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THE EXAMPLE OF PHYSICAL THERAPY

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VALUE NEGOTIATION AS THE BASIS FOR PROFESSIONAL SOCIALIZATION: THE EXAMPLE OF PHYSICAL THERAPY

By

Christine Stiller-Sermo

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ABSTRACT

VALUE NEGOTIATION AS THE BASIS FOR PROFESSIONAL SOCIALIZATION: THE EXAMPLE OF PHYSICAL THERAPY

By

Christine Stiller-Sermo

One of the goals of professional education is to assist students in becoming a part of the professional community by helping them internalize an ethos that reflects the culture of the profession. Because a professional ethos is formed and influenced by social, cultural, and historical events and the individual identities of the people who enter the profession, it is necessary to understand these events and individuals to establish a starting point for what it is that educators wish students to learn through the process of professional socialization. In spite of the importance of describing the professional ethos as a basis for professional socialization, many professions have not clearly defined their ethos. In addition, educators may not realize the importance of establishing clear expectations for behaviors that reflect the professional ethos and utilizing specific teaching methods to assist students in becoming successful members of the professional community. The purposes of the study are to describe the culture and professional ethos of physical therapy, to identify current methods used to help students internalize the professional ethos, and to describe and analyze the experiences of students and their teachers in the socialization process of physical therapists as an example of professional socialization.

In Part 1 of this study data obtained through historical documents and interviews with individuals who have been in the profession for a long period of

time revealed that there are some traits and values that form the core ethos of the profession that have not changed since the inception of the profession and are unlikely to change in the future. There are also factors from both within and outside the profession that influence the professional ethos resulting in changes in values and beliefs. This evolution of the professional ethos over time ultimately results in the need for new methods of professional socialization.

Based on interviews with faculty, students, and clinicians from two programs that were identified as making a conscious effort to socialize students into the profession, Part 2 of this study examined methods of socialization in the profession of physical therapy. Analysis of the data revealed that faculty, clinicians, and students were able to identify methods used by educators to socialize students into the profession, and that students' perceptions of these methods are similar to those of their teachers. These methods reflect good teaching practices applied to professional socialization, as well as changes in the profession and society throughout the history of physical therapy. Some evidence suggests that methods employed by educators in these two programs were effective in facilitating the internalization of the professional ethos.

Based on the relationship between the data from the two parts of this study a model, "Value Negotiation," for understanding the role of educators and students in the socialization process was developed. The role of educators in this model is to provide opportunities within academic and clinical environments that facilitate the internalization of the professional ethos. The more important role, however, belongs to students as they assume responsibility for their own professional development by taking advantage of educational opportunities and becoming active participants in the socialization process.

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The Importance of the Professional Ethos

One of the goals of professional education is to assist students in becoming part of a professional community. Tammivaara and Yarborough (1984) have referred to this process of enculturation into a profession as "attaining a professional ethos." Ethos is defined as "the distinguishing character, sentiment, moral nature, or guiding beliefs of a person, group, or institution" (Merriam-Webster Dictionary, 1974, p. 247). The ethos of a profession, then, is comprised of the distinguishing characteristics, sentiments, and beliefs of that profession that guide the behavior of practitioners. This professional ethos is most often reflected in Codes of Ethics and Standards of Practice founded in the norms and mores of the profession, which, in turn, can be viewed as a reflection of the values, attitudes, and beliefs of the profession (Abbott, 1988). Because of the importance of the professional ethos to successful practice, I believe it is as important for faculty in professional education programs to address values and professional socialization issues, as it is to teach cognitive and psychomotor skills. The incorporation of the idea of a professional ethos into the profession's culture and educational program expands the definition of professional culture beyond a mere description of what practitioners do to a description of who the practitioners are as a group and what meaning they find in their work.

Like educators in other professional programs, the faculty of physical therapy programs want their students to emerge from academia as competent professionals - problem solvers who can evaluate patients and devise treatment plans based on the evaluation, who can interact with people of all cultures, who are responsible for their own learning, who serve as ethically exemplary role

models for future students, making contributions to their profession and communities (Packard, 1986). They want students to internalize the ethos of the profession as they are enculturated into the world of physical therapy. According to Tammivaara and Yarborough (1984):

> To do this, educational programs must develop a cultural orientation toward professional behavior, a professional ethos. This is not something to be offered as a course or even as a series of courses; this is an attitude, a set of values, which must be conveyed and practiced by the clinical and academic faculty. It must be manifest for students in expectations of their behavior, in the conduct and content of all courses, in the procedures of faculty/student interaction, in the evaluation of the students, in the use of space, in clinical education, in the designation of professional heroes and valuing of the field's history, and most of all in the faculty's and clinical faculty's commitments to patient care, the primary task of physical therapy. (p. 25)

The students must move from a world of college life to a professional one. The cultural values of "student" must be transformed into the "professional ethos." The individual must stop being merely a competent student and must become a competent professional. This occurs as the student begins the process of "internalizing the values, traditions, and obligations of the profession . . . [it] occurs when the student develops a clear and accurate perception of the role of the profession and of the self as part of that profession" (Saarman, Freitas, Raps, and Riegel, 1992, p. 27). Learning about the professional world thus involves not only mastering the skills needed to perform the work of the profession competently, but also includes learning about the many roles that a professional assumes in terms of ethical behavior, standards of practice, and appropriate interactions with a variety of clients, colleagues, and superiors. It involves internalizing the values and beliefs shared by others in the profession so that collectively held professional values and ideals come to characterize the

very identity of the novice physical therapist.

The Origins of a Professional Ethos - Social, Cultural, and Historical Influences

The questions in this study concern the origins and evolution of the norms, values, and beliefs of physical therapy, described as "professional ethos" by Tammivaara and Yarborough (1984), and the processes by which the professional ethos is transmitted to new members of the physical therapy profession. I contend that a professional culture is embedded in a cultural, historical, and social framework. A profession evolves in response to these larger influences and the changes they produce. In order to survive, professionals and their national associations must be responsive to historical events, societal pressures, and changes in cultural values. For example, current advances in technology are changing the ways children are educated and the services offered to individuals with disease or disability. The use of computer technology, in particular, is opening up new avenues of communication and care. Elementary school children can communicate with peers all over the world via the Internet and can access information never before available to them on the World Wide Web. Similarly, individuals with disabilities can use the Internet to communicate with others without the stigma of having a conspicuous disability. As a result of this technology, the world is becoming a smaller place, creating a need for understanding other cultures and societies.

In contrast to these positive aspects of living in a technological world, Kenneth Gergen (1991) describes different consequences of living with increasing technology. Unlike those who lived in the past, those living in today's postmodern world are constantly bombarded with information and people via television, radio, fax, and e-mail. In addition, the relative ease of

global travel offers many more opportunities for face-to-face interaction with culturally exotic people around the world. Because each of us is constantly bombarded with information and encounters with cultural strangers, Gergen claims that today's citizens experience a sense of social saturation in which individuals have little time for nurturing relationships either at work or home and each person develops so many perspectives from all that he or she comes into contact with that a committed and solid sense of identity is impossible. As a result, one begins to experience what he terms a multiphrenic condition. "A multiphrenic condition emerges in which one swims in ever-shifting, concatenating, and contentious currents of being. One bears the burden of an increasing array of oughts, or self-doubts, and irrationalities." (p. 80) In order to cope with social saturation and the multiphrenic condition, Gergen suggests that we turn this multiphrenic condition into a positive experience by considering what we can gain from this postmodern phenomenon. He describes how this cultural change gives us the ability to consider issues from different perspectives, to blend the beliefs of yester-year's romantic and modern versions of the world with the beliefs of today, and to be more accepting of others who are unlike us, leading to a greater ability to deal with diversity. This ability has evolved from several aspects of social saturation - a plurality of perspectives that comes from multiple interactions with people and places all over the globe and the moral and ontological relativism of the postmodern world. Postmodernism, Gergen believes, speaks to the importance of interdependence between people around the globe in terms of personal, social, and economic matters, and he offers us a way to accomplish and cope with this interdependence.

An example of how this plurality of perspectives, a social change, affects

professional cultures, at least in the United States, is the move from a "melting pot" orientation to one that recognizes the positive value of differences and the need to embrace cultural diversity. Professional associations and academic programs are responding by establishing goals aimed at understanding and respecting people from all walks of life, a change reflected in the evolution of these professions. This emphasis on diversity is evidenced in courses or units of courses within professional programs that address the need for students to learn to interact with individuals from a wide variety of cultures, as well as an increased effort on the part of academic programs to admit students from a different cultures and walks of life.

Diversity can also be seen from a historical perspective as each cohort of students entering professional preparation programs brings with them a unique identity that results not just from their personal experiences, but also from their collective experiences related to the historical era during which they were born. Perhaps the best example of this cohort effect on a societal level is the powerful influence that the baby boomers have had on every institution and era with which they have come into contact. From the free spirit days of the 1960s to their entrance into the American Association of Retired People within the next few years, this group has had a significant impact on the way we think and function. The professional arena feels this influence as well. As formerly novice practitioners become the leaders in the field, their influence becomes greater and their ability to incorporate their ideas and values into the discipline is enhanced.

The Social Construction of Professional Identity: Where are we in Understanding our Professional Ethos?

This study is grounded in the theoretical assumption that the development of a professional culture, its values and ideals, is a social construction resulting from the interactions and discourse among practitioners, clients, other professionals, and the general public. Based on their personal histories, practitioners, as well as consumers of professional services, bring unique identities to the practice setting that influence the development of a professional ethos. In addition, a variety of cultural, historical, and social factors shape the emergence and development of all professions. In this way changes in society influence the evolution of a profession and, subsequently, what and how educators teach students in order to prepare them to practice ethically and effectively in an ever changing society.

The influence of these larger changes in society on the practice of physical therapy has been reflected primarily in the technical aspects of the profession. But in recent years researchers and practitioners in physical therapy have begun to recognize the importance of acknowledging the contributions of history to present and future practice, research, and education. To celebrate the 75th anniversary of the profession, for example, the American Physical Therapy Association published Healing the Generations: A History of Physical Therapy and the American Physical Therapy Association (Murphy, 1995). For the first time, a history of the profession can be found in one comprehensive source. As a result of this book, as well as other historical articles and presentations that chronicle the history of the profession, the evolution of the scientific and technical aspects of physical therapy has been well documented. Changes in the types of treatment used, the diagnoses of our patients, practice patterns, and

other demographic variables have been delineated in these various places.

In contrast to this clear picture of what physical therapists have done and presently do, who they were, are, and may become is not as well documented. In spite of the fact that the American Physical Therapy Association creates many documents aimed at the socialization of newcomers into the profession (e.g., Code of Ethics, Standards of Practice, Accreditation Standards), little scientific inquiry has been carried out to describe more precisely what it is that physical therapists want to socialize students into. While some authors have made attempts to define some individual characteristics of physical therapists such as helping behaviors (Curtis, Davis, Trimble, & Papoulidis, 1995) and sensitivity to gender issues (Raz, Jensen, Walter, & Drake, 1991), there is currently no description of the norms, values, and beliefs--the culture--of physical therapy. We have no clear picture of who we are and what we represent today. Further, we have no real idea of whether and how the essence of what it means to be a physical therapist has changed over the years. If the culture has changed, why have these changes occurred and what do they mean for professional socialization? More specifically for the purposes of this study, what does the development of the professional culture imply for the physical therapist educator who is trying to help students to internalize a professional ethos?

Because of this lack of a clear description of the culture of physical therapy, students may be receiving mixed messages from academic and clinical faculty as to what it is that defines the profession. While to some extent there may always be ambiguity in the professional world portrayed to students, the ability of educators and practitioners to share core beliefs and views of how the professional world operates is important in helping foster students' understanding of professional culture. Examples of how this lack of agreement

between educators and practitioners can confuse students has been reported in the literature on professional socialization in nursing (Myers, 1982; Cohen and Jordet, 1979). Similarly, while academic faculty in physical therapy are presenting an ideal view of patient care based on their past experiences as practitioners, clinical faculty, who are working in the real world, may have seen changes in practice (e.g., managed care) that are quickly changing the role of the physical therapist in practice. Additionally, faculty may be presenting the world of physical therapy as a black and white world with easy answers to difficult ethical dilemmas. This world of absolute rights and wrongs does not exist in today's world. This loss of absolutes is described by Gergen (1991):

> In the traditional community, where relationships were reliable, continuous, and face-to-face, a firm sense of self was favored. One's sense of identity was broadly and continuously supported. Further, there was strong agreement on patterns of 'right' and 'wrong' behavior. One could simply and unself-consciously *be* (italics in original), for there was little question of being otherwise. . . . As one interacts with persons from diverse backgrounds, and is exposed to various media representations of 'good persons', the range of self-evaluative criteria expands manifold. It is not simply the local community that dictates the nature of the good, but virtually any visible community. (pp. 147-148)

Even worse than receiving mixed messages, students often receive no message at all, with faculty expecting students to internalize the faculty's professional ethos by intuition and osmosis. Today, students are affected by many potential role models. In spite of the best intentions of their faculty to be "good role models," the common indirect and implicit approach to professional socialization does not serve our students well in the cacophonous marketplace of ideals and values. As described above by Gergen, there is not the "strong agreement on patterns of 'right' and 'wrong' behavior" (Gergen, 1991, p. 147) today that there was years ago. As a result, students with no means for

identifying and dealing with professional development or ethical issues that arise as they begin their journey into the professional world will be at a disadvantage. Personal conversations with practicing physical therapists and direct experience in dealing with students who are experiencing problems with the transition from student to professional often reveal that some students have little idea of who it is they are supposed to be as a physical therapist and how they are supposed to get there.

An Evolving Professional Ethos in a Changing World

Because faculty are responsible for educating future professionals, they need to be cognizant of the fact that they have an obligation to prepare students for a changing world--one that the profession must change with to remain viable. Change is an integral component of the concept of the culture of a profession. As described earlier by Gergen (1991), change is occurring at a faster rate due to the rapid growth in technology and our constant interaction with multitudes of individuals via television, phone networks, e-mail, and increasing travel. Because professions are subcultures of the larger societal culture in which they are embedded, rather than isolated entities, these changes are reflected in professional norms, values, and beliefs of professional cultures. As a result, the ability to deal with new roles, values, and technology in an evolving society is an important asset for any professional.

Fox (1957) has coined the term "training for uncertainty" to describe this phenomenon. Fox claims that there are three sources of uncertainty with which students in professional training deal (Fox's subjects were medical students, but her views can be applied other professions as well). These are "(1) incomplete or imperfect mastery of available knowledge; (2) limitations in current . . . knowledge; and (3) difficulty in distinguishing between personal ignorance or

ineptitude and the limitations of present . . . knowledge" (pp.208-209). Fox feels that it is imperative that educators use teaching methods that will help future professionals deal with these uncertainties. For the medical students she studied, these methods include acknowledging uncertainty by having students be active, responsible learners rather than "spoon feeding" them information; helping students to realize that they will never be able to master everything due to the limitations of the human brain and the daily new discoveries that are made in the field; acknowledging the limitations of human senses and technology in detecting problems; sharing experiences of uncertainty with fellow students to help them realize that their peers, as well as attending physicians, also are uncertain at times; and providing real life situations in which students can learn to cope with this uncertainty and, thus, increase their confidence and sense of responsibility in their professional role. Fox does not claim that we can eliminate uncertainty. Rather, educators must help students cope with and take responsibility for it. Similarly, while it may be unrealistic to expect that educators can prepare students for a future world that we may not be able to even imagine, they can, I believe, prepare them for functioning in today's world and give them tools for dealing with future professional changes.

Floden and Clark (1988) applied the principle of "training for uncertainty" to the teaching profession. They discuss the meaning of uncertainty for teacher education and identify several variables about which teachers are uncertain, including " what . . . students know, what effects teaching has had and will have, the content they should be trying to teach, what instructional authority they have, and how they can improve their teaching" (p. 504). Like Fox (1957), Floden and Clark (1988) acknowledge that some uncertainty will always be present since no one can know everything and there are some things about which no one is

certain. Pursuing certainty, in fact, can lead to teaching methods that result in "factual content that can be taught by rote memorization and tested by requests for recall . . . a focus on immediate, obvious, specific difficulties, away from global, long-term plans and goals . . . (and) discomfort to students" (p. 513) due to excessive questioning by the teacher in an effort to be certain about what students know.

Floden and Clark's suggestions for decreasing the tension that results from uncertainty fall into two major categories. First, they suggest that faculty in teacher education programs teach strategies for reducing uncertainty such as the ability to create well-established, yet flexible classroom routines, and knowing when and how to increase their own knowledge and skills. Second, they feel that teacher education programs need to raise teachers' awareness of uncertainties without conveying an "anything goes" perspective, and teaching them strategies for dealing with the stress that results from living with uncertainty. Educators can help teachers cope with this stress by teaching them the art of engaging in professional conversations with colleagues about their feelings of uncertainty in spite of initial difficulties in revealing some of their weaknesses, and by helping them to create an atmosphere of certainty in their classrooms by taking decisive action so that students and parents can be confident in their abilities as a classroom teacher. Finally, the importance of inservice education and field research for experienced teachers are nominated ways to keep these professionals in touch with the reality of uncertainty so that they do not become overly confident or rigid in their teaching techniques.

Purposes of the Study

This study has three purposes: I. To describe the culture and professional ethos of physical therapy; II. To identify current methods used to help students

internalize the professional ethos; and III. to describe and analyze the experience of students and their teachers in the socialization process of physical therapists as an example of professional socialization. Table 1 portrays the research design in relation to these three purposes, each of which is discussed in detail below.

I. Description of the professional ethos of physical therapy. The first purpose of this study is to describe the culture and professional ethos of the profession of physical therapy, acknowledging that many factors (i.e. social, cultural, historical, economic, political) must be considered in this description. For purposes of this study, culture is broadly defined as "that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society" (Tyler, 1903, cited in Goodenough, 1981, p. 1). A professional culture can then be further defined as the knowledge, belief, art, morals, law, custom, and other habits and capabilities acquired by practitioners as members of a profession.

Although a complete examination of all the social, cultural, and historical events that have occurred since the inception of the profession is beyond the scope of this study, there are many events both within and outside of the profession that have had a direct impact on its professional culture. This first step of describing the contemporary professional culture--its acceptable norms, values, and beliefs--is important in helping to gain an understanding of the meanings embedded in these norms, values, and beliefs. According to Goodenough (1981), before we can examine behaviors or come to any understanding of their meaning, it is important to establish the rules and standards by which these behaviors are judged. He states that we must be able to istinguish the relevant from the irrelevant. "(W)e can count all kinds of

Table 1. Overview of Research Design

PURPOSE OF STUDY	SOURCES OF INFORMATION	METHODS OF DATA COLLECTION	TYPE OF INFORMATION
1. Describe the culture and professional ethos of physical therapy.	Part 1A - Leaders in the Field - Fellows in the American Physical Therapy Association (3)	Individual Interviews	Historical and contemporary construction of the field
	Part 1B - Established Practitioners - Prime Timers (10)	Focus Group Interview	Historical and contemporary construction of the field
	Part 1C - Historical Documents - Mary MacMillan Lectures (28) and Presidential Addresses (approximately 50)	Review of Historical Documents	Historical and contemporary construction of the field
2. Identify current methods used to help students internalize the professional ethos.	Active Practitioners/Educators - Faculty and Clinical Educators (6 of each) Aspiring Practitioners - Students (6)	Individual Interviews	Historical and contemporary construction of the field; current methods of professional socialization; views of how students are socialized will be compared with those of students
3. Describe and analyze the experience of students and their teachers in the socialization process of physical therapists as an example of professional socialization.	Active Practitioners/Educators - Faculty and Clinical Educators (6 of each) Aspiring Practitioners -Students (6)	Individual Interviews	Experience of being socialized into a profession; will be compared with views of faculty and clinical educators

things; but all of these things are significant units in a complicated game of living. We cannot count them if we cannot recognize them; and before we can recognize them, we have to know the standards and rules of the game. To make predictive statements about actual behavior, we must first know the culture of which that behavior is an expression" (p. 58). The first part of this study, describing the evolution of the professional culture of physical therapy, then, is important for several reasons. First, it will help to establish and define the beliefs, values, and norms of the culture[1] that are evidenced in professional behavior. Next it will help to identify those beliefs, values, and norms that may have stayed constant and those that have changed over the life of the profession so that the core characteristics of the profession can be identified and the evolution of those that have changed can be described. Second, examining the past will help put the present in perspective and explain why it is that the profession is "what it is" today. While the fluid nature of cultures prevents anyone from ever portraying a concrete picture of exactly what constitutes any culture over an extended period of time, I feel that tracing the evolution of the culture and professional ethos of physical therapy will at least offer a useful snapshot of how the profession evolved to where it is today. The present view of the profession can then be used as a point of contrast with the past to better appreciate where the profession has come from, as well as offering a glimpse into the future to see what it is that students need to learn about the professional ethos and the skills and behaviors that are part of that ethos. That is, as described by Goodenough, we must define the culture

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[1]Riverside Webster's II Dictionary: Revised Edition (Berkley Books, 1996)) gives the following definitions of these terms: belief - "something, as a tenet, that is believed: conviction" (p. 64); norm - "a model or pattern considered typical for a particular group" (p. 468); value - "a standard or principle regarded as desirable or worthwhile" (p. 810). These definitions are the basis for the use of these terms in this study.

including its core, shared standards, and domains of contention, before we can begin to discuss the ways in which we pass this culture on to the next generation of professionals.

II. Pragmatic approaches to socialization to core values. The second purpose of this study is to describe some methods that are used to pass on the professional ethos to students. Through a case study approach, I have identified some of the current methods that are used to socialize students into the culture of physical therapy as an example of professional socialization. These methods are used by physical therapy educators to facilitate the internalization of a professional ethos in physical therapy students, as well as to enhance the students' ability to recognize and adapt to the societal and professional changes that will likely occur over the lifetimes of their professional careers in response to social, cultural, and historical events.

III. The phenomenology of professional socialization. Finally, but perhaps most importantly for faculty and students in professional education programs, the third purpose is to describe the experiences of students and educators in the process of professional socialization in these programs. Because physical therapy is being used as the example of professional socialization, however, the first two purposes of this study must be addressed in order to help the reader gain an understanding of the current state of the field in terms of its culture and educational programs. Those reading this study can then draw their own conclusions about the similarities and differences between the culture and education of physical therapists and that of other professions. For those in fields other than physical therapy, I hope to offer a picture of professional socialization that will shed some light on issues such as the ways in which students feel that faculty help or hinder them in the process of socialization and

making the transition from student to professional, how students come to recognize the core concepts of a professional ethos, and how they learn to apply these core concepts in practice and in their professional behavior.

Chapter 2

Professional Cultures and Professional Socialization

There are two major concepts that are necessary to understand in order to put this study into perspective. These concepts are professional culture and professional socialization. While culture offers a basis for understanding what it is that a profession believes in and values, professional socialization provides a means for understanding the process by which students in professional education programs learn about and become part of that culture. Both the content (i.e., culture) and the process (i.e. socialization) are important components of fostering the internalization of the professional ethos in students.

This section is intended to describe a framework for defining professional cultures and tracing their evolution, and for describing the means by which educators attempt to socialize students into their respective professional cultures. Figure 1 depicts a model for understanding the relationship between the professional culture and professional socialization. The two large circles represent the concepts of culture and socialization in a much broader sense. That is, culture within the large circle can be thought of as a way of life or the beliefs, values, and norms of a society in general. Socialization within this model is defined as the process by which members of a culture learn social roles (Mehan, 1980; Merton, Reader, and Kendall, 1957). Embedded within each culture are a multitude of subcultures, including professional cultures (represented by the oval within the circle of culture). Similarly, one type of socialization, organizational socialization, is embedded within the context of socialization. Organizational socialization, as a subset of socialization in general, is defined as the process by which individuals are socialized into an

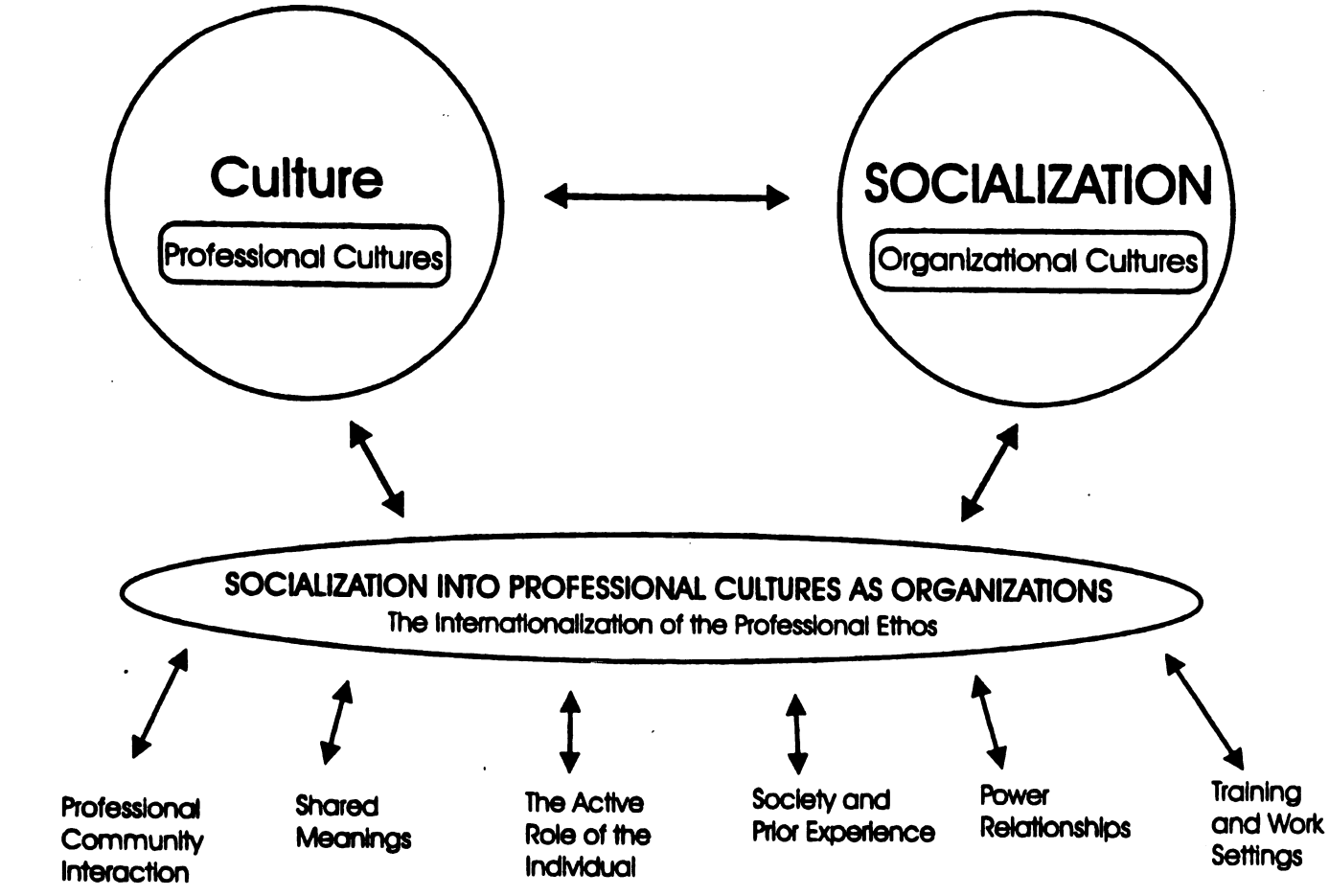

Figure 1. A Model of Professional Socialization as the Product of Culture and Socialization

organization. Understanding the concepts of and relationship between professional cultures and organizational socialization helps put the process by which students are socialized into professional cultures as organizations into perspective. In addition to the influence of culture and socialization on the internalization of the professional ethos, other influences, such as community interaction, shared meanings, society and prior experience, the active role of the individual, power relationships, and training and work settings, are also important. The influence of all these concepts on socialization of students in professional programs are indicated by the arrows from each of them to the "socialization into professional cultures as organizations" oval.

In addition to the information regarding professional cultures and socialization depicted in the model just described, the remainder of this chapter offers a summary of literature concerning the processes by which students in professional programs are socialized into their respective professions. The concepts and ideas included in both the model and the literature are described in more detail below.

A Definition of Culture

Over the years, culture has been defined in various ways. Tyler (1903, cited in Goodenough, 1981) first defined culture as "that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society" (p. 1). At that time in the history of the modern world, culture was something that was considered to be more developed in some societies than in others.

> In this view, societies did not have discrete cultures but a greater or lesser share in the degree of general culture so far created and developed by mankind as a whole. . . .The object of cultural anthropology was to try to reconstruct the steps or stages that had marked the growth of culture. Societies with the simplest

> technologies and the least elaborate political orders presumably represented the lowest stage of growth; others represented various intermediate stages; while western European societies, politically and militarily dominating the rest of the world in the nineteenth century, represented the most advanced stage. (Goodenough, 1981, p. 48)

In the early nineteenth century, this ethnocentric and hierarchical conception of culture began to be replaced, primarily through the work of Franz Boas, with a more egalitarian view of culture in which each society was seen as having their own distinct form of culture (Goodenough, 1981). Since that time, anthropologists have combined Tyler's conception of culture as "the complex whole" with Boas' view of cultures as distinct, rather than hierarchical. In addition, the "complex whole" described by Tyler was expanded to include language. "Language and culture went together as a body of distinctive things about a community that were transmitted by learning and that gave to each community its own peculiar linguistic and cultural tradition" (Goodenough, 1981, p. 49).

Two of the most influential scholars involved in determining how cultures are studied today are Ward Goodenough and Clifford Geertz. While agreeing on the basic beliefs about culture described by Franz Boas, each sees the ways in which culture is shared and transmitted to new members in a slightly different context. Geertz (1973) views culture as a semiotic field or shared symbol system. The shared meaning that results from the symbol system is how societies come to also share knowledge, beliefs, norms, etc. Culture, in Geertz's view, is public. It is by analyzing the meaning behind behavior (i.e. social action) and social discourse in a society that one comes to understand the culture of others. "Meanings are not 'in people's heads;' symbols and meanings are shared by social actors--between, not in them: they are public. . .

. To study culture is to study shared codes of meaning. . . and interpretation becomes 'thick description' that must be deeply embedded in the contextual richness of social life" (Keesing, 1974, p. 79).

Goodenough (1981) views "cultures . . . as systems of knowledge. . . . [and] language [as] . . . a subsystem of culture" (Keesing, 1974, p. 77). In contrast to Geertz, he views culture as "being in the minds and hearts of men." Without this private view of the individual as the center of culture, Goodenough (1981) feels that the study of culture is reduced to simply the study of behavior without meaning behind it or to a study of a collective unconscious, neither of which is acceptable to him. Instead, he posits that because culture is learned through language and the study of the meaning behind behavior, language, and material artifacts, and because we can only learn things as individuals, it is the *relationship* between individuals and the societies in which they live that determines the standards by which people are accepted by others as viable members of a group.

Based on the work of Geertz and Goodenough, as well as others in the field of anthropology, key features of cultures have been identified. These include: (1) the importance of language; (2) the importance of understanding the meaning behind social discourse, behavior, and material artifacts rather than simply recording what, how, and when individuals engage in behaviors and discourse; (3) the adaptability of cultures over time in response to environmental and other demands; (4) the belief that culture is learned, not biological; (5) the belief that culture is shared; (6) the belief that culture is a complex, interconnected whole, not just random bits and pieces; and (7) the belief that culture offers rules or standards for knowing, for behavior, for feelings, and for thoughts so that one is acceptable to his or her culture (Geertz,

1973; Goodenough, 1981; Keesing, 1974). The definition of culture reflected in these common key features serves as the definition used in this study. In professional cultures, for example, there is shared meaning between members of the profession which is evidenced in the professional ethos; professional cultures change over time in response to broader societal changes; and, like societal cultures, professional cultures are complex, interconnected wholes that share meaning with individuals from other professional cultures and walks of life.

A Definition of Professional Culture

As stated earlier, a professional culture is the knowledge, belief, morals, laws, customs, and other habits and capabilities acquired by practitioners as members of a profession. Based on this definition, the culture of a profession cannot be defined only by what the profession does. Rather, the identification of the values, norms, and beliefs that determine how and why the profession functions the way it does and the meaning behind them are also critical components. Professional cultures are somewhat fluid, changing over time as new cultural, social, and historical events occur and various people move into and out of it, shaping their evolution as they do so. They are composed not only of what is obvious to the causal observer, but also of many things that may not be entirely describable, but still exist in minds and hearts of the individuals who have attained the professional ethos.

Professional cultures are influenced by a multitude of factors, rather than by a single event or person. They respond to changes within and outside themselves. They reflect the ability of the practitioners in the field to articulate what they do and who they are as unique, yet related to what others do, and for these views to be consistent with beliefs of those outside the field so that what is

claimed as distinctive about the profession is accepted by the culture at large.

Defining a professional culture and some of the factors that influence it, although important, is only the first step in the process of understanding how it is that students internalize the professional ethos of their more experienced colleagues. A second step, described in the following section, is to try to describe the processes by which professional cultures develop over time.

Development of the Culture of a Profession

Understanding the history and evolution of the culture of a profession can be important in avoiding mistakes that predecessors have made, gaining an appreciation of who and what has been helpful in the evolution of the profession, and perhaps most importantly, realizing that what happens today will shape the future of the profession (Woods, 1995). Multiple variables need to be considered to gain an understanding of this evolutionary process. For example, each cohort of members brings new and different views to the culture. The addition of new members to a professional culture is one of the ways in which differences in subcultures within a profession develop and the culture evolves. To the extent that new members become more powerful members of the group, the culture will adapt to these views. Next, the profession does not develop its culture in isolation. Rather, it should be viewed as a part of society, a subculture that evolves as a result of being situated in a larger societal culture. It is influenced by other social, cultural, and historical changes in the world. In addition, how one profession views another has an impact on who the practitioners and the profession become. Just as interactions with family members, peers, and authority figures influence how people see themselves and consequently behave, so does the view of others influence how a profession sees itself. If a more powerful group sees another group as less

powerful and incapable of making decisions, the interactions between the two groups will continue to perpetuate this view. The less powerful group may continue to behave as they are treated and viewed by those in power.

Physical Therapy as an Example of Historical Evolution

The development of physical therapy is a case in point. In the early years of the profession, physicians were a powerful group that viewed physical therapists, or reconstruction aides as they were called at the time (during and shortly after World War I), as technicians who needed guidance in order to carry out their jobs. Although there were some who were offended by this technical role, a review of the writings of the pioneers in the field revealed that many of the reconstruction aides shared this sentiment (American Physical Therapy Association, 1979). Similarly, physicians "urged the use of the term technician . . . . A well known physician and friend of the Association said: 'You can't fight the medical profession. If you wish to stand you must cooperate' " (American Physical Therapy Association, 1979, p. 74-75).

It was only as the women who chose physical therapy as a career began to gain a more independent sense of self as a result of the changing views of women beginning with the Women's Rights movement in the sixties, and as more males began to enter the field, that the profession responded by moving away from the direction of the American Medical Association and began to seek autonomy. The view from within changed as a new cohort of working women, as well as men, who embraced the ideals of independence and equality between sexes and rejected a more passive role, became the leaders in the field. It was as recently as 1981 that the American Physical Therapy Association adopted a resolution to actively pursue autonomous practice by seeking to change state licensure laws to allow practice without physician

referral and to enhance the image of the profession portrayed to consumers and other health care providers as independent practitioners. This is but one example of how the views of new members and societal changes helped change the professional ethos and the practice of a profession.

Understanding Relationships in Professional Cultures

A description of professional culture, then, goes beyond the dictionary definition that can be found in state licensure laws that merely describe the "jobs" that those in the field perform and the credentials they must have. Rather, each culture is socially constructed through interactions and discourse among practitioners, clients, other professionals, and the general public. Each new practitioner is not a final product that can be fit into the profession much as one would put the final piece into a jigsaw puzzle to make it complete. Instead, the culture of the profession is continually being constructed and reconstructed over time. It is always a work in progress. Many of the foundations are in place, yet much remains to be built. The construction continues as active, reciprocal, ongoing relationships develop between the profession itself and other people, events, and institutions that surround it.

To carry the construction metaphor further, the profession can be viewed as a complex of buildings with each individual building or person contributing to the function of the complex. While the complex does not look complete or function adequately without each building, neither can the buildings stand alone. Each segment of the whole is incomplete without considering it in relation to other segments. One can imagine that those buildings outside the complex are also important to the function, much as other professions, clients, and the general public are essential for the evolution of each discipline.

Physical therapy can be viewed as an example of the points illustrated in the

above paragraphs. The many people and sectors of the profession - the buildings - who make up the profession form the integrated whole - the complex. Within the American Physical Therapy Association, for example, there are "Sections" which are special interest factions devoted to a specific part of practice, such as pediatrics, orthopedics, private practice, or home care. These sectors influence the core of the profession - the norms, values, and beliefs that transcend boundaries between these various groups - that form the basis of the professional ethos. Similarly,other professions (e.g., medicine, occupational therapy, speech therapy, etc.) and social institutions (e.g., federal and state regulating bodies and insurance companies) outside the complex of physical therapy influence the development of the professional ethos of a field by interacting with and sometimes exerting influence over the profession. To the extent that physical therapy as a profession reacts to these influences, the core or ethos of the profession can change over time.

Social, Historical, and Cultural Influences on Professional Cultures

There are many outside influences that contribute to the evolution of professional culture. For example, in the book, Constructing the Subject: Historical Origins of Psychological Research, Danziger (1990) argues that the development of a profession and its practices is a socio-cultural-historical phenomenon. He outlines the many forces that shaped the practice of psychological inquiry and emphasizes the social nature of scientific inquiry and the interactions that occur between the investigator and the subject, the investigator and colleagues, and the investigator and society. He describes the importance of political power in determining what will be investigated and how the investigation will be carried out. For example, while educational psychology originally was linked with teaching in the late 1890s, an alliance

that helped make psychology popular with the general public, after the turn of the century psychologists began to ally themselves more closely with educational administrators who were more powerful and changed the focus of psychological research from issues related to classroom teaching to those related to further increasing the power of administrators by demonstrating which programs were successful in relation to what parents and the general public wanted. In regard to broader societal needs and politics, Danziger (1990) states:

> . . . the crucial point is that the successful establishment of a new discipline is very much a *political* process in which alliances have to be formed, competitors have to be defeated, programs have to be formulated, recruits have to be won, power bases have to be captured, organizations have to be formed, and so on. These political exigencies necessarily leave their mark on the discipline itself. . . . Being obliged to operate in an external political environment, the community of knowledge producers is bound to develop an internal political environment . . . . As the community of knowledge producers grows it develops internal norms and values that reflect its external alliances. Its professional project is directed at carving out and filling a particular set of niches in the professional ecosystem of its society, and its internal norms reflect the conditions for the success of this project. These norms tend to govern both the production of knowledge and the production of the producers of knowledge through appropriate training programs. (p. 181-182)

In this quote, Danzinger is summarizing one of the major assumptions underlying this study. That is, in order to understand the professional ethos of any profession, it is necessary to understand the social, political, cultural, and historical changes that have influenced its evolution. As stated earlier, each profession is a subculture embedded in a larger societal culture. As a result, those events and changes that affect the societal culture also affect the professional culture.

Occupational Therapy. Other professions offer similar examples of the power of larger forces outside the profession in shaping the culture and professional ethos of that profession. Levine (1983), for example, describes how the field of occupational therapy emerged during the period from 1890-1920 as a result of the relationship between culture and medicine. She describes three major forces that not only influenced the initial development of occupational therapy, but continue to have an impact to this day. These include "(1) the selection of crafts as therapeutic modalities, (2) the role of women at the turn of the 20th century, and (3) the influx of Eastern European immigrants into American society" (p. 187-188). The use of crafts as a therapeutic modality occurred in response to the increasing isolation and decrease in family life that resulted from widespread industrialization in the early 20th century. Americans turned to the use of arts and crafts as a means of returning to a simpler life. At about the same time several prominent physicians began to appreciate the use of these modalities and modified their use as goal-directed occupational activities for individuals with medical and/or mental health conditions. The role of women at the turn of the century began to change as machines begin to take over some of their traditional roles such as weaving and sewing. Although they continued to hold lesser roles in society, more women began to go to college and continued to look for professions where they could use their strengths as nurturing and caring individuals. As a result, "some women entered health and social service professions. . . . They were responsible for religious, moral, and cultural values at home and now in their work" (Levine, 1983, p. 189).

Unlike the last two factors, the influx of Eastern European immigrants had a more negative impact on occupational therapy. As the number of immigrants increased, a need arose for vocational training, educational opportunities, and

health care services in their homes and communities. Occupational therapy, however, did not become involved in this movement and remained involved in medical care only in institutions such as hospitals and rehabilitation centers. As a result, the profession did not begin to grow until the late 1940s. "The slow growth rate may have been influenced by the way early practitioners handled the immigrant problems. Therapists, recruited from the middle and upper class, were reluctant to expand their services to a foreign community. The present dominance of the medical model continues as modern therapists move into the community in greater numbers" (Levine, 1983, p. 190). It is only recently that changes in health care and increases in cultural diversity have led occupational therapists, like many other allied health care professionals, into more community and home care based practice.

Teaching. In the field of education, Warren (1985) describes the emergence and development of the teaching profession in response to societal beliefs, pressures, and needs. For example, he traces the use of memorization to a time (i.e. the late 1800s) when people, including teachers, had very few books and so used memorization out of necessity. Since the teacher had the information in her head, this contributed to the routinized, teacher-directed learning that is still universal today. Teacher qualifications were usually most stringent on the moral character of the individual, with less emphasis placed on the teacher's knowledge of education. This is seen as a reflection of the times (as noted in the review of the development of occupational therapy above) when women were supposed to reflect the Victorian values of morality and purity and were viewed as nurturing and caring individuals without much need or capacity for acquiring knowledge. In addition, because the numbers of students increased rapidly during this time and most women were required to leave the profession

if they got married, the demand for teachers increased, leaving little opportunity for schools to be particular about the educational status of their employees.

These issues, as well as the low pay offered to women at the time, did little to contribute to the need for schools of education to prepare teachers. As a result of these factors, teaching was held in low esteem, leading to a further decrease in perceived need for elaborate academic preparation of teachers. It wasn't until many years later that teacher education programs at the 4 year college level emerged, and then only in response to the public outcry to improve the quality of education (Warren, 1985). As with the fields discussed in the previous paragraphs, it was the values society placed on women and the need to improve schools as seen through the eyes of the general public that ultimately shaped teacher education programs.

