeah, I don't think it bogs my judgment, too much. I mean, we have an ACL post surgery so I have to like push down on his knee to get him into like extension. I know like those 30 seconds or so painful for him. I remember telling my preceptor like I don't want to do it. I don't want to hurt him. But I know that it's helping him, like this is part of his treatment. So I think about it like that. Like, I know like it's hurting. I'm feeling for you, but I'm doing this to help you. So I think the compassion part is what like gets me out of that. Like just being afraid to hurt someone, but it will ultimately help them. So that's what I carry and take away from it to try to give the better patient centered care.

Duckett, Emily: Perfect. Wonderful. So you talked about a few different incidences at your clinical site and injuries, but is there a specific time when you feel like you demonstrated empathy and compassion at your clinical site? Like what were the actions that you took or what were those thoughts you were having?

17: Um, I think the first time I remember like having empathy. I was just talking to one of the track athletes and it was their senior year. And they were so upset that they couldn't go to school. I related to them because it's my senior year even though I have class, all my roommates are home like no, it's not like a real senior year, because not everyone's going to class. So I definitely related in that way. I could understand what she was going through. So I think that was like the

first time I noticed I had empathy. It was one of like my first days there. The compassion part like just trying to help them. I like tried to give her advice like we're going to get through this. Like just the pandemic, like we're all going through this everyone is going remote, we must, take the precautions and be safe. So I kind of tried to help her see, the better side because also one of my strengths is positivity. So I'm always trying to, like, just like see the good outlook, even though there's like a bad time. There's always a way to turn it around and see like from a better point of view.

Duckett, Emily: Great. Do you feel like, all, all of that is innate to you or have you maybe watched your preceptor or your mentor? How did you learn to apply that positivity and those perspectives?

17: Um, I think some of it was innate but also a lot of it was like seeing even like my teachers this semester XX has been like so helpful because I had to quarantine, I had COVID. She was honestly like I would text her with anything that I needed, and she would always like, help me and get me through it. So I feel like even that… my teachers are almost like role models to me and I feel like seeing that makes me want to be better. Like, I want to be a better clinician because I'm like learning from you guys and you guys all do that too.

Duckett, Emily: That's very nice. Yeah.

17: I say all the time… like my sister is a nursing major and like her teachers aren't as understanding and I'm always like, talking about how amazing you guys are like the staff.

Duckett, Emily: That's wonderful. So besides academically, have you seen your preceptor at XX demonstrate empathy or compassion at all?

17: Definitely, but also not as much. Like sometimes I noticed that the person will come in and he'll be like, "How's your shoulder?" or something and I'll always be like, "How are you?" So I try to, even though they're not always doing it, I'm always just like asking how the person is. But yeah, I think they definitely sometimes will demonstrate empathy and compassion, like the same way I do but um I think they're more just like clinician based but we're trying to get away from that.

Duckett, Emily: Yeah, absolutely. So what do you think makes you notice those little things like asking a patient when they walk in, like, how are you, rather than how's your shoulder doing buddy? What makes you, in your education or like, what makes you notice those things or want to do those things?

17: Honestly, I think it's from the class that we had. Because I remember like doing the modules and them specifically being like the, your patient isn't their injury. You have to like refer to them as the patient and I that always like, stuck with me. So that's why I noticed it all the time, because we like talked about it. I feel like if we didn't have that class and I just went into clinical I would have been like, okay, this is what we're supposed to do, like, ask them how their injury is. But I feel like because of the class, now I'm like noticing like you want to make sure the person is okay because like their injury could be fine but how are they doing like the other

factors, like if they're working, like money, like all that other stuff could be affecting their injury as well.

Duckett, Emily: Absolutely- multifaceted for sure. Yeah, um, I lost my train of thought my question so…That's so interesting to me that stuck with you. Like that's that treating the person as the center is really what stuck with you from that class. Have you noticed any difference in the patient when say like, you will ask them, those things versus somebody else, asking them just strictly about their injury, do you are you able to observe anything?

