

FINDING VOCATION IN ACADEMIC WORK:
EARLY CAREER IN THE EVOLVING FIELD OF PHYSICAL THERAPY

By

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ABSTRACT

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Faculty development is a pressing issue in higher education and for the profession of physical therapy, a relatively new field in health education with a growing number of programs and a shortage of qualified academic faculty. Successful faculty development efforts in higher education require a thorough understanding of faculty and their academic careers. An understanding of faculty and careers requires not only an understanding of roles and responsibilities but also the meaning and vocation that individuals find in their work.

Careers were conceptualized as having three interrelated components; the external career, the internal career and vocation. The external career is the position, roles and responsibilities. The internal career is the personal meaning and identity in work. Vocation is the understanding and acting on your true self. The purpose of the study was to describe and analyze the internal careers

and vocation of full time faculty members in physical therapy education programs as they entered into academic careers.

Interviews of four full time physical therapy faculty members explored how and why they became faculty members, their roles and responsibilities as faculty and the meaning that academic work holds for them. Profiles and vignettes, which are stories in the words of the participants were crafted from the interviews. The profiles revealed four common issues in the participants external careers; obtaining a doctoral degree, managing a clinical role, perceiving possibilities in an academic setting and managing responsibilities in professional education, in addition to issues new faculty usually face.

Participants described two common themes in their internal careers that were meaningful to them, the centrality of patients and the expression of the professional ethos in physical therapy. Participants also described personal meaning related to their vocations in their internal careers. Implications for physical therapy education and professional education are presented.

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Chapter 1

Academic Career Development

Introduction

Faculty development is a pressing issue in higher education and for the profession of physical therapy. Physical therapist education programs are health professional education programs offered in liberal arts, comprehensive, and research universities as well as academic medical centers. Physical therapy is a relatively new field with a growing number of academic physical therapy education programs and a shortage of qualified academic faculty (Hayes, 1997; Rothstein, 1999).

Successful faculty development efforts in higher education require a thorough understanding of faculty and their academic careers (Baldwin and Blackburn, 1981). An understanding of faculty and their careers requires not only an understanding of their roles and responsibilities but also the vocation or meaning that individuals derive from their work. The meaning that individuals seek in their work shapes their careers and their career development (Bok, 1986; Baldwin, 1990; Cochran, 1990; Palmer, 1998). For the purpose of this study careers were

conceptualized as having three interrelated components; the external career, the internal career and vocation.

Careers

Careers have been defined and described in a number of ways. The dictionary defines careers as, "A chosen pursuit; a profession or occupation. The general course or progression of one's working life or one's professional achievements" (Houghton-Mifflin Company, 1992). The word career comes from Latin and means "the way of the cart" or a sense of direction or progress through life (Charland, 1986, p.57). For the purpose of this study career is defined as "the evolving sequence of a person's work experiences over time" (Arthur, Hall, Lawrence, 1989,p.9).

Careers have been conceptualized as a sequence of positions and roles. Cochran (1997) notes in his book on career counseling however that there is an objective or external career and a subjective or internal career. The external career is a series of positions, roles and responsibilities. The internal career is "the way personal meanings are formed and lived out in a career- emphasizes identity rather than social roles" (Cochran, 1997, p.140).

Derr and Laurent (1989) discuss the importance and usefulness of differentiating the internal and external career concepts.

"The internal career is obviously one's own subjective map, but the external career is like wise a construction and interpretation of selected external events and stimuli. Nevertheless, the usefulness of delineating these concepts (the internal and external careers) lies in differentiating two important foci of career dynamics: individual aspirations and occupational "realities." The framework stresses the dialectical nature of a career by locating it at the interface between the person and his or her work environment, while recognizing the careerist's perceptually constructed and individualistic view of the "realities" of work" (p.456).

The External Career

The external or objective career is a series of positions, roles and responsibilities. The core of the external career is how an individual understands and makes sense of the organizational and occupational context. The question that illuminates the external career is "What's possible and realistic in my organization and occupation, given my perceptions of the world of work?" (Derr and Laurent, 1989, p.456). Career development often focuses on the development of skills related to the roles and responsibilities required in certain positions. Career management is often equated with positions and the sequence of advancement with positions. It has been suggested that the focus of career management should be on understanding

the internal career and vocation, as they are more critical in the development of productive and satisfying careers (Charland,1986; Hitchcock, Hekelman, Monteiro, and Snyder,1997; Palmer, 1998).

The Internal Career

The internal or subjective career for the purpose of this study is the "way personal meanings are formed and lived out in a career- emphasizes identity rather than social roles" (Cochran, 1997, p. 140). Derr and Laurent (1989) suggest that the core of the internal career is the individual's career self-concept within the context of organizations and occupations. An important personal question regarding the internal career they suggest is, "What do I want from work, given my perceptions of who I am and what's possible?" (p.456). Vocation is a concept allied with the internal career in that vocation provides a sense of identity and personal meaning.