Nursing. As another example of a societal change affecting professional practice and education, Andrews (1992) describes the influence that increasing cultural diversity in the United States has had on the nursing profession. Like Danziger, she states "nursing does not exist in social isolation, but rather within the broader political, economic, and sociocultural milieu in which its members practice their profession" (p. 11-12). She cites statistics that predict that "by the year 2080, minorities will account for 51.1 per cent of the total population. . . . (In addition), as the 21st century approaches, there is projected to be a continuous increase in the number of immigrants and refugees in the United States" (p. 8). Unlike the immigrants of Eastern Europe that journeyed to this country in the past, these immigrants, as well as the African-American, Hispanic, and Asian minorities in the United States, are no longer looking for a "melting pot." Rather, they are looking for a place where they can live without losing their cultural and historical identities. The need for understanding these different cultural groups

is imperative in order to provide adequate health care to people from other than the white majority, and to avoid misdiagnoses and misinterpretation of actions on the part of these different groups of people. In response to these changes in American society, Andrews states that nursing curriculums and continuing education must reflect the need to deal with cultural diversity. "During the remaining decade of the 20th century, nurses should plan and implement strategies that will prepare present and future members of the profession for cultural diversity that will characterize both society and nursing" (p. 14). In other words, the professional ethos of nurses and other professionals must evolve in response to changes in society's expectations if they wish to remain a viable service provider.

Social, Cultural, and Historical Changes: Their Impact on Physical Therapy

Like the professions described above, the field of physical therapy has been shaped by a variety of social, historical, and cultural factors. One purpose of this study, therefore, is to describe the influence of these factors on the profession. The historical events, such as wars and medical epidemics (e.g., tuberculosis and polio) and their subsequent cures, have obvious direct effects on the profession as the clients of the practice and the types of problems to be treated have changed. These events can be documented fairly easily. The social and cultural factors, however, may not be quite so obvious and have not been addressed directly in the past. For example, the emergence of the civil rights movement during the 1960's had an indirect but powerful impact on the profession in many ways. As minorities began to demand equality and laws began to reflect these demands, the view of the role of women also began to change. Because physical therapy is primarily a female profession, this changing view of women as capable, independent decision makers has helped

move the profession from a technically oriented one in which orders are received from the traditionally male profession of doctors, to a more autonomous practice where students must be taught problem solving and critical decision making skills. These changes are reflected in the current educational goals and accreditation criteria of the American Physical Therapy Association, as well in physical therapy curricula across the country. Other societal changes reflected in physical therapy education include such issues as increasing cultural diversity, increased acceptance of individuals with disabilities in our society (as evidenced by special education laws and the Americans with Disabilities Act), and increased societal emphasis on accountability and liability in all professions.

The Process of Socialization

Having defined culture, it is important to define the process by which individuals are enculturated. According to Mehan, "socialization denotes the process by which culture is transmitted from one generation to the next" (Mehan, 1980, p. 134). Similarly, Merton, Reader, and Kendall (1957) define socialization as "the processes by which people selectively acquire the values and attitudes, the interests, skills, and knowledge--in short, the culture--current in the groups of which they are, or seek to become, a member. It refers to the learning of social roles" (p. 287). Professional socialization, then, is the process by which individuals, initially as students, are enculturated into professional practice by assimilating the values, attitudes, norms, beliefs, skills, and knowledge of their chosen profession in order that they may successfully assume the roles of the profession (Merton, et. al., 1957; Stroot & Williamson,1993; Sabari, 1985; Hayden, 1995; Levinson, 1977). "The student becomes the professional by learning the content, acquiring the skills, and

internalizing the values of the profession" (Hayden, 1995, p. 271).

Organizational Socialization

In order to understand professional socialization, it is first necessary to understand the process by which individuals are socialized into organizations in general. Organizational socialization, based on theories of adult socialization, is defined as "the learning on the part of the individual who is adjusting to a new or changed role within the organization" (Chao, O'Leary-Kelly, Wolf, Klein, and Gardner, 1994), with an organization being defined as "a complex social system made up of individuals, their facilities, and the products yielded. . . a small corner store qualifies as an . . . organization as does a multinational corporation, a political party or a university" (Reber, 1985, p. 501). "This learning occurs in two general content areas: learning about the necessary knowledge, skills, and abilities to successfully perform the job, and learning about the way the organization functions in terms of its culture" (Chao, 1988). Without this learning, newcomers cannot be effectively socialized into the organization. The result is "increased turnover, lower performance, dissatisfaction, negative work attitudes, and stress" (Ostroff and Kozlowski, 1992).

Although an in depth analysis of organizational socialization is beyond the scope of this study, a brief review of the major components of organizational socialization theory is included here for several reasons. First, the educational settings in which students complete their formal training are themselves organizations that will impact professional development and socialization (Becker, Geer, Hughes, and Strauss, 1961). For this reason, it is important to understand how these organizations work and what effects the organizational structure may or may not have on students. In addition, although formal

education is the major focus of this study, the end product of this phase of socialization is to prepare students to function as competent professionals within a variety of organizations (i.e. hospitals, clinics, public schools, home care agencies, etc.). An understanding of the organizations in which the students will ultimately work and the processes by which students continue to be socialized in these work environments once they complete the professional education program may shed some light on what students need to learn while still in school.

Finally, in a broad sense, a profession can be viewed as an organization. While this organizational view is perhaps best exemplified by professional associations, such as the American Physical Therapy Association, it can also be seen in the day to day activities of professionals as they interact with peers, clients, and administrators in a variety of situations. If individuals are to be successful in these professional roles, they must not only possess technical knowledge and skills, but must also know how to make the transition from the student to the professional role in order to be able to fit in with the organization's conception of competent professional (Chao, 1988). In order to facilitate this transition, it is important that educators in professional programs help students internalize the necessary values and standards of behavior to assume a professional role in a variety of organizations in order to decrease professional attrition and job turnover (Chao, 1988).

Three phases of organizational socialization. Theorists in the field of organizational socialization have described the changes that newcomers go through in order to attain successful socialization. These include anticipatory socialization, surprise and sense making. *Anticipatory socialization* "represents all the newcomer's learning experiences prior to joining a specific

organization" (Chao, 1988). For students in professional education programs this period is often equated with the formal education or training process (Brief, Van Sell, Aldag, and Melone, 1979). These students gather information about their future roles in organizations through academic course work, internships, written informational material, and interactions with professionals in volunteer or work experience. Once the students graduate from their respective programs and begin their careers, they often experience a sense of *initial surprise*, the second phase of organizational socialization, as the things they learned about and anticipated do not occur exactly as expected (Chao, 1988). As they continue to evaluate and adjust to the discrepancies between their expectations of practice and those of the "real world " (Yelon, 1996), they enter the third phase of *sense making* (Chao, 1988). Others (Brief, et. al, 1979) have referred to this third phase as one of role management. "In the final phase of socialization, role management, individuals impose their own definitions on the roles they occupy, negotiating or modifying the roles to fit both the expectations of role senders and their own preferences" (Brief, et. al., 1979, p. 161).

Learning social roles and norms. Another area of emphasis in organizational socialization has been the study of how it is that newcomers actually attain the necessary knowledge and values of the organizational structure as described above by Chao (1988). Several authors (Ostroff and Kozlowski,1992; Ostroff and Kozlowski,1993; Chao, O'Leary-Kelly, Wolf, Klein, and Gardner, 1994) discuss the importance of understanding the learning process that occurs as newcomers "learn the ropes" in order to become a successful part of the organizational culture. The success of the newcomer in an organizational setting depends on the ability to gather information about four domains within the organizational culture. These include "job-related tasks, work roles, group

processes, and organizational attributes" (Ostroff and Kozlowski, 1993, p. 171). Newcomers to an organization gather this information from a variety of individuals, including supervisors, peers, and mentors. In addition, Ostroff and Kozlowski (1992; 1993) describe other sources of information, such as organizational literature, observation of others, and experimenting with new behaviors. The choice of which of these various methods of information gathering to use depends on which domain (i.e. job-related tasks, work roles, group processes, or organizational attributes) they are trying to learn about and whether they are trying to obtain factual information or attain knowledge about their task, role, group, or the organization (Ostroff and Kozlowski, 1992; 1993). Ostroff and Kozlowski (1992) report that newcomers rely primarily on observation of others, followed by gathering information from supervisors and coworkers to acquire information and knowledge, and focus primarily on "task and role-related" aspects of the organization during the initial socialization stage. In addition, these authors report that "acquiring more information from supervisors or more task knowledge is related to positive changes in socialization" (p. 867). In a related study, Ostroff and Kozlowski (1993) examined the role of mentoring in the socialization process. They discovered that mentors provided the most valuable information about the organizational domain, producing newcomers who were more politically aware of the organization's social system, its culture, and its history. As a result, they feel, well-mentored individuals are more successful in the organization and in their careers. The authors conclude that mentors provide information not acquired through other sources (i.e., coworkers or supervisors), and therefore suggest that mentors be used to enhance assimilation of new personnel.

Scholars in the field of organizational socialization describe the importance

of early, positive experiences to enhance professional commitment and career effectiveness. "Generally, people who are well socialized in their organizational roles have greater personal incomes, are more satisfied, more involved with their careers, more adaptable, and have a better sense of their personal identity than people who are less well socialized" (Chao, et. al., 1994).

The Development of Cultures in Organizations

Since the 1980's, those interested in organizational studies have begun to look at "organizations as cultures" as a way to understand how these complex systems function in order to improve "morale, loyalty, harmony, productivity, and -- ultimately -- profitability" (Frost, Moore, Louis, Lundberg, and Martin 1991, p. 7). In spite of the proliferation of studies on organizational culture, however, there was little in the way of the development of a theoretical perspective, causing some scholars to view the concept of organizational culture as a passing fad. In response to this, Martin and Meyerson (1988, as cited in Frost, et. al., 1991) developed theoretical perspectives that would account for differences in thinking about cultures in organizations. In Reframing Organizational Culture, Frost, et. al. (1991) describe these three theoretical perspectives of culture as developed by Martin and Meyerson (1988; in Frost, et. al., 1991). The first of these, the integration perspective assumes that culture is consistent. There is a consensus about what to do and why to do it, with no ambiguity. "[T]o the extent that inconsistencies, conflict, ambiguities, or even subcultural differentiation appear . . . they are seen as evidence of the absence of . . . culture" (Frost, et. al., 1991, p. 13). In contrast, the other two perspectives allow for inconsistencies and ambiguities. The differentiation perspective allows for inconsistencies through subcultures which ". . . may co-exist in

harmony, conflict, or indifference to each other . . . subcultures are islands of clarity; ambiguity is channeled outside their boundaries" (Frost, et. al, 1991, p. 8). These subcultures may exist as equal groups or may manifest themselves in a hierarchical nature, such as that which might exist between salaried and hourly workers. In the last of these perspectives, the fragmentation perspective, ambiguity is always present. "According to this viewpoint, consensus and dissensus co-exist in a constantly fluctuating pattern influenced by changes, for example, in events, attention, salience and cognitive overload" (Frost, et. al., 1991, p. 8). Because of a lack of consensus at both the organizational and subculture level, those who believe in this perspective focus on what is unclear in organizational cultures as a result of the complexity of the system or of unclear expectations of performance.

A Multi-faceted Perspective on Professional Socialization

In thinking about the culture of the profession, the educational system, and the work settings in which students will eventually be employed as organizations that are considered important for this study, I have adopted a view of culture that combines these three perspectives.[2] I believe that there is set of core beliefs and values of a profession that is manifested in the profession's ethos. For this reason, the integration perspective is well suited for this study, particularly as it relates to the first purpose (Part 1) of the study, to describe the culture and professional ethos of physical therapy. In contrast, I also believe that there are subcultures within professions (e.g., specialty sections of national organizations) that exhibit differences and result in

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2 Frost, et. al. (1991) accept that different studies may focus on either one or several of these perspectives. "These three perspectives . . are not meant to pigeonhole individual researchers or even all the characteristics of a single piece of work" (p. 9).

inconsistencies and ambiguities within the profession. To the extent that issues are related to the core beliefs and values of the profession, these subcultures exist in harmony. To the extent that issues are not related to the core beliefs, however, there may be disagreement or indifference among these subcultures. Of the three perspectives, the fragmentation perspective is, I feel, least related to defining the professional ethos and culture of physical therapy since it allows for very little cultural clarity. I do think, however, that the emphasis on dissensus and complexity of viewpoints of those who are part of the culture is very important to consider when one is attempting to understand a professional culture and its ethos. By keeping this perspective in mind, I think I have been able to better understand the professional culture and its ethos since I looked not only for similarities, but also for differences as a means of explaining the evolution of the culture and the professional socialization of students. These differences may, in fact, be the impetus for changes in the professional ethos over time and for the problems that students face as they move from the academic to the professional world.

One example of a current controversy within the field of physical therapy that is reflective of the fragmentation perspective is the recent increase in the use of physical therapist assistants in a variety of settings compared to their use in the past. When there was an extreme shortage of physical therapists, the urgent need for qualified personnel led to the creation of the physical therapist assistant. In light of the pressure to lower costs in health care today there is an increasing shift in work load in many settings from physical therapists to physical therapist assistants. Many physical therapists are alarmed about job security due to the use of physical therapist assistants and the increasing number of educational programs for both physical therapists and physical

therapist assistants. Contrary to yesterday's pressing need for more and more physical therapists, a recent study (American Physical Therapy Association, 1997c) described the need for physical therapists as shrinking. One offshoot of this situation is that there is beginning to be job competition between physical therapists and paraprofessionals, physical therapist assistants, who filled an important need in the past. In addition, the House of Delegates of the APTA recently passed a resolution to restructure the organization into two factions -- the American College of Physical Therapists and the National Assembly of Physical Therapist Assistants. Although proponents of the resolution feel it will give a greater voice to physical therapist assistants within the Association, there are those who disagree and feel that the measure will decrease the power of assistants, destroy the unity of the Association, and fragment the profession. The combination of factors that has shifted the roles and responsibilities of physical therapists and physical therapist assistants within the Association and the clinical setting continues to create controversy and ambiguity within the field as these two factions struggle to define their function within the profession. The result has been an increasing disparity in opinions regarding which road the profession should take to best serve both its members and its clients. As these disparities disappear and some consensus is reached regarding the relationship between the physical therapist and the physical therapist assistant, I feel the profession will have evolved to a new level, one that is not necessarily better or worse, but simply different.

In addition to being important for understanding the values and evolution of a professional culture, the dissensus and complexity reflected in the fragmentation perspective is also important in that it parallels that of the postmodern perspective of Gergen (1991) discussed earlier. That is, the

emergence of a multiplicity of view points and diversity due to the increasing pace of change in today's world has lead to ambiguities within professional cultures and society at large that need to be addressed in professional education. Because the world is no longer one in which there are black and white solutions to problems and because students and clients come from increasingly diverse backgrounds, there is a need to focus more intensely and explicitly on both the existence of diversity and methods for dealing with it in a professional world.

Influences on the Process of Professional Socialization

The process of professional socialization is a complex one that requires the internalization of a multitude of influences on the developing professional. These influences can come from personal sources such as family, school, and religious affiliations, as well as from professional and societal sources such as the work setting, professional organizations, cultural beliefs and values, economic and political climates, and legislation that affects the profession and society. Each of these influences is not enough in and of itself to determine how successful one will be in being socialized into the profession. Rather it is the integration of these multiple influences that shapes the developing professional. The reader should keep in mind, therefore, that while each influence is described in the following section as a separate entity for purposes of description, it is the integration of all these influences that ultimately determines the success or failure of the process of professional socialization.

Professional socialization through community interaction. The fields of education and educational psychology have begun to look at the development and socialization of teachers in this regard. Goodman (1987), for example, stresses the active role of beginning teachers in the socialization process.

Others (Ambrose, 1993; Bruner, 1987; Gee, 1990, Polkinghorne, 1988; and Steinem, 1992) describe the importance of interaction within a community through narrative discourse and personal storytelling, the recognition of ever changing selves that evolve as a result of this discourse, and the impact of these different discourses on our many selves. The use of the words "community" and "discourse" require definition in order to understand the role of the active participant in the construction of a profession. First, the word community must be thought of in a broader context than merely a group of people living together. Schwab (1976) defines a community as a "state or condition of person, of internalized propensities, of tendencies to feel and act in certain ways with other people" (p. 11). The sharing of values, goals, and ideas are the essential ingredients that create a community. Harris (1995) describes a community as follows:

> A group can become a community, then, if there is a degree of intimacy and perceived connection with the members that is manifested through certain rituals, events, and interactions, that take place over a period of time. In this way, even strangers who initially may appear to have little in common with one another can become a "community," if they are able to come together -- either in face-to-face interaction or over time and distance . . . Communities do not spontaneously appear but are rather "constructed" and maintained by a mutual sense of connection and care among members. (p. 9)

In comparing this definition of community to the definition of culture, it appears that it is through the community that the professional culture evolves and is passed on to new members. That is, one comes to know about the culture of the profession by interacting with others through communities of practice.

Shared meanings in communities: discourse versus Discourse. The second word needing clarification, discourse, is defined by James Gee (1990) as both a language interaction (discourse) and as a "way of being" within the context of a community (Discourse). In regard to the second definition Gee (1990) states:

> Each Discourse is tied to a particular social identity within a particular social group and to certain social settings and institutions. Each is a form of life, a way of being in the world, a way of being a "person like us," in terms of action, interaction, values, school, local drinking group, church, nation, ethnic group, sewing circle, business, job site, profession, gender, club, peer group, gang, and so on through a very long list. (p. 175)

Discourse within the field of physical therapy can be viewed as occurring in two communities. First, professional organizations serve as one major community of discourse for practitioners. Scholars share their knowledge through presentations at conferences and publications in professional journals, political action committees are formed, continuing education sessions are held, items of interest regarding related fields are shared through magazines and newsletters, and social gatherings are planned in conjunction with professional meetings. For physical therapists, the American Physical Therapy Association (APTA) is the primary professional organization. In addition to offering a means of discourse for practitioners, this organization also provides the major community, or Discourse, for physical therapists. As discussed earlier, a community involves shared meaning, values, and ideas. An expression of these shared meanings, values, and ideas can be found in the Code of Ethics and Standards of Practice of professional organizations, as well as in the more subtle forms such as how one dresses and acts when representing the profession. In this way, a professional organization serves as a starting point for entrance into the Discourse of the profession.

The second means of community discourse can be found in the everyday lives of those who practice in the field. In many ways, this community is more important than that of the professional organization, for while a professional association offers a common forum for the sharing of ideas and beliefs, it is within the day-to-day working life of a professional that the realization of these ideas and beliefs is played out. Without practice, one could easily espouse the values of the common organization without ever being put to the test. For physical therapy, a very "hands on" and people-oriented profession, the interaction between the therapist and the client is one of the major ways in which we exemplify professional ethics and high standards of care that are part of the discourse of our practice. Within this same setting, therapists also interact with other health care professionals, staff, and the general public. As with the client, behaviors that reflect the identity of the profession are played out in these interactions as a community is created.

The role of society and prior experience on professional socialization. A number of socializing agents other than formal education have been identified in the literature (Bradby, 1980; Eli, 1984; Rezler, 1974; Sabari, 1985). Students in professional programs are not socialized in isolation within the educational setting. Rather, they interact reciprocally with a host of others outside of and prior to their educational experience (Kondo, 1990; Myers, 1982; Sabari, 1985). The type of family upbringing, the individual's religious beliefs, and the influence of peers are examples of personal history that students bring with them to the educational setting. Similarly, while enrolled in professional programs students interact with others in home, work, and recreational settings. The experiences of students in these settings and those with whom they interact continue to influence the student's response to efforts by educators to socialize

students into the profession. In addition to these more personal influences, individuals are embedded within a societal culture that also influences their thoughts, feelings, and actions as they enculturated into their chosen profession.

Several authors (Abbott, 1988; Heck, 1995; Sabari, 1985; Stroot and Williamson, 1983) discuss the issue of prior experiences and societal influences on professional socialization. Abbott (1988), in a discussion of the role of values and moral development in the professional socialization of social workers, talks about the influence of societal values on personal values and the subsequent influence of both of these constructs on professional values. Professions exist within a larger cultural context and cannot be arbitrarily separated from it. Rather, the values and standards of the culture as a whole must be considered in any conception of professional socialization. The role of personal values in the process of professional socialization not only is important in helping social work students to develop a sense of professional identity while in school, but also serves as a form of self-selection as individuals whose values most match the profession's will choose to enter that profession.

Professional socialization as an active and reciprocal process. The idea of self selection into a profession is an example of how professional socialization is both an active and reciprocal process. Students come into educational programs with certain values and expectations that educators hope to alter, but educators cannot dramatically change the basic norms, values, and beliefs that students bring with them (Bradby, 1980; Eli, 1984; Rezler, 1974). Students are not empty vessels into which faculty pour their own set of beliefs. In addition, students are not only affected by what happens to them during their professional education, they also affect those around them and, in at least some

sense, determine the extent to which they will allow themselves to be socialized into the profession. Because of this several authors (Bradby, 1980; Eli, 1984; Rezler, 1974) take the idea of the importance of a match between personal and professional values further by suggesting that professional education programs establish selection criteria that identify individuals who possess the qualities, traits, and beliefs that the profession desires.

In the field of physical education, Stroot and Williamson (1993) describe the various pre-admission factors that affect professional socialization of these students. These factors include self selection due to early socialization experiences in sport, early observation of coaches and physical education teachers, and low GPA requirements for admission. In addition, although these authors acknowledge the contribution of researchers in professional socialization of physical educators, they recommend that future efforts be expanded beyond the current focus on individuals and small groups. "Influences of politics and socio-cultural factors require that we view socialization from macro-perspectives as well as a micro-perspective. It becomes imperative that we examine and understand values and perspectives upheld within the society, in the context of study and work, and by researchers and participants" (Stroot and Williamson, 1993, p. 343).

Levinson (1967) emphasizes the important role of "both the external, socio-cultural aspects and the internal, personalogical aspects. Both are crucial in the analysis of socialization. . . . The student is not only acted upon by the environment, he is also an active agent who plays a vital part in his own learning and development. The kind of person he is at the start has an influence upon, and is influenced by, the course of his school experience" (pp. 261-262). Furthermore, Levinson (1977) describes the importance of

considering the impact of other organizations with which professionals (in this case, physicians) will come into contact, with the different roles they will play in various settings, and with different encounters they will have throughout their professional lives.

Power relationships. Societal and contextual influence in the form of power in professional settings has also been examined. In Crafting Selves, Dorrine Kondo (1990) discusses the importance of power relationships in the construction of personal and professional identity. She states that it is important "to make issues of power central to our discussions of self (because we) . . . are shaped by relations of power" (p. 9). Power relationships, both those that are present in our immediate surroundings, as well as socio-cultural and historical influences that are more indirect are an important consideration in professional socialization.

In a study of nurses in a hospital setting, for example, Myers (1982) describes the process by which "neophyte nurses learn to behave like old timer nurses" (p. 11). Myers stresses the importance of considering socialization as a "reciprocal process by which neophyte nurses learn what others will demand of them in a specific role and in turn, learn how to exert control over their environment" (p. 1). She discusses the importance of the power structure for socialization. "Registered nurses or medical doctors exerted social control over neophyte nurses through the temporal, spatial, social, and medical organization of activities" (p. 113). When assisting doctors, however, all nurses subordinated their positions of power. "During verbal interactions, doctors talked; nurses listened. Doctors led in pacing and timing; nurses following. Doctors initiated interactions to parents; nurses listened" (p 115). This hierarchical structure helped shaped the socialization process of neophyte

nurses. In addition, prior training and other life experiences also influenced both the rate and degree to which these participants were able to take on a more professional role in the work setting. Overall, the degree to which neophyte nurses were able to find a fit between idealistic and real world views of nursing and to adapt to inconsistencies between these two views ultimately shaped their professional socialization.

The influence of training versus work settings on professional socialization. Lurie (1981) studied the socialization process of nurse practitioners[3] to try to determine if the professional socialization that occurs during training or the expectations and constraints of the work setting are more powerful in determining professional behaviors in this group. Self-report, observations, and interviews were used in a longitudinal study that examined professional socialization in five cohorts of nurses who graduated from the Allied Health Nurse Practitioner Training Program at the University of California. In addition, nurse practitioners were compared with non-practitioners through self report and observations, and the views of physicians and nursing supervisors toward nurse practitioners were compared through interviews. Results of this study indicate that while the educational setting is the initial, primary determinant of professional socialization since "without this initial socialization, there would be no professional at all" (p. 46), it is the work setting that is the more powerful socializing force because it is within the work setting that professionals ultimately must live. If professionals are to maintain employment, they must work within the constraints of the organizational setting where they are employed. These constraints include not only the rules or standards of

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3 Nurse practitioners are nurses with advanced training in clinical assessment, management of illness, patient education, and counseling who assist physicians in the routine care of patients.

behavior of the organization itself, but also the roles different members of the organization play in terms of power. In Lurie's study, for example, only those work roles prescribed by the training program that were consistent with the views of physicians (i.e. clinical assessment and management activities), the ultimate power authority in health care settings, were supported and practiced regularly, while those that were inconsistent with physicians' views were not (i.e. patient education and counseling). Lurie speaks to the power of the setting and the individuals in the setting in determining the success of carryover between formal education and work settings. The extent to which there is consistency in the goals of each and the degree to which individuals, as employees, are willing to challenge the power structure of their employment setting will determine the ultimate success of the professional socialization experience.

Multiple socializing influences: Implications for educators. Based on these studies, there are number of issues related to professional socialization that need to be considered by educators as they attempt to help students internalize a professional ethos. First, educators are not the only people who influence students. Prior experience and significant others, such as family members and friends, have at least the same amount if not more influence on the developing professional. By recognizing and acknowledging the role of influences outside the academic setting educators may be able to help students deal with inconsistencies between the values, norms, and beliefs of the profession and those outside the field. This issue also has implications for program selection by students and program admissions. As discussed by several authors (Sabari, 1985; Abbott, 1988; Stroot and Williamson, 1983; and Heck, 1995), students most often select those professions whose values and beliefs are consistent

with their personal beliefs and values. When this is not the case, and the student's values and beliefs are so inconsistent with the profession that the possibility of reconciling the differences seems remote, educators may be wiser to advise the student to find a career whose ethos more closely matches the personal ethos of the student rather than trying to change the beliefs and values of the student.

Based on the descriptions of power and the nursing studies cited in this section, it also seems that the ability to deal with issues of power is an important skill to teach. One of the responsibilities of faculty in the socialization process, then, may be to help students recognize and deal with those in positions of power so that they can be successful in their careers. The ultimate ability to carry out this skill, however, would seem to go beyond the mere logistical processes of doing so, and would instead rely on the belief that what one does is important to the client (whether that client is a patient, a student, or a customer). Recognition of one's worth within the organizational setting as part of the professional ethos is one way to help empower students and novice professionals.

Socialization in Health Care and Other Professions

For students in health care, as well as in other professional programs, the socialization process can be seen as occurring in three separate stages: formal education within the academic setting, practical experiences within a clinical or apprenticeship setting, and work related experiences following graduation (Sabari, 1985; Myers, 1982). The questions posed in this study address the socialization process that occurs primarily during preparatory education within an academic setting. Specific practical experiences within the apprenticeship setting and work related experiences are beyond the scope of this study and

are addressed only to the extent that they are related to and influenced by the socialization that occurs in the students' initial training in schools.

Most studies of professional socialization in health care fields have been conducted with medical and nursing students. Other fields reviewed here include dentistry, occupational therapy, public health education, and educational administration. At this time, no research could be found that specifically addresses the process by which students are socialized into the profession of physical therapy. The findings and conclusions of those in other professions, therefore, are used as the starting point for the description of professional socialization applied to physical therapy. Table 2 summarizes these studies as they are related to the idea that professional socialization is a complex process and as recommendations or implications for educators in professional programs.

Professional Socialization During Formal Education

In Boys in White (Becker, et al., 1961), the classic study of medical students, the authors describe the process by which medical students move through the medical education system. According to these authors, the medical student is never a "young doctor." On the contrary, medical students are simply "students (who) occupy a defined position in the medical school and interact in ways that are specified by institutional roles with people occupying other socially defined positions" (p.34). They participate, not as members of a professional culture, but as members of a "student culture." When viewed from this perspective, the authors contend, students are fulfilling their role in the organization of medical school. As a result, these future doctors display behaviors that are reflective of their efforts to deal with problems that they face as students, such as passing exams and pleasing faculty. It is only as students near the completion of

Table 2. Review of Findings of Studies of Professional Socialization

AUTHORS	PROFESSION	MAJOR FINDINGS	
		Professional Socialization as a Complex Process	Recommendations and Implications for Professional Socialization
Becker, Geer, Hughes, & Strauss (1961)	Medicine	1. Medical students function in a student culture, not a professional one, and therefore, behave like and are influenced more by other students while they are in medical school. These behaviors become more professional once students graduate.	1. Professional socialization is a developmental process that takes time.
Levinson (1977)	Medicine	1. Medical school is an important first step in professional socialization. 2. Students are influences by a variety of sources, including peers, other professionals and sources outside the educational setting	1. Professional socialization is a developmental process that takes time. 2. Faculty should make attempts to admit students who are active, reflective, and responsible learners and whose values and beliefs are consistent with the profession.
Merton, Reader, & Kendall (1957)	Medicine	1. Medical school is an important first step in professional socialization.	1. Professional socialization is a developmental process that takes time. 2. Educators should make attempts to build on students' values and beliefs that are consistent with the profession.
Baszanger (1985)	Medicine General Practice	1. Medical school is an important first step in professional socialization.	
Cohen & Jordet (1979)	Nursing	1. Professional education is the basis upon which the professional ethos is built.	

Table 2. (cont'd).

AUTHORS	PROFESSION	MAJOR FINDINGS	
		Professional Socialization as a Complex Process	Recommendations and Implications for Professional Socialization
Brief, Van Sell, Aldag, & Melone (1979)	Nursing	1. Professional education is the basis upon which the professional ethos is built. 2. Discrepancies between anticipated and real world expectations results in role stress and decreased ability to modify role expectations.	1. Professional education programs should provide a realistic view of the profession and organizational demands to decrease role stress and success in the profession.
Lurie (1981)	Nursing	1. Professional education is the basis upon which the professional ethos is built, but organizational socialization during employment following graduation has a more profound effect on job success than professional socialization.	1. Educators should establish clear goals that reflect the real world to allow students to be successful in the work place. 2. Professional socialization must be extremely successful to enable students to deal with obstacles and alternative views in the work place. 3. Students should be trained to deal with power and politics in the work place.
Rezler (1974)	Medicine	1. Professional socialization can only occur if consistently supported by the total environment (e.g., positive faculty role models; systematic, consistent rewards for desired behavior; consistent expectations in courses and clinics; and consistency in attitudes of peers, faculty and others. 2. It is difficult to change students' attitudes. 3. Students' values and attitudes can be altered, but cannot be significantly changed.	1. Faculty should select students for admission who already possess attitudes and values that are similar to the those of the profession.

Table 2. (cont'd).

AUTHORS	PROFESSION	MAJOR FINDINGS	
		Professional Socialization as a Complex Process	Recommendations and Implications for Professional Socialization
Eli (1984)	Dentistry	1. There is no significant change in students' basic values and norms during formal training. 2. Dental students function and have values reflective of a student culture during formal training, but revert to a more idealistic outlook and an increased value on intrinsic rewards once students are out in the work force.	1. Student attitudes can be altered, but not significantly changed.
Sabari (1985)	Occupational Therapy	1. Peers are a more powerful influence on professional socialization during times when students are educated as a group. 2. As students begin their clinical work on an individual basis, they begin to identify more with clinical supervisors than with faculty or peers. 3. Selective admission and certification increases motivation and commitment to the program. 4. The student's image of self as a professional is influenced by interactions with clients, peers, and outside sources. 5. Students select professions whose values and beliefs are consistent with their own.	1. Active and responsible learning and consistent role models are important for successful professional socialization. 2. Educators should have clear goals that are consistently reinforced in both the academic and clinical settings. 3. Faculty should admit students whose values and beliefs are consistent with the profession.
Hayden (1995)	Public Health Education	1. Student intent to take a certification exam resulted in increased professionalism. 2.. Socialization occurs early in the process of education in professional programs.	

Table 2. (cont'd).

AUTHORS	PROFESSION	MAJOR FINDINGS	
		Professional Socialization as a Complex Process	Recommendations and Implications for Professional Socialization
Bradby (1990)	Nursing	1. Students' values and attitudes can be altered, but cannot be significantly changed. 2. Some "reality shock" normally occurs when students enter the work force. 3. It is not possible for educators to prepare students completely for the work world. Some aspects need to be experienced. 4. The use of mentors in the work place helps decrease stress for new graduates.	1. Educators should inform students that some amount of "reality shock" is normal upon entering the work force. 2. Educators should prepare students to function as active, reflective and responsible learners. 3. Faculty should admit students whose values and beliefs are consistent with the profession. 4. Consistent role models are important for successful professional socialization.
Heck (1995)	School Administrator	1. Administrators who has more real world experiences by completing an internship as part of their formal training exhibited greater job success than those who had not internship. 2. Organizational socialization has a greater effect on job success than professional socialization in educational programs. 3. Personal attributes, particularly gender, has affect job performance. 4. Students select professions whose values and beliefs are consistent with their own.	

Table 2. (cont'd).

AUTHORS	PROFESSION	MAJOR FINDINGS	
		Professional Socialization as a Complex Process	Recommendations and Implications for Professional Socialization
Myers (1982)	Nursing	1. Observations of power relationships during their first job experience helped shaped neophyte nurses perceptions of their professional role. 2. Prior training and life experience influence nurses' success in assuming professional roles, but organizational socialization in the first job is a more powerful influence.	

medical school that they begin to imagine the roles they will play in new organizations when they begin the practice of medicine. While life as medical students may offer a glimpse of the culture of real doctors, as students they can only identify with the culture of medical students. In fact, the only change that Becker, et al. (1961) report is that students move from a feeling of idealism regarding the medical profession to cynicism throughout school to a final feeling of pragmatic idealism at the end of medical school. This temporary cynicism is thought to be the result of the tremendous demands of medical school. As such, they represent the students' feelings toward medical school, as a temporary response to their educational situation, rather than their feelings toward medicine as a career.

Levinson (1977) offers a different perspective and a critique of Boys in White. He feels that Becker and his colleagues do an injustice to the importance of medical education and theories of adult socialization by not giving more credit to medical school as the first step in socializing students into the professional culture of medicine. In contrast to Becker, et. al. (1961), Levinson (1977) states:

> One need not assume that the characteristics of the graduating students are fixed and immutable, and that they prefigure his entire medical career. However, socialization theory does involve the premise that the most significant changes wrought in the student are the relatively enduring ones, and that they will exert an appreciable influence on his further professional development even though they may also be modified in the process. (p. 258)

This view is also supported by Merton, Reader, and Kendall (1957) in one of the earliest studies on professional socialization in medicine and by Baszanger (1985) in her study of the professional specialty of general practice. Similarly, professional socialization literature in nursing supports the idea that formal professional education is the basis on which the professional ethos is built

(Cohen and Jordet, 1979; Brief, Van Sell, Aldag, and Mellone, 1979; Lurie, 1981). Lurie (1981) states, "In professional socialization, training or education may be seen as the fundamental building block of all further socialization. It conveys the basic knowledge, skills, and 'theory', the world view and attitudes, that are the essence of each profession" (p 45).

Similar to Levinson, Rezler (1974), in a review of the literature on attitude changes in medical school, reports that medical students do experience attitude changes to some extent during medical school. Rezler's (1974) review supports the change from cynicism to realistic idealism reported in Boys in White (Becker, et. al., 1961). In a further analysis of the literature on comprehensive care programs[4] and high interaction specialties such as family practice, Rezler (1974) reports that cynicism could be decreased and a more humanistic attitude toward patients could be fostered, but many of the changes reported in the studies she reviewed were weak and/or temporary due to a number of other factors. The factors that positively influenced the degree to which attitude changes could be fostered include positive faculty role models; systematic and consistent rewards for desired behaviors; consistency in expectations throughout courses and clinical work; and consistency in attitudes of those groups with whom the students come into contact (i.e. peers, interns, faculty). In spite of some changes in attitudes, Rezler concludes that, based on the studies she reviewed, "attitudes are highly resistant to change, unless supported and reinforced by the total environment" (p. 1029). In addition, she suggests that promoting consistency in training is not enough. As described earlier, she feels that educators also need to place a greater emphasis on

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4 A comprehensive care program is defined by Rezler as "an approach that is not confined to organic pathology but encompasses the patient's emotional and family problems" (p. 1025).

"selecting students who possess certain attitudes prior to entrance, attitudes that the medical profession considers important, instead of trying to develop such attitudes in students after they enter medical school" (p. 1029), rather than selecting students primarily on the basis of their intellectual qualifications. Further, she suggests that this type of attitude assessment be used to select faculty if medical schools are to provide students with appropriate and consistent role models for quality and humanistic care.

Like medical students, dental students display increased cynicism and decreased humanitarianism throughout their formal education (Sherlock and Morris, 1972; Morris and Sherlock, 1971, cited in Eli, 1984). In order to determine whether these attitudes were permanent, or were merely a result of being in a "student culture" as described by Becker, et al. (1961), Eli (1984) conducted a longitudinal study of expected professional rewards in dentistry. Individuals from an educational system in which dental and medical students complete identical course work during the first three years of professional school and complete clinical work in their respective professions in the last two years participated in the study. All students completed questionnaires about their expectations for professional rewards prior to admission, and at the end of their fourth, fifth, and sixth years of study. In addition, the questionnaire was completed by the dentists eight years post graduation. Two findings Eli's study are particularly applicable to my research with physical therapists. First, Eli notes that there was no change in the relative ranking of expected rewards in either group during their period of formal training, indicating that there was no significant change in the students' basic norms and values. Secondly, a comparison of responses between medical and dental students revealed that dental students displayed more cynicism and materialism than medical

students and placed increased emphasis on extrinsic rewards (i.e., high income, job status, high social status). In spite of the fact that these students displayed even more cynicism than medical students, after eight years of practice, these same individuals returned to a more idealistic outlook on their profession and placed a higher value on intrinsic (e.g., opportunity to help others, intellectual challenge) rather than extrinsic rewards. On the surface, these findings support the conclusions of Becker, et. al. in stating that the increased cynicism in medical students is a situational response to medical school that is replaced by a pragmatic realism at the time of graduation. However, because a significant amount of time (i.e., eight years) had elapsed between the time of graduation and completion of the final questionnaire, it is also feasible that many other factors affected the respondents' answers. For example, because these dentists were well established in their practices after eight years, the material rewards they were receiving may have been taken for granted allowing a shift in their thinking to the idealism of their early school years and an emphasis on more intrinsic rewards. In addition, the process of professional socialization throughout the time from graduation may also have helped them to learn to respond to the questions in a more socially desirable manner.

Sabari (1985) describes the process of socialization of occupational therapy students, a group that is most likely to resemble physical therapy students. Two types of socialization patterns are present in occupational therapy education. First, in the initial academic component of the program students are socialized in a collective (i.e., group) and serial pattern, in which they have opportunities to interact with "previous members who have experienced the same process and who can teach them about the setting . . . This structural factor has implications

for the role of the peer group in the professional socialization process. The students are in contact with other members of the collective group. In addition, students in advanced classes are available to share their experiences and teach entrants about the setting" (p. 97). In contrast, as students begin their clinical training, they usually interact individually and in a disjunctive pattern, where neither a peer group or members of a previous cohort are available. At this point in the socialization process, Sabari feels that individual interaction and the absence of other students ultimately leads to the students having a stronger identification with their clinical supervisors than with the faculty. Other aspects of professional socialization in occupational therapy include selective admission, which Sabari feels increases motivation and commitment to the program; separation from other socializing influences as a result of a unique program; the large amount of work required to successfully complete the program; and certification of graduates upon completion of their education. She stresses the importance of active and responsible learning, having appropriate role models in the form of faculty and clinical instructors, the availability of clear and consistent goals that are articulated and reinforced in both the academic and clinical settings, the influence of clients' expectations on professional self image, and realistic expectations for practice in the real world.

Hayden (1995) examined the extent to which public health education majors are professionalized during formal education training. She surveyed 179 students from 30 programs in health education. Subjects completed the Occupation Inventory (OI), "an instrument used to measure the extent to which students are professionalized" (p. 272), and gathered information about student involvement in various professional activities (e.g.., taking the certification exam in health education, membership and participation in professional

organizations). High OI scores indicated a moderately high degree of professionalism with only the intent to take the certification exam having any significant impact on the degree of professional socialization (other factors included class status, age, race, sex, program, and membership in professional organization). In regard to the positive relationship between plans to take the certification exam and increased professionalism, Hayden states, "this supports the assertion that credentialing and professionalism can and should co-exist" (p. 273). The author also states that the fact that there were no differences between junior and senior students in the program supports the idea that socialization in these students occurred early in the program. Another possibility, not considered by Hayden but evident in other studies cited earlier, is that students possessed certain professional traits of health educators prior to entrance and so self-selected into the profession.

Anticipatory Versus Real World Expectations

Anticipatory socialization is often viewed as the first phase of training or professional socialization, which occurs before and during formal educational training as students complete courses and come into contact with other individuals who are knowledgeable about their chosen career (Chao, 1988). The importance of anticipatory socialization is described by Chao, who states that "the degree to which the anticipatory socialization experiences of newcomers match the organizational reality of a prospective employer can be a key determinant of an individual's ability to quickly and successfully adjust to the new environment and demands" (p. 34). Presenting a realistic view of the professional world through the anticipatory socialization that occurs as a result of formal education in professional programs is an important precursor for predicting success in one's chosen profession.

Brief, Van Sell, Aldag, and Melone (1979) examined the discrepancy between anticipatory socialization and real world expectations that resulted in role stress for new nurses. They found that the degree of incongruence between role definitions acquired during formal education (i.e. anticipatory socialization) and those of employing organizations is related to the amount of role stress experienced by nurses. Further, these authors report that role management, defined as the ability to modify role expectations based on both personal and organizational ideals, does not occur over time when there are significant discrepancies between these two models of role expectations. The authors conclude that formal educational programs must present a realistic view of career and organizational demands if the profession of nursing wishes to decrease role stress and professional attrition in their graduates.

Bradby (1990) examined the role of status passage from student to nurse. Status passage is described as "a life transition from one social status to another . . . (including) the anticipations and anxieties experienced prior to the event. This may be accompanied by some preparations such as asking about the rights and obligations associated with this new position, actually making an attempt to experience it to some extent, or gaining work experience in a similar work setting" (Bradby, 1990, p. 1220). Bradby concludes that although anticipatory socialization during professional training is an important component of successful status passage from nurse to student, there are some aspects of the professional role that "can never be completely revealed and assimilated while the person is not part of the organization" (p. 1224). Although Bradby acknowledges that individuals will always experience some of the problems associated with status passage, she suggests that students will anticipate less stress and feel more in control of their passage from one social

status to another if, as students, they are both nurtured and made to take responsibility for their own actions and learning; if there is someone in the work organization who can serve as a mentor to help the newcomer "learn the ropes"; if individuals are emotionally and psychologically prepared for the changes and feelings that they will experience as they move from student to nurse; and if the individual has high self esteem and low anxiety. In regard to the last finding of high self esteem and low anxiety, Bradby suggests that educators examine their selection process to allow for a preference for students who display those characteristics prior to entering the formal training program. In addition, she urges educators to consider the impact of previous life experiences and the role of interacting with patients and others outside of the formal training session when evaluating the effectiveness of the educational institution in helping students cope with the change in roles from student to professional.