17: Yeah, usually when someone asked, like, oh, how's your shoulder? There'll be like, good or bad, but like when you ask how they are, it opens up a conversation. I feel like it's more open ended because then they have more stuff to explain if you're asking how they are, they'll say like how their day was, or how their weekend was and then there'll be like "oh, but it was hurting when I was doing this." So I feel like it just opens up more of a conversation. It feels more natural than just, I feel like how's your injury? It's just like a one-word answer, like oh it's better or worse.

Duckett, Emily: Yeah. What do you think that conversation does for people/for patients?

17: Um, I feel like that makes it more like personable or they feel like you care more like about them instead of just their injury.

Duckett, Emily: Yeah, great. I have two questions left for you. Okay. So this question is, do you think your own wellbeing, is associated with the delivery of compassionate/empathetic patient centered care? If so, how, if not why not?

17: I think this is one of Allison's questions in our reflection logs. So I have thought about this a lot because one of the questions is, like, how is your wellbeing and like sometimes I'll put like Oh, I was in quarantine and now I'm back. So I'm like, overwhelmed because I'm back to all my classes and then I've clinical so like even if I am overwhelmed. The next question was, like, how does this impact your patient centered care and I said that it really doesn't because I feel like my clinical was like almost like my happy place. Like I feel like I'm in a different… like I'm not in that same overwhelmed headspace on there and I'm like excited to learn and excited to Just like the experience. So I feel like I'm almost not really clouded by my wellbeing. Just because like I feel like I'm always like, happier when I'm at clinical because I love doing it. I almost try to separate it from the rest of my life. I know there's like a lot going on. But when I'm at clinical. It's like I'm focused I'm zoned in so it doesn't affect me negatively.

Duckett, Emily: Yeah, that's great. So something that I've heard peers of yours describe, I think this is what you're describing? So I want to ask you. They've used this term called like flipping a switch almost where no matter what's going on in their personal life once they know that they have to be there for a patient they flip this switch and they're all in.

17: Yeah, that's exactly what I was trying to say.

Duckett, Emily: Is that that's exactly how you feel? Do you like that analogy? Does that connect with you?

17: Flipping the switch. Yeah.

Duckett, Emily: Interesting. Love that. It's my new my new term. Okay. So my last question for you, is given the pandemic. Can you talk to me about providing patient centered care during this time?

17: Yeah, I, started in the beginning when we were filling out these reflection logs answering that question like, it does affect our patient centered care because I would say like, oh, we try to like tell the patient, how to do rehab instead of like touching them or like showing them. But, um, now I kind of say that we don't because that's not really a patient centered care. It's more that you're treating the patient as the patient and I can do that just fine, even with the pandemic. Like I'm still asking them, like how they're doing and how they are so I feel like that's more the patient centered care. When I was answering the question, previously I feel like just like having to touch someone or like, even though we're restricting that or like distancing I still feel like you can deliver patient centered care. So I guess telehealth would be how the pandemic effecting us. Um, that's like something that's new, we're doing a lot of Telehealth with even in virtual clinical. But I feel like you can still deliver great patient centered care if you're asking the right questions and making sure that you're treating the patient as a patient like their whole, not just the injury.

Duckett, Emily: And where do you feel like you learned to ask the right questions?

17: Definitely from the modules and the classes and also just from like experience also from like virtual clinical those but they have us watch a bunch of videos and I feel like I get a lot of ideas, just like learning from like everything that I learned. Yeah.

Duckett, Emily: Yeah, that's interesting. Something else I've heard described is, I don't know if you have kind of like a head count or like a certain amount of patients allowed in the room. Is that happening at your clinical site? It's actually you're providing more patient centered care because you're having more one on one time with people.

17: Yeah, that is true. Um, one like the room is full, like we have people waiting the hallway, but there is like there's three of us at the clinical site and then we have our preceptor and our GA. So there's like the five of us, and then we're allowed to have like five or six patients. So it is very one on one, like at the beginning the students would like pair up but now that we're comfortable, we do get like more one on one time. So I like get to know my patients better.