Heck (1995) studied the effect of organizational and professional socialization on new school administrators. He cites the importance of success in both professional (i.e., formal training, including internships) and organizational socialization on a new assistant principal's job performance. One hundred and fifty beginning administrators and their immediate supervisors completed a questionnaire evaluating the assistant principal's school year performance. Results revealed that organizational socialization had the most powerful effect on job performance, with professional socialization exerting an indirect effect via its effect on organizational socialization (e.g., administrators who had completed an internship during their formal training had more real world experience, and, therefore, functioned at a higher level than those who had not completed this type of training). Personal attributes,

especially gender (e.g., women had higher job performance ratings), also affected job performance rating. This study supports the findings of Lurie (1981), discussed earlier, who also found professional socialization to be a necessary but less powerful influence than organizational socialization on measures of professional success in nursing. Similarly, Myers (1981), discussed earlier, described how neophyte nurses' observations of power relationships in the work setting ultimately shape their perceptions of professional roles more than prior training or life experiences.

Summary of Literature Review

There are a number of issues related to these studies that can shed some light on the questions posed in this study. First, educators should keep in mind that there are several socialization processes occurring while students are enrolled in formal training. While the faculty are working hard to help students attain a professional ethos, the students are also attaining a "student ethos" as they become part of the student culture (Becker, et al., 1961). Although the professional socialization process that occurs while students are in school is a powerful influence (Baszanger, 1985; Levinson, 1977; Merton, et al., 1957), students also need to deal with "getting through the program" before they can ever hope to apply what they have learned outside the academic setting. This finding may have more implications for faculty than for students. In particular, being aware of this phenomenon may keep faculty from becoming frustrated as they expect students to assume professional roles while they are still students. In addition, knowing that the values and beliefs of students do come closer to those of the professional ethos when students graduate and begin practice may also help faculty gain a more realistic outlook on the process of professional socialization. Time becomes an important element when professional

socialization is viewed from this lens. Faculty cannot expect students to internalize the professional ethos entirely during the short time they are in the professional preparation program.

Next, the process by which students internalize the professional ethos of a culture and subsequently display behaviors that reflect that ethos is a complex one with multiple interactions occurring among students, society, and the professional culture (Abbott, 1988; Bradby, 1990; Levinson, 1977; Stroot and Williamson, 1993). The student does not appear one day as a blank slate ready to be inscribed with the professional ethos of choice. They bring with them a multitude of life experiences both related and unrelated to the profession that influence their professional values, norms, beliefs, and behaviors (Myers, 1982). In fact, the idea that students self-select into careers because of a match between their own personal beliefs and those espoused by a profession has been postulated by several of the authors included in this review (Abbott, 1988; Stroot and Williamson, 1993). Moreover, they are influenced not only by faculty, but also by peers (Becker, et al., 1961; Sabari, 1985; Stroot and Williamson, 1993), other professionals (Levinson, 1977; Lurie, 1981), clients (Sabari, 1985; Stroot and Williamson, 1993), and other outside forces (Levinson, 1977; Sabari, 1985). Some of the students' attitudes can be altered, but it appears that none can be substantially changed (Bradby, 1990; Eli, 1984; Rezler, 1974). Instead, educators can hope to capitalize on those values and beliefs that students already possess and that are consistent with those of the profession (Baszanger, 1985; Levinson, 1977; Merton, et al., 1957), helping them to apply personal values and beliefs in professional situations. The firm establishment of a professional ethos during formal training is important. Formal training not only provides the base of socialization (Brief, et.

al, 1979; Cohen and Jordet, 1979; Hayden, 1995; Levinson, 1977; Lurie, 1981; Merton, et. al, 1957), but also must be extremely successful in this endeavor if educators wish students to be able to overcome any alternative or questionable views once they begin the organizational socialization that occurs in the work force, a more powerful influence than that of formal training (Heck, 1995; Lurie, 1982).

This review of the literature offers several recommendations for socialization of students in professional programs. The most often cited of these is the existence of clear and realistic goals that are explicitly presented to students and are applied consistently across the situations and people with whom students come into contact, and that represent the real world (Fox, 1957; Lurie, 1981; Myers, 1982; Sabari, 1985). These goals would not include descriptions of exactly how to act in all situations, but might include such things as the fact that faculty do expect students to behave in the best interest of their clients to the best of their ability, and that they expect students to be problem solvers and lifelong learners.

As discussed by Bradby (1990) some sense of surprise ("reality shock") and eventual sense making is a normal part of the developmental process in organizational socialization. It appears, however, that educators can minimize the trauma of this transition and the role stress that accompanies it by providing students with a real world view of professional life. This includes things like letting students know that they may experience these feelings and that they are a normal part of the developmental process (Bradby, 1990) and training them for uncertainty as proposed by Fox (1957) and Floden and Clark (1988). The second most often cited way in which educators can hope to successfully prepare students to function as effective and ethical practitioners is to be sure

that the student is an active, reflective, and responsible learner (Bradby, 1990; Fox, 1957; Levinson, 1977; Sabari, 1985). Students who actively take responsibility for their education appear to develop more problem solving and information seeking strategies, are more adaptable, and experience less role stress than their peers.

Other methods, while not as common as those described above, also deserve consideration as possible ways to facilitate the internalization of a professional ethos in students. These include clear admissions criteria that allow selection of students who already demonstrate behaviors indicative of the values and beliefs of the profession (Bradby, 1990; Sabari, 1985), positive and consistent role models (Bradby, 1990; Sabari, 1985), and the use of appropriate mentors to help students through the period of organizational socialization that occurs as new graduates enter the job market (Bradby, 1990; Ostroff and Kozlowski, 1993; Stroot and Williamson, 1993).

In addition to these various methods, the authors cited in this review also offer several words of advice for educators in professional programs. First, based on the work of Becker, et al. (1961) and Eli (1984) there is some evidence to suggest that some of the behaviors and attitudes exhibited by students during enrollment in a professional educational program are situational and temporary and will reverse themselves once the students attain their own sense of professional identity when they are out in the field. Personal experience and conversations with other physical therapy faculty reveal that this is often the case in physical therapy education. Many students who display negative behaviors and attitudes in the educational setting often do well in the clinical setting. This is not to say that all students will successfully graduate and begin their careers with a strong sense of professional ethos, but it certainly

offers hope to faculty who feel that many of their students are behaving unprofessionally while in the educational setting. Other factors that may be important considerations for educators, as cited in this section, include the type of socialization pattern (Sabari, 1985), separation from other outside influences (Sabari, 1985), and certification processes following the educational period (Hayden, 1995; Sabari, 1985). Finally, several authors discussed the importance of power and politics in any organizational setting (Kondo, 1990; Lurie, 1981; Myers, 1982). I feel these are important issues to discuss with students as they develop more realistic views of the professional world they are about to enter.

Chapter 3

Gathering Evidence for Describing the Process of Professional Socialization

Overview of the Design

This study is designed in two parts, each of which addresses different questions (See Table 1 for an overview of the design). In Part 1, I used several sources to gather data about the history, culture, and ethos of the profession of physical therapy. Because I was seeking information about the evolution of the professional culture across the years, I interviewed senior members of the profession who have been and, in some cases, continue to be leaders in the field. These individuals offer a more historical outlook and draw on their experiences across their lives and the life of the profession to come to some conclusions about the core characteristics of the ethos of physical therapy. This data was gathered in several ways. First, I conducted and analyzed individual interviews with three physical therapists who are Fellows in the American Physical Therapy Association (Part 1A) to look for major themes that address the questions posed in this study. Next, a focus group interview was conducted with 11 members of the Prime Timers (Part 1B), an unofficial subset of the American Physical Therapy Association composed of members of the Association who are over the age of fifty. While fifty is the lower limit for membership in the Prime Timers, most members are of retirement age and continue to serve the Association by providing guidance to younger members (Ketter, 1995). As with the Fellows of the APTA, these older members of the profession offer insight into questions that younger members cannot. In Part 1C, the Mary MacMillan Lectures (28 Mary MacMillan Lectures have been given since 1964) and APTA Presidential Addresses (29 documents) were used to

gather information on major themes addressed over the history of the profession. These two lectures, presented at the Association's annual conference, are given by leaders in the field and reflect issues that the profession is struggling with, as well as those topics in which we have established a strong sense of identity and success.

The contemporary culture of physical therapy was described using these three sources of data and this description was used as the basis for developing the second part of the study, which addressed methods used by physical therapy faculty to instill a professional ethos in their students, and to gather information about the professional socialization experiences of physical therapy students and their educators (academic faculty and clinical educators). The program directors of two physical therapy programs were contacted to inquire if they, the program faculty, and students would be willing to participate in the study. Six faculty members, six students, and six clinical instructors[5] from two physical therapy programs (three of each from each program) were interviewed about the various ways program faculty attempt to instill a professional ethos in students and about their views on the experiences of students and educators in the socialization process.

Part 1A - Interviews with leaders in the field [6]

Participants. Drawing from a list of physical therapists who are Fellows in the American Physical Therapy Association (APTA), input from a variety of practitioners, and personal knowledge of the influential people in the profession in the areas of research, practice and education, three APTA Fellows were identified as being knowledgeable about past events and people who have

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5 Clinical Instructors are physical therapists who supervise students while they are completing clinical internships.

6 These interviews were conducted as part of a pilot study for my Research Practicum which was completed in August, 1996.

influenced the practice of physical therapy, as well as the values espoused by the profession (See Appendix G for a description of the subjects). This group was chosen because it was felt that more mature individuals (both chronologically and in terms of years of practice in the field) would be able to shed the most light on the evolution of the profession since they have witnessed, and may have even been major contributors to this evolution.

Those physical therapists identified by the above methods were contacted by mail, by phone, and in person to determine their availability and willingness to participate in a pilot study. Participants were interviewed in a private location convenient for the researcher and the participant.

Instrumentation. A semistructured interview was conducted by the investigator with three physical therapists who had been determined to be knowledgeable leaders in the field, as discussed above. Interview questions (Appendix B) were used as a guide and were administered in a nonstandardized format. In addition, demographic information was obtained prior to beginning the interview and participants were asked for permission to be contacted for any clarification or follow up questions. Interviews lasted approximately one to one and one-half hours. All interviews were conducted in person and were audio recorded for later transcription and analysis. Because this information was initially gathered as part of a pilot study, a new signed consent form (Appendix A) was obtained and this information was incorporated into the present study.

Part 1B - Focus groups with Prime Timers

Participants. Eleven veteran physical therapists were recruited for a focus group discussion from the "Prime Timers," a group of American Physical Therapy Association members who are at least 50 years old (See Appendix G

for a description of these subjects). These individuals have formed this group because they "do not want to work full-time anymore, (but) many are still interested in staying active in the physical therapy profession" (Ketter, 1995). Subjects were contacted by phone, by mail, and in person to determine their availability and willingness to participate in the study. Because the Prime Timers are from a variety of geographical locations in the United States, they were invited to participate in the focus group at the American Physical Therapy Association Annual Conference held in June of each year. As with the APTA Fellows who were interviewed individually, this group was chosen because I believe that more mature individuals are able to shed the most light on the evolution of the profession since they have witnessed and/or been involved with many of the changes that have occurred as part of this evolution.

Instrumentation. Following receipt of a signed consent form (Appendix C) and verbal assent, a focus group was conducted by the investigator with 11 members of the Prime Timers of the American Physical Therapy Association for approximately two hours. Focus group questions can be found in Appendix D. In addition, demographic information was obtained and a request was made for permission to contact the subjects after the study for any follow-up questions or for clarification of data collected during the focus group. The focus group interview was video taped for later transcription and analysis.

Part 1C - Historical documents

While primary data analysis focused on the views and descriptions of the professional ethos and culture offered by the individuals involved in the interviews, historical documents were also reviewed as a supplementary source of information about issues of importance to the identity of the profession throughout its history.

Mary MacMillan Lectures. The Mary MacMillan Lecture is given each year by a person chosen by an awards committee within the profession. It is considered to be a reflection of the issues most important to the field at the time. This very prestigious honor is named in honor of Mary MacMillan, the first physical therapist in the United States. The first Lecture was given in 1964. There have been 28 Mary MacMillan lectures.

Presidential Addresses of the American Physical Therapy Association. Like the Mary MacMillan Lectures, the Presidential Addresses are a reflection of issues of importance to the field. Although Presidential Addresses have been given since the inception of the professional organization in 1921, some of the addresses that have been given by the same person during their consecutive years in office have been condensed into one published document. In addition, there are a number of years (1974-1988 and 1990-1991) for which the Presidential Address was not published. As a result, 29 documents were reviewed for this portion of the study.

Part 2 - Program Interviews

This portion of the study addresses the question of how physical therapy educators in professional programs attempt to instill a sense of professional ethos in physical therapy students. The description of professional culture and its professional ethos obtained in Part 1, as well as the information obtained from the review of the literature on professional socialization (see pages 57-61 for a summary of this literature), was used as the basis for the development of questions asked of interviewees in this section (See Appendix F for a list of guiding questions). Questions focused on the means by which faculty attempt to socialize students during the period of formal educational training, and the experience of students and educators in the process of professional

socialization in physical therapy.

Participants. A purposive sample (Bogdan & Biklen, 1992) of six educators, six students, and six clinical instructors (three of each from two different programs) were interviewed to obtain their views on methods used by program faculty to instill a sense of professional ethos in students and the success of these methods in doing so (See Appendix G for a description of the subjects). According to Bogdan & Biklen (1992), purposive sampling "ensures that a variety of types of subjects are included. . . . You choose particular subjects to include because they are believed to facilitate the expansion of the developing theory" (p. 71-72). In this study, purposive sampling procedures consisted of identifying programs having different philosophies regarding the level of explicit instruction necessary to help students internalize the professional ethos of physical therapy. Program directors were contacted by mail, phone, fax, e-mail, or in person to determine their availability and willingness to participate in the study. They were asked to identify faculty, clinical instructors, and students willing to be interviewed for this project. Newly hired faculty were excluded from the pool, and clinical instructors selected as participants had to have personally supervised at least one student from the program. Students had to be completing their final internships or have graduated no more than six months before the interview. Once identified, these individuals were contacted by phone (by myself or the Program Director) to assess their willingness to be interviewed. Interview times were arranged by phone or through the Program Director for those who responded favorably to the request for participation. Following receipt of a signed informed consent and oral assent, interviews were conducted by the investigator in person in a private location convenient for the participants and the researcher.

Questions asked of faculty and clinical instructors emphasized the process by which they feel they socialize students into the profession, as well as their views on how they feel the students experience the socialization process in their program (See Appendix F). Student interviews focused primarily on the student experience of being socialized (See Appendix F). A comparative analysis of the views of students and educators (faculty and clinical instructors) was also conducted.

In addition to obtaining demographic information about the participants, a copy of the mission statement, philosophy, and curricular goals, as well as those of the academic institution with which they are affiliated were obtained from or discussed with the appropriate person designated by the Program Director. Demographics regarding such things as type of institution, size of student body, and organizational charts indicating where the physical therapy program is situated were also obtained.

Instrumentation. Following receipt of a signed informed consent and verbal assent, a semistructured interview was conducted with individuals meeting the above criteria and willing to participate in this study. Interview questions (See Appendix F), based on the findings of Part 1 of this study and the review of the literature, were used as a guide and were administered in a nonstandardized format. Demographic information was obtained, along with permission to be contacted at a later date for any future questions or clarification. Interviews lasted approximately one to one and a half hours. All interviews were conducted in person and were audio recorded for later transcription and analysis.

Data Analysis

While some qualitative researchers prefer to conduct data analysis following the collection of all data, several authorities on qualitative research methodology (Erickson, 1992; LeCompte & Priessle, 1993; Miles & Huberman, 1994) suggest that data analysis is not a separate component of the qualitative research process, but rather an integral component that should occur at all phases of a study. Following their suggestions, data obtained as part of this study was reviewed as it was collected in order to search for emerging concepts and themes, noting regularities in the data as well as negative cases (LeCompte & Priessle, 1993). As the data was reviewed prior to completion of the project, the information was used to guide subsequent data collection and to begin to formulate inferences and hypotheses about how the culture of physical therapy might be described and possible ways to instill the professional ethos that reflects this culture in students. (As previously noted, the description of physical therapy culture obtained from Part 1 of this study was used as the basis of the interviews for Part 2. The description of data analysis described below was used for each portion of this study.)

Once data collection was complete, all materials (i.e., transcriptions of all audio and videotaped interviews, Mary MacMillan Lectures, and Presidential Addresses) were reviewed in their entirety, a process called "scanning" by LeCompte & Priessle (1993). Scanning "means rereading the data. . . . (in order to) recheck the data for completeness. . . (and) to wander through the record, jotting notes and observations as the reading progresses. The notes serve to isolate the initially most striking, if not ultimately most important, aspects of the data" (p. 236).

The notes obtained through rereading all materials and the guiding interview

questions were used as a broad, initial organizational framework for organizing the data (LeCompte & Priessle, 1993; Miles & Huberman, 1994). Each data source was then reviewed individually and further coded inductively for common concepts or patterns that emerged as distinct units of analysis (Miles & Huberman, 1994). Codes were revised (i.e, expanded, collapsed, or deleted) as needed (i.e., too many discrepant cases emerge or some categories become too cumbersome) based on the emerging conceptual framework. Miles & Huberman (1994) also suggest that memos, reflections, and marginal remarks be written throughout data analysis in order to record ideas, interpretations, elaborations, and connections among the various data sources.

Once coding was complete, the codes were reviewed for discrepancies (which may lead to changes in coding) and common themes were identified. Themes from all data sources were compared using the constant-comparative method (Glaser & Strauss, 1967). As such, data were compared across the variable data sources, and changes in themes were made as necessary. Relationships among themes and common descriptions were used to generate a framework that served as the basis for describing the culture and professional ethos of physical therapy (Part 1). In addition, a framework was devised to begin to identify methods that are used to socialize students into the profession and which, in some instances, are claimed to be effective in helping students to internalize the professional ethos (Part 2) (Schmoll, 1993). As common themes and concepts were identified, vignettes and exemplars were used to illustrate what they look like in context and to establish their validity.

Chapter 4

Part 1: The Evolution of the Professional Ethos of Physical Therapy: Passing the Torch from One Generation to the Next

A Brief History

The profession of physical therapy in the United States began in 1917 during World War I when then surgeon general, William Gorgas, commissioned two orthopedic surgeons to go to France and England to study medical programs, called reconstruction programs, whose purpose it was to treat individuals wounded in the war. Based on these visits, the Division of Special Hospitals and Physical Reconstruction was formed in the United States upon their return and a woman named Marguerite Sanderson was assigned the task of supervising the training of more than 200 young women who volunteered for duty as reconstruction aides, later to be called physical and occupational therapists (Murphy, 1995). The first volunteer for the job of reconstruction aide was Mary MacMillan, who was soon placed in charge of training the reconstruction aides to rehabilitate young soldiers who were hurt in combat. The Reconstruction Aide Training Program, under the direction of Mary MacMillan and Marguerite Sanderson, was soon up and running with seven War Emergency Training Centers across the country (Murphy, 1995).

Following the end of World War I, some of the volunteers returned to civilian life, but others continued and in 1921 the American Women's Physical Therapeutic Association (in 1922 the name was changed to the American Physiotherapy Association and in 1947 the name was again changed to the American Physical Therapy Association, the name of the professional organization today) was formed with Mary MacMillan as its president

(Pagliarulo, 1996). Under Ms. MacMillan's leadership, the term reconstruction aide was changed to the title of physiotherapist (in the 1940s the term physical therapist began to be used), educational standards were established, annual meeting dates were established in conjunction with meetings of the American Medical Association, and a professional journal, the P.T. Review (today the journal is named Physical Therapy) was published (Murphy, 1996; Pagliarulo, 1995). In spite of these great strides, however, these women, and later the few men that joined them early on, remained in a technician role as they worked under the strict supervision of physicians and the business and actions of the professional organization were conducted under the direction of the American Medical Association.

Since the early days of the reconstruction aides, the profession of physical therapy has grown in number and professional stature. World War II and the polio epidemics of this century were a great boost to the profession as these events increased the patient populations with which the physical therapists were to work. As the number of wounded veterans decreased and polio disappeared when the Salk vaccine was introduced in the 1950's, physical therapists turned to other types of patients and treatments. Today there are approximately 109,000 practicing physical therapists in a variety of capacities from direct patient care to consultation to education and research (APTA staff, personal communication, June 29, 1998). In addition, the types of settings in which physical therapists practice has expanded tremendously with therapists now treating patients in hospitals, outpatient orthopedic clinics, public schools, homes, nursing homes, wellness and prevention centers, and research centers.

The physical therapy professionals of today have come a long way from the era of the reconstruction aides. The purpose of Part 1 of this study is to trace the

evolution of the profession and its ethos from the early days of the reconstruction aides to the present time. How was it, for example, that these professionals evolved from technicians who treated wounded soldiers under the watchful eye of a physician to the increasingly versatile and autonomous practitioners that exist today? From an all female profession to one that readily welcomes males? From a professional organization that relied on the American Medical Association to help run its professional association to an independent agency with approximately 75,000 members? These are but a few of the questions that I have explored and hope to provide some answers to in Part 1 of this study.

As I analyzed the data to look for answers to these questions, I found that many changes were noted by the participants in the study. These changes are important in trying to describe the evolution of the profession. Equally important, however, were the participants' descriptions of those traits and values that have survived throughout the history of the profession, what I refer to as the core of the professional ethos. It is these enduring traits and values that I turn to first, followed by an analysis of the changes that have occurred both from within and outside of the profession. An overview of the results of Part 1 can be found in Table 3.

Enduring Traits and Values: Caring, Hard Work and Dedication, Warmth and Openness, and a Positive Attitude

Not surprisingly, the most often cited value of physical therapists is the premium that they put on **caring**, on helping people to be the best they can be. All respondents, in both parts of this study, mentioned caring as the most important, enduring trait of the profession. For example, participants in the Prime Timers Focus Group said:

> I entered the profession to help people with my head and my

Table 3. The Evolution of the Profession -- Summary of Results -- Part 1

ENDURING TRAITS	CHANGES FROM OUTSIDE THE PROFESSION	CHANGES WITHIN THE PROFESSION
An emphasis on caring and helping	Types of patients served -Wars, medical discoveries, legal mandates, the "graying of America", improvements in technology	The appearance of males in the profession -increased salaries -increased autonomy
Hard work and dedication	Societal change -increased litigation -changes in health care delivery -increased economic pressure on students -technological changes	Increased delegation -the use of physical therapist assistants and other professionals -need to become good teachers -improved consultative and supervisory skills
Warmth and openess	Subtle influences of Social Change -changes in values and standards of society -more informal society -increased emphasis on diversity -increased emphasis on monetary rewards -political changes of the Vietnam era	Changes in educational requirements -from four month training to post-baccalaureate
Positive attitude -excuses for behaviors -finding the good in a bad situation		Increased respnsiblity and autonomy
		Increased emphasis on scholarly activity

> hands and we're a service profession...You want to help people. Therapists like to help people...you use your knowledge and experience [to do so]. (Prime Timer 2[7], p. 8-9)
>
> I think most PTs are still basically caring people. (Prime Timer 10, p. 23)
>
> This is a caring profession. I don't see a lack of that. There is a greed that...wasn't there before..., but when they are working at the moment that they are hands on, the caring seems to come out. (Prime Timers 9, p. 23)

Similarly, one of the Fellows conveyed this message about caring and helping others:

> They [the values of the profession] certainly were [when I started practice] ones of providing service to others, for caring for others, for helping others to become independent and functional as they could become...and actually those core values persist today. If you were to ask people thirty years ago why they chose to be a physical therapist and compared it with what people would say today I would guess they would be very similar. (FAPTA 3, p. 3)

As predicted in this quote, even the newcomers, the students who were interviewed for Part 2 of this study, described themselves and their cohorts as caring, helping individuals. Students expressed this notion in one way or another, using such terminology as 'providing quality care to patients' (P2S1, p. 1), 'having to be patient oriented' (P2S2, p. 1), or 'helping people the best way you know how' (P1S1, P1S2, P1S3, p. 1).

A second enduring trait described by a variety of people was the amount of **hard work and dedication** exhibited by members of the physical therapy profession, not only to their patients, but also to the profession itself.

> I think, as a whole, physical therapists are some of the most

[7] In order to ensure confidentiality, all participants in the study are referred to only by the name of the group they were part of (i.e., Fellows, Prime Timers, Program, Faculty, etc.). In addition, each participant is assigned a number based on the order in which they were interviewed within their group or the order in which they first spoke in the Prime Timers focus group interview. Abbreviations are used for Program Interviews. For example, Prime Timers 4 was the fourth person to speak in the focus group; P2S1 is the first student interviewed in Program 2; P2F2 is the second faculty interviewed in Program 2, and P1C3 is the third clinician interviewed in Program 1

dedicated people you could possibly find...it's the dedication by so many people to help other people." (FAPTA 2, p. 7)

[The goal for most physical therapists I know is] dedicating one's self to a life of service. (FAPTA 1, notes)

One Prime Timer described how there was a love of the profession and a **warmth and openness** by all members of the profession regardless of age or time of entry into the profession. Others in the group echoed her ideas:

You know something that hasn't changed...when you go into the clinic...you see the same fun...in all these young people, you know, that we always had and they still, there's something about being with physical therapists. You just feel at home, you know. I think all my colleagues have often felt like, they felt in just a real atmosphere of trust and love, I mean, really among colleagues even if they know them just...tangentially and I think I see that among the young people even now...they really do put their arms around each other, you know, have some openness and warmth and it really brings [me]...close to tears...I love to watch the love they have for each other...I love to watch the love they have for the profession. It's just so fun to watch them. (Prime Timer 7, p. 9)

It is warmth. (Prime Timer 11, p. 9)

And absolutely unique, I think. (Prime Timer 7, p. 9)

Students interviewed for Part 2 of this study also recognize this warmth and excitement in the profession as they are socialized into the field. One student said:

I think the profession is one that you feel very welcome in. You get that feeling from everyone. There is a lot of excitement, you know. Even though there are changes, there is a lot of excitement and that's what my big feeling was. Like I always felt good about the community and who is around you and supporting you, which is really nice. (P2S3, p. 6)

From my perspective, it was also interesting that all the individuals interviewed for this study, including those students, faculty, and clinicians who

participated in Part 2 exhibited a very **positive attitude**--a knack for seeing the best in every situation. Although no one specifically mentioned this as an enduring trait or value, it was apparent throughout all the data, including the Mary MacMillan Lectures and Presidential Addresses. I first noticed this trait when reviewing the focus group interview, particularly in relation to two negative changes noted in values between those who had been in the profession for a long time and newcomers who had been out of school for a short time. These two changes, an increased emphasis on monetary rewards and a decrease in professional standards were cited by both the Fellows and the Prime Timers (see Changes in The Profession, below). In both of these instances, someone in the group, or in some cases even the person who made the initial accusation found something good to say about the newcomers or offered excuses, usually in the form of societal changes, for why these students and new graduates would act as they do.

> It was a time when you didn't have the worries that you have today. There weren't law suits and there weren't all the problems of filling out insurance forms, none of those things. I mean, I'm sure that if I went into physical therapy today, I would have a different attitude, because you're so burdened with some of the problems that you can't give yourself totally to the patient. (FAPTA 1, p. 2)

> I agree with all of you that that's what we're seeing. I'm teaching in school regularly and . . . the majority of the young people coming through are really absolutely wonderful citizens, and wonderful individuals who humble you when you're with them. They do - just like the kind of people we are talking about. . . we never had to separate the personal, you and I, our citizen's responsibility and privilege before. . . I wonder if you and I might not also be reacting in different ways had we been brought up in this; because they're subject to some stresses. I'm not forgiving them, because I see it out there too, but they don't seem to me to be basically changed. I mean when you talk with them, clinically you don't see them cutting corners...they're doing their best. They're staying long hours. They are saying they want to help. They're kind to their

> clients. But the things that we see are the things that are...instilling habits in them. For example, most of them are . . . much deeper in debt even proportionately than they've been before and they have to get through school. And when you're talking, "Shall I go ahead and take a scholarship from a place that I have never visited or heard of in my life" or even know who they're going to work with - to you or I that would be impossible - "and they'll give me [a] first year salary to do so or shall I wind up out of school and keep this kind of principle and be fifty thousand dollars, sixty thousand dollars in debt?", and . . . they don't think of this as doing a bad thing...their actions in relation to society are very different. They can't survive economically. (Prime Timers 7, p. 2-3)

> Sexual harassment was something none of us even talked about, thought about. . . . But now youngsters are going out to environments in which they find themselves . . . innocent to my way of thinking, innocent bystanders and become involved in the most horrendous and very difficult problems that you've ever seen. I don't know that that happened to any of us. It just wasn't there. (Prime Timers 7, p 3)

> I think . . . that we do need to have standards, but how can you teach these standards when they have not been taught in the home, because these are college students and they have a lot of years of other kind of training. You might be able to do it with a six year old, but it's pretty difficult to do it in an 18 year old. (Prime Timers 6, p. 19)

This same attitude was present not just when speaking about the people in the profession, but also in describing the changes that have occurred in the profession over time. These types of changes included a more rigorous form of note writing first mandated by Medicare and Medicaid, reimbursement for services from insurance companies, delegation to paraprofessionals (physical therapist assistants) and aides, and a more autonomous relationship with physicians as evidenced in the clinics by more latitude in providing services to patients. These types of changes, when first discussed were mentioned in a more negative tone within the Prime Timers group, but eventually someone in the group talked about the "good part" of the change. For example, the

following dialogue took place in regard to more stringent requirements for note writing:

> One of the things that really [changed] . . . for years . . . no one wrote notes. (Prime Timers 10, p. 11)
>
> That's true. (Prime Timers 11, p. 11)
>
> We did not write notes. When I . . . took a new job in 1969, . . . there were no notes from a physical therapist. . . the job I had before that I was just learning how to write notes. (Prime Timers 10, p. 11)
>
> [T]his is one of the things that came out of public regulations and Medicare specifically, regulations that you have to have a progress note
> . . . every day on an acute patient and once a week on a chronic patient. (Prime Timers 2, p. 11)
>
> Forget the once a week, they want it everyday, every time you visit. (Prime Timers 11, p. 11)
>
> .
> .
> .
>
> The fact that we didn't write notes had a lot of impact. I mean, you spent your time with the patients, and you had time to talk to the patients. (Prime Timers 10, p. 11)
>
> .
> .
> .
>
> And the fact is that the people are more concerned about getting that note in than they are in the care of the patient. (Prime Timers 1, p. 13)
>
> .
> .
> .
> but that also has a good ramification because now therapists have to think about what they're doing and why they're doing it, and we didn't do that . . .You have to think through the reasons for doing things. (Prime Timers 10, p. 13)
>
> Medicare made us do what we should have been doing, what

some of us didn't do before. (Prime Timers 3, p. 13)

In her Presidential Address of 1996, Marilyn Moffatt epitomized this positive attitude as she traced the evolution of the profession throughout its seventy-five year history. Moffatt (1996) described the evolution of the profession as one that, in spite of ups and downs, of having to fight and search for a professional niche in the health care environment has provided the field with a good impetus for positive change. The pioneers in the field, as well as the current active members of the professional association have managed to find an approach to meet the problems of the profession head on. The end of World War II and the use the Salk vaccine that ended the polio era, for example, may have been a signal for some professionals to conclude that their work and their profession was finished since their primary patient populations had dwindled to almost nothing. But this was not the case for physical therapists. Instead they saw this as an opportunity to help other groups of individuals with disabilities and looked to other avenues of helping people, most specifically to the treatment of children with cerebral palsy and adults with strokes and other forms of neurological disorders (Moffatt, 1996).

More recently, in the last ten years, physical therapists, as well as other health care providers, have been forced to deal with changes in the health care delivery system. The introduction of DRGs or diagnosis related groups, which limited hospital stays for patients and the more recent introduction of managed care systems of health care delivery have had a major impact on the provision of therapy services to patients. Rather than simply lamenting the effect of these devastating changes on physical therapists in this country, Moffatt (1996) encouraged her fellow practitioners to see the opportunities this change in delivery models has produced for the profession. A greater emphasis on self

monitoring, outcomes effectiveness studies, and appropriate charges for therapeutic services, all described as good changes for the profession, also emerged as managed care and health care reform wreaked havoc on the delivery of health care services to those in need. Moffatt described these effects of health care reform, as well as some positive changes that were occurring in the system as follows:

> We are often caught up in the downsides of rapid change, confusion about our roles, and a health care environment that has been threatening to us. . . In contrast to these trends, we are seeing litigation against provider organizations for withholding services. Successful managed care corporations. . . are now considering payment systems that use quality of care as one criterion for reimbursement. We see physical therapists reevaluating whether it is appropriate and right to treat more than 20 patients in a normal practice day. We also hopefully will see an appropriate pricing of our services that is equitable with the services we actually render. . . And we must always look at the positive aspects that do emerge from any change. We surely will have learned many things during this time of upheaval; we will have learned to provide high-quality services in even less time than we have had in the past with the patient or client as a true partner, whenever possible, in the recovery or rehabilitation process; we will have learned the importance of practice patterns that represent appropriate provision of services and, when possible, that are supported by data; and we will have learned that we must be ever more cognizant of the need to provide services in a financially responsible manner. . . Not one of our predecessors has had the opportunity that we have today, and that is to leap from one century to the next. As a profession and as an association, we are well poised to take that giant step for humankind. (Moffat, 1996, p. 1252)

Changes from Outside the Profession: Types of Patients Served, Societal Changes, and Subtle Influences of Social Change

Some the changes that have shaped the development of the culture of physical therapy that occurred outside the profession are quite obvious as they are related to the **change in the type of patients served**. Within this

category are such events as World War I, World War II, the Korean War, and the Vietnam War; the development of a vaccine for and eventual eradication of diseases such as polio; legal mandates such as the Social Security Act and the newly reauthorized Individuals with Disabilities Act of 1997 that have dictated who will be serviced and how the services will be carried out and paid for; the graying of America, resulting in the treatment of more older patients with more complex, multiple, and serious conditions; and the advent of the atomic age with subsequent improvements in medical technology that have resulted in earlier diagnosis and treatment and are allowing individuals to live who would have died in the past. Other **societal changes**, not related specifically to historical events, but ones which are fairly clear cut in terms of their impact on not only physical therapists, but all health care practitioners, include such issues as increased litigation in our society (Prime Timers 7, p. 7; Prime Timers 1, p. 8), changes in health care delivery systems (Moffatt, 1995, 1996, 1997; Prime Timers 2, p. 22), increased economic pressures on students in terms of the increased cost of education (Prime Timers 7, p. 3, p. 6), and technological changes that have resulted in different systems of communication and record keeping (Prime Timers 1, p. 10).

While these events are certainly very important in the role they have played in the evolution of physical therapy, the more **subtle influences of social change** are much more interesting to explore. The influence most cited by participants in the study and by those whose documents were reviewed in the Mary MacMillan Lectures and the Presidential Addresses was the overall change in the values and standards of society. Early Presidential Addresses and Mary MacMillan Lectures emphasized the need to set high standards for the profession based on the needs of the patients and the values and standards

of society. These early pioneers aimed high in the areas of patient care, education, and ethical practice. This legacy of high standards is seen in the first Presidential Address delivered in 1921 by then President Mary MacMillan who stated, "One of the most important tasks for the National Association is to set a standard for physiotherapy and neither in act, word, or deed to lower that standard" (MacMillan, 1921, as cited in American Physical Therapy Association, 1971, p. 622).

In contrast to this emphasis by previous generations of physical therapists, the Fellows and Prime Timers who looked back over the profession through the interviews conducted for this study, described how the standards of the profession and the newcomers into the profession have been lowered as a result of societal changes. The following excerpt from the Prime Timers illustrates this change in standards:

> One of the things that existed then that doesn't exist now is standards, and there was just a certain standard. It wasn't so much the background that you came from, the amount of poverty, or how affluent you were, or what culture you came from. There was, in this country, something called a standard and you just kept it. There were right and wrongs. There was black and white. No gray areas. (Prime Timers 9, p. 4)
>
> And everybody respected the flag. (Prime Timers 10, p. 4)
>
> There were things that were just respected. (Prime Timers 9, p. 4)

Similarly, one of the Fellows described this adherence to high standards and expectations in professional behavior.

> I wouldn't have thought it was necessary, hardly to have started it out with ethics . . . It was as if we just did the things we ought to do and we were expected to do them. (FAPTA 2, p. 2)

On a more positive note, participants noted that one of the changes in the profession that reflects social change is the more relaxed atmosphere with

which practitioners interact with each other and with patients. For example, the Prime Timers felt that the less formal way of interacting with each other in society today compared to days gone by has resulted in a closer relationship with patients and with peers. One Prime Timer, for example, discussed how today's students are very open in their love of the profession and the people in it and how one way she sees that expressed is when students just appear to be having fun and hug their fellow classmates at graduation (Prime Timers 7, p.9). In response, others in the group offered the following:

> Well, I think that has a lot to do also (with the fact that) we were taught not to do that. (Prime Timers 6, p. 9)
>
> Oh, yes, absolutely. (Prime Timers 7, p. 9)
>
> I know I that I practically never hugged my patients, and I didn't start doing it until I retired and started working with Huntington's Disease and I felt those people needed to be touch. (Prime Timers 6, p. 10)
>
> You know the old expression that's coming to me, "Friendly, but not familiar." (Prime Timers 3, p. 10)

An increase in the diversity of American society is another outside factor thought to have influenced the evolution of the professional ethos of physical therapy. The decreased emphasis on America as a melting pot in the years when great numbers of Europeans migrated to the United States has been replaced with an era of cultural diversity where individual cultures from all over the world take pride in their heritage and their differences. This sense of ethnic and cultural ownership is seen not only among immigrants to this country, but also within the realm of our own citizenship as African Americans, Hispanic Americans, Native Americans, and Asian Americans openly acknowledge their pride in being unique in their cultural background. This same sense of

difference that has resulted in and from much of the Civil Rights legislation of the early 60s, and which has continued to the present day, has impacted the professional ethos of physical therapy in two ways. First, we can no longer assume that students are created in our image. We must not only consider differences due to their cultural background, but also to generational values and beliefs. No one would dispute the fact, for example, that individuals born during the Baby Boom years and those who are identified as Generation X see things in much different ways. This change in diversity was noted by many of the participants. One Prime Timer discussed the impact of this diversity on facilitating the ethos of the profession:

> [W]e're seeing such an enormous diversity of background that you'll get a classful of students who you can't predict what they're going to do individually or collectively, and so ethically we're much more in the process of having to be very, very overt instead of operating on assumptions. So we need to bring out, "Where did you come from? How do you think you developed the ideals that you think you're going along with? How do you think you are going to make decisions? How do you judge right and wrong in finances or in patient care or in what you are doing in your professional life?" We just can't assume that their backgrounds are going to be like our backgrounds. (Prime Timers 8, p. 3)

Of the generational differences noted by the Fellows and Prime Timers, the most disturbing to them was the increased emphasis on monetary rewards in some students and new graduates. It was felt that this was something that was very damaging to the ethos of the profession and needed to be stopped. Some newcomers to the profession were described as "more interested in financial matters" (Prime Timers 5, p. 2) or "money driven" (Prime Timers 11, p. 7). As mentioned earlier, the positive attitude displayed by the participants in the study was an enduring theme that I noted. This positive attitude was very evident in one Fellow's perspective on how to solve the temptation of greed on the part of

the newcomers to the profession. Rather than seeing all the health care changes as bad, this Fellow felt they would help to decrease, if not eliminate, those who come into the profession simply because it sounds lucrative.

> One of the things that really bothers me is that when new grads come out and they're looking for jobs and the first thing they want to know is how much is the pay. I think that's really sad, [but] . . . I think it's [this increased interest in monetary rewards] going to take care of itself. It's going to take care of itself in many ways because salaries are going to come down, there's going to be a lot of competition. There's going to be a lot of people who are going to just be real glad they have a job. . . When people find that they have to do much better and satisfy professional demands if you want to keep patients coming, it's going to change. (FAPTA 2, p. 10)

Finally, the changes in the political frame of mind during the Vietnam War and the sixties was cited as a major outside influence on the development of the professional ethos of physical therapy. While in one sense this era of equal rights for minorities and women and the view that everyone should "do their own thing" created a generation that is more "self serving" (FAPTA, 1), it also influenced physical therapists to more aggressively pursue their quest for autonomous practice, away from the American Medical Association (AMA). One way in which this fight for independence from the AMA was played out was in the arena of accreditation of educational programs for physical therapists and physical therapist assistants. After many years of battling with the AMA, the APTA was recognized by the Council on Postsecondary Accreditation as a second independent accrediting agency (in addition to the AMA) for physical therapist and physical therapist assistant programs in 1977, and in 1983 APTA was finally approved as the sole accrediting agency for these educational programs (Moffatt, 1996; Murphy, 1995; Pagliarulo, 1996).

Changes from Within the Profession: The Appearance of Males, Increased Delegation, Increased Responsibility and Autonomy, Changes in Educational Requirements, and an Increased Emphasis on Scholarly Activity

According to the participants, some of the most drastic changes within the profession occurred as a result of **the appearance of males** in the profession after World War II. As males entered the profession during this era of inequality between men and women, female physical therapists began to realize more of their worth within the health care community. This may have been the beginning of the more autonomous, less technician oriented professional that the average physical therapist is today. The entrance of males in the profession, for example, provided more continuity of staffing within the profession since they were not expected to leave the profession if they were married or had a family. In addition, males received significantly greater salaries than females since it was felt they needed to make enough to support a family. One Prime Timer who was a director of a department at the time stated, "I began to feel a change . . . in the male therapists coming in versus the female therapists. They were looking at the future as heads of household, whereas the female was more service oriented, more career, PT minded, the males had to make a living" (Prime Timer 2, p. 5). What was thought of as a "need to make a living" resulted in higher wages for men, particularly in light of the fact that "many women, pick a time, 1945 or later, used nursing or teaching or physical therapy as a stepping stone before they got married" (Prime Timer 1, p. 5).

This increase in wages for men, as well as the increased independence that was fostered during World War II as women entered the work force to replace the men who had gone off to War, resulted in greater demands by women in the field. One Prime Timer, for example, explained how she realized that she should demand the same pay and benefits as her male counterparts. "[F]or me,

when I saw what the men could do, it just made me think, well there's no reason I can't do that too, and I think a lot of women did the same thing and this sort of helped women to empower themselves by saying, 'If you can do that so can I' . . . . Before that I didn't ask for it [a higher salary]" (Prime Timers 10, p. 22). In addition to higher salaries, males were also more aggressive in opening up other areas of practice, most notably private practice (Prime Timers, p. 22). Although therapists were still required to strictly treat under the orders of a physician, this move to private practice was the beginning of practicing in a setting that offered much more autonomy than a hospital.

Next, as the demand for physical therapists rose[8] and the educational levels increased, the members of the professional association saw the need for paraprofessionals to fill the gap created by this shortage and to perform the more technical aspects of the job. As a result, physical therapist assistants were created by the APTA House of Delegates in 1967 and the first class of physical therapist assistants graduated in 1969 (Murphy, 1995). While many therapists were not sure how to delegate to these paraprofessionals as they first entered the field, the advent of managed care in the last few years has quickly led to an increase in delegation of therapeutic exercises and modalities not only to PTAs, but also to aides, other professionals, such as athletic trainers and exercise physiologists, and patients and their families. As a result of the shared responsibility and delegation that occurred with the use of physical therapist assistants, the appearance of these paraprofessionals in the profession was thought to be an impetus of change for physical therapists.

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8 Until the last few years, the demand for physical therapists has continued to rise in disproportion to the number of new graduates. The advent of managed care and the increasing number of physical therapist and physical therapist assistant programs has an impact on this need and the profession is seeing a decline in the number of physical therapists that will be needed in the future. Although it is projected that therapists will still be able to find jobs, there is concern within the profession regarding the issue of future needs for physical therapists.

> A lot of the young therapists, and older ones, too, do not want . . . to delegate to the physical therapist assistants or to other supportive personnel . . . we have to change . . . We have to recognize that there are levels of care and where do we fit in that chain." (Prime Timers 1, p. 24)

Another important change from within the profession was the **change in educational level** required to practice as a physical therapist. The requirements and training of today's students have come a long way from the time when the first seven War Emergency Training Centers opened in several locations across the country to train the then called reconstruction aides. At that time, the major educational requirement for entering one of these training sessions was to have completed a four month course "in any two of the basic modalities of reconstruction - hydrotherapy, electrotherapy therapy, mechanotherapy, and massage" (Murphy, 1995, p. 47), or to have graduated from either a nursing of physical education program, or to have been individually trained by a recognized orthopedist (Murphy, 1995). In addition, "to be considered for training and ultimately for work in physical therapy . . ., candidates had to be citizens of the United States or in the process of being naturalized. They also had to pass physical fitness standards, which included standing between 60" and 70" tall and weighing between 100 and 195 pounds, with no 'marked disproportion' between the two. Cheerful demeanor, coupled with 'powers of personal subordination, able to cooperate generally and capable of demonstrating team play,' were also deemed essential. Because the army was particularly sensitive to the potential strains of bringing men and women together in the highly charged atmosphere of wartime hospitals, candidates were also expected to be able to 'associate with young men on a friendly footing without encouragement of undue familiarity' " (Murphy, 1995,

pp. 47-48). As World War I came to an end and the reconstruction aides formed the first professional association, the American Women's Physical Therapeutic Association, in 1921, the leaders in the field began to look more closely at the educational requirements in order to standardize them even more and to eliminate personal requirements such as height, weight, and the ability to "associate with young men on a friendly footing without encouragement of undue familiarity" (Murphy, 1995), and in 1928 the first standards for accreditation for physical therapy education programs were established (Moffatt, 1996). By 1947 four schools offered bachelor's degrees in physical therapy (Murphy, 1995), and in 1956, the baccalaureate degree was established as a minimum for entry-level practice (Moffatt, 1996). By 1979 the House of Delegates, the legislative body of the APTA, passed a resolution to require a postbaccalaureate degree as the entry level degree for physical therapy practice by 1990. Unfortunately, there was much opposition to this movement and the current date for the establishment all programs at the post-baccalaureate level has been moved to 2001. In addition, there is currently a move by some individuals within the field to establish a doctorate (primarily a clinical DPT instead of a PhD) as the minimal educational requirement for practice. While there is still much controversy regarding this move, several entry level DPT programs have become established throughout the country. All of these changes in and results of increased education were recognized by the Prime Timers.

One of the most cited effects of this move to increasing education was that with an increase in education, comes **increased responsibility and autonomy** and **more delegation** to others.

> We're not recognizing that the more education we require or want, . . . [also will affect] what they're asking of us, it's not just what we

> want, it's what we're asked to do and we have to have that higher education to be able to make good judgments, etc. (Prime Timers 1, p. 24)

Increased education and more delegation, as well as the changes in health care noted earlier, have also led to changes in educational requirements in that as therapists delegate more responsibilities to paraprofessionals and patients, it becomes increasingly important for them to become good teachers and communicators (Prime Timers 2, 10, and 11), so that a need then arises for educational programs to prepare students to function in this capacity. This has indeed become the case as accreditation standards now require that information on teaching and learning be included in every physical therapy curriculum (American Physical Therapy Association, 1997a; American Physical Therapy Association, 1997b).

Finally, as physical therapy has increased its professional status through increased education and autonomy, there has been an increased emphasis on **developing a body of professional literature and unique knowledge**, one of the hallmarks of a profession (Friedson, 1994). While there has always been an identified need for scholarly activity, as evidenced by the establishment of the first professional journal, the P.T. Review, in 1921, scholarly activity has become increasingly important as the field of physical therapy strives for an increased professional status in the health care arena. In addition to this desire for increased professional status, changes in health care have also made practitioners in the field more aware of the need for outcomes studies to prove the efficacy of their work with patients. As a result, more and more members of the profession today are becoming increasingly involved in conducting research resulting in the production of scholarly publications. This change was noted as a needed and exceptional one by all members of the Prime Timers

group and the Fellows. As with the increased emphasis on autonomy and delegation, this need for a growing body of literature has also resulted in increased demands on educational programs as courses on research theory and design have become required components of educational curriculums (American Physical Therapy Association, 1997a; American Physical Therapy Association, 1997b).

Summary of Historical and Developmental Interviews and Document Analysis

Data analysis of the interviews and documents revealed that there are core values and norms within the professional ethos of physical therapy. These core values and norms primarily reflect the role of the physical therapist as a clinician and include an emphasis on caring and helping, hard work and dedication, a warmth and openness within the profession, and a positive attitude. Changes in the professional ethos occurred both from within and outside of the profession. Changes from outside that were felt to affect the ethos of the profession and the ways in which students needed to be socialized included changes in the types of patients served due to wars, new medical treatments such as the invention of the polio vaccine, legislation, improvements in technology that are keeping people alive longer, and the "graying" of America; changes in society in general that affect students in all professions such as increased litigation, changes in health care delivery systems, increased economic pressure on students, and technological changes; and subtle influences in society including changes in social values and standards, less formality, an increased emphasis on diversity and monetary rewards, and political changes that occurred in concert with and since the Vietnam War. Within the profession, the appearance of males resulted in increased salaries and increased autonomy. Changes in educational requirements from the first

four month courses to the present masters entry level requirements have resulted in increased responsibilities. This increase in autonomy and responsibilities, coupled with changes in health care, have resulted in increased delegation to paraprofessionals, other professionals, and patients and their families. Increased delegation has, in turn, led to an increased emphasis in educational programs on teaching and the need for improved consultative and supervisory skills. Finally, the move toward a more professional posture has resulted in an increased need for scholarly activity within the field.

Chapter 5

Part 2: Professional Socialization in Physical Therapy: The Experience of Two Programs

The two programs selected for this study were chosen because of their explicit perspective on and methods used to socialize students into the profession of physical therapy. Faculty at both programs have made a conscious effort to incorporate a strong emphasis on professional socialization into their programs as described below. An overview of the methods used by these two programs can be found in Table 4. In addition, a description of the feelings and experience of students during the socialization process is included in this chapter.

Overview of Program 1

Program 1, which has been in existence since 1945, is an urban, Midwestern university of approximately 40,000 students overall. The physical therapy program enrolls 60 students each year. Students completing this program, receive a bachelor of science degree in physical therapy (although the program is moving to a masters level within the year). Students are admitted to the program after completing two years of prerequisite courses and complete another two years of a professional program once admitted. Clinical internships comprise 24 weeks of the two year program, with students completing three full time internships of six weeks each at the completion of the academic program. Program 1 has eight full time faculty positions.

Program 1 accomplishes their goals for professional socialization primarily through the use of what has been termed ability based assessment which "involves multidimensional observation and appraisal, based on explicit

Table 4. Socialization Methods -- Summary of Results -- Part 2

PROGRAM 1

1. Generic Abilities
   a. specific expectations
      -faculty
      -clinicians
   b. self-assessment at regular intervals
   c. regular feedback on self-assessments

PROGRAM 2

1. Clinical Internships
   a. longer final clinical experiences
   b. Regional Coordinators of Clinical Education
2. Strong emphasis on reflection
   a. journals
   b. portfolios
   c. interviews
3. Strong emphasis on ethics
4. Mock clinic

PROGRAM 1 AND 2 WHAT DO THEY HAVE IN COMMON?

1. Strong emphasis on sharing expectations with students
2. Professional development courses - one each semester
3. Attempts to evaluate effectiveness of methods of socialization
4. Many opportunities to practice professional behaviors
5. Expectations and practice are part of the entire curriculum
6. Regular and consistent feedback
   a. both positive and negative
   b. problems are corrected as soon as they occur
7. Use of principles of adult learning
8. Recognition that socialization is a developmental process

WHAT DO ALL PROGRAMS HAVE IN COMMON?

1. Role modeling
2. Courses to help students internalize professional ethos
3. Use real life examples as much as possible to facilitate transfer
4. Provision of examples and non-examples
5. Encouragement to join professional organizations and attend professional meetings

behavioral criteria of the individual learner in action" (May, Morgan, Lemke, Karst, and Stone, 1995). The behavioral criteria used for professional behavior are the Generic Abilities (GAs). Generic abilities are "attributes, characteristics, or behaviors that are not explicitly part of a professional's core of knowledge and technical skills but nevertheless are required for success in that profession" (May, et al, 1995). Using the Delphi technique of research, ten generic abilities were developed by the faculty from the physical therapy program at the University of Wisconsin-Madison (UW-M) based on input collected from practicing clinicians. The generic abilities consist of ten behavioral characteristics that physical therapy graduates should possess, including commitment to learning, communication skills, interpersonal skills, communication skills, effective use of time and resources, use of constructive feedback problem solving, professionalism, responsibility, critical thinking, and stress management. In the early 1990s, when the generic abilities were first developed for the University of Wisconsin-Madison, each was accompanied by a beginning, developing, and entry level set of behaviors that indicate the student's level of functioning on each of the generic abilities. The initial set of GAs was adopted and put into use by Program 1 in the fall of 1993. In 1997, using feedback from clinicians, students, and faculty from their own and other programs, the GAs were revised to include a post-entry level category (Warren May, personal communication, June, 1997). (See Appendix H for a list of the generic abilities and a sample of the behavioral criteria for several of the abilities.)

The GAs are used on a regular basis by Program 1 to assess the level of professional behavior of their students. Students are introduced to the concept, use, and specific expectations of the GA scale during program orientation and

are told that they must function at acceptable levels on the scales if they are to continue in the program. That is, failure to meet the expectations of the faculty in generic ability functioning can result in dismissal from the program, just as failure to meet academic expectations can result in dismissal. Each semester during the program, students complete a self-assessment of their level of function on the generic abilities scales, establish goals and objectives for themselves that will move them along the behavioral criteria, and set time lines for accomplishing their goals. Students meet with their advisors to discuss their self-assessment and the advisors then present the students' self-assessments to the entire faculty. Each student is discussed every semester. Students whose self-assessment accurately matches the faculty's have their assessments returned following a brief meeting with the advisors. Students whose self-assessments are inconsistent with the observations of the faculty meet with their advisors to devise a remedial action plan, including goals, objectives, a time line for accomplishing the goals and objectives, and the actions that will be undertaken to accomplish the goals and objectives. Students continue to meet with their advisors to monitor progress toward their goals. If, after several attempts are made to remediate a student on the generic abilities, no progress or little progress is observed, that student can be dismissed from the program. To date, two students have been dismissed from Program 1 for failure to meet the professional expectations outlined in the generic abilities.

For students who successfully complete the academic portion of the curriculum and move on to their clinical internships, the generic abilities continue to be used as part of the assessment process in the clinics. At the beginning of each clinical rotation, students complete a self-assessment, listing

their strengths and weaknesses and goals and objectives for the clinical experience. Both the students and their clinical instructors periodically complete an assessment of student progress toward their goals. As in the academic portion of the program, failure to meet generic abilities expectations can result in remediation or dismissal from the clinical site or the program just as easily as failure to meet expectations of clinical expertise.

The success of the generic abilities approach to professional socialization in Program 1, coupled with the enthusiasm of the original proponents of the use of the GAs for professional socialization in physical therapy has led many other schools to adopt the use of the generic abilities for their own programs. In addition, other programs are adopting the generic abilities for use in other areas of the program such as using them as admissions criteria (Warren May, personal communication, June, 1997).

What's special about Program 1?: Generic Abilities, Specific Criteria and Expectations, Self-Assessment, and Regular Feedback

All participants in Program 1 identified the use of the **generic abilities** as a very strong socializing force in the program. Students, in fact, answered many questions simply with the words "generic abilities" and one student apologized for "sounding like a broken record" (P1S1). Beyond a mere description of the term generic abilities, however, all participants were able to identify ways that the generic abilities behavioral checklists helped facilitate professional socialization and internalization of the professional ethos of physical therapy. The use of **specific criteria and expectations** for the goals and objectives of socialization in the program, for example, were cited as important by students, faculty, and clinicians, as illustrated in the following quotes:

> I believe [that] raising the students' awareness is at least 80% of it. I think most people are just dying to know, "What are the

> expectations?" That is where the problem in your professional behavior in our profession is because it has not really been dealt with, the affective domain, etc., etc. We had difficulty getting across to students what our expectations were. If there is one thing that the behavioral criteria has done it, it spelled out, these are the expectations. I've had student after student say, you know, "Thank you. Now I know what you're looking for." It goes back to if you give them expectations, they'll meet them. The higher the expectations, the better they'll do. . . I can tell you what my expectations are. I know exactly how I want you to behave. If I tell you 99% of the time, they'll do it. They'll just figure it out. (P1F3, p. 14)

> Students are very aware [of our expectations for professional behavior] because of this program that we have of ability based assessment. (P1F2, p. 4)

> I think that since the advent of the generic abilities, it has really made them a lot more aware of what it takes. Not only with psychomotor skills, but all the other intangibles, so called intangibles. (P1C1, p. 8)

> I think that with generic abilities, that [program expectations and goals for professional behavior] is pretty much laid out for us. (P1S2, p.5)

Not only were these expectations presented clearly, but the fact that clinicians were very involved in the development of the behavioral criteria is also made quite clear to students. Because students often have a visions of clinicians, versus the faculty, as "the real physical therapists," I feel that passing this information on to students as something that was developed by and expected by clinicians is a very important part of motivating students to aspire to the professional behaviors delineated in the behavioral checklists. This was also recognized by the faculty in Program 1.

> Of course in our program we do that [help students internalize the professional ethos] through generic abilities, and we share with our students that these are the abilities which have become accepted as professional behavior. More importantly, they are the expectations of the clinicians they are going to be working with

and for, which then gives it credibility. (P1F3, p. 3-4)

The incorporation of **self-assessment** into the generic abilities evaluation process was also cited as an important component of developing into a professional.

> The process, the way in which they [the GAs] . . . are used to facilitate professional development is that each semester we do a self-assessment based on the generic abilities, which would mean you would sit down and look at each generic ability and rate yourself . . . based on the number of different criteria . . . and then give examples of why you felt you met these criteria. Then you give a plan based on knowing where you are and where you'd like to be eventually. . . That really was very effective because lo and behold, every semester there it was again, and you would once again be reviewing yourself, doing your self-assessment, and then . . . you would submit your self assessment to your advisor [who would share it with the faculty]. . . Then you would arrange a meeting with your advisor to discuss [if] . . . my assessment matched up with the faculty assessment. . . . That felt like it was a very effective means of communicating and helping students be a very active participant in their own evolution professionally. (P1S1, p. 9-10)

One faculty member thought that self-assessment should be part of an ideal program for socializing students into the profession. He stated, "[In an ideal program] students would be mature enough to actually do a self-assessment and know what they're looking for and how to do a self-assessment" (P1F1, p. 22).

The use of **regular feedback** through the assessment process was felt to be a significant factor in facilitating professional development.

> We get feedback on a regular basis, and that is part of the generic abilities, but it's not necessarily just generic abilities based. They'll give you feedback on other aspects as well. (P1S2, p. 2)

> Each semester we sit down with the students and bring feedback from the faculty as whole and say here is where we see you. So they already get accustomed to getting feedback. . . With the students' increased level of awareness of these issues, all of them,

> from professionalism to the effective use of resources . . . something happens by them being more aware and by being asked to review these and keep these in their minds on an ongoing basis. The importance of these and the value of them, I think, becomes integrated and the students take ownership of that. (P1F1, p. 6)

This program also does other things that help the students internalize the ethos of the profession (e.g., role modeling), but they are program features that are also present in Program 2, and in other physical therapy training programs and will be discussed in subsequent sections of this chapter.

Overview of Program 2

Program 2 is a Midwestern university that has approximately 17,000 students and is located in a semirural area. Forty-eight students are admitted to the physical therapy program after completing three years of prerequisite courses. After an additional three years of enrollment in the professional program, students are awarded a masters degree in physical therapy (a bachelors of health sciences is awarded after four years of schooling). Clinical internships comprise 34 weeks of the program and students complete two fourteen-week internships after the academic phase of the program. Program 2 has 10.5 full time faculty positions. It admitted its first class in 1994.

Of particular interest in regard to this program is that 28 weeks of full time clinical internships at the end of the academic portion of the program is on the high end of that recommended by the APTA. In addition, this program has regional coordinators of clinical education who meet with students individually and in groups during their internships to discuss cases and to address questions or concerns students are having. While all programs have one person who is designated as the Academic Coordinator of Clinical Education (ACCE), a requirement of accreditation by the APTA, who meets with students

and their clinical instructors periodically to evaluate student progress during internships, the use of regional coordinators and group meetings during the final, full-time internships is, to the best of my knowledge, unique to this program.

Program 2 has a strong emphasis on the use of reflective learning. During the academic phase of the program students complete reflective journals every two weeks as part of a 1 credit professional issues course offered each semester. Journal entries are also completed at regular intervals during the clinical education component of the program. Feedback regarding journal entries is provided on a regular basis. In addition to journal writing, students participate in entry, mid-program, and exit interviews to discuss their goals, accomplishments, and meaningful experiences in the program. In conjunction with the mid-program and exit interviews, students also submit portfolios consisting of written information that will be discussed at the interview, as well as samples of their work since the last interview.

In regard to course work, a three credit ethics course is included as part of Program 2. While all programs incorporate an ethics unit or component into the curriculum, Program 2 includes ethics as part of a separate three credit course. Finally, Program 2 has instituted the use of "Mock Clinic", a course, or in some cases, a unit of a course, that is specifically geared toward imitating a real world clinical experience in which students role play the parts of both the therapist and the client in the clinical setting. Mock clinic was first described in the physical therapy literature by Sanders & Ruvolo (1981). These authors describe some of the advantages of mock clinic as providing an avenue

> for the students to see themselves in situations and to learn from errors without involving real patients . . . [to allow students the opportunity to] practice over and over again, . . . [to] allow early clinical contact in which newly acquired skills and knowledge can

> be practiced and student motivation and interest maintained at a high level . . . . [and to allow students to practice] the same skills that will be used with real patients in other clinical settings. (Sanders and Ruvolo, 1981, p. 1164)

Further, students are active participants in the learning and problem solving processes and instructors can provide immediate feedback without worrying about what effect their feedback may have on patients, as occurs in the clinical setting (Sanders and Ruvolo, 1981). In Program 2, in addition to receiving feedback from peers and instructors during mock clinic, some of these "therapy sessions" are videotaped for student review and self-assessment of their psychomotor skills, as well as their interpersonal and professional behaviors with the "patient."

What's Special about Program 2?: Reflection through Journals, Portfolios, and Interviews, a Strong Emphasis on Ethics, Longer Clinical Internships, Regional Coordinators of Clinical Education, and Mock Clinic

As just discussed, the primary ways in which Program 2 socialized students into the professional culture of physical therapy involves the use of reflective journals and portfolios, a separate ethics course, longer clinical internships with the use of Regional Clinical Coordinators to meet with students in groups during their final clinical rotations, and the use of mock clinic. These methods were apparent to all students, faculty, and clinicians that were part of this study.

All participants in Program 2 cited the facilitation of **reflection** through journals and portfolios as a strong socializing force for professional socialization.

> [T]he journal helped us to reflect on what our experiences were and maybe understand them better and it helped us to be a little more empathetic or kind of step back and grow and see what we were doing with people. . . They [the faculty] really emphasize reflection-based practice in my curriculum and they emphasize it a lot . (P2S3, p. 6-7)

> [I]t [reflective journal writing] really made you think about your profession and . . . it helped you to focus more on the lectures and get a sense of what you felt about any issues that came up if you talked about an ethical issue or if you had different people come in. (P2S1, p. 7)

> Another thing that we did was we had a professional portfolio. Within the portfolio we had to ask ourselves what . . . we had learned from that particular year. We did a portfolio for each year, and we would pick two to three items from each semester that were important to us and we would incorporate that in our portfolio and we would answer questions as far as what we thought we were weak in and what we had benefited from that year as far as knowledge. . . and [we would write] long and short term goals. . . we had a pre-interview which was the first semester and then midterm, which was in the second year and then in the final year, the exit interview. . . I think they [all the above mentioned methods] helped us to kind of develop into the role. It helped you to focus on particular goals. What your strengths and weaknesses were and from that I felt like I just walked into the role. (P2S1, p. 5-6)

> My understanding is that there is a focus in their curriculum on reflective learning and that they encourage students to spend time after they have had a particular learning experience, thinking about it in a way such that they can integrate what they learned. And I think that [reflection] is missing in a lot of programs. (P2C1, p. 4)

The **strong emphasis on ethics** in the profession, incorporated into the program in the form of a separate three credit ethics course, was cited as a strong factor in the socialization process. All students and faculty discussed the ethics course as part of socialization of students into the profession (P2F1, P2F2, P2F3, P2S1, P2S2, P2S3). One faculty member said:

> The ethics course is directed toward that aspect . . . [the instructor] emphasizes very heavily the ethics of care . . . and people's work on that and tries to introduce them to that concept and also what the professional role of physical therapists is in relationship to a lot of virtues. (P2F1, p. 2)

The **longer clinical internships and use of Regional Coordinators**

of Clinical Education were also thought to be a very important contributor to the socialization process.

> [H]aving the long clinical internship, our whole clinical internship program. The way it is set up allows them such a greater opportunity to make that transition [from student to professional]. We think socialization in the field is best accomplished . . . in [that way]. That is one of the reasons we moved to the longer clinical format, where the students are able to get much [more] involved in many more activities than they do in six weeks. If they have fourteen weeks, they have time to really get involved in the ethos of that whole clinic and learn a lot more things than they would have [in a shorter clinical internship]. And also having [the clinicals] over two semesters (helps). (P2F1, p. 6)

> I think the things that Program 2 has in place that helps them [to help students internalize the professional ethos] are the regional meetings [with the students and the Regional Coordinators of Clinical Education], the longer clinicals, and the reflective learning. (P2C2, p. 5)

> In our last year we did our clinicals, which were 14 week clinicals . . . I think that was very helpful because when you're there long enough, you get to learn what to do. You've got to juggle insurance information, discharge planning. Critical decision making was enhanced, or you got to actually take a bigger part in that decisions rather than sort of collaborating with your CI. You got to really grow and learn like what your judgment call should be. More responsibility. That way they weren't doing everything for you . . . You did everything mostly yourself and I think that really helped me [when I started my first job]. (P2S3, p. 9)

In contrast to those who felt that the longer internships were extremely helpful in the socialization process, one clinician felt that the longer internships were not as necessary since other students, who complete shorter rotations, also do well in the area of professional socialization (P2C3, pp. 10-11). This different opinion, I think, addresses concerns of efficiency. If students can internalize the ethos of the profession in less than 14 weeks, is that longer time, although helpful, necessary? Another comment made by this same clinician, however,

speaks to the goal of the program faculty in socializing students. They (the program faculty) discussed how these longer internships were a way of helping students to transition into the profession, a way to help them internalize the subtleties of how to behave and think as a physical therapist -- to go beyond simply the skills needed to be an effective physical therapist. The clinician's comment was that one of the reasons she felt that 14 weeks may be too long was because the clinical instructors often had a hard time identifying something to "teach" the student on the last several weeks of the internship (P2C3, pp. 13-14). Perhaps, as suggested by the faculty comments, this is the time that students have achieved clinical competence in the areas of cognitive and psychomotor skills, and are working on affective development, part of which is the internalization of the ethos of the profession. This question, however, cannot be answered by the data gathered as part of this study and remains a question for future research.

"Mock clinic" was felt by participants to be a useful tool in socializing students into the profession. Some of the factors about mock clinic that were thought to contribute to professional socialization included opportunities for practicing professional behaviors, problem solving, self-evaluation and evaluation by peers.

> To get us set up for clinicals, one of the things we did was we had the patient care labs, where we had mock clinic, and I think that helped us
> . . . one student would be the therapist and one student would be the patient and they videotaped us and we got to see the videotape of how we acted. It was really interesting to see how we were when we first started the program compared to the second year when we had mock clinic again. (P2S2, p. 5)

> We have mock clinic. We have a lot in the labs. We have a lot of patient scenarios and we are trying to get the students to think through and come up with different solutions. (P2F2, p. 5)

What do these two Programs have in common?: Shared Expectations, Opportunities for Practice, Consistent Expectations, Professional Development Courses, Feedback, Adult Learning, Evaluation of Effectiveness of Socialization, and Recognition of Socialization as a Developmental Process

While certain processes by which students are made aware of and socialized into the ethos of the profession in these two programs were identified as unique or special by the participants (generic abilities assessment in Program 1 and the use of reflective journals and longer clinicals, etc. in Program 2) , many other instances of professional socialization were noted, some of which are typical of most physical therapy programs and some of which are shared by fewer programs, and may, in fact, be unique only to these two programs.

A strong emphasis on **sharing expectations** of professional behaviors with students was felt to be important. Both Programs included expectations of professional behaviors in such documents as the university catalog, student handbook, course syllabi, APTA documents such as the Code of Ethics and Standards of Practice, and clinical policies and procedures manuals. Faculty explicitly shared their expectations for professional behavior. In addition, faculty in Program 1 made the program expectations and consequences of failing to meet expectations, known quite explicitly through the generic abilities. Interestingly, the faculty in Program 2 felt that they did not make their expectations as clear and explicit as they wanted to and felt this was a weakness in their program. Consequently, they had plans to incorporate the generic abilities into their curriculum for the next incoming class. This trend is also being instituted in many programs across the country, including the one in which I currently teach.

Next, both of these programs offer the students many opportunities to **practice professional behaviors** as a way to help them internalize the

ethos of the profession.

> Well, I think it [the use of GAs] gives them a clue what clinicians, or people outside of the school expect. They'll know what people out there are expecting the first day that they show up as an intern. I mean it just helps with instilling all of those qualities that they'll need . . . I think it is just practice for what they're going to have to do when they get there. (P1F2, p. 6)

> I think when we had mock clinic we had our labs and we have every kind of . . . hands on experience. That helped a lot because, like I said before, the first time you go in there and you are very uncomfortable even talking to your own classmates and it is not even a real situation where somebody is in pain. After two years of doing this, it just becomes very natural and after your first clinical, you get used to interacting with the patients. . . . I think [it is] just practice. (P2S2, p. 5)

The fact that **expectations and practice are part of the entire curriculum**, rather than simply being presented as part of one or two courses or units of courses, and are consistent across settings was also felt to be important.

> "I think even the instant we step into the program it's kind of ingrained into us - respect, treat patients how you want to be treated. I think every class emphasizes good care and skills. (P1S1, p. 5)

> [T]his [professional socialization] is something that you have to give students over a period of time to develop, and it has to be part of the curriculum at every single level, starting with pre-admission. If you're going to expect students to be socialized into the profession at entry level by the time they graduate, you have to give them time to do that because the socialization process takes time. . . and we can do this in part of every course. (P1F3, p. 5-6)

> It was basically expected that you would conduct yourself that way [as a professional] throughout all your education. (P2S3, p. 2)

> There are a lot of things that have been consistent from day one of coming into the program through this moment, in any setting whether that was in the professional classes that we had at [Program 1] . . . or in any given clinical setting that I've been going

> through or, . . . any [state Physical Therapy Association] function that I've been part of . . . I mean that that [ways of socializing students into the profession] has been articulated very clearly in [Program 1] . . . , and I think it is implicit in the clinical settings, if you're following what I mean by that. It's been stated pretty clearly, "This is what's expected of you if you're acting in a professional manner." (P1S1, p. 5-6)

One method of socialization that these two programs shared that is not present in many other programs is a series of **professional development courses**, one per semester, in which students are exposed to and discuss current ethical, societal, economic, political, and professional issues that affect practice and, ultimately, the evolution of the profession. These seminar courses were described by participants in both programs as a strong force in the socialization process.

> [T]here are credit/non-credit courses that are each semester. Professional issues, professional development, things like that [are covered in these courses]. During those classes there is a lot of ability to interact and it [helps] . . . to explore the evolution of the generic abilities on one level, and the professional qualities that we've been talking about on another level. (P1S2, p. 7)

> [W]e had seminars and we would break up into small groups and we did a lot of just talking amongst ourselves. . . I think that really helped to just talk about different ideas that were out there . . . we just got used to hearing about these issues and how we [the profession] were dealing with it and everybody got to talk about how they would deal with it. So you got to hear everybody's ideas and learn from that. (P2S2, p. 2)

> Throughout our academic course we had seminar courses that we had speakers talking about current topics and controversies within our profession. We do a lot of reflective journal writing on subjects that were presented there. A lot of dialogue and discussion [in those courses]. (P2S3, p. 3)

Educators in both Program 1 and Program 2 provide **feedback** not only on a **regular and consistent** basis, but also provide feedback to **correct**

problems as soon as they occur rather than letting unprofessional behavior go unnoticed or waiting for a scheduled appointment with a student. Faculty felt that this method of immediate feedback would decrease the chance that the unwanted behavior would continue or get worse.

> Well, we get feedback on a regular basis, and that is part of the generic abilities, but it's not necessarily just generic abilities based. They'll give you feedback on other aspects as well. (P1S2, p. 6)

> I always correct unprofessional behaviors as soon as I see it. (This statement was made by several faculty members and clinicians)

> [W]e have more students who are having problems [because they are being identified now]. The thing is, we are identifying them early and they're not as big of problems. We don't have students dropping from the program in the final six weeks rotation, that have been all the way through the program (and have been having problems) . . .If we have a student like that, it's somebody that we've known about all along and we've been working with it and it just hasn't worked out. (P1F3, p. 9)

Both programs used **principles of adult learning**. There was an emphasis on being self-directed, being an active learner, being responsible for one's own learning, and being reflective. In addition, as mentioned earlier, Program 2 placed a great emphasis on reflection through the use of reflective journals and portfolios; and Program 1, through the use of the generic abilities, stressed self assessment and self direction.

> He [one of the faculty] believes himself to be in the "Socratic" method of teaching to help you discover what you know, and I felt that worked for me. I liked that a lot. I know that some of my classmates, that was hard for them, but I do believe that that really is a good preparatory tool as each of us goes on to continue in our professional lives. There will always be times where we're not going to go, "Chris, what's the answer?" We'll need to go to our own resources within and find out, well, what journal can I look up to figure this out, or how can I put together what knowledge I already have at my fingertips to solve part of the puzzle, or

perhaps all of the puzzle. (P1S2, p. 13)

> There are also specific parts of the didactic curriculum where we try to incorporate this responsibility for lifelong learning and responsibility for evaluating new literature that deals with our profession. Responsibility for creating new knowledge. (P2F2, p. 2)

> I'm trying to get away from the 50 minute lecture format as much as possible . . . I think they learn things better when they are asked to get it on their own . . . I think if you are careful in your selection of assigned readings toward the textbook and that sort of thing, the information will always be there and students can benefit from using the in class time to do some sort of active work rather than just listen to a lecture. (P1F2, p. 7)

> I think that we have instituted a whole bunch of ways throughout our curriculum to try to encourage active learning and also reflective learning and I think looking at the development [course], reflective journals, the seminar series, all those things are methods that are trying to get them to reflect on a lot of topics. Active learning is something that we're working on . . . I think we have quite a bit of that in our curriculum where we try to do a lot of case kind of studies and try to get the students to simulate kinds of continuing education . . . Getting to go on to do it and trying to get them to search out things on their own. I think we are continuing to work on that. (P2F1, p. 5)

Another shared quality of these two programs was the process by which they attempted to **evaluate the effectiveness** of their program. All physical therapy programs must perform outcomes effectiveness studies of their students to meet the accreditation requirements of the American Physical Therapy Association. While all programs do make some efforts to assess professional behaviors as part of this accreditation criterion, Programs 1 and 2 not only made efforts to design their curriculum to explicitly include methods to help students internalize the professional ethos of physical therapy, but also attempted to evaluate the effectiveness of the program in this area. Faculty from both programs were able to cite specific evidence of the effectiveness of the program

in facilitating professional development.

> I think it is effective, particularly because the students relate well to that [professional seminars]. Students consistently cite the seminar series as being very helpful, enlightening in their professional socialization, in their identity with the professional and learning more than just technical or practical issues. We do this consistently. (P2F3, p. 3)

> We have journal writing, too. In each of our seminars we do journal writing and we do portfolio reviews and they have to write evaluations of their own. From those kinds of things and the exit interviews and things like that, you get a sense, and also on the papers they write in ethics and other courses, you get certainly a sense that they are incorporating some of those values into their own values and solidifying some of the values. (P2F1, p. 3)

> Well, we think they [the GAs] (are effective]. . . I could give you a list of as many clinicians as you would want to talk to that will tell you that our students are more professional than they were a few years ago. The only thing that is any different is the generic abilities. . . from the clinical point of view, I have students with less problems when they go into the clinical in the last internship, and when they do have a student who has a problem, they are much easier to address. . . As another quick example, I got a call from a 1996 graduate who called me up and said, . . . "I'm about to be a clinical instructor for the first time and we just had a student here from another program and . . . we had a lot of issues with the student. None of these issues related to the school's evaluation tool. They all related to the generic abilities." She said, "When I was there in school, . . . [I thought] this is common sense . . . I took it as a given . . . Now I realize how important it is." Of course, I said to myself, "Another student has another ah-ha experience." (P2F3, p. 8-9)

Finally, faculty, as well as students, from these two programs recognized that the process of **professional socialization is a developmental process**. As such it takes time, with students progressing through the process at different rates and in different ways. In addition, there is a recognition that some students will never make it to the final stages and truly internalize what it means to be a physical therapist.

> [T]here are still some students that come through and no matter

how hard you work with them, at the end of two years it still seems like they want the answer to memorize rather than trying to use all they know to [find the answer]. (P2F2, p. 5)

[S]ome students will get it and some won't have a clue. . . we tell them that this is more than just facts and skills that we expect from them, that we expect certain behaviors and values to also be taken on as part of their professional socialization. Some identify with it and some do not. (P2F3, p. 8)

[At the beginning] they sort of a little bit [looked down on] the seminar and having speakers come in and talk about why we do this or talk about professionalism. But by the end of that, almost everybody felt that these were the most important things that they learned. There were things that just made them ready to go into the clinics. (P2F1, p. 7)

The process of GAs is hard, it takes a lot of time, and it is worth it because it lasts a lifetime. (P1F3, p. 4)

I think they [the students] are aware [of the socialization process, . . . but] students see the value more once they graduate. (P2F2, p.10)

I'll be honest. My first year I was a lot more dissatisfied than I am now. I think maybe a lot of it is because I've matured as a student, and I'm sure that has a lot to do with it. (P1S2, p. 13)

Socialization Methods Common to Most Physical Therapy Programs: Role Modeling, Course Work, Real Life Examples, Provision of Examples and Nonexamples, and Encouragement to Join Professional Organizations

Of the other means of socializing students into the profession, those methods that these two programs share with other physical therapy programs, **role modeling** was felt to be the most important by faculty and clinicians. They discussed their personal role in socializing the student as one in which they had to "teach by example" or "by demonstration" (P1F1, p. 3; P1F3, p. 4; P2F3, p. 2), and to, first and most importantly, "be a good role model for students" (P1F2, p 2; P1C2, p. 2; P1C3, p. 4; P2F2, p. 2; P2C1, p. 1; P2C2, p. 3; P2C3, p. 3).

Students also noted that they learned by watching and role modeling their clinical instructors and other therapists they observed. One student said, "These values are implicit in the clinical setting and are exemplified by what I see rather than that they are [just' explicitly spoken of in those settings" (P1S1, p. 6). In addition, although students identified behaviors in some clinicians that they did not find they would want to role model, overall all participants felt that the academic and clinical expectations for behavior and the role models were consistent across these two settings (P1,P2 all participants). More specifically, one student from Program 2 described the learning that occurred as a result of role modeling as follows:

> [T]hat is the way I would learn from the therapist, is by watching them first, and by seeing another professional. I think that you kind of pick up on . . . how they are doing things and incorporating that into your well-being. I think that is something through all my clinicals that I have had as far as just observing the different therapists . . . you agree or disagree with certain things and you incorporate that into a whole and I think you kind of come up with your own recipe that you like and you use that and that is what I have done. (P2S1, p. 2)

Other methods that I have personally encountered that these two programs share with other physical therapy programs include **presentation and discussion of professional issues in other courses** such as an Introduction to Physical Therapy, Research, or an Administration course; the use of **real-life examples** to the greatest extent possible in the form of paper patients, role-playing, evaluation and treatment demonstration with real patients in the classroom, evaluation and treatment of real patients by students, exposure to real patients with one day visits to practice clinical skill, and, of course, exposure to real patients during clinical internships; provision of **examples and nonexamples** of professional behaviors in various classes;

and encouragement or expectations to be socialized into the profession by **joining professional associations** and attending professional meetings. Each of these methods was cited as a way in which students are socialized into the profession by the participants in this study.

> It seems like anytime they go to a professional meeting or read some article, they come back and they say, "This is really what the profession stands for. Read this article.'" This is the gist of what we heard from clinicians and I think that type of thing and I think that helped us too. (P1S3, p. 4)

> Going through practice practicals. Going through having actual patients come in to work with them in class in small groups, or going out to see the clinic and seeing patients. Seeing actual patients. All of those, I think, are very valuable bridges [from being a student to being a profession]. (P1S1, p. 17-18)

> ([] use clinical examples from my past experience to try to get across a concept. (P2F1, p. 5)

> The faculty has been very supportive of student enrollment in the APTA and the . . . [State meetings], and participation in those annual meetings and/or regional meetings, student conclaves. (P1S2, p. 2)

> I help teach the spinal cord injury unit . . . [and] we ask the students to personally interview patients and not only get a subjective history from them, but also ask them questions like, "What does it feel like to have this?", or "What did you do when you were confronted with that?" (P2C3, p. 11)

> It seems like most schools are really encouraging professional involvement in the association, as well as . . . district meetings. (P2C3, p. 8)

> The . . . clinical education series . . . and then the social psych course [help address issues of professional socialization. (P2F1, p. 5)

The Phenomenology of Professional Socialization: The Voices of Students

The previous section described the methods used in Programs 1 and 2 to socialize students into the profession of physical therapy and to help facilitate internalization of the professional ethos. The views of both educators and students regarding these methods and their effectiveness were integrated into this description. In contrast, this final section of the chapter emphasizes the views and feelings of students only. It highlights their perception of the experience of professional socialization.

Recognition of the need for socialization. The need to behave professionally was cited as a definite plus when interacting with patients, colleagues, and the general public. Students identified such issues as interacting appropriately with patients, explaining what will be done and why, treating patients with respect, open communication with team members, being willing to help coworkers, being active in the professional association, and behaving appropriately both within and outside the clinical setting as important characteristics of professional behavior. In general, they recognized that a professional demeanor is not just something that is put on upon entering the work setting as one would put on a lab coat or name tag to indicate job status. One student summed up her feelings on professional behavior as follows:

> I think basically it [professional behavior] is shown in how we act towards them [patients], [and] how we act when we are in public, just pretty much everything that you do, and not just when you are at work. I think, just in general, not only when I am at work, but when I am out I try to help people if I can. If I see somebody who needs help, even if they are just lost or need directions, I just try to help them. (P2S2, p. 1)

Awareness of problems with professional behavior. Like the educators who socialize future colleagues into the profession, students also expressed awareness of and disappointment with unprofessional behaviors they had witnessed in both the classroom and the clinic settings. For the students who participated in this study, classmates who behaved unprofessionally were felt to be an embarrassment to their cohort, the program, and the profession in general. This sentiment was expressed in a variety of ways.

> I can think of specific cases [of unprofessional behavior] maybe in the classroom when we have speakers come speak to us and people are maybe, I don't want to say short tempered because it isn't the right word, but they're very unaccepting. Not that we have to accept what everybody says, but I think tolerance is a big key in showing respect . . . We had somebody come to speak to us about [tape unclear]. She had come and she specifically said that the example she had given was non-functional, but this was they only way she could make us kind of apply it to our knowledge at that point. One student specifically, I remember, kept saying, 'I don't understand this. It doesn't make sense'. He literally said to her, 'I don't see why we even have to listen to this'. I was really disappointed. I was really more embarrassed for all of us than anything else. (P1S2, p. 3)

> I think it is really rude to talk when a professor is teaching a class and giving a lecture. I think that was one of the things where in this particular class, people had a little bit more laid back attitude than they should . . . . I though it was unprofessional [to talk when a professor was teaching]. (P2S1, p 3)

Unprofessional behavior on the part of professionals in the clinic was also considered to be unacceptable by these students, and students recognized times when they (the students themselves) may have not acted as professionally as they could have. Several instances of unprofessional behavior on the part of clinicians and the students themselves were described.