Duckett, Emily: That's great. So I'm going to use one of your questions here anything that I didn't ask or anything that you would like to add talking about your experiences of using the soft skills at clinical?

17: See I'm getting stumped. Not off the top of my head, but I would just like to thank you guys because I think that class like helped me so much. And I think I'm definitely like growing and being the best clinician that I can be because of it.

Duckett, Emily: Oh well thank you so much. I really appreciate you sharing that.

Participant ID: 19
Semi-Structured Interview
11/4/20

Duckett, Emily: The topic of my dissertation, is teaching empathy and compassion during a soft skills curriculum to preprofessional AT students and how soft skills are transferred to clinical practice during patient interactions.

Duckett, Emily: So this will kind of cumulate to what you did last spring in your class and then what you're doing now your clinical site.

Duckett, Emily: Alright, so first question is in your own words. Can you describe empathy?

19: Geez. I didn't realize it was gonna be a quiz. [Laughter]

Duckett, Emily: It's not, that's why it's in your own words…

19: Okay, so for me, empathy is like understanding someone else's perspective and their feelings and then not just recognizing that but taking it on with them and going next to them through whatever they're feeling.

Duckett, Emily: Wonderful. And then how about compassion. So in your own words. Could you describe what compassion means?

19: Sure. So I think they're quite similar. I think empathy kind of has that action part of it as well, like going alongside them and compassion is kind of that initial like feeling that you get of like concern or like understanding and wanting to understand them. So I think it's kind of that initial drive to understand one another and then the empathy part kind of takes into action. So there they go hand in hand.

Duckett, Emily: Perfect. So based upon what you did in the springtime, your capstone class, was there anything in that course that helped influence your empathy and compassion that you're providing clinically?

19: Hmm, I think I mean going through, like the definitions and we would do those different PowerPoints, and then kind of work through them in a structured way. I think that's definitely something that's helpful because I'll like every once awhile I'll remember something like some little image or some little phrase. So I think those kind of tidbits like pop up in daily life then and then at clinical so I guess kind of going through it in a structured way was very useful and still is useful.

Duckett, Emily: So specifically, the structure of those lessons?

19: Yes. And then, of course, I mean you go from which structure to like more organic when you kind of do a little breakouts and stuff. And then we'll reconvene so but I think having like actual definitions and like imagery is super helpful.

Duckett, Emily: Perfect. And are you talking about, specifically the empathy and compassion lessons or were there any other aspects of that class?

19: Okay, not one was more geared towards specifically empathy and compassion, but, um, I would say for me… one of the things I remember most is like the your strengths and then your balconies, and your basements and stuff like that. So that one stuck, out still sticks out a lot. That one is kind of more personal, I'd say, but it can still help you understand other people and then help them find their balconies in their basements, so…

Duckett, Emily: That's awesome. Yeah, so when we're thinking about balconies and basements and the Strength Finders... how does that come into your clinical practice? Like, when is that triggered, or can you think of a certain incident?

19: Um, I think, just maybe, if I'm facing a challenge where I have to kind of go outside my comfort zone, like the first few times I do an eval. Like, oh, you've never done this, but you know how to do this. So you want to give this like an eval on someone's back like we haven't even covered that. They're like, go ahead and do the initial part of it. So just kind of like remembering like your strengths and then using that to help you step outside your comfort zone. For like specifically like patient interaction, ummm, maybe not off the top of my head that might be just something that happens without me even noticing, but I would say if I'm pushed outside of my comfort zone, that's what I'm like gotta rely on this! [Laughter]

Duckett, Emily: Right. It sounds like that experience helped with some self-awareness to then be able to build that confidence when you're asked to step outside of the comfort zone. Is that correct?

19: Yes. Precisely.

Duckett, Emily: Great. Okay, so forth question. So can you talk to me about your clinical site? What does empathy and compassion look like to you at your clinical site?

19: Okay. Um, so I'm at XX high school and we haven't had a whole lot of patient interaction, whenever have to answer this question on the reflection log… I'm like, AHH, I don't know [Laughter]. But, one example I can think of wasn't necessarily me, but my preceptor. Um, there's like this one little thing that just happened with the girls soccer team and then one player was super worried about something that's completely out of her control and not really something she shouldn't have to worry about it. Like all she has to worry about is playing like it's playoffs, whatever, and they had like this whole like little conversation in the ATR and then out at practice because you could tell that was something that was really bugging her and really concerning her.

And she just kept reminding her like this isn't something you have to worry about like you just go out there and you play like we got this, the coaches got this. There's so many things to worry about this is not one of them. So it was cool to like see that rapport, just like firsthand, even though it wasn't me. Like, I can. I was clearly right there. Then going alongside your player and listening to her concerns and then, you know, helping her through it. So that was like a good example. And it's cool, because It's like a younger population. So I don't know, I guess, a few times, like we'll see stuff, or I'll hear them say things. Like, oh yeah, like you're in high school and you're on zoom at home like with the parents all day long. So there's like little things here and there that just kind of remind you of the bigger picture. And then you're like, okay, yeah, we have to have a little conversation and take a step back. So I think that was a prime example.

Duckett, Emily: So, do you consider your preceptor to be a mentor to you?

19: Yeah, yeah. I have to two there are my clinical site. So yeah, I would say both.

Duckett, Emily: And can you describe, how you view that mentoring relationship?

19: Umm, I've never thought about that before... let's see. I would say like they're...they're there to answer whatever questions I have, but also to provide an example of some of the things that you don't see in your classes or in other places like in a different type of setting like since this is a high school, things are always a little bit differently... you have to worry about parents and stuff like that. So just kind of them being an example of what it's really like and then being that support system for me and providing a space for me to learn and grow. So I'd say that's what it would be.

Duckett, Emily: So you specifically said your preceptor you saw an interaction between them and us and a student athlete about something was clearly bothering the athlete and your preceptor took the time to listen and calm them down and tell them they didn't have to worry about it. Um, do you feel like that is a behavior that you will then be able to mirror since you've watched it?

19: I think so. If the opportunity arises. Probably she obviously has like more of a relationship with them because I'm only there a few days and she's been there for 15 years or something like that [Laughter]. Obviously, um, but I think so. I don't see myself not doing that.

Duckett, Emily: So then, at your site. So that was an example from your preceptor do you can you think of any example where you demonstrated empathy and compassion?

19: Um, this was kind of like a team effort between me and the other student at my site. Did we tell you about this? I don't know if we did or not, we have this one girl on the other girl's soccer team have like a possible hip avulsion. She was like in a lot of pain. We just got her off the field. She's like, stressing out crying her coach was not helping at all. So we just, they're like, trying to get her mind off of it. I'm just talking to her about literally anything else. Just because you could tell that she was, she the senior like she's like this is it like, blah, blah, blah. So, blah blah blah, very empathetic. [Laughter] So we were talking to her because her coach finally left. And we're like, go away... you're making it worse [Laughter]. So we were just trying to like get her mind off of it. And then also, one little thing that I like consciously thought to do. Was we were right

next to the sideline, and the ball was still there. And I was like, God forbid, this girl is on the ground in so much pain crying, and someone goes to clear the ball on it nails are in the back of the head. So I was like, I'm going to stand in between me and her in the field. And I was like, I don't know, this kind of whatever, but I was like well, I'm standing here.

Duckett, Emily: I mean, then crowd control and positioning can make a big difference. Yeah.

19: Absolutely. Other than that, we haven't really had a lot of things to be empathetic or compassionate about other than just, I feel like just being a good human and talking to someone as a human. So beyond that…

Duckett, Emily: Is there something in your lived experiences that made you realize that empathy and compassion is talking to people like their a human being?

19: I guess I mean maybe just like how I was raised, or I don't know. I feel like I've done a lot of work to try and understand myself and have that helped me understand others. So that's just something that's important to me is like being a good person and I think understanding that everyone is their own person, you have to talk to them as a person. I think we've lost that… that's a little whole other conversation but I don't know if there's something specific or not. But just.. I don't know about that.