> I guess one of the first clinical instructors that I had on my two week was somebody who tended to use excuses for not knowing certain procedures or ideas. Excuses being, 'They didn't teach my

> that in school, the program wasn't very good where I was'. Instead of taking it upon himself to go to continuing ed courses or to develop himself as a clinician, instead he chose to make excuses. Because of that, at that time it was only my two week [clinical] after my first year, but I didn't think he was necessarily practicing all the values that he should have. (P1S2, p. 3)

> I guess one example of just myself, is that at my first clinic I found myself getting frustrated with patients. I was kind of like wishing that they could do more and finding myself becoming frustrated. I think now after just a little more schooling and a little more experience that would not happen any more. I think back and I should have been more patient. (P2S2, p. 2)

> I had a boss that had been practicing for 14 years and she's never been to continuing ed. There are people out there . . . well some people are out there making money and they're not dedicated to maintaining that [professional] standard. (P2S3, p. 14)

On the other hand, students also readily discussed positive examples of professional behavior they had witnessed.

> I think the majority of educators and our staff were extremely professional and they were all very active in the state PTA (Physical Therapy Association) and the APTA. They went the extra mile to make sure our needs were met in terms of our learning needs and stuff like that . I think they represented the profession in excellence of care and things like that with their teaching. (P2S3, p. 4)

> Well, at the last clinical I was at, my clinical instructor had been working for about 20 years and she had a difficult patient and she just knew how to handle him, his family, and his doctors. She just knew the right thing to say, the right tone to say it in. I don't really remember a specific situation or exactly what it was, but she just always knew what to say, how to say it, how to act and how to approach the patient. (P2S2, p. 2)

Overall, although students said that they were aware of some problems, they also felt that part of the process of socialization was this witnessing of many different types of behavior in order to mold their own

view of how they should function as professionals. Consequently, they felt that exposure to different role models, including negative ones, were an important part of the socialization process.

> I guess for me, that is the way I would learn from the therapists, is by watching them first and by seeing another professional. I think that you kind of pick up on . . . how they are doing things and incorporating that into your well being. I think that is something through all my clinicals that I have had as far as just observing the different therapists . . . you know you agree and disagree certain things and you incorporate that into whole and I think you kind of come up with something of your own recipe that you like and use and that is kind of what I have done.
>
> In any given professional that I've encountered, faculty or clinician, I do feel that each of them exemplifies all of them [the values of the profession] quite well, and some of them better than others, and some of them not quite as well as others, . . . [but they] do exemplify these values that we talked about that are important to physical therapy. (P1S1, p. 17)

Awareness of goals, expectations, and methods of professional socialization. In addition to being aware of problems with professional behavior and being able to provide examples of both professional and unprofessional behaviors, students were also aware that professional socialization was a goal of their programs. All students felt that goals and expectations were made very explicit throughout the program. In addition, they stated that the faculty goals were realistic and, for the most part consistent with those of the clinical settings. They used terms like "there are a lot of things that have been so consistent from day one coming into the program" (P1S1, p. 6), "I think with the generic abilities that is pretty well laid out for us" (P1S2, p. 5), "It was basically expected that you would conduct yourself [as a professional] throughout all your education" (P2S3, p. 2), "I think even the instant we stepped into the program it's kind of ingrained into us" (P1S2, p. 2), and "it was very structured and very organized

and written out as far as goals and objectives" (P2S1, p, 4).

Students were also able to describe methods educators used to help evaluate and facilitate professional socialization. In general, students' perception paralleled those of educators. They clearly identified the same methods of socialization identified by educators that were discussed earlier. For Program 1, these included primarily the generic abilities and all their component parts (i.e., explicit goals and expectations for behavior, regular meetings and feedback with advisors, self assessment, etc.) (P1S1; P1S2; P1S3); feedback in other classroom situations unrelated to the generic abilities assessment; consistent role models (P1S1; P1S2; P1S3); encouragement to join and become involved in the professional organization (P1S2); and professional development courses (P1S1; P1S2; P1S3). Students in Program 2 described the longer clinical internships (P2S1; P2S2; P2S3); the strong emphasis on reflection and ethics (P2S1; P2S2;P2S3; mock clinic (P2S2; P2S2) consistent role models (P2S1; P2S2; P2S3); and the professional development courses (P2S1; P2S2; P2S3) as effective means of professional socialization. It should be noted, however, that all students reported that they were relatively unfamiliar with what methods of socialization were used in other programs, and, therefore, their perceptions of the effectiveness of these methods in relation to other methods that might be used in other programs is not available from the data in this study.

Students provided many examples of how these methods helped them to internalize the professional ethos. They specifically noted that it was important for faculty to use methods that would allow them to be active and responsible learners who could perform self assessment and goal setting; to reflect on their learning; and to become aware of and involved in addressing professional

issues. In addition, they said it was helpful if faculty created opportunities to allow adequate time to practice the skills they would need to be successful in the profession; to discuss important issues with classmates and educators; and to interact with a variety of professionals and patients through course work, clinical internships, and involvement in professional activities.

> [T]he journal helped us to reflect on what our experiences were and maybe understand them better and it helped us to be a little more empathetic or kind of step back and grow and see what we were doing with people . . . . I think it [the use of journals] did [help with professional socialization]. Just to look at your thoughts and things again and see what you could change or what you couldn't change. It gives you a sense of perspective on what you're doing. (P2S3, pp.6-7)

> [Reflective journal writing] really made you think about your profession and . . . it helped you to focus more on the lectures and get sense of what you felt about any issues that came up if you talked about an ethical issue or if you had different people come in. (P2S1, p. 7)

> We are constantly writing goals and objectives and for each clinical we have to write them and we have to keep journal for our clinicals and we have to read them over and thin back of how we felt the first week and how we felt the last week . . . . I think it helps a little, [but] for me personally, just kind of doing it [helps, too]. Getting out there and just knowing that each week you grew a little bit more. (P2S2, p. 4)

> Even the first day when we have our little orientation, they [the faculty] talked about being active learners and that we are responsible for our own learning and that they have the reflective journals and we have to look back and see how we are doing. I think it is just something that was always talked about so we just grew to expect it . . . once you are out there actually working, it just becomes natural. You just come to expect it and this is how it is and this is how it should be and it's not anything that is new or something that you have to get used to or think about. It is just natural. (P2S2, pp. 4-5)

> [To help us make the transition from student to professional] I think that we had mock clinics, we had our labs, and we had every kind

of hands on experience. That helped a lot . . . . After two years of doing this, it just becomes very natural and after your first clinical you get used to interacting with patients. (P2S2, p. 5)

The faculty has been very supportive of student enrollment in the APTA and the . . . [State meetings], and participation in those annual meetings and/or regional meetings, student conclaves. (P1S2, p. 2)

In our last year we did our clinicals, which were 14 week clinicals. We just did two and while we were out, we didn't have any other classes to go to, so you were done after you were finished with your clinicals. I think that was very helpful . . . . You really got to grow and learn what your judgment call should be. More responsibility. That way they weren't doing everything for you, like the little things. You did everything mostly yourself and I think that really helped me [when I started my first job]. (P2S3, p. 9)

I think that the things that they did were probably right on track in terms of what they did in my program. If we didn't have the seminar courses, there are a lot of issues and things going on in the profession that I just wouldn't know about. That was really helpful. (P2S3, p. 11)

I think [the generic abilities] helps with that [making the transition from student to professional] a lot. The affiliations that are set up help with that a lot . . . . there are lots of things within the program the way it is that feel like it facilitates that. I'll give you a couple of examples. Going through practice practicals, going through having actual patient come in to work with them in class in small groups, or going out and seeing patients. Seeing actual patients. All of those, I think, are valuable bridges. (P1S1, pp. 17-18)

It seems like any time they [the faculty] go to a professional meeting or read some article, they come back and say, 'This is really what the profession stands for -- read this article.' This is [also] the gist of what we heard from clinicians and I think that helped us too. (P1S3, p. 4)

[The faculty help us make the transition to being a professional] I think definitely by having the generic abilities and then the forms they've set up [as part of the generic abilities]. We keep having to sort of check back after every clinical . . . we have to be to a certain level in our generic abilities. We have to make sure that we have either gotten a skill or developed that professional behavior in

order to go onto the next one.

> That [the use of the generic abilities] felt like it was a very effective means of communicating and helping students be a very active participant in their own evolution professionally. (P1S1, p. 10)

> [W]e had seminars and we would break up into small groups and we did a lot of just talking amongst ourselves. . . I think that really helped to just talk about different ideas that were out there . . . we just got used to hearing about these issues and how we [the profession] were dealing with it and everybody got to talk about how they would deal with it. So you got to hear everybody's ideas and learn from that. (P2S2, p. 2)

> Another thing that we did was we had a professional portfolio. Within the portfolio we had to ask ourselves what . . . we had learned from that particular year. We did a portfolio for each year, and we would pick two to three items from each semester that were important to us and we would incorporate that in our portfolio and we would answer questions as far as what we thought we were weak in and what we had benefited from that year as far as knowledge. . . and [we would write] long and short term goals. . . we had a pre-interview which was the first semester and then midterm, which was in the second year and then in the final year, the exit interview. . . I think they [all the above mentioned methods] helped us to kind of develop into the role. It helped you to focus on particular goals. What your strengths and weaknesses were and from that I felt like I just walked into the role. (P2S1, p. 5-6)

While most methods and most educators were viewed as helpful in the socialization process, there were also "negative" methods used by some faculty that students felt did not contribute to their professional growth. One student in Program 2, in particular, mentioned several aspects of her education that were not helpful for her or her classmates.

> I can think of one faculty member who I think has shown maybe a condescending attitude, not so much maybe condescending, but has treated students and colleagues, I think with . . . disrespect . . . . I think [that] was not appropriate. (P1S2, p. 5)

> I think some methods are effective and some aren't . . . . Encouragement and feedback are really effective. But I think

> threatening students, or we've not really had threatening, but we've been told previously that we're not a very good class, . . . our first semester we had a practical and it said we were below average and that was very frustrating. (P1S2, p. 11)

Finally, although students overall felt that their programs were doing a fairly good job in the area of professional socialization in general, they had suggestions for improving the process even more. They realized, however, that some of their suggestions might be beyond the realm of what could be accomplished during their enrollment in a program due to constraints such as time, money, and the logistics of carrying out the program. For example, students felt more time in the clinic and interacting with patients would be a very effective way of facilitating professional socialization even more than their programs did (P1S1, P1S2, P2S2), but they realized that the time, money and the logistics of arranging more clinical time might make this desire an impossibility. Similarly, one student discussed how the program could have been longer, but realized that a lot of time and money on the part of both students and faculty would be needed to do so. Several students suggested that putting more emphasis on ethical and socialization issues might help, but acknowledged that the faculty were doing a good job of doing so within the financial, time, and logistical constraints of the educational system.

> I feel, at times, that our program was too short. I mean, in two years we stuffed in all these classes, and I think we could have maybe spread things out and really focused in more . . . my Patient-Practitioner Interaction class, which I know was a really important class, was kind of pushed lower on the agenda because other classes took over. I think making things like that have more emphasis would be a really good thing to do . . . . [but] I'm sure funding is a big obstacle. With more time spent on the ethical and social issues, I'm sure people just aren't going to be interested. There's always students who aren't interested, who have other things they'd rather be doing. Maybe there are faculty members who aren't just interested in teaching them. (P1S2, pp. 12-13)

> I just think that there is so much information that you need to know before you go out on your clinicals that your first concern isn't . . . 'I have to act this way when I get there.' [Instead it's] 'Am I going to know the information that I need to know?' so that might be part of it because you are so worried about knowing everything before you get there, that that part might be overlooked . . . . [One way to get rid of that obstacle is] kind of what they are doing in my program, where even though you have all this academic work that you have to worry about, you always talking about [professional issues]. So even though you might not be thinking about it, you kind of have the sense of, 'OK, yeah that's right. I have to act this way and I have to be professional.' (P2S2, p. 7)

Recognition of the role of the student in the socialization process. All the students acknowledged their role and responsibility in the socialization process and recognized that it was not enough to just be familiar with knowledge and technical skills of the profession. They seemed to readily accept this responsibility while in the program and acknowledged the relationship between continued professional development and good patient care.

> Most of what they said was that the skills, I mean you can come in with set skills and that's fine and skills can be improved, but when students come in and they don't have a good base as far as the generic abilities, that's where they really struggle. They don't necessarily become good therapists than. (P1S3, pp. 3-4)

> They [the faculty] talked about being active learners and that we are responsible for our own learning. (P2S2, p. 4)

> They [the reflective journals] were more for you, the student, just to help you reflect what was going on for you. (P2S1, p. 7)

> It [the generic abilities] encourages and fosters students being responsible for their own learning. (P1S1, p. 12)

> [F]ostering students' thinking for themselves is also critical, as I see it, to facilitating patient care. That I need to be able to, you know that's not to say that it's inappropriate to ask somebody else for something, but I do need to take responsibility on my own for what it is that I think and what it is that I'm wanting to do and how

am I going to get there. (P1S1, p. 16)

> I think [being an active learner and being responsible for myself is an important part of getting an identity as a physical therapist], although I don't know that I so much realized that while I was in the classroom. I think it was emphasized, but I think now that I'm in the clinic, these things are kind of coming out and I'm seeing them more. (P1S2, p. 7)

> [I think the program] definitely [prepares students to be active and reflective learners who are responsible for themselves]. I think [they do this] partly through the generic abilities because they have critical thinking and problem solving. Partly [by the fact that] we had an instructor who believed very strongly in active learning and we were really forced into that model which helped a lot of people to get out of their old way of learning . . . . He really just gave use a backbone of knowledge and expected that we would go out and fill in the blanks. If we had trouble doing that, then we could go to him and ask for advice . . . . The clinical instructor ^have now really believes in active learning as well, and he questions your rationale at every step that you take. I think that forces you to think about why you're doing what you're doing. I think that helps you provide better care for patients. (P1S3, p. 5)

Preparing for the future: Awareness of changes in the profession. Like their educators, the Prime Timers, and the Fellows, students recognized that the society and health care are changing and that professions must change with them in order for the profession to continue to survive. They realized that they would have to personally deal with these changes and respond to and change with the profession if they wished to continue to develop as a professional. Overall, students felt that the faculty in their programs were up to date with the latest changes in the field and society that would affect practice, and that faculty had adequately prepared them to deal with these changes.

> My belief is that things are changing so fast. Medicare, the whole picture is changing so rapidly that I don't know . . . . Three years ago is a huge amount of time in terms of what it's like to be a student in trying to prepare yourself professionally . . . . It [the profession] was different [years ago] and it can't help but be

different. I mean, the world's changing . . . . It's just the nature of the beast. (P1S1, p. 19)

Well, certainly, what is happening in health care [will affect the profession], and who knows what will happen ultimately. It certainly looks like we're moving this way, but you can't, as a good friend once said, 'You can't predict tomorrow's dream.' So it looks like it's moving in a certain direction, but it sure could do an about face and who knows? (P1S1 pp. 23-24)
I would say it's [the faculty being in touch and up to date with changes in the field] is stellar on all accounts. (P1S1, p 5)

They [the faculty] were very up to date [with professional issues]. (P2S1, p. 4)

I think they [the faculty] are well read or they knew what is going on. Most of them are very active within the therapy community even though they're in the academic setting. There are a few of my instructors clinically that were still practicing and some of them were just doing academics. But they were still very, very active within the organizations and knew the political things going on. They would keep up with that. (P2S3, p. 5)

Well, there are changes that seem to go on every year. As I was going through the program, one thing they did that was good is that they always kept us updated. They had the president of the APTA come in and talk to our class, just about different issues that were going on. They had somebody from the ethics committee come in . . . just to talk about ethical issues. (P2S1, p. 11)

We talked about a lot of this [changes in health care and their effect on practice] in our seminar, about actually just how physical therapy is changing. How it was, how it started out, and how it has changed through the years, and how it is probably going to change in the future. They [the faculty] talked about what we need to do to keep up with it . . . . We need to be knowledgeable for the insurance companies, . . . we know that we have to be educators to our patients. Basically, they just talked about all that and how we have to be on top of everything. (P2S2, p. 8)

Recognition of professional socialization as a development process. Students recognized that, like the profession, they also go through a series of changes as they progress through their respective programs. They discussed

how the process of professional socialization is really a lifelong process that actually begins prior to entering the program and continues past the time of graduation. They were able to reflect on their growth and see the relationships between socialization methods used by faculty and their professional development. Like faculty, however, they realized that students progress through the socialization process at different rates and that some students will fail to internalize the professional ethos, at least by the time they graduate.

> I think it [professional behavior] kind of has to be who you are too. I think that there is just no way that everybody can go through school and come out exactly what you think a professional is going to be. Everyone is brought up differently. I think it has to be a sense of who you are to begin with and then you grow on that . . . . I think that some people can change and some people can't change. I think the time you grow up, your values that you are taught when you are younger, I think it makes a difference. (P2S2, pp. 7-9)

> I'll be honest. My first year I was a lot more dissatisfied than I am now. I think maybe a lot of it is because I've matured as a student, and I'm sure that has a lot to do with it. (P1S2, p. 13)

> To get us set up for clinicals, one of the things we did was we had the patient care labs, where we had mock clinic, and I think that helped us . . . one student would be the therapist and one student would be the patient and they videotaped us and we got to see the videotape of how we acted. It was really interesting to see how we were when we first started the program compared to the second year when we had mock clinic again. (P2S2, p. 5)

> My belief is that if you were to ask the class as a whole and they were candidly to answer in the beginning, that you would have gotten a significant number that would feel like, geez, this is a joke. If you were to do an exit poll, I think you would find that there is a significant difference in the way people viewed them [the generic abilities] . . . . I think that as a collective, there weren't a lot of people that were like, 'Oh great, we get to work with the generic abilities,' but I think that by the time we ended, I think that a lot of people, if they really allowed themselves to reflect on it, would have said, 'This was a valuable process for us.' (P1S2, p. 10)

> I felt for me . . . [the first year] was a transition year. I was still at the point where grades were still really important to me, and if I got an A . . . somehow between by first and second year I realized, okay, the A doesn't matter. Can I apply this knowledge and be functional and effective? I think the way one of our professors teaches specifically, really emphasizes that. (P1S2, p. 6)

> I think part of the reason why it's kind of hard to make the transition and really feeling like I'm the professional now and I have all this down, it's just the fact that you from 'I'm the student' and they respect you, but you're still the student, [and then] suddenly you're the one making decisions. I think with anyone the transition for you to feel like you're really competent is just going to take a little time to feel out, you know, I'm this professional and things like that. I think it just has a transition period and that is going to happen no matter what. (P2S3, p. 11)

> [I think our program helps us make the transition from student to professional by] just emphasizing the continuing education and that we should continually try to keep learning and that that is something that helps you strive to be more comfortable as far as what area you chose . . . . some facilities offer a mentor program and that was something they did here [at the current place of employment]. They have a buddy system where you have one physical therapist that you can ask questions to and it is almost kind of like having a clinical instructor, but not as strict, I guess. So that is how I adjusted, and that is something that they recommended to us in the program . . . . Toward the end of the program they had a speaker come in just for us to ask questions as far as interviews . . . getting us ready as far as having an interview and what questions we should be asking and what we should be thinking of, and asking if they have some kind of mentor program. That is kind of how they helped integrate us into the profession. (P2S1, pp. 9-10)

> Just because you get out of school, you don't stop learning. Always going to continuing education, reading, asking others around you and learning from them [are important]. (P2S2, p. 8)

Summary of student perceptions. Overall, students felt that professional behavior was an important part of the physical therapy culture and was something that should be facilitated in professional education programs . They

recognized both inappropriate and appropriate behaviors in themselves, their classmates, and professionals and were able to provide specific examples of both. They stated that exposure to a variety of behaviors was an important part of their professional socialization and was part of the process that was necessary for the internalization of the professional ethos.

Students recognized the role of faculty in providing them with explicit and realistic goals for professional behavior. The establishment of clear and consistent goals and objectives, either those of the faculty or their own, was viewed as an important first step in the socialization process. The ability to establish goals for themselves as part of reflection and self assessment and their ability to assume responsibility for their own learning were felt to be skills that would help them continue to develop once they completed the program and were practicing therapists.

Students were able to describe methods used by faculty to facilitate socialization and their descriptions of these socialization methods matched those of educators. More importantly, their descriptions went beyond a mere list of what the methods were to how they enhanced learning about what was expected of them as a member of the professional community and how they were helpful as a means of facilitating the internalization of the professional ethos. For example, they described how reflection helped them identify strengths and weaknesses, establish goals, and see how much they had grown over the course of their programs, and how active learning in the program served as the basis for continued professional development following graduation. They also described how traditional teaching methods such as the provision of information about professional issues in the seminar courses, practice, interaction with real patients and clinicians, and role modeling were

important in helping professional behavior to become a "natural" part of who they were.

Finally, students were aware of the evolutionary nature of professional cultures and the need to be aware of and learn to deal with changes in the profession as the culture evolves. They were similarly aware of their own development and the need to continue to engage in learning and professional activities following graduation if they hoped to remain a contributing member of the professional community. They felt that educators had prepared them to recognize and deal with changes in the profession and had provided them with avenues to pursue in order to continue to develop professionally. These avenues included such as activities as self assessment, reflection, active learning, continuing education, using mentors, asking questions, and becoming involved in professional organizations.

Overall, students were satisfied with the process of socialization that was used in their respective programs. As noted earlier, however, they were not familiar with methods of socialization used in other programs and, therefore, had no basis for comparing their experiences with that of other students. In spite of being unfamiliar with any other models of professional socialization, however, they did offer a few suggestions for improving the process within their own programs, recognizing that some of their suggestions might be helpful but were unrealistic.

Summary of Part 2

Although each participant in Part 2 had their own unique way of describing the socialization process and what was expected as an end result, there was overall agreement as to the general process used by each program to facilitate internalization of the professional ethos in their students. Participants from

Program 1 credited the use of the generic abilities with providing the most effective means of professional socialization in the program due to the fact that they provided specific expectations for behavior, opportunities for self-assessment, and regular feedback on the self-assessment as part of the process of abilities based assessment. In Program 2, participants felt that the use of reflective journals and portfolios, a strong emphasis on ethics, longer clinical internships, the use of Regional Coordinators of Clinical Education, and mock clinic were strong factors in the socialization process. Both programs were felt to share all program expectations with students and required professional behavior throughout all phases of the curriculum, offered a series of professional development courses, offered many opportunities to practice professional behavior throughout the curriculum, gave feedback that was regular, consistent, and immediate, used principles of adult learning, and recognized that socialization is a developmental process that takes time. Finally, in concert with other physical therapy programs, Program 1 and 2 used role modeling, courses or units of courses about ethics or professionalism, real life examples of patients and case scenarios, personal examples and nonexamples, and encouragement to become involved in the profession by joining the professional association and attending professional meetings.

In addition to these methods of socialization, both Programs attempted to evaluate the effectiveness of their programs. For example, faculty in Program 1 discussed how clinicians reported an increase in professional behavior in students with the advent of the generic abilities. In addition, faculty reported how graduates of the Program would call the school to get a copy of the generic abilities to use with problem students if they were working in a facility where they were not available. Finally, faculty and clinicians in Program 1 discussed

how the generic abilities were felt to be so effective that they were being incorporated into staff assessments of practicing therapists. Faculty from Program 2 described how information gathered from student journals, exit interviews, and outcomes assessments revealed that their methods of professional socialization were apparent to and successful with students.

Like educators, students felt that professional socialization was an important part of their education. Their perceptions of methods used to help them internalize the ethos of the profession as part of the socialization process paralleled that of clinicians. They described how these methods helped them become part of the professional community and how they would lead to more effective practice. In general, students were satisfied with the methods of socialization used in their respective programs and felt that these methods were effective.

Chapter 6

Putting It All Together: The Relationships Between Values, Teaching, and Professional Socialization in a Changing World

Although the data from the two parts of this study have thus far been presented separately in order to address each purpose of the study and the views of the different participants, Parts 1 and 2 of this study have their strongest meaning when considered in relation to each other. As mentioned earlier, Part 1 of this study was conducted in order to define the professional ethos of physical therapy, to trace its evolution since the inception of the profession, and to identify both static and dynamic aspects of the ethos. Once defined, the description of the culture and ethos of physical therapy was used as a basis for deciding what it is that physical therapy educators hope to socialize students into and to describe their methods for doing so.

When considered on their own merit, the findings of Part 2 offer a framework for understanding how contemporary physical therapy educators attempt to socialize students into the culture of physical therapy. However, when considered in light of the historical values identified in Part 1, the description of the socialization methods of physical therapy educators moves beyond a list of techniques to a reflection of the changing world and changed ethos of the profession in several ways. First, the necessity of increased content on ethics and professional issues is a reflection of the fact that the world and the profession have changed over the years. Participants discussed the fact that it was not even necessary to discuss such issues in the past because everyone had similar values and just "did the right thing." Unlike the diverse students of today, much of the professional ethos was already a part of student's personal

ethos and did not need to be emphasized in professional education programs. Next, the role of the faculty in the past in regard to professional issues was simply to serve as good role models to students. In contrast, faculty must now apply other teaching methods to facilitate professional socialization to account for the changed views of the world, expectations of professionals on the part of the consumers of services, and the need for increased involvement in the professional and political arenas. Finally, contemporary teaching methods, such as reflection and active learning, discussed by the participants in Part 2, reflect the new values of physical therapists preparing to practice in the twenty-first century, as well as an increased emphasis on adult learning in higher education in general. Following a brief comparison of the values discussed by the participants in Parts 1 and 2, the need for an increased emphasis on content about professional values, the changed role of faculty in regard to professional socialization, and the need for applying both more traditional and contemporary teaching methods to socialization in professional education programs are described in more detail. A summary of these changes can be found in Table 5.

Contemporary Values: Similarities and Differences with the Past.

As described earlier, data from Part 1 (i.e., interviews with Fellows and Prime Timers and review of historical documents) revealed the core values of the professional ethos to be caring and helping, hard work and dedication, warmth and openness, and a positive attitude. Of these, the most important overall was helping and caring for patients. Similarly, when asked to describe the ethos (i.e., core values, norms, and beliefs) of physical therapy today, all participants in Part 2 described the importance of providing good patient care at all times as the number one value of the core of physical therapy. This value was described in a number of ways including: "provid[ing] quality care to patients through

Table 5. Putting it All Together: The Relationships Between Values, Teaching, and Professional Socialization in a Changing World

Content as Values: A Reflection of the Core Ethos

- Bringing Core Values to the Forefront
  - History
  - Code of Ethics
  - Standards of Practice
- Application of Core Values to Contemporary Issues
  - Legal Issues
  - Political Issues
  - Professional Issues

Traditional Teaching Methods: A Changed Role for Faculty

- Role Modeling
- Expectations
- Practice
- Feedback
- Motivation
- Transfer

Content as Values: New Roles for Practitioners as a Reflection of a Changing Ethos

- Research
- Teaching
- Delegation
- Supervision
- Consultation
- Diversity

Process as Values: Contemporary Teaching Methods for a Changing Ethos

- Active Learning
- Autonomous Practice
- Responsibility
- Problem Solving
- Critical Thinking
- Self-Assessment
- Independent Thinking
- Life Long Learning
- Reflection
- Creating Meaning in Communities of Practice

expertise and knowledge" (P2S1); "we have our patients' best interest at heart at all times" (P2F2); "we are probably one of the strong caring professions" (P2F1); "help the patient in any way you can to make their life more functional and more rewarding for them" (P1S3); and "a sense of responsibility to provide the best patient care" (P1F1).

Interestingly, although students discussed many of the contemporary values indirectly when describing socialization methods, they mentioned only patient care, issues related to patient care, or very general professional traits such as following the Code of Ethics or "acting like a professional" when specifically asked to describe the ethos of the profession. In contrast, faculty and clinical educators described the ethos in much broader terms. They mentioned many of the same issues discussed by the Fellows and Prime Timers that describe the roles and responsibilities outside of the clinician role of caring for patients. For example, they discussed critical thinking, problem solving, independent thinking, a desire for more autonomy, educating patients and other health care professionals, research, valuing diversity, taking responsibility for one's own learning and continued professional development, and the importance of being involved in political, professional, and legal issues. In this respect, the values identified by participants in Part 2 as important in a contemporary culture echoed and elaborated those in Part 1.

> [T]he bottom line is that as physical therapists we have the core belief that there is value in human life and that everyone, regardless of [what] their external appearances or their behaviors are, has value as a human being. (P2C1)

> A commitment to learning and continued professional growth [is important]. I think the person needs to be self-motivated, as well as able to motivate others . . . . you should be responsible for [your] self and accountable for your actions . . . . . being an independent thinker." (P2C3)

> In physical therapy, particularly in the last few years, meaning in the last ten or so, is the change to really being a professional as a physical therapist, as opposed to when I graduated and we were nothing more than glorified technicians. I think as we've grown as a profession, the whole area of professionalism and everything with that involves or includes the ethics of it [has grown] . . . . we value ethical behavior. We have ethical dilemmas that we didn't have twenty years ago. We were never put in that position . . . . . We certainly value, particularly commitment to learning, because I think we particularly value the responsibility which relates to our desire for autonomy which is another value . . . . [problem] solving skills, critical thinking and being able to deal effectively with other people and their personal skills. (P1F3)

> Well, it even extends beyond the patient care arena, I think, in terms of the value system as to working and integrating and educating . . . with other health care providers. Making sure we are cognizant of these issues . . . the value, too, in terms of what we provide for research. Looking at outcomes and quality in terms of what we do and provide. (P1C3)

> In [regard to] professional autonomy . . . I think we are attempting to be better at our political agenda regarding our profession more . . . . Finding that we need to be a little more politically active to save our license. (P2C2)

The differences in the description of the values and ethos of the profession between students and educators reflect other aspects of professional socialization and development described earlier in this study. Students' inability to identify values outside those essential to practicing as a clinician or practicing in an ethical manner is similar to the view proposed by Becker, et. al. (1961). Becker and his colleagues found that students in medical school were part of a "student culture." They behaved and functioned as students -- fulfilling their roles by attending class and completing course work. They had little time to think or do anything about their roles as professionals. The students in these physical therapy programs are also part of a student culture. Although they

have begun the process of professional socialization, they still function in the role of a student. Consequently, they identify and participate in activities in the only way they can as students -- by identifying with and behaving ethically in their student culture and role. They see their role as functioning as educators expect them to, knowing that ethical practice is part of what they are expected to do as both students and professionals. Second, they see the role of the physical therapist through the eyes of a student, with limited exposure and experiences, and have difficulty moving beyond the primary value they place on helping people. Because the role of "clinician as helper" is the primary one they have observed, they fail to see other roles such as manager, researcher, or teacher as important. Students who have not yet been admitted into a physical therapy program, for example, rarely spend time observing therapists performing research or administrative functions, or attending professional meetings. Their role models are clinicians and it is clinicians they wish to become without awareness of the additional roles that physical therapists have had to assume in a changing world. Because all physical therapists with whom they come into contact are usually in the process of "helping someone," they easily identify this most important function of helping as the core ethos, and often self select into the profession based on their desire to do the same. In addition, during clinical internships, students are primarily assigned the role of clinicians, focusing on tasks that are part of being in a helping profession. This is another factor that might influence them to better identify with values at the core level -- values necessary to fulfill the role of a clinician.

Content as Values: A Reflection of the Core Ethos

Participants from both Parts 1 and 2 of this study identified the need for an increased emphasis on values, ethics, and professional behavior as a result of

changing societal values and increasing diversity among students and clients. As described by participants, students no longer share exactly the same values with either educators or peers. They come from varied social, economic, religious, and ethnic backgrounds. Even students recognized that today's students are different than their predecessors. Several students discussed changes across time:

> I think the road of being a student in a physical therapy program . . . is an incredibly difficulty and austere row to hoe. My belief is that things are changing so fast . . . . I think that there are levels that the faculty have empathy, but I'm not sure they really do . . . . each faculty member . . . has been a student 40 years ago, 30 years ago, 20 years ago, 5 years ago, and as much a neophyte as I am, it feels like my gosh, it's changing so rapidly . . . It was different, and it can't help but be different. I mean, the world's changing. (P1S1)

> I think that the time people grow up, your values that you are taught when you are younger, I think it makes a difference. Demographic and economic standards [make a difference]. (P2S2)

Because there have been so many changes since the inception of the profession, even the core values and beliefs, which students may possess on an unconscious level, may not be obvious to students and must be made explicit. Without the presentation of information that represents core beliefs, students may not even be aware that they exist or that their personal values may be in conflict with those of the profession.

Content related to core values and the professional ethos that was felt to be important to emphasize in contemporary curriculums includes the history of the profession and professional organization, the Code of Ethics and Standards of Practice, and legal, professional, and political issues. Exposure to the history, ethics and standards of practice primarily involves bringing core values to the

forefront. The addition of professional issues courses that include content on professional, legal, and political issues exposes students to the application of ethics and standards of good practice to contemporary problems of the profession. Current issues discussed in the professional issues courses included dealing with managed care and other types of insurance reimbursement, the importance of outcomes effectiveness studies, patients' right to refuse care, dealing with cultural diversity, and treating patients with communicable diseases such as AIDS and Hepatitis-B. These issues did not exist to the same degree in the past. There was little need to prove the effectiveness of treatment for reimbursement purposes, for example, and awareness of the epidemic of AIDS is relatively recent. Educators in Part 2 of this study described the importance of presenting this information to students in order to help them understand how the profession has grown and changed over the years in response to societal and health care changes. Students echoed this sentiment, stating that they would never have known about certain issues and would have not been adequately prepared for practice if information about core values and current diagnosis and problems had not been presented to them.

The emergence of new ethical problems discussed by the participants in this study is also supported by other authors in the field. In the book, Ethical Dimensions in the Health Professions (2nd Ed.), Purtillo (1993), for example uses case studies involving problems with reimbursement or confronting a physician in order to best serve a patient to help students understand the importance of the difficult ethical decisions that they will be faced with as professionals. Similarly, in a recent study, Treizenberg (1996), identified four ethical issues likely to occur in the future for physical therapists that have not

been a problem in the past.

> [These issues include] the responsibility of physical therapists to respond to environmental issues of pollutants and health hazards associated with physical therapy treatment, the duty of physical therapists to report misconduct in colleagues, the need for therapists to define the limits of personal relationships within the professional setting, [and] the sexual and physical abuse of patients by physical therapists or those supervised by physical therapists. (p. 1104)

In addition, Treizenberg includes a discussion of a "health care as a business" orientation, an issue that has not previously been addressed in the physical therapy literature as an ethical one.

Based on the findings of this study, as well as the writing of authors such as Purtillo and Treizenberg, the importance of exposing students to the values and ethical beliefs of the profession takes on new urgency. Although these ethical standards and beliefs have been part of the core ethos for many years, there are increasing challenges to maintaining high ethical standards. This is due not only to the fact that students entering programs have more diverse values, but also to the rapidly changing world where new ethical issues and dilemmas continue to surface. Students must, therefore, have greater confidence in their ability to apply high ethical standards to professional practice. Several participants discussed the need for belief and confidence in standards as follows:

> So somehow you have to instill [in them], you have to have discussions where they're going to believe it, not you're telling them, but they're going to believe it, and they're going to go out there and say, well maybe . . . [I] can help to change [the things that are wrong]. (Prime Timer 1, p. 17)

> I think a lot of people have these values and understand them intellectually, what we do and what we are talking about. But I think a lot of times they need to establish not only their own values, but a confidence that those are the right values and that they are

> able to act on them. I think there is a difference in that. I think that is one of the things . . . that our students will need to have. When they get out there and they have to make a decision, that they are able to act on it. (P2F1, p. 13)

Traditional Teaching Methods: A Changed Role for Faculty

One change in methods of professional socialization due to increasing diversity and a changing society is the application of traditional teaching methods to this area. The most often cited method of professional socialization by all participants in this study was the use of role modeling. As previously discussed, however, role modeling alone may no longer enough to facilitate the internalization of the professional ethos due to the increasing diversity of the student population and the increasing pace of change in our society as described earlier by Gergen (1991). It is also now necessary to apply explicit and direct teaching methods to professional socialization in order to help students internalize the core values and develop confidence in their ability to apply them when faced with difficult professional decisions. Educators from Programs 1 and 2, as well as the Prime Timers and Fellows interviewed for Part 1 of this study, identified the need for explicit expectations about professional behavior as a result of increasing diversity and a changed world. In addition, educators cited the importance of providing opportunities to practice professional behavior throughout the program and the need for consistent feedback from both academic and clinical faculty regarding students' behaviors. The importance of motivating students to demonstrate professional behaviors and informing them that clinicians and other professionals will also expect this behavior when they go out to clinics was also discussed.

In addition to providing a motivating force for students to begin to internalize the professional ethos while still in the academic portion of the program,

consistency in expectations in the academic and apprenticeship settings also helped reinforce issues related to transfer. Other methods related to transfer discussed by participants included practicing in as realistic a manner as possible through case studies and clinical visits and allowing adequate time to practice professional behaviors throughout the curriculum so that these expected behaviors became automatic and internalized as part of the students' professional ethos. Many of these instructional methods were also discussed by the Fellows and Prime Timers as they described what educators need to do today in order to help students internalize the professional ethos and cope with today's changing world. The following quotes illustrate their feelings about the need for explicit methods to help students internalize the professional ethos:

> I think when we talk about values both for ourselves and others we need to . . . put things in context so they can understand where our values emerge and we do have certain things in common, and also that we're very tuned into our own set of values and what makes us tick, and we recognize that other people have different sets of values that may or may not be different than ours, and we need to be prepared for how to deal with that . . . . Then when you start to talk about the Code of Ethics and what that means to the professional, versus legal things, versus what is just important to you and why you make the choices you make, they can begin to build a continuum of different kinds of concerns that relate to values, but to begin with you need to start with yourself, and I don't think a lot of curriculums spend enough time starting with those kinds of things. (FAPTA 3, p. 10)

> We have to get the students into a dialogue about where they see [themselves and] how do they feel about these types of issues. (Prime Timer 1, p. 14)

> If some way they could develop the self-monitoring, with perhaps their own checklist in a way that they would enjoy doing it . . . If some way they could just do it as part of being a professional -- that self monitor[ing] and have a check list that these are the things that will make me better, improve me . . . this is going to improve them and be a part of becoming a good physical therapist. (Prime Timer 10, p. 21-22)

> The therapist must be aware of our association and support our association. As a group we have strength, as a single therapist we have nothing. (Prime Timer 2, p. 15)

> [E]thically we're much more in the process of having to be very, very overt instead of operating on assumptions. (Prime Timers, 9, p. 3)

Content as Values: New Roles for Practitioners as a Reflection of a Changing Ethos

As with the need to be explicit about content that represents the core ethos of the profession, there is also additional content that is now part of the curriculum of physical therapy programs that is indicative of the new ethos that has moved beyond the role of the clinician. While the clinician role of helping patients remains the primary focus of the profession, other roles such as teacher, consultant, and researcher have emerged and must also now be assumed if the profession hopes to remain a viable one in a changing world.

Specifically, there were several areas mentioned as important content that need to be passed on to students if the profession is to move successfully into the twenty-first century. These include research, teaching, delegation, supervision, and consultation. In addition, the increasing diversity of society that produced the need to make professional values and expectations explicit to students from a variety of backgrounds has also led to a need for educators to prepare students to interact with culturally diverse clients, other professionals, and the general public. The need for increased content that moves beyond the role of the clinician is also recognized by the American Physical Therapy Association and is included in core documents such as the Standards for Accreditation (American Physical Therapy Association, 1997a) and the Normative Model for Physical Therapy Education (American Physical Therapy

Association, 1997b).

Process as Values: Contemporary Teaching Methods for a Changing Ethos

Many of the methods used to facilitate socialization of students into a professional culture in Programs 1 and 2 reflect the new ethos of the profession and the changed world described by participants in Part 1. Although these methods are important as a means of helping students internalize the professional ethos, they are even more essential when considered as an end to the new values themselves. This is particularly true of the use of more contemporary teaching methods that are part of an adult learning model and reflective practice. The fact that the current values of the profession include a more autonomous and active learner, for example, can be seen in the fact that the goal of these more contemporary methods is to teach students a process that will last them a lifetime -- a process that will allow them to continue to learn and keep up with future changes in the profession and the evolving professional ethos. In contrast, the methods described in the previous sections describe the role of faculty in providing an appropriate learning environment (e.g., sharing expectations, allowing opportunities for practice), content related to the core ethos (history, ethics, professional issues), and content related to the contemporary ethos (e.g., research, teaching) that students need to learn in order to understand and internalize the professional ethos. The major role in the educational process related to these issues is played by the faculty, with students cast as the recipients of knowledge. This does not mean that active teaching methods such as discussion or role playing are not used to help students in the process of professional socialization, but it is educators who are primarily creating the learning environments that students take advantage of as they progress through the program.

In contrast, contemporary teaching methods currently being used in the two programs in this study can be described as facilitating active learning and are also intended to produce graduates who will continue to be more active in their own professional development and who will exemplify the more active and autonomous role that is reflective of the contemporary professional ethos. Not only were these teaching methods described by faculty as a means of producing a more independent and active learner, but students also felt that the use of active learning methods such as reflection, self-assessment, establishing goals based on self-assessment, and devising personal action plans to accomplish the goals were important for helping them to become a professional that would be able to deal with their own professional development and changes in the profession in the future. Several examples of this more active role of the learner can be seen in the methods used in Programs 1 and 2. In Program 1, for example, the process of completing the generic abilities assessment and the behavioral criteria that are part of the assessment includes many of the contemporary values discussed by participants in this study. The behavioral abilities, for example, include such traits as responsibility, problem solving, professionalism, commitment to learning, critical thinking, and use of constructive feedback, all of which were also described as part of the contemporary professional ethos of physical therapy. In addition, the ability to complete the self assessment form that is part of the generic abilities is not only a means to socialize students into the profession and to help educators evaluate student progress, it is also a way for students to learn to critically assess their own strengths and weaknesses, to set goals, and to devise action plans to achieve their goals -- an important process for independent thinking and lifelong learning, two other contemporary values of the profession.

Similarly, in Program 2 the use of portfolios and reflective journals is not only an important method by which educators socialize students into the profession, but is also a way to help students become more reflective, to be effective in self assessment, and to be better able to articulate their values, beliefs and views about professional, political, and legal issues. The ability to form opinions based on knowledge of the facts leads students to be better able to make informed decisions that are necessary to practice as an autonomous professional, something else the profession values today. In addition, the provision of opportunities to practice professional behaviors and to solve professional problems through the use of active learning methods such as case study analysis, role playing, mock clinic, and clinical education helps students in their quest to become critical thinkers and autonomous professionals. Finally, as students are encouraged to share their opinions about themselves and professional issues through class discussions in the professional issues and ethics courses (Programs 1 and 2), journals and portfolios (Program 2), generic abilities assessment (Program 1), interviews (Program 2), and clinical education evaluations (Programs 1 and 2) throughout their education, I feel they will be able to begin the process of creating meaning for themselves and others in their professional world. This ability to think for one's self and to influence the opinions of others is another component of autonomous practice important in today's society.

Summary of Chapter 6

This chapter describes the relationship between the core and changing values of the profession and current methods of professional socialization in two physical therapy programs. More specifically, both the content and the process necessary for internalizing the contemporary professional ethos were

discussed. In today's changing world, the educators in Programs 1 and 2 have found it necessary to expand their curricula to include specific content related to the core ethos and values (history, Code of Ethics, Standards of Practice), to the application of these values to contemporary practice (legal, political, and professional issues), and to the expanding image of the contemporary physical therapist that has moved beyond the role of the clinician (research, teaching, delegation). In addition, they have expanded their role in professional socialization. Instead of just role modeling the behaviors they would like students to display, faculty in these two programs apply direct and explicit teaching methods such as articulating professional expectations, giving students adequate opportunities to practice these expected behaviors, and providing timely and honest feedback about student behaviors. Finally, the values that are part of the present day ethos of the profession have resulted in the need for teaching process as well as content. That is, if educators wish students to internalize an ethos that includes such valued traits as autonomous and reflective practice, lifelong active learning, self assessment, and critical thinking, they are obligated to teach them the process of engaging in these activities effectively.

The participants in this study recognized the need to have students become actively involved in the process of learning in order to address both their own needs and those of the profession in the future. Important contemporary values such as lifelong learning, reflection, autonomy, and diversity which are now in the forefront of the dynamic portion of the professional ethos may someday take a back seat to the new values that will likely develop in response to a changing world. Although we cannot see into the future to prepare students for exactly what these changes will be, I, along with the participants in this study, feel that

we can teach students a process for dealing with these changes personally and professionally so that they are more likely to be able to respond to and even help to create a changing ethos.

Chapter 7

Evolution and the Process of Professional Socialization

The purposes of this study were to describe the culture and the professional ethos of physical therapy, to identify current methods used to help students internalize the professional ethos, and to describe and analyze the experiences of students and their teachers in the socialization process of physical therapists as an example of professional socialization. Data collected through interviews and a review of historical documents revealed that although there is a core ethos that remains constant throughout the history of a profession, there is also a portion of the ethos that changes across time as a result of changes within the profession and outside of it. These three pieces of the puzzle of how a professional ethos evolves (i.e., the core, changes occurring from within the profession, and changes occurring as a result of outside forces) are essential to gaining an understanding of what the profession was, is, and will be, in order to help educators facilitate an internalization of the professional ethos in their students. Data from Part 2 of this study suggest that faculty, clinicians, and students are able to describe methods used to socialize students into the profession of physical therapy and that there is consistency among the three groups in terms of the importance of these methods for internalization of the professional ethos. In addition, these individuals were also able to describe the experiences of students and educators in the process of professional socialization. As with the methods, participants provided comparable descriptions of the experiences of students and educators in the socialization process.

The purpose of this final chapter is to describe the importance of

understanding the culture and ethos of a profession as a basis for the process of professional socialization. An analysis of the professional socialization methods used in the two programs that were the focus of this study and the experiences of students and educators in the socialization process will also be presented. A theoretical framework for understanding this process will be offered as a way to understand socialization in all professional programs. This framework is based primarily on the results of this study, but also incorporates information from the review of the literature, my experience as a physical therapy faculty member, knowledge of physical therapy curriculums and the documents that effect physical therapy education (i.e, Accreditation Standards, The Normative Model of Physical Therapy Education), knowledge of changes in the field, and general and adult learning theories. Using information beyond the data from this study was necessary in order to extrapolate these findings to the process of professional socialization before and after entry to a professional program. That is, based on the knowledge I have gained from this study and my experiences as a physical therapy educator, I feel the process of professional development begins prior to acceptance into a professional program and, like other areas of development, continues throughout one's life. Had I only used data from this study that focused on the experiences of students while they were actually enrolled in a program, I feel my theory would have been incomplete. In order to justify any parts of the theory that are not directly based on the evidence from this study I have included information about the basis for each of the concepts and relationships I have postulated about professional development. In the concluding sections of this chapter, implications of the results of this study for physical therapy and professional education in general will be explored, and limitations of this study will be discussed. Finally, suggestions for future

research will be offered as a way to expand the concepts that resulted from this study.

Understanding Professional Cultures as the Basis for Professional Socialization

Based on the remarks of participants in this study and the review of the historical documents related to the evolution of the profession of physical therapy, I feel it is essential to understand a profession as a culture and to explore its evolution by reviewing its history prior to attempting to design a curriculum that will enhance professional socialization. It is important to know what it is we want to socialize students into in order to develop appropriate goals and objectives for professional behavior and to devise effective methods of facilitating the internalization of the professional ethos in students. In addition, I feel that a professional culture must be examined from multiple perspectives if one hopes to design a curriculum that will help students truly understand and internalize a professional ethos that will lead to effective and ethical practice.

A Multiperspective View of Culture

As described in the review of the literature, several authors (Frost, et. al., 1991; Martin and Meyerson, 1988, as cited in Frost, et. al., 1991) have described a three perspective view of cultures. In the first of these, the Integration perspective, there is little ambiguity, and consensus is thought to exist between various factions within the culture. For those who believe in this perspective, a lack of consensus equals a lack of culture. In the second perspective, the Differentiation perspective, consensus occurs not at the cultural, but rather at the subcultural level. These subcultures "may co-exist in harmony, conflict or indifference to each other . . . subcultures are islands of clarity; ambiguity is channeled outside their boundaries" (Frost, et. al., 1991, p.

8). Further, subcultures may be hierarchical in nature or may exist as equal groups. In the Fragmentation perspective, ambiguity is always present, with consensus and dissensus being present on a fluctuating basis depending on the events, time, and other contextual patterns that exist in the culture.

Many scholars in the field of organizational cultures have examined a variety of organizations from one of these perspectives (Martin, 1992). In contrast to the objective, single perspective view of culture represented by these studies, Martin suggests that it is far better to examine any culture from a subjective, multiperspective view. She states that to truly understand the complexities of any organizational culture, one must make use of the strengths of each of the three perspectives.

> At any point in time, a few fundamental aspects of an organization's culture will be congruent with an Integration perspective -- that is, some cultural manifestations will be interpreted in similar ways throughout the organization, so they appear clear and mutually consistent. At the same time, in accord with the Differentiation perspective, other issues will surface as inconsistencies and will generate clear subcultural differences. Simultaneously, in congruence with the Fragmentation viewpoint, still other issues will be seen as ambiguous, generating unclear relationships and manifestations and only ephemeral issue-specific coalitions that fail to coalesce in either organization-wide or subcultural consensus. Furthermore, individuals viewing the same cultural context will perceive, remember, and interpret things differently. (pp. 168-169)

> Any cultural context can be understood more fully if it is regarded, at any point in time, from all three perspectives. To exclude any of these perspectives from the domain of organizational research would be to limit what we could try to understand. (p. 174)

Martin (1992) further explains how, although all three perspectives are ultimately necessary to understand the complexity of any organizational culture, it is possible for one perspective to be most salient at one time, while the other

two perspectives recede into the background. Martin refers to the perspective in the foreground as the home perspective. The two perspectives that remain in the background are referred to as suppressed perspectives, and one of these is usually more accessible than the other (Martin, 1992).

The Integration perspective. Like Martin, I feel that I was only able to understand the complexity of the cultural ethos of physical therapy by examining the data from this study in light of all three perspectives, as well as within the larger context of societal change. For example, my original intent, as described in Purpose #1, was to "describe the professional ethos of physical therapy." The major emphasis in carrying out this part of the project was to identify the common beliefs, values, and norms of the profession, a purpose that reflects the Integration perspective as the home perspective. By following a line of questioning and data analysis guided by this perspective I was able to identify some enduring traits of the profession, including caring and helping, a positive attitude, hard work and dedication, and warmth and openness. In addition, further analysis of all the data revealed other evidence of consistency in the profession in the form of documents such as the Code of Ethics, Standards of Practice, and Accreditation Standards. This information helped me identify what I refer to as the Core Ethos -- that part of the profession that does not change over time. The identification of the Core Ethos as a foundation for professional practice was enlightening and played an important role as the basis for understanding major beliefs and values of the profession.

The Differentiation perspective. Had I stopped at this point and not attempted to look at the data in light of the other two perspectives, my study would have been incomplete. It is, in fact, the changes surrounding the culture and professional ethos that have necessitated a major shift in the education of

physical therapists and in the education of students in other professional programs. For example, based on the description of changes in the profession due to generational and cultural differences, the participants in this study described how information about the professional ethos and its accompanying professional behaviors must now be taught explicitly to today's students. What used to be an implicit curriculum related to professional values and behaviors (e.g., " I wouldn't have thought it was necessary, hardly, to have started it out with ethics . . . it was as if we just did the things we ought to do and we were expected to do them") has to be made explicit today in order to make it very clear to students who hold different values what professional behaviors are expected of them as part of being a physical therapist. The Prime Timers' description of how the profession changed due to the entrance of males into the profession is also an example of how a very small subculture (males), with different expectations and values changed the profession, and subsequently changed what we teach students about the practice of physical therapy. This examination of different subcultures within the profession based on age, gender, and ethnic background is one of the ways in which the Differentiation perspective is illustrated in this study. In addition, differences within the field of physical therapy, as in other professions, can also be seen in various special interest groups (referred to as Sections in the American Physical Therapy Association), in geographical differences between different regions of the country (such as the state level Chapters of the APTA), in differences between those who belong to the professional association and those who do not, or between those in the field who hold different levels of degrees (physical therapists and physical therapist assistants).

Taking the Differentiation perspective is also helpful in seeing the entire

profession as being a subculture within the context of a larger culture. For example, physical therapists in the United States represent only one subculture of the larger culture of physical therapists all over the world. On an organizational level, this can be seen in the relationship between the American Physical Therapy Association and the World Confederation of Physical Therapists. In addition, physical therapy is only one of many health care professions within the larger context of health care. Physical therapists work as part of a team with doctors, nurses, occupational therapists, and speech therapists. A review of the history of physical therapy revealed that physicians, in particular, have been a major influence on the values of the profession. It was only as physical therapists and the APTA gained freedom from the American Medical Association with distinct and separate governance, professional meetings, and accreditation of educational programs, that those within the profession were able to more fully achieve professional autonomy.

Aside from individuals who are directly involved with patient care, physical therapists must also work with those in the system who are not involved in direct patient care, but have a profound impact on the services that clients receive. These others include administrators, insurance company employees, and government workers who determine how care will be provided and what types of services will be reimbursed. As discussed by the Prime Timers, the introduction of progress note writing, an essential part of practice today, came about as a result of Medicare and Medicaid legislation. In addition, the advent of special education laws helped expand the role of the physical therapist to practice outside of the medical setting. Even individuals involved in nonprofessional activities such as those who work in maintenance, housekeeping, secretarial services, and food service are part of the health care

culture and can have a direct or indirect influence on the provision of services. Secretarial services, for example, may be responsible for scheduling, billing, and typing progress notes, all of which are important aspects of helping patients to receive the best services with the greatest efficiency. The importance of understanding these inter-relationships between physical therapists and others speaks to the need to incorporate the Differentiation perspective into the concept of a professional ethos.

Ultimately, the health care professions also become a subculture, embedded in a larger societal culture. The health care system is influenced by the norms and values of the society of which it is a part. These norms and values evolve in relation to the history of the society, various ethnic, generational, and gender issues within these types of cultures, and other systems or subcultures of the society (education, business, government). While a complete evaluation of these systems is beyond the scope of this study, a few examples from the analysis of the interviews will help to illustrate this point. Many of the participants discussed the impact of managed care and legislation on the provision of health care. Others mentioned the effect of ethnic diversity and the different values of newer generations on the professional ethos of physical therapy. Finally, the history of our country in wars and the impact of historical events like the Depression and the turbulent 60s were cited as important influences on society, health care, and physical therapy. I believe that it is only by understanding the role of the professional within this larger, more complex world that educators can hope to design programs and implement methods necessary to create and sustain a profession that can survive in a dynamically changing world.

The Fragmentation perspective. Finally, the Fragmentation perspective is important in helping to understand the ambiguities within a profession (Martin, 1992). One prominent example of the Fragmentation perspective in physical therapy is the current controversy over the question of what should be the entry-level degree for PTs. Beginning in the 1940s a baccalaureate degree or a baccalaureate degree with a certificate was established as the entry-level degree for practice. In 1980 the entry-level degree was raised to post-baccalaureate, with implementation of this degree in all programs set for a target date of 1990 (this date has been moved to 2001). As more and more programs are moving to the masters entry-level, there are many leaders in the profession who are now calling for a move to a doctoral entry-level degree, and some DPT and PhD programs have already been established. At this point, though the majority of programs have moved to a masters entry-level, there are still some baccalaureate degrees and certificate programs, as well as some new doctoral programs.

The move to higher and higher levels of formal education and credentialing has created controversy and ambiguity within the field. This controversy becomes further convoluted in light of recent changes in health care, the proliferation of both physical therapy and physical therapist assistant training programs, and the recent reorganization of the American Physical Therapy Association discussed earlier. In addition, the increasing diversity of students and clients in health care fields coupled with the multiplicity of viewpoints and dissensus that is part of the fragmentation perspective, as well as a reflection of the postmodern perspective of Gergen (1991) discussed earlier, has created a need to focus more intensely and explicitly on both the existence of diversity and methods for dealing with it in a professional world. This creates an

interesting paradox in that although the multiphrenic condition described by Gergen and reflected in the fragmentation perspective has resulted in a world that is becoming increasing complex and ambiguous, there is a need in the world of professional education for less ambiguity in teaching methods. That is, methods of professional socialization must be very explicit in describing the professional ethos and the behaviors that are reflective of internalization of the ethos in order to make these ambiguities clear to students, to help them identify consensus and dissensus between their personal values and those of the profession, to help them deal with diversity in their interactions as professionals, and to help them learn to deal with a professional ethos that will surely continue to evolve.

The interplay between the use of physical therapist assistants versus physical therapists, entry-level degree controversies, changes in health care provisions, and increasing diversity in the profession and society are creating multiple ambiguities within the field. Should the doctoral degree be the entry-level degree? If so, what does this mean for the role of the physical therapist in relation to physical therapist assistant? Should the entry-level degree of physical therapist assistants also be raised? What is the best way to prepare students to practice in the new millennium? And what effect will health care changes, many of which no one can predict, have on the profession? These are but a few of the questions that physical therapists face today, and opinions are as abundant as are the number of physical therapists and physical therapist assistants practicing in this country.

The Fragmentation perspective offers an avenue for beginning to understand how these ambiguities will affect practice. The acknowledgement of the Fragmentation perspective as an important component of professional culture

will help educators realize that the physical therapist of today must be well prepared to deal with ambiguity, to be willing to take a stand for what he or she believes in, and to adapt to changes in the field. I believe that graduates who are prepared to do so will be more successful and may ultimately shape the course of the evolution of the professional culture and its ethos.

The Process of Professional Evolution

The results of this study support the notion that it is important to understand the culture and ethos of the profession in order to design an effective curriculum that will facilitate professional socialization, and that the culture and ethos are best understood when examined from a multiperspective, historical view. These two views, multiperspective and historical, have led me to believe that the process by which a professional culture develops is an evolutionary one. This evolutionary process goes beyond a mere description of historical events by exploring how and why cultural changes have occurred, analogous to the way species evolve. It helps explain the rational and political dynamics of the changes that have occurred over time.

A Model for Professional Evolution

Figure 2 illustrates the concept of the evolution of a professional ethos based on a multiperspective view of culture and the importance of examining changes in the profession in relation to societal change. This model is based primarily on data from Part 1 of the study (individual interviews with the Fellows, the focus group interview with the Prime Timers, Mary MacMillan Addresses, and Presidential Addresses) that resulted in a view of a professional culture that consisted of core values or enduring traits (the core ethos), and values and roles that change throughout the history of the profession (an evolving ethos). In addition, the multiperspective views of culture as described by Martin (1992)

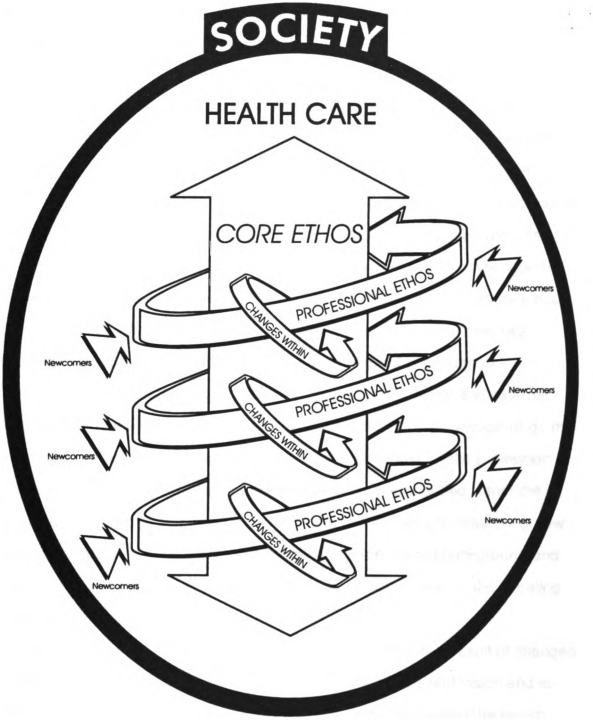

Figure 2. The Evolution of the Professional Ethos

and the review of the literature that described social, historical and cultural influences on professional cultures (see pages 24-29) also served as part of the foundation for this theoretical model.

As can be seen in Figure 2, the Core Ethos (the large double-arrowed area in the center of the figure) is the central anchor of the profession, extends throughout its history (the arrow in each direction indicates that the core ethos has been present since the inception of the profession in the past and will continue into the future), and is the basis upon which the rest of the professional ethos (indicated by the large spiraling arrow) is built. The spiraling process reflects the belief that each new view of the ethos is built on what has occurred in the past, and that, while the Core Ethos remains stable, the rest of the ethos undergoes an evolutionary process. In much the same way that man has evolved over time in response to adaptations to internal and external influences, a professional ethos evolves in response to internal and external influences on the profession over time. Changes within the profession (e.g., the entrance of males into the field and the quest for autonomy for the profession of physical therapy) are illustrated by the smaller arrows embedded within the spiraling professional ethos and by newcomers to the field who may bring new values and ideas into the profession based on their personal background and history (illustrated by the smaller arrows outside of, but closest to, the spiraling professional ethos).

The fact that alterations in the professional ethos occur as a result of changes outside of the profession is also illustrated in Figure 2. The profession and its ethos do not exist in isolation. Rather, they are embedded within the health care system. In this way, changes in health care, such as the rise of managed care, effect the evolution of each of the professions that comprise this system.

All health care professionals could certainly speak to the tremendous effect that managed care has had on their practice. Although not depicted in Figure 2 for simplicity's sake, other medical professions, each with their own ethos, are part of the health care system and affect and are affected by the practice of physical therapy. The powerful influence of the AMA on the practice of physical therapy is the most prominent example of this reciprocal process.

While the health care system is the umbrella for the individual health professions, it is, in turn, part of our larger society, which includes other systems such as education, business, and government. The health care system and the profession are, therefore, influenced by changes in the values, norms, and beliefs of society. For example, as described by the participants in this study, one of the ways in which the profession has changed is that there is a more relaxed atmosphere during direct interactions with patients Contrary to this friendlier relationship with patients, there is also an undercurrent of litigiousness related to alleged malpractice. This paradox within the profession parallels the changing standards of society. As with the existence of other health professions within the health care system that are present but not depicted in Figure 2, there are also other systems such as education or business within society that are not reflected in the model. These systems both affect and are affected by the health care system within each society.

The model of professional evolution illustrated in Figure 2 reflects the complex process by which a professional ethos develops over time. Each generation brings new life to a professional culture and changes continually occur within and outside the profession. Having described the process by which the view from outside and within the profession of physical therapy have evolved over time it is important to consider what effect all this change in

professional ethos has had on the contemporary physical therapy practitioner. How is this individual different from the professional of the past and why are these differences important for educational programs?

The Physical Therapist of Today

The data obtained as part of this study clearly highlight many historical changes in the profession. Although physical therapists have maintained their caring, helping, and positive attitude, they are very different from Mary MacMillan and her colleagues from the early 1900's. As the world around them has evolved, so has the culture and ethos of the profession. These changes are apparent in a variety of ways, related not so much to the core characteristics of caring and helping as they are to the ethnic and generational backgrounds of newcomers and to the ways in which one must practice today in order to be viewed as effective and successful to those within and those outside of the profession.

In contrast to the technician role of the reconstruction aides, physical therapists today are more autonomous, more diverse, more educated, more involved in delegation, and more scholarly. In addition, the world of health care has caused a huge shift in practice. In the beginning years of the profession, for example, the issue of who would pay for services was not an important consideration for the practitioner. There was money to pay for all services and as many services as were needed for as long as they were needed. The Prime Timers discussed how they never even thought about how much services cost and who would pay for them. They simply sent their patients to the payment department of the hospital, and didn't give it a second thought. Today, with a shrinking health care dollar and the advent of managed care, it has become necessary for all health care practitioners to be wiser about reimbursement.

They must now demonstrate that their services are, in fact, helping their clients in order to prove their effectiveness to those who are providing reimbursement. The shrinking health care dollar, coupled with increased litigation in our country, has also caused health care workers to be more accountable. This, in turn, has led to an increasing number of outcomes effectiveness studies, pressing physical therapists to become research consumers, if not producers of research, in order to understand how they can truly be effective in helping their patients. In addition, because there is less money to go around in every field, professionals must be better able to influence those in power, both within their work setting (supervisors, administrators, physicians), and outside it. It is now important to be able to influence legislators who hold many of the strings tied to reimbursement money and the policy makers who make decisions about who will provide services. The physical therapist today is also practicing in a wider variety of settings than did the pioneers in the field. In contrast to the first physical therapists who treated injured war veterans in hospital settings or children with polio, students today must be educated to practice not just in hospitals, but also in private practice, outpatient clinics, rehabilitation centers, cardiac rehabilitation programs, public schools, nursing homes, home care, etc. Each of these settings not only has different types of patients, but also different forms of administration, rules, and reimbursement and legislative issues. This increased variety in treatment settings is another change that demands a more complex educational process. Finally, as the role of the physical therapist as a delegator has expanded it has become increasingly important for them to gain skills in teaching, consulting, and empowering patients to care for themselves.

All of these changes have had an impact on the culture and ethos of the profession. While the core of helping and caring, dedication and hard work,

warmth and openness, and a positive attitude continues to be at the heart of the professional ethos, the changes described in this study have resulted in a new view of the physical therapist. This new physical therapist, the one who must teach, delegate, manage, keep up with rapid changes in health care and technology, worry about reimbursement, conduct outcomes effectiveness studies (or at least be able to read and understand them), and be able to treat a variety of patients in many different settings has added new dimensions to the core of the ethos of the profession. The contemporary physical therapist is not just a clinician who can be involved in helping patients. Therefore, the old ethos, consisting of a small handful of core values, is no longer enough. New roles, an ever evolving technological society, and changes in educational theory have added new values to the ethos. In addition to valuing helping patients and hard work, physical therapists today also value reflection, self-assessment, critical thinking, problem solving, and lifelong learning. They put a premium on understanding and accepting diversity in their patients and in their colleagues. As autonomous practitioners, they embrace advances in health care and proactively respond to changes in reimbursement and practice patterns that affect patient treatment even when it means changing the ways they practice.

In spite of this changing ethos, some educational programs in physical therapy continue to function as if they are preparing students to function only as clinicians. But just as students and society have changed, so must educational programs. Educators need to be aware of the changes in the ethos in order to successfully socialize students into the profession, and students should carefully consider the changed roles and ethos of physical therapy in order to be sure they have chosen the profession that is right for them. Within the

educational setting, the methods used by both faculty and clinicians to help students attain the professional ethos need to reflect the new world in which the physical therapist must now live and work. Part 2 of this study, to which I now turn, illustrates some of the ways in which this can be accomplished.

Facilitating the Internalization of the Professional Ethos in Professional Education Programs

Prior to beginning this study, I was often confused by comments from my colleagues that it was not possible to "teach" affective behavior and that this type of learning could not be measured. I felt that there had to be something that could be done to help students attain the professional skills and behaviors that would indicate that they had, indeed, internalized the ethos of the profession. At the very least, I felt, faculty needed to make attempts to do so. To do nothing seemed unwise for educators and unfair to students.

Having been fortunate enough to conduct this study, I can say with some conviction that my pessimistic colleagues were wrong. It is, in fact, very possible to describe some of the ways in which educators attempt to help students become part of the professional culture and display the behaviors that indicate that they have internalized the professional ethos. The participants in this study described a number of ways in which students are socialized into the profession. Beyond the fact that everyone was able to describe some of the ways in which educators facilitated the socialization process, it is most interesting to note that the perceptions of students matched those of faculty and clinicians. Students could describe the methods educators used to help them internalize the ethos of the profession as well as their teachers. For example, like the educators in Program 1, students in Program 1 clearly identified the generic abilities and the professional issues courses as two of the most

important ways in which they were socialized into the profession.

Beyond the generic abilities and these courses, however, they also cited such methods as receiving consistent and regular feedback about their display of professionalism, having clear goals and expectations for professional behavior, being given opportunities to practice professional behaviors, being responsible for their own learning, having appropriate and consistent role models, and attempting to practice in as realistic a setting as possible. While students recognized that it is important to practice techniques on each other initially, the opportunities they were provided to interact with clinicians and patients in the academic setting, to visit clinical sites, and finally and most realistically, to treat and interact with patients and professionals during clinical internships were cited as especially important parts of the socialization process. Likewise, students from Program 2 consistently cited the use of reflective journals, portfolios, mock clinic, a strong emphasis on ethics through the separate ethics courses, the use of regional clinical coordinators, and the professional issues courses as important aspects of their professional socialization. Like the students in Program 1, they were also able to describe other methods of socialization that were described by their faculty. Based on this information, it can be seen that students are aware of the ways in which they are initiated into the culture of physical therapy, at least in these two programs.

In addition to the educator-student match between perceptions of methods of socialization, faculty described other ways in which they felt that students had become aware of the methods and felt they were successful in their socialization attempts. This evidence included information obtained primarily from the students in journals, exit interviews, and in conversations following

graduation when graduates were looking for ways to handle difficult students now that they (the graduates) were functioning as clinical instructors. In addition, faculty from Program 1 talked about the improvement in their students since the advent of the generic abilities and faculty from Program 2 discussed how students cited the professional issues seminars and reflective journals as effective means of socialization during exit interviews. Clinicians, although not as familiar with the curriculum of the programs, were also able to talk about how students in Program 1 had changed since the generic abilities had been instituted, and students in Program 2 were articulate in reflecting on their growth and applying their newly attained knowledge of professional issues in the clinic.

While I would like to think that the methods applied by these programs provide at least part of the answer to effective socialization, I also interpret these remarks with some caution since there are many other factors that affect the behavior, professional and otherwise, of individuals in all professions. First, physical therapy students are often described by university administrators and faculty as one of the best groups of students on campus, a fact that certainly would contribute to their high standards once they enter the program. Even those students who start out with lower or unarticulated standards when they first enter college quickly realize that they must change their presentation of themselves in order to be accepted into these very competitive programs. Secondly, as suggested by other authors (Abbott, 1988; Stroot and Williamson, 1993), students may self select into professions that match traits that they already possess, another confounding factor. Finally, the lack of controlled studies and the small number of participants in this study speaks to the need for more evidence in this regard.

The question remains, what methods were used in these two programs that

caused students to perceive that they had been successfully socialized into the profession? One answer, I believe, lies in the more active and process oriented methods used by educators in these two programs which reflect a changing world and a changed profession. Faculty and students described the importance of active learning for the process of professional development in these two programs. In contrast, my experience in educating physical therapy students, conversations with experts in the field of physical therapy education, and knowledge of physical therapy curriculums in other programs indicate that other professional educators have not responded as readily to changes in the world and the professional ethos and continue to use old methods to try to help students internalize the new ethos. For example, although role modeling continues to be an important aspect of socialization, it is not enough in and of itself to effectively help students become part of the ever more complex professional culture and to prepare them to be able to cope with future changes. Changes in the world and resulting changes in the professional ethos necessitate that methods of professional socialization be very explicit and that they be expanded to reflect the values of this new ethos. That is, changes in student diversity, changes in society, and changes within the profession have resulted in a new professional ethos that cannot be successfully facilitated by doing the things that were done when the world was a much less complex and more local place, and when students held basically the same values as their teachers.

Internalization of the Professional Ethos Through "Value Negotiation"

Value negotiation -- What is it? Based on the integration of the knowledge I have gained from my past experiences as a physical therapy educator, conversations with colleagues and experts in the field, and the results of this

study, I feel that in order for students to be successfully socialized into a profession, they must be able to combine the personal values they hold prior to admission with the core or stable values of the professional ethos, and with the dynamic or changing values of the profession that continue to influence the evolution of the professional culture and ethos over time. Several authors cited in the literature review (Myers, 1982; Abbott, 1988; Stroot & Williamson, 1993) discussed how personal values affect the student's initial decision to enter the field and how willing they are to change in response to new learning experiences in the professional program. As previously discussed, students may be able to compare their personal values to some of the core values of the profession prior to admission based on their observations and interactions with practitioners. This comparison is possible because the core values (which are the basis of the Core Ethos as discussed earlier in this chapter) do not change over time and thus are reflected in the words and deeds of most practitioners with whom students come into contact. For example, every applicant to physical therapy programs, without exception, when asked why he or she wants to be a physical therapist responds, "I want to help people", the number one core value identified by the participants in this study. Because the core values are universal and easy to identify, I feel that these are the primary values students use to compare with their own values when self selecting into a profession.

In contrast, the changing values of the profession are ones with which students are not as familiar. Students, in fact, described how they were not familiar with many of the changed roles and contemporary issues of the profession and discussed how they first became aware of these changed roles and issues in the professional issues courses once they were admitted into the program. This lack of familiarity with evolving values, changes roles, and

contemporary issues occurs for two reasons. The first is that some of these changes are not directly observable. That is, students may not know that physical therapists are now more autonomous because they do have not a previous history to compare the practitioners of today with those of yesterday. One faculty member in Program 2, for example, stated,

> I think that the thing that students don't often understand is . . . how we got to where we are. They . . . walk into the curriculum and they are . . . professionally socialized today . . . . They don't understand where we have been and why we are progressing in the direction we are progressing and what sacrifices or efforts people have put out to get there. (P2F3, p. 12)

In addition, depending on where in the evolutionary process the culture and ethos are, there may be many practitioners who are unaware of major changes because they have not been exposed to them or because they refuse to change their practice and, therefore, continue to operate using the values and skills of the past, values which may have worked for them, but will not prepare future practitioners to function effectively. For example, it is no longer enough for physical therapists to be simply clinicians who want to help people without dealing with the cost and documented effectiveness of their services, problems with reimbursement and management, or the politics of power in the workplace and outside of it. Several faculty members and students identified this problem, stating that while role models in the academic and clinical settings were basically consistent at the core level (caring and helping), there were practitioners who were functioning as technicians and were not keeping up with changes in the profession. These individuals, as well as those few practitioners who students felt were not as professional as they could be, were described as negative role models whose values were not consistent with those of the faculty or the profession. Students discussed how they would not want to practice in

the same manner as these negative role models.

The process by which students become part of a community of practitioners by melding their personal values with the core of the ethos and the changing values of the ethos I call "value negotiation." It is how I conceptualize the process by which students come to internalize the professional ethos throughout their education and how they continue do so throughout their professional careers. More specifically, value negotiation can be defined by looking more closely at the definitions of the two words, value and negotiation. A value is defined as "a standard or principle regarded as desirable or worthwhile . . . worth in importance or usefulness to the possessor" (Riverside Webster's II Dictionary, 1996, p. 746). Negotiation is defined as the process by which one is able "to meet and discuss with another in order to reach an agreement, . . . to settle by meeting and discussing, . . . to accomplish or cope with successfully" (Riverside Webster's II Dictionary, 1996, p. 546). Combining these definitions, value negotiation can be more specifically defined as the process by which students in professional programs meet and discuss fundamental beliefs and rules of behavior that are based on desirable standards and principles of the profession in order to successfully become a member of the professional community of practitioners, to internalize the ethos of the profession, and to be able to cope with the responsibilities inherent in the profession.

The role of the educator in value negotiation. I feel that both educators and students are important entities in value negotiation. The primary responsibility of educators is to provide an environment that will facilitate the internalization of the professional ethos in their students. This socialization is accomplished by making students aware of what is expected of them and allowing them

opportunities to engage in and receive feedback about their level of understanding and application of professional values and behaviors. These roles for the educator parallel those in other teacher-learner scenarios. As described by the participants in this study, these explicit and systematic methods have become a necessity in the area of professional socialization due to increasing student diversity and changes in society. In addition, faculty must apply good teaching methods to the process of professional socialization. These include methods such as establishing appropriate goals and objectives for professional socialization, providing opportunities for practice and feedback, motivating students to want to internalize the professional ethos, facilitating transfer of professional behaviors to all settings, and assessing professional behavior. Both students and educators described these methods as helpful in the socialization process.

Although an in depth discussion of principles of teaching and learning is beyond the scope of this study, it is necessary to at least mention their importance in professional education for several reasons. First, in contrast to professionals trained in the fields of education or educational psychology, professionals in other fields are not familiar with these principles and methods. Physical therapy is a good example of this lack of preparation in principles of teaching and learning. The ever present need for physical therapists throughout the history of the profession coupled with the proliferation of physical therapy education programs has resulted in a corresponding shortage of faculty. In contrast to being hired for their pedagogical beliefs or their expertise in teaching and research, physical therapy faculty were hired more for their clinical expertise in various content areas. In essence, the paucity of physical therapy faculty led many universities to hire practitioners for their license, their

content knowledge, and their desire to become part of the academic world. Many faculty knew little about teaching or learning. They felt that because they had an interest in teaching and content expertise, and had been successful in one-on-one clinical instruction of students, they would like to try teaching. In addition, new faculty often were hired without any thought to training or mentoring them in order to help them learn the basic principles of teaching and learning. My personal experience reflects this scenario as I began my teaching career in a program that had two new full-time faculty and many clinicians who taught part-time. Although I am not familiar with all other professional education programs, I have had conversations with faculty from other fields who have found themselves in similar situations as they began their teaching careers.

A second reason for describing explicit socialization methods used by these two programs related to principles of good teaching is that many educators may not think that these issues are applicable to or important for the process of professional socialization. Instead, many physical therapy educators with whom I am familiar are operating on the assumption that, like in the past, role modeling is enough to help students learn and internalize the values and behaviors reflective of the professional ethos. In contrast to this view, experts in the field (i.e., Fellows and Prime Timers), students and educators supported the notion that role modeling is simply not enough in today's complex world for successful socialization into a profession. Today's educators, like the participants in this study, must go beyond role modeling if they hope to graduate competent and ethical professionals.

Today there are more educators within the field of physical therapy, and I imagine in other fields as well, who are familiar with principles of teaching and learning through formal education, continuing education, or mentoring

programs within their university than there have been in the past. Unfortunately, there are still many educators in professional programs who know little or nothing about teaching, learning, or the process of professional socialization. This situation has implications for professional education, which will be discussed later in this chapter.

Creating meaning in communities of practice. Although the application of principles of teaching and learning are important to the process of professional socialization, they are only one small part of a much more complex process. More importantly, I feel that educators need to create meaningful interactions within the environment in order to motivate students to become full participants in the professional arena or the community of practice. A community of practice is defined by Lave and Wenger (1991) as "a set of relations among persons, activities, and the world, over time and in relation to other tangential and overlapping communities of practice" (p. 98). Newcomers are drawn into the community through a process that Lave and Wenger (1991) have termed legitimate peripheral participation. Legitimate peripheral participation is defined as "the process by which newcomers become part of a community of practice. A person's intentions to learn are engaged and the meaning of learning is configured through the process of becoming a full participant in a sociocultural practice. This process includes, indeed it subsumes, the learning of knowledgeable skills" (Lave & Wenger, 1991, p. 29). As students progress through professional programs, they are afforded more and more opportunities in the community of practice, until, in their final apprenticeships they are afforded the opportunity to function as independent professionals. Through these opportunities, they learn what is expected of them as a member of the profession. Because these opportunities are the primary ways in which

students are exposed to and subsume the identity of a professional, at least according to Lave and Wenger (1991), the ability of educators to create early opportunities that are meaningful, appropriate, and effective is crucial to helping newcomers become true members of the community who have internalized the ethos of the profession.

Students described the importance of creating meaning for themselves, as well as how they assumed more responsibility and interacted more in the clinics, as they progressed through the program. They cited the use of discussions with classmates and practitioners in the professional seminar courses (Programs 1 and 2), reflection in the journals and portfolios (Program 2) and the self-assessment process that is incorporated into the generic abilities (Program 1) as ways in which they were able to "get a sense of" and "a better understanding of" how they felt about an issue in order to create meaning for themselves. In addition, they described how input from faculty, clinicians, and leaders in the field regarding new developments in health care and the profession helped give them a better understanding of "what the profession stands for". Faculty discussed how they felt students were becoming part of the community based on feedback they received from the students during exit interviews, journal entries, and course assignments. Students also discussed how increased responsibility during their clinical internships helped them begin to make the transition from students to professionals and to feel more like contributing members of the professional community. This was particularly true of the students in Program 2, where students did longer 14 week internships. Faculty from Program 2 also discussed how these longer internships allowed students more time to "really get involved in the ethos of the clinic". Overall, reflection, discussion, and involvement with practitioners seemed to be the

primary ways in which students begin the process of sense making and creating meaning for themselves and others in the community of practice.

The process of providing such opportunities early in the educational process has become even more crucial as the world has become more global and fast-paced. In the past, the process of legitimate peripheral participation during the educational program was a much slower one. Graduates of physical therapy programs had the luxury of a more gradual transition from the culture of a student to that of a professional. Students were often protected from difficult patients, demanding physicians, and worry about reimbursement for services. They could take their time, even after graduation, learning to evaluate and treat patients who stayed in the medical system for much longer periods of time. New graduates of the past could slowly build up their case load as they spent time observing other therapists and getting used to handling the demands of being a professional. Today, this is not the case as patients are being discharged sooner due to limits on insurance coverage and practitioners are under pressure to provide intense, short-term services. Graduates, therefore, must be able to step into their professional roles quickly; they must learn to both evaluate and treat patients during the initial therapy session; and they must know how to react in a timely manner to political and professional issues. Educators, therefore, must prepare students for these roles earlier in the educational process. Just as the world has become more fast-paced, so must the process of legitimate peripheral participation. This is the reason cited by educators in Program 2 for longer clinical internships. That is, Program 2 faculty felt that a full academic year of apprenticeships would give students time to function more effectively as a clinician, and would also prepare them to move beyond the role of the clinician and to begin to create meaning for themselves

and others in their community of practice -- to begin the process of legitimate peripheral participation in a more timely fashion so that students are well prepared to function as professionals upon graduation. In addition, as discussed earlier, the use of reflection and discussion also helped students to become familiar with and begin to make sense of issues important to the profession early in their education so they were better prepared for practice upon graduation.

The role of the student in value negotiation. Although the educator provides an appropriate learning environment that facilitates legitimate peripheral participation and professional socialization, this is only the first step in value negotiation. Ultimately, the learner is responsible for "deciding" to become an actively contributing member of the community of practitioners. As stated by one of the faculty members interviewed for this study, "the faculty will do everything possible for you to develop these behaviors. It is up to you to develop them" (P1F3). Students, therefore, play the major role in professional socialization.

Educators acknowledged the importance of providing active learning environments through case studies, outside readings, and teaching methods that made the students responsible for their own learning. Students also acknowledged the importance of developing active learning skills since they will have to "figure things out for themselves" once they graduate. They readily accepted responsibility for their own learning and development and felt that this was one of the ways in which they were able to internalize the ethos of the profession. Based on the data from this study, theories of adult learning, and my experience in teaching physical therapy students, I feel that active learning is accomplished through students being open to identifying and exploring their

own values and behaviors in relation to those of the profession; actively participating in class discussions, lab sessions, and clinical internships; being open and honest with oneself and others around issues related to professional socialization (e.g., reflection and self-assessment, critical discussions, and peer and mentoring conversations); displaying behaviors consistent with the values and beliefs of the profession; and contributing to creating meaning within the community of physical therapy. Because the data from this study supports the premise that students who are actively involved in the socialization process perceive themselves as being successful in internalizing the professional ethos, primary emphasis in descriptions of the student's role will be related to how he or she functions as an active participant in a community of practitioners during professional education.

The process of value negotiation: The big picture. The process of value negotiation can be divided into three phases: Awareness of Values and Expectations, Active Learning, and Artistry. Ideally, students progress through the stages successfully, and have entered the Artistry phase by the time they graduate. Value negotiation, however, is a developmental process. As such, it is important to keep in mind that, just as children do not always follow the same trajectory of development, neither do students in professional programs. Rather, students will progress through the phases at their own rate, may go back and forth between phases or stages, and may not reach the final stage by the time they graduate. The phases, then, should be interpreted merely as guidelines and not rigid stages that all students must pass through in the exact order at the same time. In general, the closer the student's values are to the ethos of the profession to begin with, the quicker and more easily he or she will progress through the phases. Lastly, the reader should keep in mind that the

process of internalizing the professional ethos is never really complete, in the same manner that human development is never complete. That is, the ethos of a profession is a moving target that evolves in response to changes in society, to newcomers to the profession, and to changes from within the profession. Professionals who do not, or cannot, change in response will lose their sense of professional ethos over time.

Figure 3 illustrates the process of value negotiation from the time the student becomes interested in and applies for entry to the professional education program and continues beyond graduation. As with the process of the evolution of a professional ethos depicted in Figure 2, the large double-arrowed area in the center of the figure represents the Core Ethos of the profession. This Core remains the same throughout the student's time in the program just as it remains constant in the evolution of the professional ethos. A second important concept depicted in Figure 3 is reflected in the smaller arrow labeled "student's personal values." This arrow represents the personal values (which may or may not overlap with the values of the profession) that students bring with them to the program based on their family background, ethnic origin, gender, age, religion, peer group, and other life experiences. As discussed by participants in this study, students do not come into professional programs as blank slates. Rather, they have a lifetime of experiences that determine who they are at the time of entry into the professional program, what personal values they possess, and what behaviors they display as a result of the values and experiences they bring with them. While some of their personal values may be the same as those of the program and the profession (often at the core level) some may differ and may need to be altered if students are to be successful in the program and ultimately in the profession.