Duckett, Emily: That's okay. So, next. Could you talk to me about your wellbeing? So my question is going to be, do you think your own wellbeing is associated with the delivery of compassion and empathetic patient centered care? If so, how, if not why not?

19: I definitely think they're connected. I think they can affect one another, either positively or negatively. Umm…because obviously if you're in a place where you're not doing well. It's harder to be empathetic and compassionate towards other just generally. But also, I think, on the flip side of that, if say I'm having a bad day, or whatever. But then there was like an opportunity or I see like my preceptor display empathy and compassion in that setting. It's like that can help my wellbeing that and I think they can kind of flip flop if one's down the other one can pick it up, sometimes, but also positively It's a lot easier if you're in a good place to like treat other people with empathy and compassion in your care. So I don't. Yeah, I think they're connected and I think they affect one another for sure. But I also think, even if you're kind of down in the dumps, you can still find a way to be empathetic and compassionate, but you have to kind of like actively make that choice then.

Duckett, Emily: So it sounds like you've had that experience, like you feel this. Can you describe that a little bit more?

19: [Laughter] I feel like I'm a very introspective person just all the time. So if I'm in a dumpy mood, I am very aware that I'm in the dumpy mood, um, so I don't know if there's a specific example. But I feel like also you kind of like if I put it into clinic, like if I'm at my clinical site and I am evaluating someone you kind of like flip that switch. So you kind of like take on a different role. So it's kind of like setting, whatever else aside, sometimes it's easier to just compartmentalize and do it like that. Um… what was the question? [Laughter]

Duckett, Emily: Great, you were talking about… you stated that you felt like there was a connection between your wellbeing and being able to provide that type that empathetic compassionate patient centered care for your patients. Like you felt there was a connection and then you further described that you said flipped that switch like you kind of go into this mode. And I was just wondering if you could explain like your thought process, your feelings, or how you know to flip that switch during your clinical experiences?

19: It's kind of like customer service in my head… like I worked in retail all my life so far. So you can like be whatever you can complain, you can be grumpy, and then as soon as you have that customer, you're like, DING customer service mode. So it's kind of similar in my head. Like, because as soon as that patient is gone, or whenever I'm done, providing care in that instance or whatever, like I can very easily go back to be in my mood or needing to talk about something or do whatever else. So I feel like whenever someone is standing right in front of you or your on your whatever telemedicine call um, kind of, I mean, for me, I know what my what that role is and how I would want to be treated and how I would how I want to be as a clinician, so I think having that goal in like, who I want to be as an athletic trainer… that is what reminds me to flip the switch. That like this is a real person in front of me, an actual patient, a student, and an athlete, so I can't be like, "I can't read any more emails from XX right now". Like, I can do that in 30 minutes when I'm not talking to them. [Laughter]

Duckett, Emily: Okay. It sounds like you get like laser focused with your purpose again.

19: Yeah yeah yeah

Duckett, Emily: So do you feel like you've established this practice. I'm going to call it a practice because it, it clearly takes effort. Because of class, because of preceptor, because of your history of being a student athlete, like, where do you think this practice was established for you?

19: I'm probably. I mean, I'm sure my classes have something to do with it. And then I mean our staff is phenomenal. So seeing you guys as an example, like the way you treat us as students, and the way I see you guys treat your athletes is like a great example because you all are great people. So I feel like that probably has something to do with it. Um, and I mean, being an athlete from that perspective. I would say, I mean, I haven't really had a like a bad experience with any athletic trainer that I want to see. So, I mean, if I did, I'd be like, oh, I don't want that. So I would want to do the opposite. But I would say, I mean I think definitely lot from classes. There's little things. That I like would pick up on and be like, this is what I would want to do like in my I'm setting like this is how I would want to be, um, and we kind of drill it home in our curriculum about patient centered care. So I think even subconsciously like even if I wasn't actively thinking about it. It's still there from our, our courses.. definitely played a role.