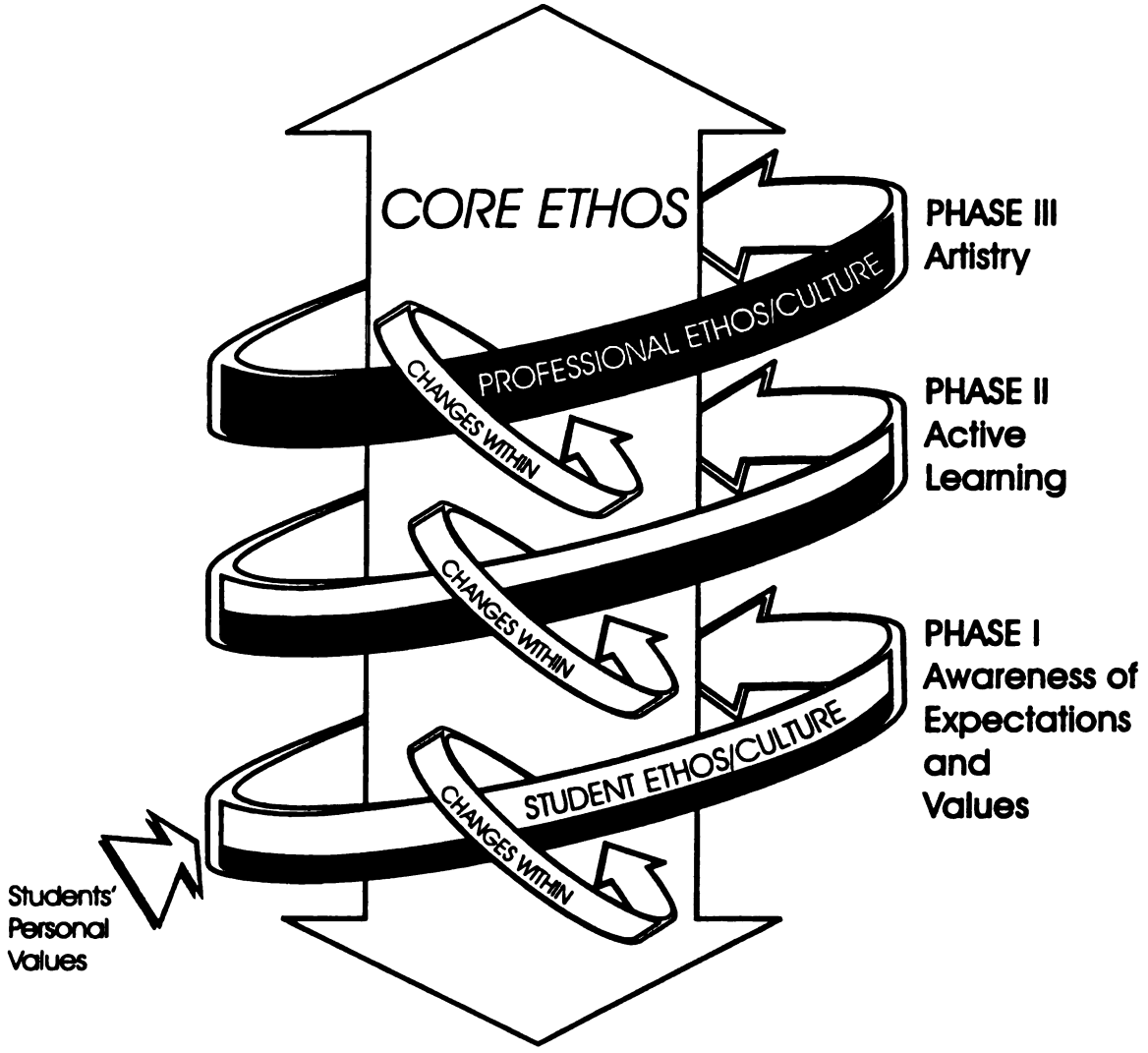

Figure 3. The Process of Value Negotiation

The ascending spiraling arrow that winds around the Core Ethos represents the ethos that students possess as they progress through the program and through the three phases of value negotiation. As can be seen from Figure 3, students enter the program with only the ethos of the student. This idea is similar to and reflective of the work of Becker, et. al. (1961) who in their classic work, Boys in White, described the world of medical students as a "student culture." According to Becker and his colleagues, students are never "young doctors" (or in this case "young physical therapists"). They participate in the community not as members of the professional culture, but as members of the student culture. Students, therefore, display behaviors that reflect their efforts to deal with the reality of being a student (e.g., successfully completing classes, pleasing faculty). This idea is reflected in Figure 3 by the large portion of the spiraling arrow representing the student ethos and culture at the beginning of the program. As the student progresses through the program, the student culture begins to be replaced by the culture and ethos of the professional until, at the time of graduation, they ideally have internalized the professional ethos and have become part of the professional culture. The spiraling process itself indicates that each level of professional socialization is continuous with and builds upon the previous level. The arrow at the end of the spiral indicates that professional socialization continues throughout one's career. Finally, the small arrows embedded within the spiraling process of the student/professional ethos represent changes that are occurring within the ethos itself.

On the following pages each phase and the accompanying stages are described in greater detail. A table describing the role of the educator, the role of the student, and the result of successfully completing the phase accompanies each description.

Phase I: Awareness of Values and Expectations

Phase I, Awareness of Values and Expectations, occurs prior to and at the beginning of the professional program. It consists of two stages, **Awareness of Program and Professional Expectations** and **Identification and Comparison of Personal and Professional Values** and establishes the base upon which the other phases are built. An overview of Phase I can be found in Table 6.

Stage 1: Awareness of expectations. During Stage 1, Awareness of Program and Professional Expectations, students are made aware of program and professional expectations related to the professional culture and the professional ethos. Providing information, on a very general level, even to students who are considering applying to the professional program is one way to prepare students for the process of professional socialization. While all faculty and students endorsed the provision of explicit goals and objectives for professional behavior for students already admitted into the program, one faculty member also described how professional socialization "is something you have to give students over a period of time to develop . . . starting with pre-admission" (P1F3, p. 5). Raising awareness of professional expectations for individuals who have not yet been formally admitted to a program can be accomplished informally through brochures and other program information that describes the philosophy of the program and the profession, through informational meetings, and by encouraging program applicants to observe and have conversations with practitioners. Because students may only be familiar with the helping role, or core ethos of the profession, this provision of additional information about the changing role of the professional will, I believe, help them make a more informed decision about their career choice. As discussed by the

Table 6. The Role of Educators and Students During Phase I

PHASE I: AWARENESS OF EXPECTATIONS AND VALUES

Stage 1: Awareness of Program and Professional Expectations

Role of Educators: Academic Faculty

1. Informal introduction prior to application and acceptance to program.
2. Formal introduction of expectations of the program and the profession upon admission.
3. Presentation of documents outlining expectations and values of the professional culture.
4. History of the profession.
5. Encouragement to join and become involved in professional organization.

Role of Student

1. Listen to lectures, videos, interviews, etc.
2. Participate in class discussions.
3. Become aware of values and expectations through participation in class discussions and assignments.
4. Join the professional organization and attend meetings.

Stage 2: Identification and Comparison of Personal and Professional Values

Role of Faculty

1. Structure learning environment to help students become aware of personal values.
2. Assist students in comparing personal and profession values through guided self-assessment.

Role of Student

1. Become aware of and articulate personal values.
2. Compare and contrast personal values with those of the profession.
3. Guided self-assessment

Results

1. Understanding of the evolution of the ethos of the profession.
2. Beginning internalization of the professional ethos
3. Ability to converse in the language of professional practice and intellectuallize about the profession.

participants in this study, as well as by a number of authors (Abbott, 1988; Stroot and Williamson, 1993), many students self select into professions whose values and beliefs match their own. For this reason, it is important for students to know where they stand in comparison to the professional ethos, since students who discover that they have a view of the profession that is not realistic or reflective of its fundamental values and beliefs may choose another career, saving themselves much time and money.

Once enrolled in the professional program, more specific information can be provided to students in this regard. The first step for educators is deciding exactly what it is they want to teach students about professional behavior and the professional ethos, followed by writing appropriate goals and behavioral objectives that reflect the mission, philosophy, and goals of the program and the profession. Following the establishment of program goals and objectives, faculty explicitly explain these goals to students so that there is no confusion about what is expected, no matter how difficult the expectations may seem to someone just beginning a professional program. In this study, for example, educators in Program 1 make students aware of their expectations during their orientation through the introduction of the generic abilities. Similarly, participants from Program 2 discussed how expectations for student behavior were made clear during the orientation process. Students from both programs testified that goals and objectives were made very explicit throughout the program, that they were realistic, and that they were consistent with the goals of the clinical sites at which they completed site visits or clinical internships. In addition, students stated that knowing what was expected of them was helpful in the socialization process.

In addition to an orientation to the specific expectations of the program, both

groups of educators introduce students to professional documents such as the Code of Ethics, Standards of Practice, and licensure laws very early in the program and encourage students to join and become actively involved in the meetings and activities of the professional association. Finally, although not specifically cited as something that is definitely done in either program, several faculty members discussed how it is important for students to understand where in the history of physical therapy they are entering the profession so that they can begin to understand how it is that physical therapists evolved to their present status and why the ethos is the way it is. This is another source of information, then, that may prove helpful to students at the beginning of their professional education.

Stage 2: Identification and comparison of personal and professional values. Just as the heterogeneity of the student population has made it necessary for educators to be very explicit about their expectations for student behavior, heterogeneity has also made it important for faculty to make the *implicit* curriculum about professional values and professional behaviors explicit. This assertion was supported by the educators in Part 2, and also by the Fellows and Prime Timers, as a recommendation to help facilitate the internalization of the professional ethos. The process of identifying and comparing personal and professional values occurs during the second stage of Phase I, Identification and Comparison of Personal and Professional Values.

All participants in this study felt that newcomers to the field today generally possess the same core values of helping and caring, hard work and dedication, warmth and openness, and a positive attitude as their predecessors. Fellows and Prime Timers alike discussed how these core values are basically unchanged. In contrast, participants felt that people entering the field today may

also have some different standards and values than those individuals who entered the field in the past due to generational differences, differences in society, ethnic differences, and family backgrounds. The metaphor of America as a melting pot with everyone having the same beliefs and values is no longer useful. Instead, this metaphor has been replaced by a postmodern view (i.e., as reflected in the work of Gergen and Martin discussed earlier) of the world in which individual differences and constant cultural change are the norm. For this reason, educators can no longer assume that students share their beliefs and values. As one Prime Timer explained, "we can't just assume that their backgrounds are going to be like our backgrounds" (Prime Timer 8, p. 3).

The implications of this change for educators are twofold. First, we can no longer expect students to just "do the right thing" since their definition of "the right thing" and ours may be very different. Also, because of the complexity of the world today, there is rarely only one right thing to do. I feel that one of the first steps in helping students to become a true member of the community of practitioners, therefore, is to help them identify what their personal values are and how they are similar to or different from those reflected in the core or evolving ethos of the profession . Students may need to participate in values clarification sessions or general discussions of what their own values are and how they have developed. One Prime Timer, for example, discussed how educators need to be much more overt in trying to get students to talk about their backgrounds and how they developed the personal ideals and values they have.

Once students have identified and articulated their values and compared them to those of the profession, faculty may then move on to other methods of exploring and expanding student values to meld with those of the profession,

co-creating meaning with students through classroom discourse that is relevant and timely in regard to the values of the profession. The professional issues courses offered in the two programs chosen for this study were described as the primary process by which students initially become familiar with and practice talking about the issues and values that are important for a practitioner in today's world. Within these courses, faculty and clinicians discussed current issues in the field and invited students to join in the conversation through small group sessions, class discussions, and writing reflective journals. Students described how the process of sharing ideas and thoughts about values and contemporary issues during the professional seminar series facilitated the process of professional socialization. The use of practicing clinicians as speakers in these courses helped students begin to see positive role models beyond the faculty, another method that was felt to contribute positively to socialization of students in these two programs. In addition, the presence of practicing clinicians in the classroom was felt to reinforce the fact that professional behavior and understanding professional issues are important to all members of the profession, not just to faculty.

Throughout the process of identifying and exploring values, students can be encouraged to compare and contrast their ideas with those of their peers and full-fledged members of the profession (i.e., faculty and clinicians). Although faculty are, at first, very involved in leading these discussions and facilitating the identification of important issues, the primary purpose of these discussions is to help students identify areas of consensus and dissensus between their values and those of the profession as a beginning step toward professional socialization. Because faculty are so involved at this stage of professional socialization the term "guided self assessment," as opposed to independent self

assessment, seems a more appropriate term to describe this process.

Summary of phase I. During Phase I, students are exposed to the expectations of the program and the profession in the area of professional behavior. In addition, they begin to become more acutely aware of their values through methods such as discussion, exposure to role models, and reflective journals. They are encouraged to compare their values to those of the profession in order to begin to understand what they must do to continue down the path of professional development. Guided self assessment, with faculty providing a lot of structure regarding relevant issues in the field and class discussions is a hallmark of this phase. Students, at this point, will ask more questions than in the later phases of the program as they attempt to understand the profession better.

Because students have just begun the journey toward professional socialization during Phase I, they may only be able to intellectualize about the ethos. That is, they can list or describe the values of the profession and compare them to their own. They can discuss the history, the Code of Ethics and Standards of Practice of the profession, but they cannot "feel" or apply them. The professional ethos has not become a part of their personality. At this point, it is rare that any student has internalized the ethos of the profession.

Phase II: Active Learning

While there is no set time for passage from one phase of value negotiation to the next, Phase II, Active Learning, begins at about the time students complete their initial semester in the professional program and have become familiar with the profession, its history, and its culture (Table 7). It is during this second phase of value negotiation, when students do most of the work of internalizing the professional ethos. This phase is characterized by more student

Table 7. The Role of Educators and Students During Phase II

PHASE II: ACTIVE LEARNING

Role of Educator: Academic and Clinical Faculty

1. Provide an educational environment that facilitates professional socialization.
    a. Opportunities to practice professional behavior in as realistic a manner as possible.
    b. Consistent, timely, and regular feedback regarding professional behavior.
    c. Multiple role models from a variety of settings.
    d. Use of adult learning strategies .
2. Emphasize active learning rather than passive reception of presented material.
3. Encourage students to join and become increasingly involved in professional organizations.

Role of Student

1. Active participation in the socialization process.
    a. Practice professional behaviors.
    b. Share thoughts, opinions, and feelings honestly and openly.
    c. Give honest feedback to peers in group projects, study groups, discussions, conversations, etc.
    d. Be open to constructive feedback from peers and educators.
    e. Apply values to specific situations.
    f. Create meaning within the classroom settings.
2. Independent Self-assessment
    a. Periodic, personal, case-grounded self assessment.
    b. Identify areas of strength and those needing improvement or development.
    c. Set goals and objectives, devise and carry out action plans for continued professional development.
3. Value Negotiation
    a. Continue to compare and contrast personal and professional values as new issues surface.
    b. Compare and contrast views of different professionals.
    c. Be open to changing opinions, values, and behaviors based on case grounded self-assessment and feedback from others and conflicts between personal and professional values and feelings.
4. Creating Meaning for Self
    a. Compare and contrast role models.
    b. Incorporate values and professional behaviors of role models into personal view of the ideal professional.

Results

1. Increased awareness of professional values/issues and possible conflicts with personal values.
2. Case Grounded self-assessment
3. Resolution of specific value conflicts or ethical dilemmas through case grounded self-assessment and value negotiation.
5. Personal and professional values begin to meld.
6. Increasing internalization of professional ethos.

involvement than in Phase I when students were first becoming familiar with the profession and faculty provided more structure in terms of presentation of material, greater involvement in leading discussions, and guided self assessment. In contrast, the role of the faculty during Phase II begins to diminish. While faculty are obviously still a very important part of the socialization process, their role is altered as they begin to question students more about their futures in the profession and what they might do in different situations.

More specifically, the faculty role during Phase II is to provide adequate opportunities for practicing professional behaviors in as realistic a manner as possible; provide consistent, constructive, and regular feedback regarding student progress in the area of professional socialization; expose students to as many role models as possible; and provide opportunities for the use of adult learning strategies such as active learning, problem solving, critical thinking, reflection and independent self assessment. In addition, the role of clinical educators becomes more prominent as students begin to make visits to clinical sites to practice newly learned skills and complete short-term apprenticeships. Consistency in expectations and professional behaviors on the part of academic and clinical educators, therefore, becomes increasingly important. Finally, educators in both the academic and apprenticeship settings continue to encourage students to join and become active in professional organizations as a beginning step in making a contribution to creating meaning within the community of practice. Faculty stated that they used these methods as an avenue for professional socialization and students perceived all of these methods as helpful for them in the socialization process.

Traditional teaching methods: Practice and feedback. The use of **regular practice** is generally believed to be important for all types of learning (Sorcinelli, 1995; Yelon, 1996) as can be seen in the often used phrase, "practice makes perfect." Unfortunately, little attention is usually paid to learning things about professional behavior through practice. In contrast to the norm, the faculty in the two Programs included in this study made a concerted effort to include opportunities to practice all skills associated with being professional, including those related to professional values. This practice went a long way toward helping students, with one student explaining that they practiced situations in class so many times that it just became natural once they were out in the clinics with real patients. In addition to a sufficient number of opportunities for practice, both programs made practice sessions as realistic as possible through the use of case studies, role playing, and whenever possible, practice with the types of real people that they will eventually be serving (patients, students, other professionals). During the academic portion of the students' education, Program 2 was especially effective in providing opportunities to practice in as realistic manner as possible through the use of Mock Clinic.

In conjunction with practice, effective educators regularly offer both positive and critical **feedback to students** when appropriate (Yelon, 1996). This feedback should be consistent, supportive, and provided at the earliest reasonable opportunity in order to motivate students to want to continue to learn by building confidence in their professional skills and helping them identify unprofessional behavior so that it can be corrected in a timely manner. Students who practice without feedback are less likely to make improvements in learning (Sorcinelli, 1995). Faculty and clinicians from both programs echoed

this sentiment. All participants were able to provide specific examples of when they had offered immediate feedback that resulted in immediate improvement when students displayed unprofessional behaviors. Feedback provided through the use of the generic abilities in Program 1 was the most consistent and regular form of feedback offered to students in that program, while the use of portfolios and review of the portfolios with faculty advisors was described as a very effective means of receiving feedback for Program 2. Students in both programs emphasized that while the generic abilities or portfolios (for their respective programs) were formal ways in which they received feedback, they also received consistent, regular, constructive feedback from academic and clinical faculty throughout the program on a more informal basis. All students described faculty feedback as helpful in the socialization process.

In addition to feedback from educators, students in these programs also received feedback from peers during class discussions, while working on group projects, and during lab practice sessions. Cooperative learning in the form of group projects, study groups, or student discussion sessions were also felt to enhance internalization of values as students were exposed to the variety of learning styles, beliefs, and values in their peers. Discussion sessions in the continuing professional issues series, in particular, were cited as an important contributor to internalization of the professional ethos. In Program 2, the Ethics course was also felt to be beneficial in facilitating discussions of ethical and professional issues that would help students develop confidence in their professional choices.

The role of the student during phase II: Value negotiation using case grounded self-assessment. According to Value Negotiation Theory, the primary role of the student during Phase II is to become an active participant in the

socialization process. I feel this can be accomplished in several ways. First, students must take advantage of all opportunities for practice. This would include such activities as using time wisely during lab sessions (e.g., mock clinic or similar lab courses), participating in class discussions (e.g., in the professional issues courses or similar courses), sharing thoughts and feelings honestly and openly in reflective journals and discussions, giving honest and constructive feedback to peers, asking questions of individual faculty when necessary, and being open to constructive feedback from educators and peers. As described by students, it is by practicing all aspects of professional development that the professional ethos becomes a "natural" part of who the students are as a people and professionals, and how they will ultimately be able to become a member of the community of practice. In addition, I feel that it is only through active participation that students will discover what they know or don't know; where they need improvement; and most importantly for this study, where conflicts in values, beliefs, or professional behaviors exist. As part of the Theory of Value Negotiation, I am proposing that the discovery of conflict occurs as students become aware of dissensus or confusion both within the profession and between their personal values and those of the profession. In other instances, students may run across situations that involve value conflicts, ethical dilemmas, or professional issues (e.g., entry level education) that they have never encountered or thought about before. In these cases students have to decide what stand they think is best for the profession and for themselves as a future professional.

The real work of value negotiation, then, occurs as students become aware of conflicts or confusion. Although they have been exposed to the big picture regarding professional values and beliefs during Phase I, they now have the

responsibility to apply these values to specific situations. Because awareness is the first step in resolving conflicts or confusion, I believe that offering students timely feedback about unprofessional behavior is very important. If students are unaware of the conflicts their values or behaviors are creating for themselves or others, it is difficult to resolve the issues on which these conflicts are based. As a result, professional development can stagnate. Faculty, in particular, supported this notion of feedback regarding professional behavior. In the examples of unprofessional behavior provided by faculty, students were often unaware that the behavior they exhibited was unprofessional. As a result, students most often thought about the behavior, apologized, and resolved the conflict. Interestingly, students were also able to describe instances of unprofessional behavior in both their classmates and, sometimes in the behavior of practicing professionals. In some instances, they described how they and their classmates had approached another student about behaviors that reflected badly on the class or on the program. Although, because of their position as students, they were unable or unwilling to provide this same type of feedback to practicing clinicians, awareness of the conflict helped them to form a better picture of themselves as an ethical, effective practitioner as they decided that these types of physical therapists were negative role models who exhibited behaviors that they would not exhibit in the future.

The importance of raising awareness of value issues is also why I believe that the use of many case studies grounded in professional ethics across the curriculum is an important component of value negotiation and professional socialization. Participants in both Parts 1 and 2 of this study stressed the importance of integrating issues related to professional socialization throughout the curriculum rather than simply presenting them in a separate course during

one semester in the program. Students, faculty, and clinicians from both programs described how professional behavior is ingrained into students from the moment they enter the program. One way in which Programs 1 and 2 accomplish this is through the professional issues seminar series which extend over the academic portion of the program. In addition, Program 2 uses Mock Clinic to present cases to students, and both programs use case studies throughout the program to help students develop problem solving skills. The extent to which these case studies incorporate issues related to professional development rather than just evaluation and treatment issues, however, is not clear from the interview data.

Based on my knowledge of physical therapy curriculums and accreditation standards of the American Physical Therapy Association, I believe that the addition of this component to case studies would be an easy and worthwhile one. For this reason, I have incorporated the integration of professional issues into case studies into my conceptualization of how it is that students come to internalize a professional issues. For example, rather than just providing students with a list of signs and symptoms from which they are to use their problem solving skills to decide what is wrong with the patient and how they would treat the problem, these scenarios could also include problems related to value judgments or ethical dilemmas. This would accomplish two things. First, students would be asked to consider their own values in relation to those depicted in the case and would have to consider how they would apply their own values and those of the profession to the problem. This type of informal self assessment of values based on specific cases would be beneficial in helping students internalize the professional ethos as they weighed the pros and cons of their decisions. Because faculty and classmates would be

available, students could also discuss their decisions for solving the dilemma with input from others around them helping students to create meaning for themselves and others within the community of practice. Students described how they used discussions in the professional issues course and other courses as a venue for being exposed to and sharing ideas with those of others as part of their quest to become a contributing member of the professional community. A second thing that would be accomplished by incorporating issues related to professional development into all case studies throughout the curriculum would be that students would realize that there is no one faculty member who is the expert on professional values and culture. Rather, as suggested by theories of situated learning, students would realize that knowledge regarding professional socialization (as well as other areas) is distributed among the entire community of practitioners (Hutchins, 1993). Although one faculty member may be responsible for a course on ethics or the professional seminar series, each faculty member and clinician would be viewed as having expertise in the area of professional development and professional socialization.

Once students become aware that a value or ethical problem exists, the next step in value negotiation is to begin to try to resolve the issue by comparing and contrasting ideas. This can be accomplished through class discussions; private discussions with faculty, peers, or clinicians; gathering more information about the topic either in class or through outside sources (i.e., library, professional journals, attending professional meetings on the topic); or reflective journals. In general, these methods reflect the process of active learning that was perceived by students as making significant contributions to the process of professional socialization. Ultimately, it is the student alone who must resolve issues for him or herself by deciding where he or she stands on an issue. I feel that it is the

resolution of the conflict through case grounded self assessment that moves the student along the road to an internalization of the professional ethos.

Formal self-assessment during phase II. On a more formal basis, self assessment can be incorporated into the curriculum in order to help students assess how they have grown in all areas. This formal type of self assessment is accomplished in Program 1 through the semester review of the generic abilities and in Program 2 through the portfolio review and interviews and is felt by the participants in Part 2 of this study to be a useful tool for helping students internalize the ethos of the profession. Although the term self assessment is used to describe this process, the actual completion of generic abilities or portfolio reviews also encompasses many other principles of adult learning, another factor which I and the participants in this study thought to be helpful in the professional socialization of students. First, the student is an active participant in the assessment process. After reflecting on the expectations of the program and the definition of a professional that they have created throughout their education, students decide where they feel they are in the process of internalizing the ethos of profession by identifying strengths and areas in need of improvement. In addition, students set goals for themselves and devise action plans that will help them achieve their goals. Although students receive feedback from faculty regarding their assessment and plan, it is only after they have established for themselves where they are in the process of professional socialization that this feedback is received. As a result, students stated that this process was helpful in establishing a pattern of setting goals and devising plans for themselves that they felt would be helpful to them upon graduation when they would encounter situations where there would be no one available to tell them what to do. This type of self assessment and goal setting

may be helpful, for example, in planning lifelong learning opportunities. Students also felt that because formal self assessment was completed several times throughout the program, they could look back on previous assessments and see how they had grown since that time. The opportunity to see growth was thought to be a motivating factor in their ability to continue to remain dedicated to and complete the program successfully.

Increasing participation in the professional community. During Phase II of value negotiation students have more opportunities to become involved in the professional association and have increased exposure to physical therapy role models as more clinicians are brought into the program to assist in classes and as students begin to visit apprenticeship sites in order to begin to use their new skills in real situations. Their community of practice begins to expand to include others outside the classroom setting. The community begins to welcome them more. For example, in most programs several weeks of clinical experience at apprenticeship sites are integrated into the academic portion of the program. In addition, local professional association meetings often make special efforts to include students in the community by personally inviting them to meetings or sponsoring special activities for students. On a local and national level, students are invited to attend student conclaves. In all of these real situations, I feel that students have the same opportunities and responsibilities to examine their values and behaviors that they had when they applied the process of value negotiation to case studies, theoretical situations, or professional issues. In addition, in this study, students perceived the exposure to an increasing number and variety of role models as contributing to their continuing professional development as they observed professionals in action, and decided for themselves which behaviors and attitudes they would incorporate into their own

view of the ideal professional. Participants in this study felt that students who had adequate opportunities to become aware of and apply ideas to case studies and issues related to the professional ethos, would be more prepared to interact with patients and with others in the community and would be better able to make good decisions about professional behavior and professional practice.

Summary of phase II. During Phase II, students begin the active process of internalizing the professional ethos. While educators provide opportunities to be socialized into the profession, it is students who must actively participate, reflect on their progress, and assess where they are and where they need to do to in order to become a professional. Initially during this phase students are provided with case studies and theoretical or professional issues in the classroom. In these instances, there are no real consequences or rewards for any decisions students make in regard to these "paper-pencil" scenarios. Faculty and peers are very available to help students explore ideas and thoughts related to professional values. In contrast, as students progress through the program, faculty input is decreased and students are afforded increasing opportunities to interact with real patients and practicing clinicians. The consequences and rewards in these situations are also real. A patient may get hurt or a future colleague may think a student is irresponsible or unprofessional if these situations are not handled appropriately. Based on the data from this study, students, faculty, and clinicians feel that if students are adequately prepared in the academic setting through the methods described above, the likelihood of unwanted results in the clinical setting is reduced since, as stated by one student, these skills, beliefs, and behaviors just become a "natural part of who you are."

At this point in the process of professional socialization, most students are

well on their way to internalizing the ethos of the profession. Although they are not totally independent in their professional role, they are being given increasing opportunities to develop independence. In addition, as they enter the clinics, they are given more opportunities to interact and receive feedback from clinicians, rather than just from faculty. As they observe practice in action, they can begin to see connections between what they have learned about professional behavior, how it can be applied, and how it can impact them as a practitioner. In addition, as described by several students, they can also examine the growth they have made as they review their portfolios, journals, or their generic abilities assessments. As a result, not only can they intellectualize about the ethos, but they are beginning to be able to apply the ethical and professional principles inherent in the ethos to practice. Their personal and professional values are beginning to meld and being a physical therapist is becoming a part of who they are.

Phase III - Artistry

Artistry, the final phase of value negotiation, begins as students enter their final apprenticeships and approach graduation (Table 8). This Phase is divided into three stages -- Approaching Graduation, After Graduation, and the Epitome. While the conceptualization of the first phase is based primarily on the data from this study, it also incorporates theoretical perspectives of educational researchers that have become reflective of contemporary views of teaching and learning (e.g., Schon, 1983; 1987). The last two stages are extrapolated from the data and literature review and are based more on my experience in the field of physical therapy education, my knowledge of the profession of physical therapy, and my belief that the process of professional socialization is a developmental one that must continue throughout one's career. While the data

Table 8. The Role of Educators and Students During Phase III

PHASE III: ARTISTRY

Stage 1: Approaching Graduation

Role of Educators: Clinical Faculty Role Increases

1. Provide opportunities for an active role in the apprenticeship site.
2. Provide opportunities to practice professional roles outside that of the clinician.
3. Continued practice and feedback regarding professional behavior.
4. Prepare students for surprise and sense-making.
5. Provide increasing opportunities for legitimate peripheral participation/creating meaning for community.

Role of Student

1. Active participation in professional development.
2. Practice reflection-in-action through problem setting and solving, and critical thinking.
3. Continue value negotiation.
4. Independent self-assessment.
5. Review of growth through GAs, self-assessment, portfolios, journals, interviews.
6. Beginning to create meaning within the clinical community.

Results

1. Increased identification with practicing professionals rather than peers or faculty.
2. Diminished student culture and ethos.
3. See world through the eyes of a professional.
4. Final process of internalization of the professional ethos.
5. Image of self as a professional emerges.
6. Personal and professional selves become one.
7. Increasing participation in professional organization and community of practice.

Stage 2: After Graduation: The Self as Educator and Student

Role of Graduate

1. Continued growth through self-assessment, goal setting and lifelong learning
2. Full participation in professional organization and community of practice.
3. Seek mentors and others for advice.
4. Continued independent value negotiation as new dilemmas and issues arise.
5. Move from the role of "the educated" to "educator" as begin to work with students

Role of Educator

1. Availability to serve as advisers, mentors, and role models for graduates
2. Offer lifelong learning opportunities through continuing and post-entry level education

Results

1. Internalization of the professional ethos as a dynamic entity.
2. Independent and Life Long Learning.
3. Successful practice in indeterminate zones of practice.
4. Full acceptance into community of practice.

Stage 3: The Epitome: The Role of Leaders/Experts as Educators

1. Define the professional ethos and culture.
2. Mentor future leaders.

from this study does not specifically support the conceptualization of continued professional development described in stages 2 and 3 of the Artistry Phase, I felt it was important to include this information in order to create a theory that would offer a complete developmental picture. Doing otherwise, I felt, might lead readers of this study to conclude that the process of professional socialization is complete at the time of graduation.

Stage 1: Approaching graduation. Stage 1, Approaching Graduation, begins as students are completing their final apprenticeships and nearing graduation. Although they are still technically students, they are beginning to function more and more as professionals as they are given increased responsibility in professional duties. As students become more immersed in the professional setting, while at the same time becoming further removed from the classroom, they begin to identify more with the clinicians who surround them rather than the classmates with whom they had spent much of their academic lives (Sabari, 1985). As part of the Theory of Value Negotiation, I feel that as this shift occurs, students become better able to see the world through the eyes of a professional rather than the eyes of the students. This helps them meld their professional with their personal views. In contrast to Phase II, where students continue to go back and forth between the student and professional worlds, comparing and contrasting the two views, students in Phase III begin to solidify their professional views, and consequently, their professional values and ethos. The ethos and culture of the student recedes farther and farther into the background until it eventually diminishes to nothing. Although some students may not complete this transition by the time they graduate most will have melded their personal and professional values with the core values of the profession and the current dynamic values, at least to some extent, by the time they graduate.

Once students have let go of their student culture and student views and have established a sense of what it means to be a professional, I feel they are well on their way to internalizing the professional ethos, at least at the core and at the most obvious of the dynamic levels. That is, their personal values, the core values and beliefs of the profession, and concerns about current issues in the profession that are affecting the roles, responsibilities, and ethos of the profession become fused as one and become part of who the person is.

One of the ways in which I believe that students are able to make this final transition is by being given increasingly active roles in the apprenticeship setting. Those students who are protected from difficult patients, demanding physicians and administrators, or the hassles of fighting for reimbursement of patient services with insurance companies will not be able to internalize the ethos of the new physical therapist and will not reach the stage of true professional socialization. Students who are merely given opportunities to function as clinicians, an important role, but only one part of the new professional ethos, will continue to function as clinicians when they graduate. While they may become extremely effective in this area, they will not be adequately prepared for the real world. The faculty in Program 2 supported this notion and offered this as an explanation for why they felt that longer clinical internships were necessary and helpful for their students. Because student placements extended over an entire semester, they were able to move beyond beyond basic patient care and become involved in working with more complex patients and participating in other aspects of the work of physical therapists. Students from this program also said they felt they were able to get more involved in their work as a result of the longer internships. Clinicians felt that the longer internships were perhaps unnecessary since they seemed to "run out

of things to teach the students" toward the end of the fourteen weeks. As discussed earlier, however, this may be because students had acquired many of the basic skills and were moving on to developing other aspects of their professional roles, such as dealing with insurance companies and physicians, becoming a part of the professional staff, and creating meaning within the community of practice, some of which is not "taught" in the same manner that one teaches a student how to apply a certain evaluation or treatment technique.

My conceptualization of the process by which students continue along the road to professional socialization during Phase III is similar to that of the earlier phases. For example, practice and feedback, this time from practicing clinicians, remain methods that are useful to students. More importantly, students continue to be active participants in their own development. In Programs 1 and 2, for example, students continue to go through the process of reflection and self assessment as they set goals for themselves in the clinical setting. They interact with other students, practicing therapists, and other professionals within the clinical setting, taking in what they see and continuing to build their view of the ideal physical therapist by comparing and contrasting what they see others doing with what they would do in similar situations.

Reflection. As students continue to be given more and more responsibility, their ability to reflect on their actions becomes increasingly important. While others may be available to offer advice at a later time, students interacting with patients and other professionals can not always stop what they are doing to find a colleague to help them solve a problem. Instead, students must develop a new kind of reflection -- one that allows them to think on their feet and solve problems as they occur. Donald Schon (1983; 1987) has coined the term "reflection-in action" to describe this process. Reflection-in-action is the process

by which professionals reflect on what they do during professional practice and how they change their actions when the usual ways of doing things do not work (Schon, 1983; 1987). This may occur, for example, when making a decision to delegate tasks to a paraprofessional results in other problems for the department, or when a patient has a complex set of problems that do not reflect any cases that have been seen before. Reflection-in-action is the process by which successful practitioners are able to reframe a situation that defies the usual into a problem that can be solved (Schon, 1983; 1987). It is a process that goes beyond the realm of the technical know-how that is necessary to solve simple, mundane, or everyday problems, to knowing how to frame problems that are unique, uncertain or laden with value conflicts (Schon, 1987). Schon refers to this process as practicing within the "indeterminate zone of practice."

> These indeterminate zones of practice -- uncertainty, uniqueness, and value conflict -- escape the canons of technical rationality. When a problematic situation is uncertain, technical problem solving depends on the prior construction of a well-formed problem -- which is not itself a technical task. When a practitioner recognizes a situation as unique, she cannot handle it solely by applying theories or techniques derived from her store of professional knowledge. And in situations of value conflict, there are not clear and self-consistent ends to guide the technical selection of means. (Schon, 1987, p. 6)

The ability to think on one's feet, to reflect-in-action, is only accomplished after many months of reflection and problem solving. The ability to blend knowledge, technical skills, and values in order to reflect-in-action and be able to solve the complex and sometimes ambiguous problems that exist in today's professional world has become an important part of the ethos of many professions. It is not, however, a skill that is easily or readily learned. Its precursors -- exposure to a variety of problems and solutions, the ability to frame situations in such a way

that they become a problem to be solved, the ability to reflect, and the willingness to not only take action, but be willing to take responsibility for that action-- are necessary components of developing this skill. These precursors are also the skills that have been described as an important part of professional socialization in Phases I and II of value negotiation and are supported by the participants in this study as a means of facilitating the internalization of the professional ethos. Reflection-in-action, therefore, is the culmination of academic and apprenticeship preparation that incorporates these skills.

The result of successful completion of stage 1 of the artistry phase. Upon graduation, most students have some sense of who they are as a professional, another sign that they have internalized the professional ethos. At this point students may be able to look back over their behaviors and beliefs during their professional program and see how they have changed their views and how they have grown. This was true of several of the students in this study, who discussed how they could now see ethical and professional matters more clearly and could now understand what educators were trying to help them see in the area of professional socialization. Students in Program 1 were able to see their progress as they reviewed their generic abilities self assessments, while those in Program 2 were able to review their portfolios and participated in exit interviews as a means of seeing how far they had come since entering the program. Finally, students discussed how they had become more involved and felt welcome in the professional world as they completed their final internships.

Stage 2: Post graduation. As mentioned earlier not all students reach the point of successful internalization of the professional ethos by the time they graduate. For these students, especially, the process of value negotiation does not stop upon graduation. Even for those who have successfully internalized

the professional ethos, value negotiation continues throughout their careers. Some of this occurs as a result of making the transition from student to professional. Other authors (Brief, et. al., 1979; Chao, 1988; Bradby, 1990) have described this period as one of surprise or reality shock. During this period there may be disappointment or surprise at how the real world functions. Students recognized this period of transition and one student very explicitly stated that this transition process is "going to happen no matter what." Students also thought that educators helped them make this transition in several ways, including realistic practice, longer clinical internships (in Program 2), the generic abilities (in Program 1), fostering independent thinking and responsibility for learning, and emphasizing the need to continue to grow through continuing education, mentor programs, reading, and asking for support from coworkers as needed. Educators can help graduates make this transition from student to professional more smoothly by letting them know that they may experience these feelings as they make the final transition from new graduate to professional and by providing a realistic picture of the professional world as possible (Brief, Van Sell, Aldag, and Melone, 1979; Bradby, 1990; Lurie, 1981). Ultimately, however, it is students who must take this final step toward independence.

A second reason for continued value negotiation and development is that, as described in Part 1, the culture and ethos of the profession are constantly changing in response to changes in society, to incorporating newcomers into the profession, and in response to changes within the profession. New generations of professionals bring their own set of personal values that will contribute to changes within the profession. The increasing pace of change in our society is producing ethical and political problems that did not exist before.

Those who choose not to keep up with these changes and deal with contemporary problems will, I feel, become stagnant. As a result, they may lose their sense of professional ethos as the profession continues to evolve without them.

One of the most important transitions that occurs during this stage is that the graduate becomes responsible for his or her own learning and professional growth. The formal role of educators has diminished to nothing in terms of their responsibility for providing the specific learning opportunities for professional socialization that are necessary for entry into the field. There is no longer someone telling the graduate what he or she must do to continue to grow with the profession. Rather, practicing professionals identify their own needs and seek appropriate resources to fulfill those needs. They may identify a mentor, attend continuing education conferences, become more active in professional organizations, form study groups or journal clubs to seek answers to specific questions within their work setting, or return to the university setting to pursue an advanced degree. All of these methods were discussed by students as ways that faculty encouraged them to continue learning after graduation. They realized that that they would be responsible for their own growth as they continue along the path of professional development through lifelong learning.

This responsibility for one's own learning does not mean that graduates cannot turn to their former educators for advice in determining which direction to take in terms of deciding if they should specialize in a certain area of treatment, how they can become more involved in professional organizations, discussing employment opportunities, or identifying courses or activities that might help them further their professional growth. On the contrary, it has been my experience that many graduates seek advice regarding the best mechanisms

for continued professional growth from educators, including faculty and former clinical instructors. The responsibility of educators to provide this advice is one of the informal ways in which they continue to become involved in the professional socialization of their graduates. Continuing to role model professional behavior is another mechanism by which educators may continue to influence the internalization of the professional ethos in new graduates. On a more formal basis many universities, including the one in which I currently teach, also offer continuing education courses, post-entry level degrees, and opportunities to interact with students in the classroom as ways for graduates to continue to learn. Continuing education opportunities may also be provided by area hospitals and clinics through formal courses or inservice education. On more of a one-to-one basis some departments have a mentor or buddy system in which new graduates are assigned to work with someone who has been in the field for some time and who is willing to help the graduate make the final transition to the professional world. One student interviewed for this study described this experience as being "similar to a clinical internship, but not as strict." Finally, graduates may seek a mentor in a former faculty member that they feel could provide them with counsel regarding the type of professional they would ultimately like to become.

Graduates make the final transition from student to professional by moving beyond the reality shock that often occurs during initial employment after graduation. They begin to gain more confidence in the independent application of both technical skills and the professional values that have been instilled throughout their education. They are faced with a variety of professional problems that will eventually lead to the development of independent reflection-in-action. For those who have had the opportunity to engage in reflection and

self-assessment, as the students in the two programs in this study have, I feel the ability to independently identify problems and reflect-in-action will develop quickly. Similarly, as graduates gain more experience in the profession and interact with others in the work environment, they become full participants in the community of practice. As with the development of reflection-in-action, I feel that those professionals who have been given opportunities as students to be meaningfully involved in the community through exposure to professional and political issues, discussion of ethical problems, and value negotiation will reach this goal sooner than those who have not been provided these same opportunities. These sentiments were also expressed by the educators and students interviewed in Part 2 of this study.

Once graduates have made this final transition from the world of the student to the that of the professional as they begin to make sense of the professional world, I contend that they have taken the final step toward the internalization of the ethos of the profession. As this occurs, the graduate takes on new responsibilities related to teaching and learning, including the responsibility for lifelong learning discussed above. Just as important for this study, they also move from the role of the educated to that of the educator as they become the professionals who provide opportunities for others to learn and to create meaning with the community.

Stage 3: The epitome. Although one is never quite finished internalizing the professional ethos since it is always changing, there does come a time for some individuals when they reach the epitome of professional socialization. I say only some individuals because most people never reach this point. It is reserved only for those who have become acknowledged leaders or experts in the field. Those who reach this point become the individuals who actually help

define the professional ethos. This is not to imply that one simply needs many years of practice or to be elected to a position of power within the professional organization to reach the epitome. In fact, I feel that very few people reach the epitome of value negotiation. Not all professionals who practice for many years become experts and not all people elected to office are truly leaders. One of the Fellows interviewed for Part 1 of this study discussed this issue. She talked about how some people are true leaders who are very dedicated and have worked hard to achieve their status as a leader. In addition, these types of leaders were created by followers who recognized leadership ability, good ideas, and dedication. In contrast, there are some people who may appear to be leaders on the surface, but in reality they are only people who happened to be in the right place at the right time. These are people who are in leadership positions, but who are not truly good leaders.

In my interactions with individuals who I, along with a number of the participants in this study, feel have reached the epitome of value negotiation and have become true leaders in the field a number of characteristics stand out. First, these are people who are humble. While they recognize that they stand at the pinnacle of the profession, they also recognize that there is always room for growth and that they can learn from others in the profession, just as others can learn from them. Several of these individuals said that they could not believe they are so well respected and loved by others in the profession because they "were just doing their job." Finally, in relation to this study, I have found an interesting paradox in that although these individuals help define the professional ethos, some of them have more difficulty in describing it than the students, who simply rattle off a list of what they think a physical therapist should be like. Perhaps this is because these leaders realize the complexity of the

situation or perhaps it is because the view from the top is so overwhelming.

Summary of the Study

This study identified methods used to socialize students into the profession of physical therapy as a specific example of professional socialization. Because it is necessary to know what it is that faculty wish to socialize students into, Part 1 of this study focused on examining data obtained through historical documents (Mary MacMillan Lectures and Presidential Addresses) and interviews with individuals who had been in the profession for a fairly long period of time (i.e., Fellows and Prime Timers). This data revealed that there are some traits and values that form the core of the ethos of the profession (e.g., caring for and helping others) that have not changed since the inception of the profession and are unlikely to change, at least in the foreseeable future. There are also a number of factors that influence the cultural ethos of a profession that result in changes in values and beliefs. These factors can be divided into those that occur as a result of changes from within the profession itself (e.g., a new generation of individuals enters the profession who are different than their predecessors) or from outside the profession (e.g., societal changes in values or new legislation). These changes have, in turn, created a new professional culture and professional ethos, resulting in a different type of practitioner who not only needs a new set of skills, but also has different values and beliefs. It is this latter finding (i.e., continual changes in values and beliefs) that has the most important implications for educators in professional programs. The evolution of the professional ethos has resulted in a need for new methods of professional socialization.

Part 2 of the study, then, was an attempt to describe exemplary methods of professional socialization based on interviews with 6 students, 6 clinical

educators, and 6 faculty members from two university programs (3 students, 3 clinical educators and 3 faculty members from each program). These two professional preparation programs were identified by myself and other physical therapy educators as making a conscious effort to utilize methods that would facilitate the internalization of the professional ethos of physical therapy and professional behaviors that reflect that ethos. Analysis of this data revealed that faculty, clinicians, and students are able to identify methods used by faculty and clinical educators to socialize students into the profession, and that students' perceptions of these methods are similar to those of their teachers. These methods are not only good teaching practice applied to professional socialization, but more importantly, are a reflection of the changes in the profession and society identified in Part 1. Further, there is some evidence provided by faculty and clinical educators that the methods employed by these two programs are effective in facilitating the internalization of the professional ethos of physical therapy and the professional behaviors that would accompany this internalization. All participants, both in Part 1 and Part 2, however, acknowledged that no method is entirely effective and that some students will " never get it." In addition, because of other influences on students' values and beliefs (e.g., family, peers, the media), the extent of the contribution of these methods to professional socialization remains tentative at this time.

Chapter 6 offered a look at the relationship between the data obtained from the two parts of this study. The historical account of the evolution of the professional ethos served as the basis for knowing what educators wish students to learn through the process of professional socialization. The use of methods, in turn, reflected the values related to the evolution of the professional ethos. While each set of data could stand alone, their real strength was found to

lie in their relationship to one another.

Finally, "value negotiation" was offered as a model for understanding the process of socialization in professional education programs. Consisting of three phases of development, Awareness of Values and Expectations, Active Learning, and Artistry, this theoretical model outlined the roles and responsibilities of educators and students in the process of professional socialization. While the role of educators is important in that they provide opportunities within the academic and clinical environments that facilitate the process of internalization of the professional ethos, it is ultimately the students' responsibility to take advantage of these opportunities by becoming active participants in the socialization process.

Implications for Physical Therapy

The results of this study have specific implications for physical therapy education in several ways. First, it has described physical therapy culture as a foundation for the establishment of a professional ethos. Establishing a clear yet dynamic picture of who physical therapists are, particularly as compared to who they have been, has implications for physical therapy education. If one of the goals of physical therapy education is for students to assimilate the culture and ethos of the profession, it is necessary for students and for physical therapy educators to have clear definitions of these two terms within the profession, as well as some of the factors that have contributed to these definitions. For example, in Part 1 of this study factors that have contributed to the evolution of physical therapists from technicians beginning with its inception in 1917 to the more autonomous individuals they are today have been described.

Based on the description of the professional ethos and the process of professional socialization described in this study, physical therapy educators

can begin to incorporate methods for facilitating the internalization of the professional ethos into their curriculums. As a first step, physical therapy educators need to become familiar with both traditional and contemporary principles of teaching and learning and the process of professional socialization. Many physical therapy educators have no background in education, possessing only their content knowledge and their desire to help students learn, as they enter the world of academia. While these two possessions are important, they are not enough to facilitate learning of any kind, including the type of learning involved in professional socialization. While understanding such things as how to write goals and objectives so that students will know what is expected of them in terms of professional behavior is one component of teaching, it is more important for faculty to recognize the need for educating reflective practitioners who are responsible and active learners. As outlined in the model of Value Negotiation, this is the type of learning that ultimately results in successful socialization into the profession. Fortunately, this problem has been recognized by the American Physical Therapy Association and the Section for Education has initiated training programs through continuing education to address this need.

Implications for Professional Education

From a broader perspective, I feel this study has implications for professional education in general. Just as physical therapy educators must define their professional ethos and the many factors that have influenced it, so must other professions seek to do so. The identification of the factors that facilitated professional development and socialization in the students in this study may aid other professional educators in the process of socializing students into their respective professions. In addition, the acknowledgement of change in

professional identity across time may assist educators in realizing that they cannot expect students to have the same values and beliefs as they (the educators) have. Each new cohort of students has grown up in a different time with new sets of norms and expectations for behaviors. These students, therefore, may not be able to simply absorb the values and beliefs of those around them. Rather, faculty and other practitioners in the professions must take an active role in helping students successfully complete the journey to obtaining a professional ethos that will help them function as competent and ethical practitioners in today's changing world. The recognition of this difference between the new and the old will, I hope, help other educators to facilitate the internalization of a professional ethos in their students. It will speak to the need for all professions to explicitly articulate a clear, yet dynamic, sense of their values and beliefs so that they will know what it is that they would like students to become. I feel that many students today are floundering as a result of unclear and unrealistic expectations for professional practice. While educators do not want, and cannot expect, students to be carbon copies of themselves, there are some professional ideals that need to be passed on from one generation to the next in order to maintain the core identity of the profession.

Because of the many ambiguities in choices that today's students must make as compared to the professionals of yesterday, we can no longer expect students to instantaneously function with a clear sense of professional identity as soon as they receive their diploma, particularly if we do not offer them any guidance during their professional education. Because of the dynamic, reciprocal, and situational nature of professional socialization, however, a static instructional design with prescribed ways of teaching students exactly how to

behave and what to think as they enter the professional world is unrealistic. The process of value negotiation, described in this study, I believe, offers a way to give students some direction, yet allow them a sense of autonomy, agency, and decision making that will ultimately make them responsible for the internalization of a professional ethos that is consistent with that of their chosen profession. Overall, educators in professional programs need to be guides, rather than masters. There is a need to provide students with information about the cultural norms, beliefs, and values of the profession (i.e., content) while giving them the ability to recognize when to apply them and how to make their own choices about appropriate professional behaviors (i.e., process).

Any plan for professional socialization should provide enough flexibility to allow for changes in the professional ethos over time as new generations of students enter the profession and the rest of the world around us continues to change. As described earlier, one faculty member interviewed for this study discussed how we must acknowledge generational differences and be careful as educators not to simply create students in our own image, since this image may not be appropriate to function in a changing world.

Finally, faculty need to recognize that the process of professional socialization is a developmental one that takes time. Further, as described earlier, some students may be late bloomers who do not demonstrate a true internalization of the professional ethos until some time after graduation. More disheartening, there are some students, who in the words of several of the individuals interviewed for this study, "will never get it." This does not mean that educators have not done a good job, particularly if most of students are successful. I feel that acknowledging developmental issues and the fact that not every student will be successful, just as not all students are successful in the

academic or psychomotor areas, will go a long way in helping educators continue on the road to trying to socialize students into the profession without excess frustration or feelings of failure. Because of the many changes that are occurring in the world today, educators cannot expect students to internalize the professional ethos by osmosis. Rather it is through art of good teaching and the science of using good teaching practices such as making students aware of expectations, allowing opportunities for practicing these expectations, and encouraging active learning in all phases of professional socialization that educators will ultimately be successful in socializing students into a profession.

Limitations and Suggestions for Future Study

As with all qualitative studies, the small number of programs and individuals involved in this study limits its generalizability. This limit to generalizability is a criticism often leveled at qualitative research, and most qualitative researchers would agree that "generalizability is clearly not the strength of qualitative research" (Firestone, 1993, p. 16). Part of the problem related to the generalizability stems from the fact that "the strongest argument for generalizing is usually thought to be extrapolation from sample to population" (Firestone, 1993, p. 16). In qualitative research, where small sample size and purposive sampling is used instead of random sampling with large number of subjects, the use of this type of sample to population generalizing clearly limits the use of qualitative research in applying research results to other setting. In addition, the results of qualitative research may not be applicable to other settings "because qualitative research is inductive and because it focuses primarily on understanding particulars rather than generalizing to universals" (Maxwell, 1992, p. 296).

Qualitative researchers readily acknowledge this limitation in sample to

population generalizability and offer alternative forms of generalizability for qualitative research. Firestone (1993) and Maxwell (1992), for example, describe applicable methods for generalizing qualitative research from data to theory, rather than to populations or other settings. The purposes of generalizing to theory, as described by Firestone and Maxwell, are to use the theory to make predictions, to confirm the predictions, and to identify the scope or limitations of the theory. According to Firestone, qualitative researchers increase confidence in a theory when similar results are obtained from a replication of a study. Confidence in a theory can also be increased, however, when different results from similar, but not replication, studies differ in predictable ways (Firestone, 1993; Maxwell, 1992). That is, the theory can predict and explain what will happen in similar, as well as different, instances of the same phenomenon. Maxwell summarizes the use of qualitative research to generalize to theory as follows:

> Generalization in qualitative research usually takes place through the development of a theory that not only makes sense of the particular persons or situations studied, but also shows how the same process, in different situations, can lead to different results. Generalizability is normally based on the assumption that this theory may be useful in making sense of similar persons or situations, rather than on an explicit sampling process and drawing conclusions about a specified population through statistical inference. (p. 293)

Maxwell (1992) and Firestone (1993) offer several avenues for generalizing to theory that will help define its scope and, thus, its ability to explain concepts and relationships between concepts in predictable ways. These methods include the use of purposive sampling to identify critical or ideal cases, the use of deviant cases, and multicase studies. "Critical and deviant cases can be used to explore or extend existing theories. Multicase studies can use the logic

of replication and comparison to strengthen conclusions drawn in single sites and provide evidence for both their broader utility and the conditions under which they hold (Firestone, 1993, p. 22)

In addition to the limits to generalizability just discussed, the many variables that influence the professional behaviors of students outside the educational setting confound the ability to accurately assess the effectiveness of the methods of professional socialization outlined in this study. Rather than being an answer to the question of how to effectively socialize students into a profession, I offer the results and my conclusions based on the results as a beginning answer to this question and as a challenge to professional colleagues in physical therapy and other fields to explore this area further.

In regard to future studies, professionals and students in other fields could participate in similar qualitative studies to describe and analyze methods used in other programs. Or, other individuals within the field of physical therapy could be interviewed to compare and contrast methods of socialization of today compared to those of the past. Individuals from several different programs, some of whose students feel they were well socialized and others whose students feel that they were not, could participate in future studies to compare methods of socialization used by these programs. Observations of faculty and students as they progress through a program could be used to describe what actually happens compared to what educators and students report to have happened, as was done in this study.

Other questions to be answered in relation to professional socialization might expand on the issues raised in this study. How, for example, can we assess the effectiveness of professional programs in successfully socializing students into our various professions? If we can assess effectiveness, are some methods

more useful than others? Are some socialization methods more effective for one type of profession than another? Are the methods outlined in the model of value negotiation proposed in this study useful or effective? Is there a difference in the process for students of different genders, ages, or cultures? How important are the professional Code of Ethics and Standards of Practice for professional socialization?

I feel that my work has provided me with a good beginning look at the process of professional socialization, specifically within the field of physical therapy, but also as an example to other professionals. I hope that others will also appreciate this beginning insight into professional socialization and that it will encourage them to continue to explore this area in order to answer the questions posed above as well as their own pressing practical and theoretical questions.

APPENDIX A

APPENDIX A
EXPLANATORY LETTERS AND CONSENT FORMS
EXPLANATORY LETTER FOR PILOT STUDY - IRB # 95-338

Dear Colleague,

I am a physical therapy educator and a doctoral student in the Educational Psychology Program at Michigan State University. As part of a research practicum requirement, I am conducting a pilot study for my dissertation. The purposes of this study are to explore explore the relationship between the identity of the individual practitioner and the identity of the profession; to describe the impact that society, culture and history have had on both of these constructs; to describe the influence of these factors on the values of our profession; and to identify methods for teaching these values to our students. In order to gather this information, I am planning to conduct a series of semistructured interviews. You have been identified as a person who is a leader in this area and who might be interested in participating. The purpose of this letter, therefore, is to inquire about your willingness and availability to be interviewed.

The interview will take approximately one hour and will be tape recorded for later analysis. I will arrange the interview at a time of greatest convenience for you. I have enclosed a copy of sample questions for the interview for your review in order to allow adequate time for you to think about your answers. Your participation in this study is, of course, completely voluntary, and can be terminated at any time, either before or during the interview. The names of all participants in the study will remain confidential and tapes and transcripts will be reviewed only by myself and my practicum and dissertation committees.

If you would be willing to participate in this pilot project, please complete and return the attached form by fax [(810) 370-4287)] or in the stamped, self-addressed envelope as soon as possible. After receiving your reply, I will contact you by phone to set up a time for the interview. In the meantime, if you have any questions about the project you can contact me at work [(810) 370-4047] or at home [(810) 641-5313]. You can also contact my advisor, Dr. Christopher Clark, by phone at Michigan State University [(517) 355-8502] or in writing at College of Education, Michigan State University, East Lansing, Michigan 48824-1034.

Thank you for your consideration of this request. I look forward to hearing from you.

Sincerely,

Chris Stiller-Sermo, M.A., P.T.

Enclosures: 2

CONSENT TO PARTICIPATE IN PILOT STUDY-IRB #95-338

I give my consent to participate in the study, "Values in Physical Therapy Education: Merging Personal and Professional Identity" and am willing to be contacted to arrange a time and place to be interviewed. I understand that I will be interviewed by the investigator at a time convenient to both of us. I also understand that the interview will take approximately one hour, will be tape recorded for future analysis by the investigator, and will be confidential. I further understand that I may terminate my participation in this project at any time.

Name _____

Address _____

Phone (work) _____ (home) _____

(fax) _____ (e-mail) _____

_____ _____

Signature of participant Date

Return to: Chris Stiller-Sermo, M. A., P. T
1891 Farmbrook
Troy, Michigan 48098

Fax: (810) 370-4287

EXPLANATORY LETTER FOR DISSERTATION STUDY

Dear Colleague,

I am a physical therapy educator and a doctoral student in the Educational Psychology Program at Michigan State University. In the past, as part of a pilot study I was conducting for my dissertation, you participated in an interview on "Values in Physical Therapy Education: Merging Personal and Professional Identity". I have completed my pilot study and am now in the process of expanding it to include other data, such as a focus group interview with the Prime Timers and a review of historical documents, for my dissertation, which is entitled "Students' Perceptions of Socialization in Professional Education Programs: The Example of Physical Therapy". As part of my dissertation, I would like to include the analysis of the data obtained in the previous interviews. I am, therefore, writing to request your permission to include the data obtained when I last interviewed you and to be able to contact you in the future for clarification of previous responses and for follow-up questions. As in the previous request for participation, all information will be kept confidential and will be available only to myself and my dissertation committee, as explained in the attached consent form. You may withdraw your consent to participate at any time.

If you would be willing to have the information from the pilot study included in my dissertation, please complete and return the attached form by fax [(810) 370-4287] or in the stamped, self-addressed envelope as soon as possible. If you have any questions about the project you can contact me at work [(810) 370-4047] or at home [(810) 641-5313]. You can also contact my advisor, Dr. Christopher Clark, by phone at Michigan State University [(517) 355-8502] or in writing at College of Education, Michigan State University, East Lansing, Michigan 48824-1034.

Thank you for your consideration of this request. I look forward to hearing from you.

Sincerely,

Chris Stiller-Sermo, M.A., P.T.

Enclosure: (1)

CONSENT FOR DISSERTATION STUDY

I give my consent to have my previous interview data from the practicum study on "Values in Physical Therapy Education: Merging Personal and Professional Identity" included in the present dissertation study on "Students' Perceptions of Socialization in Professional Education Programs: The Example of Physical Therapy", and to be contacted in the future for clarification of previous responses and for follow-up questions. I understand that, as in the pilot study, all results will remain confidential, that I can terminate my participation in the project at any time, and that I can request that any statement I have made not be used in this study. I also understand that because of the limited number of individuals who are possible subjects for this study, there is a possibility that someone may recognize an idea that I have shared, in spite of the fact that every attempt will be made to protect my identity.

Name_____

Address_____

Phone (work)_____(home)_____

(fax) _____ (e-mail)_____

_____ _____

Signature of participant Date

Return to: Chris Stiller-Sermo, M. A., P. T
1891 Farmbrook
Troy, Michigan 48098

Fax: (810) 370-4287

APPENDIX B

APPENDIX B
INTERVIEW QUESTIONS FOR PILOT STUDY

INTRODUCTION

As a leader in the profession of physical therapy, you have experienced many changes in practice over the years. These changes in practice resulted from the impact of influential people both within and outside of the profession, as well as social, political, economic, cultural, and historical events that have occurred over the years. As a doctoral student in educational psychology, I am interested in finding out how these people and events have shaped the values that serve as the foundation for our Code of Ethics and Standards of Practice. The following questions are my attempt to get your thoughts on how our professional values developed and how we can best pass these values on to the students that we teach in physical therapy education.

Because this interview is part of a pilot study, I am interested in your opinion and feedback about this experience in order to improve my ability to gather similar data for my dissertation. For example, are there ways in which you think this project can be improved; do you have any suggestions for other people to interview; did the interview questions adequately address the issues of professional values, and if not do you have any suggestions for improvement? Please feel free to add any information that you feel is important to my topic, but is not adequately addressed in my questions. In addition, keep in mind that we can stop the interview at any time if you decide you no longer want to participate.

MAJOR AREAS OF INTEREST AND GUIDING QUESTIONS

I. Autobiography

How did you become a physical therapist? What was it like for you personally and for the profession at the time? What drew you to where you are today? What do you think causes others to become physical therapists? How did you come to be recognized as a leader in the field?

II. Ideals/Values

What were your ideals and values as you entered the profession? How have they evolved and changed over the years? How and why do you think the ideals and values of the profession have evolved and changed over the years? Are there any personality traits of physical therapists that you think have remained constant throughout the history of our profession? If so, what and why? Which have changed and why?

III. Influential people and events

What social, cultural, or historical events do you think have impacted the profession/you personally the most and why? What people have done so and why?

IV. Educating students

What advice would you give to someone like me who is completing a doctorate in the field of educational psychology about teaching professional values to students?

APPENDIX C

APPENDIX C
EXPLANATORY LETTER/CONSENT FORM - PRIME TIMERS FOCUS GROUP

Dear Colleague,

I am a physical therapy educator and a doctoral student in the Educational Psychology Program at Michigan State University. As part of my dissertation, I am conducting a study to identify values held by physical therapy practitioners and the profession. The purposes of this study are to explore explore the relationship between the identity of the individual practitioner and the identity of the profession; to describe the impact that society, culture and history have had on both of these constructs; to describe the influence of these factors on the values of our profession; and to identify methods for teaching these values to our students. In order to gather this information, I am planning to conduct a focus group interview with members of the Prime Timers. As a member of this group, I feel you would have some insight into the development of the profession. The purpose of this letter, therefore, is to inquire about your willingness and availability to participate in the focus group interview and to be contacted in the future for clarification of interview responses and follow-up questions as needed.

The session will take approximately two hours and will be videotaped for later analysis. I will arrange the group meeting at a time of greatest convenience for all those that will be involved. I have enclosed a copy of sample questions for the interview for your review in order to allow adequate time for you to think about your answers. Your participation in this study is, of course, completely voluntary, and can be terminated at any time, either before or during the focus group interview. The names of all participants in the study will remain confidential and tapes and transcripts will be reviewed only by myself and my dissertation committee. Because of the limited number of possible subjects for this study, however, please keep in mind that it is not 100% guaranteed that I can completely conceal your identity in all instances (particularly if there is an idea that you feel strongly about and have shared with many other people).

If you would be willing to participate in this study, please complete and return the attached form by fax [(810) 370-4287)] or in the stamped, self-addressed envelope as soon as possible. After receiving your reply, I will contact you by phone to set up a time for the focus group interview. In the meantime, if you have any questions about the project you can contact me at work [(810) 370-4047] or at home [(810) 641-5313]. You can also contact my advisor, Dr. Christopher Clark, by phone at Michigan State University [(517) 355-8502] or in writing at College of Education, Michigan State University, East Lansing, Michigan 48824-1034.

Thank you for your consideration of this request. I look forward to hearing from you.

Sincerely,

Chris Stiller-Sermo, M.A., P.T.

Enclosures: 2

CONSENT TO PARTICIPATE IN PRIME TIMERS FOCUS GROUP

I give my consent to participate in the study, "Values in Physical Therapy Education: Merging Personal and Professional Identity". I am willing to be contacted to arrange a time and place to be participate in the focus group and to be contacted for clarification of any of my responses and for follow-up questions. I understand that the group session will be arranged at a time convenient to the investigator and other Prime Timers who give their consent to participate in this study. I also understand that the group session will take approximately two hours, will be videotaped for future analysis by the investigator, and will be confidential. Confidentiality will be maintained within the limits of the study: that is, because of the small number of possible subjects for this study, I understand that someone may recognize an individual idea I have shared, in spite of all attempts by the researcher to conceal my identity. I further understand that I may terminate my participation in this project at any time, that I can refuse to answer any questions, and that I can request that the video recorder be turned off at any time or that I any response I have given not be used in this study.

Name _____

Address _____

Phone (work)_____ (home)_____

(fax) _____ (e-mail)_____

_____ _____

Signature of participant Date

Return to: Chris Stiller-Sermo, M. A., P. T
1891 Farmbrook
Troy, Michigan 48098

Fax: (810) 370-4287

APPENDIX D

APPENDIX D
QUESTIONS FOR FOCUS GROUP

INTRODUCTION

As a member of the Prime Timers, you have experienced many changes in practice over the years. These changes in practice resulted from the impact of influential people both within and outside of the profession, as well as social, political, economic, cultural, and historical events that have occurred over the years. As a doctoral student in educational psychology, I am interested in finding out how these people and events have shaped the values that serve as the foundation for our Code of Ethics and Standards of Practice. The following questions are my attempt to get your thoughts on how our professional values developed and how we can best pass these values on to the students that we teach in physical therapy education.

MAJOR AREAS OF INTEREST AND GUIDING QUESTIONS

I. Autobiography of the profession

How do you think the profession has changed over the years? Do you think the reasons for people wanting to become a physical therapist have changed? What do you think Mary MacMillan might say if she saw what was happening in physical therapy today?

II. Ideals/Values

What were the ideals and values of the profession when you first began practicing? How have they evolved and changed over the years? How and why do you think the ideals and values of the profession have evolved and changed over the years? Are there any personality traits of physical therapists that you think have remained constant throughout the history of our profession? If so, what and why? Which have changed and why?

III. Influential people and events

What social, cultural, or historical events do you think have impacted the profession/you personally the most and why? What people have done so and why?

As someone who has been practicing for a long time, how do you think you have impacted the profession? How has the Prime Timers influenced others in the profession?

IV. Educating students

What advice would you give to someone like me who is completing a doctorate in the field of educational psychology about teaching professional values to students?

APPENDIX E

APPENDIX E
EXPLANATORY LETTER/CONSENT FORM FOR PROGRAM INTERVIEWS

Dear Colleague,

I am a physical therapy educator and a doctoral student in the Educational Psychology Program at Michigan State University, and am currently in the process of completing my dissertation research. The purposes of my study are to describe the culture and professional ethos of physical therapy and to identify methods for helping our students to internalize a professional ethos that is consistent with the beliefs of practicing clinicians and the APTA. In order to gather this information, I am planning to conduct a series of semistructured interviews. You have been identified as someone who might be interested in participating in this study. The purpose of this letter, therefore, is to inquire about your willingness and availability to be interviewed.

The interview will take approximately one to and and one half hours and will be tape recorded for later analysis. I will arrange the interview at a time of greatest convenience for you. I have enclosed a copy of sample questions for the interview for your review in order to allow adequate time for you to think about your answers. Your participation in this study is, of course, completely voluntary, and can be terminated at any time, either before or during the interview. The names of all participants in the study will remain confidential and tapes and transcripts will be reviewed only by myself and my dissertation committee.

If you would be willing to participate in this study, please complete and return the attached form by fax [(810) 952-5273)] or in the stamped, self-addressed envelope as soon as possible. After receiving your reply, I will contact you by phone to set up a time for the interview. In the meantime, if you have any questions about the project you can contact me at work [(810) 370-4047] or at home [(810) 641-5313]. You can also contact my advisor, Dr. Christopher Clark, by phone at Michigan State University [(517) 355-8502] or in writing at College of Education, Michigan State University, East Lansing, Michigan 48824-1034.

Thank you for your consideration of this request. I look forward to hearing from you.

Sincerely,

Chris Stiller-Sermo, M.A., P.T.

Enclosures: 2

CONSENT TO PARTICIPATE IN PROGRAM INTERVIEWS

I give my consent to participate in the study, "Students' Perceptions of Socialization in Professional Education Programs: The Example of Physical Therapy" and am willing to be contacted to arrange a time and place to be interviewed. I understand that I will be interviewed by the investigator at a time convenient to both of us. I also understand that the interview will take approximately one to one and one half hours, will be tape recorded for future analysis by the investigator, and will be confidential. I further understand that I may terminate my participation in this project at any time.

Name _____

Address _____

Phone (work) _____ (home) _____

(fax) _____ (e-mail) _____

_____ _____

Signature Date

Return to: Chris Stiller Sermo, M.A., P.T.
1891 Farmbrook
Troy, Michigan 48098

Fax: (810) 370-4287

APPENDIX F

APPENDIX F
INTERVIEW QUESTIONS FOR PROGRAM INTERVIEWS

INTRODUCTION

One of the goals of professional education in physical therapy is to help students attain a professional identity that is consistent with the values and beliefs of practitioners and the American Physical Therapy Association. As a student in a physical therapy program, I am interested in your experiences in being socialized into the profession. The following areas of interest and guiding questions are my attempt to obtain your thoughts on this topic. Please feel free to add any information that you feel is important to the topic, but is not adequately addressed in my questions. In addition, keep in mind that we can stop the interview at any time if you decide you no longer want to participate.

MAJOR AREAS OF INTEREST AND GUIDING QUESTIONS - STUDENTS

I. Definition of the Professional Ethos of Physical Therapy

What do you think are the core beliefs, values, and characteristics of physical therapy (i.e. the professional ethos)? Can you give me an example of how you think physical therapists portray an image of this professional ethos to their colleagues, patients, other health care team members, and the general public? Can you give me a specific example of how you have portrayed this image to others either while you were in the academic setting or while you were on your clinical affiliations?

II. Personal Experience

What are some of the ways that you think the faculty and clinical educators in your program attempt to socialize students into the profession? Can you give specific examples? Can you describe an incident that stands out in your mind as "the" example of professional socialization based on your experience as a physical therapy student in your program? Are there any times when you feel you may have acted unprofessionally or have questioned the professional behavior of others? If so, can you describe these incidents? Do you feel your faculty and clinical instructors are in touch with current changes in the field in terms of the professional culture of physical therapy? Why or why not? Are you aware of what other programs do to help students become part of the professional culture of physical therapy? If so, what do they do?

III. Experience with Program "X"

Do you feel students in your program are made aware of the program goals for professional behavior and the attainment of a professional ethos? If so, how? Do you think these goals are realistic for professional practice?

Are you aware of anything program "X" does to help students to internalize the professional ethos of physical therapy? If so, what and how do you feel this contributes to the professionalization of the students?

Do you feel your program prepares students to be active and reflective learners who are responsible for their own learning? If so, how? Do you feel this contributes to students' internalization of a professional ethos? If so, how?

Do you think the role models in the academic and clinical settings in which you participate are consistent? Why or why not?

Do you think your program does anything to help students make the transition from student to professional? If so, what?

Compared to other programs, how effective do you think your program is in helping students internalize the professional ethos of physical therapy? What evidence can you provide of its effectiveness?

Do you think the faculty and clinical instructors in your program are aware of your experiences in becoming socialized into the profession? Why? Can you give a specific example to support your answer?

IV. The Ideal

If you could design an ideal situation to help students attain a sense of profession identity, what would that look like? How could this be accomplished and what obstacles might you have to overcome in order to set up your ideal situation? How close does program "X" come to this ideal situation?

V. The Future

What, if any, changes can you foresee in our professional ethos and culture in the future as a result of social, political, historical, or cultural changes? How do you think faculty and clinical educators can best prepare students to be able to deal with these changes? Do you think your program has prepared you to deal with these changes?

VI. As part of this study I conducted interviews with Fellows and Prime Timers in order to define the contemporary professional ethos and any changes that have occurred over time. I will read a short synopsis ** of what they said and I'd like to know whether you agree or disagree with this and why you feel the way you do?

> **Summary Statement of Values and Identity
> Physical therapists are generally good people who ware glad to be in a helping profession. They value hard work, dedication, and seeing others get better. They are concerned about maintaining high standards of care and professional ethics. They are warm hearted and caring and enjoy having fun. On the negative side, some younger therapists and some students today have become more interested in self-fulfillment and making money rather than providing good patient care.

MAJOR AREAS OF INTEREST AND GUIDING QUESTIONS - FACULTY AND CLINICAL EDUCATORS

I. Definition of the Professional Ethos of Physical Therapy

What do you think are the core beliefs, values, and characteristics (i.e. professional ethos) of physical therapy? Can you give me an example of how you think physical therapists portray an image of this professional ethos to their colleagues, patients, other health care team members, and the general public? Can you give me a specific example of how you help students to attain this professional ethos?

II. Personal Experience

In your present position, or in previous positions you have held, what are some of the ways in which you, personally, have helped students to attain a sense of professional ethos? Does the institution in which you currently work, or those in which you have worked in the past have specific policies or procedures for helping students attain a professional ethos? If so, what are they? Do any courses specifically address this issue? If so, what are they? How effective do you think the methods or courses are in helping students internalize the professional ethos of physical therapy? Why? Can you give me a specific example of a student that you have witnessed acting unprofessionally? Very professional? What did you do in each situation? Why?

III. Experience with Program "X"

In regard to the physical therapy program at "X", do you feel students are made aware of the program goals for professional behavior and the attainment of a professional ethos? If so, how? Do you think these goals are realistic for professional practice?

Are you aware of anything program "X" does to help students to internalize the professional ethos of physical therapy? If so, what and how do you feel this contributes to the professionalization of the students?

Do you feel program "X" prepares students to be active and reflective learners who are responsible for their own learning? If so, how? Do you feel this contributes to students' internalization of a professional ethos? If so, how?

Do you think the role models in the academic and clinical settings in which students from program X" participate are consistent? Why or why not?

Do you think program "X" does anything to help students make the transition from student to professional? If so, what?

Compared to other programs, how effective do you think program "X" is in helping students internalize the professional ethos of physical therapy? What evidence can you provide of its effectiveness?

Are you aware of how the students feel about the process of professional socialization at program "X"? Do you think their views are consistent with those of the faculty and clinical educators? Can you give me a specific example of

how you know this?

IV. The Ideal

If you could design an ideal situation to help students attain a sense of profession identity, what would that look like? How could this be accomplished and what obstacles might you have to overcome in order to set up your ideal situation? How close does program "X" come to this ideal situation?

V. The Future

What, if any, changes can you foresee in our professional identity in the future as a result of social, political, historical, or cultural changes? How do you think we can best prepare students to be able to deal with these changes? Do you think program "X" has prepared students to deal with these changes? How have they done so?

VI. As part of this study I conducted interviews with Fellows and Prime Timers in order to define the contemporary professional ethos and any changes that have occurred over time. I will read a short synopsis ** of what they said and I'd like to know whether you agree or disagree with this and why you feel the way you do?

> **Summary Statement of Values and Identity
> Physical therapists are generally good people who ware glad to be in a helping profession. They value hard work, dedication, and seeing others get better. They are concerned about maintaining high standards of care and professional ethics. They are warm hearted and caring and enjoy having fun. On the negative side, some younger therapists and some students today have become more interested in self-fulfillment and making money rather than providing good patient care.

APPENDIX G

APPENDIX G
DESCRIPTION OF SUBJECTS

Fellows

1= 85 year old female; 65 years of experience in PT; certificate in PT in 1930; has several honorary doctorates; has been a Fellow since 1986; currently lectures and writes about musculoskeletal problems

2= 62 year old male; 39 years of experience in PT; BSPT in 1956; MA Rehabilitation Counseling in 1964; PhD in Rehabilitation Counseling in 1971; has been a Fellow since 1991; currently teaching in a physical therapy program

3= 52 year old female; 28 years of experience in PT; BSPT in 1967; MA in Human Development; PhD in Higher Education Administration; has been a Fellow since 1995; currently is the Dean of Graduate Studies at a university in a large urban setting and also teaches in the PT program at the same university

Prime Timers

1= 76 year old female; 52 years of experience in PT; BS in 1943; Certificate in PT in 1944; MA in 1961; currently is working as an independent contractor

2= 75 year old female; 52 years of experience in PT; BS in Education in 1943; Certificate in PT in 1944; MEd in 1970; Licensed Nursing Home Administrator in 1974; founded and is currently employed in a multidisciplinary rehabilitation agency; is a consultant to an archdiocese in a large city; is a PT instructor for a State Department of Public Health

3= 73 year old female; 50 years of experience in PT; BS in 1945; Certificate in PT in 1946; MSPT in 1952; retired

4= 60 year old female; 39 years of experience in PT; BSPT in 1957; currently working in an acute care hospital

5= 70 year old female; 45 years of experience in PT; BSPT in 1951; Graduate work in geriatrics; retired

6= 74 year old female; 46 years of experience in PT; BSPT in 1950; retired

7= 77 year old female; 52 years of experience in PT; BS in 1942; Secondary Teaching Certificate in 1943; Certificate in PT in 1944; currently retired, but does volunteer work with patients with Huntington's Disease

8= 63 year old female; 38 years of experience in PT; BS in Ed. in 1955; Certificate in PT in 1958; MS in 1971; PhD in 1981; Currently Chair and Distinguished Professor in a PT Program

9= 52 year old female; 28 years of experience in PT; BA in 1966; MS in 1968; PhD in 1980; currently self-employed

10= 67 year old female; 43 years of experience in PT; BS in 1952; Certificate in PT in 1953; Master's in 1966; currently employed in home health care

11= 73 year old female; 50 years of experience in PT; BA in 1945; Certificate in PT in 1946; MA in 1947; currently employed in home health care

Program 1

Faculty 1= 49 year old female; 26 years of experience in PT; BSPT in 1971; also has MEd in 1980; PhD in Physiology in 1988; three year post-doc in physiology 1988-1991; clinical area of interest is acute care, orthopedics, and rehabilitation; has been teaching in Program 1 for 6 years; no previous teaching experience

Faculty 2= 36 year old male; 14 years of experience in PT; BSPT in 1983; MA in Higher Education in 1995; clinical area of interest is orthopedics; is a certified Feldenkrais Practitioner; has been teaching in Program 1 for 5 years; no previous teaching experience

Faculty 3= 59 year old male; 35 years of experience in PT; BS in PE and Certificate in PT in 1962; MPH in 1968; clinical area of interest is orthopedics; has been teaching in Program 1 for 9 years; no previous teaching experience

Clinician 1= 28 year old male; 5 years of experience in PT; BSPT in 1992; clinical area of interest is neurorehabilitation; currently employed as the Director of Rehabilitation and the Center Coordinator of Clinical Education in a small rural hospital

Clinician 2= 48 year old female; 24 years of experience in PT; BSPT in 1973; clinical area of interest is neurorehabilitation; currently employed as a clinical specialist in a large hospital system

Clinician 3= 43 year old female; 20 years of experience in PT; BSPT in 1977; clinical area of interest is neurorehabilitation; currently employed as the Rehabilitation Medicine Supervisor and Center Coordinator of Clinical Education in a Veterans Hospital

Student 1= 39 year old male; BS in PE; completing final clinical internships; expected to graduate in four months

Student 2= 23 year old female; completing final clinical internships; expected to graduate in four months

Student 3= 27 year old female; BS in Anthropology; completing final clinical internships; expected to graduate in four months

Program 2

Faculty 1= 28 year old female; 6 years of experience in PT; B.S. in Fine Arts in 1981; MPT in 1991; Clinical area of practice is in neurorehabilitation; is certified as a Neuro Clinical Specialist by the APTA and has completed a 6 month residency in neurorehabilitation; has been teaching in Program 2 for one year; no previous academic teaching experience prior to Program 2

Faculty 2= 41 year old male; 19 years of experience in PT; B.S. in PT in 1978; M.S. in Anatomy in 1982; PhD in Anatomy in 1986; Clinical area of practice is orthopedics and sports medicine; is also an certified athletic trainer; has been teaching in Program 2 for four years; has previous and concurrent academic teaching experience at two other universities; has been teaching for 14 years

Faculty 3= 48 year old male; 22 years of experience in PT; B.S. in 1971; MS in PT in 1975; PhD in Higher Adult and Lifelong Learning in 1992; clinical area of practice is pediatrics; has been teaching at Program 2 for 5 years; has previous teaching experience at two other universities; has been teaching since 1980.

Clinician 1= 39 year old female; 17 years of experience in PT; BSPT in 1980; MS in Cardiopulmonary PT in 1987; is certified as a Cardiopulmonary Specialist by the APTA; clinical area of interest is cardiopulmonary PT; is currently a clinical specialist in a large hospital setting

Clinician 2= 30 year old female; 6 years of experience in PT; BSHS/MPT in 1991; clinical area of interest is orthopedics; currently employed by a large hospital working in an outpatient orthopedic clinic

Clinician 3= 33 year old female; 11 years of experience in PT; BSPT in 1986; clinical area of interest is in general practice; currently employed as a supervisor and Center Coordinator of Clinical Education in a large hospital system

Student 1= 27 year old female; BS in Physiology in 1992; new graduate of MPT program; working in acute care in a large hospital setting

Student 2= 26 year old female; new graduate of MPT program; working in a large hospital setting

Student 3= age not provided by participant (estimated to be in early to mid twenties); female; in the process of completing her first of two fourteen week internships; expected date of graduation is one year

APPENDIX H

APPENDIX H
GENERIC ABILITIES

Generic Ability	Definition
1. Commitment to Learning	The ability to self-assess, self-correct, and self-direct; to identify needs and sources of learning; and to continually seek new knowledge and understanding
2. Interpersonal Skills	The ability to interact effectively with patients, families, colleagues, other health professionals, and the community and to deal effectively with cultural and ethnic diversity issues.
3. Communication Skills	The ability to communicate effectively (i.e., speaking, body language, reading, writing, listening) for varied audiences and purposes.
4. Effective Use of Time and Resources	The ability to obtain the maximum benefit from a minimum investment of time and resources.
5. Use of Constructive Feedback	The ability to identify sources of and seek out feedback and to effectively use and provide feedback for improving personal interaction.
6. Problem-Solving	The ability to recognize and define problems, analyze data, develop and mplement solutions, and evaluate outcomes.
7. Professional	The ability to exhibit appropriate professional conduct and to represent the profession effectively.
8. Responsibility	The ability to fulfill commitments and to be accountable for actions and outcomes.
9. Critical Thinking	The ability to question logically; to identify, generate, and evaluate elements of logical argument; to recognize and differentiate facts, illusions, assumptions, and hidden assumptions; and to distinguish the relevant from the irrelevant.

10. Stress Management — The ability to identify sources of stress and to develop effective coping behaviors.

Sample Behavioral Criteria for Commitment to Learning

Beginning Level
- -Identifies problems
- -Formulates appropriate questions
- -Demonstrates a positive attitude (motivation) toward learning
- -Offers own thoughts and ideas
- -Identifies need for further information

Developing Level (builds on preceding level)
- -Prioritizes information needs
- -Analyzes and subdivides larger questions into components
- -Seeks out professional literature
- -Sets personal and professional goals
- -identifies own learning needs based on previous experiences
- -Plans and presents and in-service, or research or case studies
- -Welcomes and/or seeks new learning opportunities

Entry Level (builds on preceding level)
- -Applies new information and reevaluates performance
- -Accepts that there may be more than one answer to a problem
- -Recognizes the need to and is able to verify solutions to problems
- -Reads articles critically and understand limits of application to professional practice
- -Researches and studies areas where knowledge is lacking

Post-Entry Level (builds on preceding level)
- -Questions conventional wisdom
- -Formulates and reevaluates position based on available evidence
- -Demonstrates confidence in sharing new knowledge with all staff levels
- -Modifies programs and treatments based on newly-learned skills and considerations
- -Consults with other allied health professionals and physical therapists for treatment ideas
- -Acts as a mentor in area of specialty for other staff

Sample Behavioral Criteria for Professionalism

Beginning Level
- -Abides by APTA Code of Ethics
- -Demonstrates awareness of state licensure regulations
- -Abides by facility policies and procedures
- -Projects professional image
- -Attends professional meetings
- -Demonstrates honesty, compassion, courage, and continuous regard for all

Developing Level (builds on previous level)
- -Identifies positive professional role models
- - Discusses societal expectations of profession
- -Acts on moral commitment
- -Involves other health care professionals in decision-making
- -Seeks informed consent from patients

Entry Level (builds on previous levels)
- -Demonstrates accountability for professional decisions
- -Treats patients within scope of practice
- -Discusses role of physical therapy in health care
- -Keeps patient as a priority

Post-Entry Level (builds on previous levels)
- -Participates actively in professional organization
- -Attends workshops
- -Actively promotes the profession
- -Acts in leadership role when needed
- -Supports research

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