Duckett, Emily: And this is going to be the toughest question I asked up the day… you just said little things. Can you think about like a memory and example, you have to give me an A-Z list, but what are those little things that stand out to you right now?

19: Thing that I would want to do that I picked up from our classes?

Duckett, Emily: Yeah.

19: Um, one is PROs those things… that was a specific one. Um, our soft skills that we talked about in XX's class that can be you're A- Z list that you can fill in- empathy, compassion, all those things that we talked about the soft skills. Um, let's see what else is in my little things bucket. Those are two right off my head. We talked a lot about like interdisciplinary practices in XX's class our special topics one. So even though we haven't really got to experience that yet, but just keeping those resources in the back of my head. Like getting connected with a psychologist or a nutritionist, dietitian or physical therapist and area all those little things. Instead of keeping everything separated and being on our own little island using the resources around us… that's a little thing that I keep back there. [Laughter] Mmm hmm and then I don't know also just any type of demographic type information to help understand where someone else is coming from and their background and the things that make them who they are and how they understand medicine and interpret healthcare. Um because that can affect how they see you and if they're going to listen to what you say at all, or if they even want to come to you. Um, so that's a little thing back there.

Duckett, Emily: Where do you feel like you learned that little thing?

19: It probably started, honestly in our first sports medicine class with XX. We talked about all that and like understanding privilege and all those little things in society that we don't think about and how that's connected to providing healthcare and being a better healthcare provider. So really, from the get go. We started talking about that and then just kind of build upon it. Like, take your pick up which class, you would like. And I'm sure we talked about it. So yeah.

Duckett, Emily: So really across the curriculum, but starting right in the beginning?

19: Yeah in HEA 210.

Duckett, Emily: Alright, last question. Okay given the pandemic, in our current environment, can you talk to me about providing patient centered care during this time?

19: Sure, um, I think it's kind of brought it to the forefront almost I think before all this, it was easier to not really think about people's home lives or I mean maybe some people do like automatically. Or just like other stresses in life that could easily be swept under the rug and now everything is just like at the front. Because everyone's going through it like there's not a single person that hasn't been touched by the pandemic in one way or another. So I think because it's so prevalent and interfaces, at least for me, I feel like it is like easier to think about those things for something like thinking about it from someone else's perspective, because I'm going through. I know they're going through it, so if it wasn't there then I would be like, "Oh, like what are you talking about, like, all you have to worry about is your classes and come on its high school, and little high school drama, and then playing on a sports team." But now it's like, no, like there's a lot more to it and there's always been a lot more to it and now it's like very, I think it's brought to the forefront. Maybe? [Laughter] And then but I guess also I don't know, there's a lot more stressors in my life now too, so there's some days where I'm like… we're still living in a

pandemic and I don't really care about anything else. That's like my what is taking over my brain today. So, I mean, I think, for in that sense. That's when you kind of have to flip your switch when you need to flip the switch and then bounce back.

Duckett, Emily: Yeah. That's very descriptive. Um, so you said that the pandemic has brought patient centered care to the forefront. How have you practice patient centered care at your clinical site?

19: I think whenever I really do my histories like whenever I or if I if they're taking their shoes and socks off or getting ready on the game ready or whatever, and we're just like chitchatting. I asked about… so like you're on zoon, like how's it going in our life? Now they're like just starting to come back to classes. So I think it's become part of my history and rapport gaining [Laughter]. Umm just trying to like get a sense of where they're coming from better because also I mean we've been doing that in virtual clinic as well. So I guess it's just It's right there for me to ask about so, I have.

Duckett, Emily: So you're learning a lot from both aspects of your clinical experience, whether it be virtual or in person?

19: Yeah, I hate to admit it, because I hate virtual clinic with a burning passion, but I'll give them that they can have that one. [Laughter]

Duckett, Emily: Well, Thank you. I really appreciate it and stop the recording. Unless you have anything to add.

19: Nope. [Laughter] Don't think so.