Conceptions of Vocation

The concept of the internal career, the way personal meaning is developed and expressed in work, is closely allied with concepts of vocation. A review of various works dealing with vocation reveals that there is not a

universal definition or understanding of vocation in work. In fact the understanding of vocation and the relationship of vocation to self, work and career varies widely. For some authors vocation is an exclusive concept that only a few achieve in their work and careers. For some vocation indicates service to others or implies "devotion" or "sacredness". For others such as Parker Palmer vocation relates more to understanding self and living by your truths and values. Concepts of vocation are discussed below.

Parker Palmer has written extensively on vocation and the inner lives of teachers. In *Let your Life Speak: Listening for the Voice of Vocation*, (2000) Palmer relates that the word vocation is rooted in the Latin word, "voice." He states, "Vocation does not mean a goal that I pursue. It means a calling that I hear. Before I can tell my life what I want to do with it, I must listen to my life telling me who I am. I must listen for the truths and values at the very heart of my own identity, not the standards by which I must live - but the standards by which I cannot help but live if I am living my own life" (pp. 4-5). For Palmer vocation does not mean that someone calls from "out there." It is not a voice that calls us to be something that we are

not. It is a voice that calls from within. Our vocation is a voice that calls us to be the person that we were born to be. Palmer relates that our deepest calling is to grow into our own authentic self-hood (p.16).

For Palmer the deepest vocational question is not "What ought I to do with my life?" It is the more elemental and demanding "Who am I? What is my nature?" (p.15). Palmer sees vocation as the understanding and acting upon your true self. Frederick Buechner has defined vocation as, "the place where your deep gladness meets the world's deep need" (p. 16). True vocation links self and service.

Understanding your true self is a journey. Palmer quotes Sartre, "May Sartre reminds us, the pilgrimage toward true self will take "time, many years and places" (Palmer, 1999, p.36). Vocation is a journey toward your true self in your work. That work may or may not be your career or your paid work. Vocation is the link between self and service. Your self is your values and the standards by which you must live if you are true to yourself. Palmer relates that vocation is you in your work.

Larry Cochran has also written and studied vocation and careers. In *The Sense of Vocation: A Study of Career and Life Development*, Cochran(1990) states,

"Vocation stands to career, in many ways, like a consummate instance, and might well be regarded as the quintessence of career. In vocation, the great questions of career come alive and can be pursued through exemplary cases. What makes work so meaningful? How does meaning arise? How do circumstances facilitate or hinder a sense of vocation? What is the proper relation of work to life? What is a vocation and how does it alter the quality of life? If a vocation centers and integrates a life, how does it do so?" (p.10)

Cochran (1990) feels that while everyone may work or hold a position not everyone has a vocation. He states, "It is an exclusive concept, indicating a special status of great value, at least to those who have achieved it" (p.2). In discussing vocation he feels that terms like "devotion, sacredness, purity, holiness, or wholeheartedness" are appropriate (p.2). Cochran states, "A sense of vocation is partially an invention, partially a discovery, partially deliberate, partially involuntary, partially in control, partially beyond control" (p.2). He feels that you can not "will" a sense of vocation. Cochran feels that for a person who has a sense of vocation "person and work" are united (p.3).

David Hansen, in his study of teachers and vocation, states, "In short, a vocation describes work that results in service to others and personal satisfaction in the rendering of that service" (Hansen, 1995, p.3). In his book Hansen argues that "teaching as a vocation comprises a form of public service to others that at the same time provides the individual a sense of identity and personal fulfillment" (Hansen, 1995, p.2). Thus for Hansen teaching as a vocation is a public service which provides a sense of identity and personal meaning. Hansen distinguishes vocation in teaching from the religious concept of vocation which indicated a calling or selfless devotion to the religious life. He sees teaching as a vocation expressed, "through a family of words such as *active, creative, engaged, outward-looking, and imaginative*" (Hansen, 1995, p.5).

Charland in his book, Life-Work, notes that the idea of vocation comes from *Kalah* in Hebrew and *Kaleo* in Greek. Both of these words mean "to call out" or "to summon". Charland states, "When we speak of an individual's vocation or calling, we give attention to whatever really counts in his world, that to which he responds ultimately" (Charland, 1986, p. 59). Charland interprets the concept of a

vocation as a "response". Individuals respond to what matters to them and to what they would like to contribute. Charland notes that not everyone expresses his or her vocation through paid work. For some people their vocation may be expressed through volunteer work.

Charland relates that some people develop a sense of vocation when they have an area of expertise for which there seems to be a need. Other people may have a talent which they can share or contribute. For some their sense of vocation develops from "coming through" a difficult experience. He notes, "To find oneself motivated and free to help others cross a past frontier is to become an agent of transformation in that process, and that may be the most personally enriching vocation of all" (Charland, 1986, p. 63).

In summary vocation has been conceptualized as an exclusive concept to describe the epitome of a career (Cochran, 1990), to describe work which links self and service (Hansen, 1985) to describe a response to deeply felt needs (Charland, 1986) and as the understanding and acting upon your true self (Palmer, 2000). For the purposes of this study vocation is not an exclusive concept that only a few

achieve in their careers. Vocation is the understanding and acting on the true self. Vocation may or may not be expressed through paid work or careers.

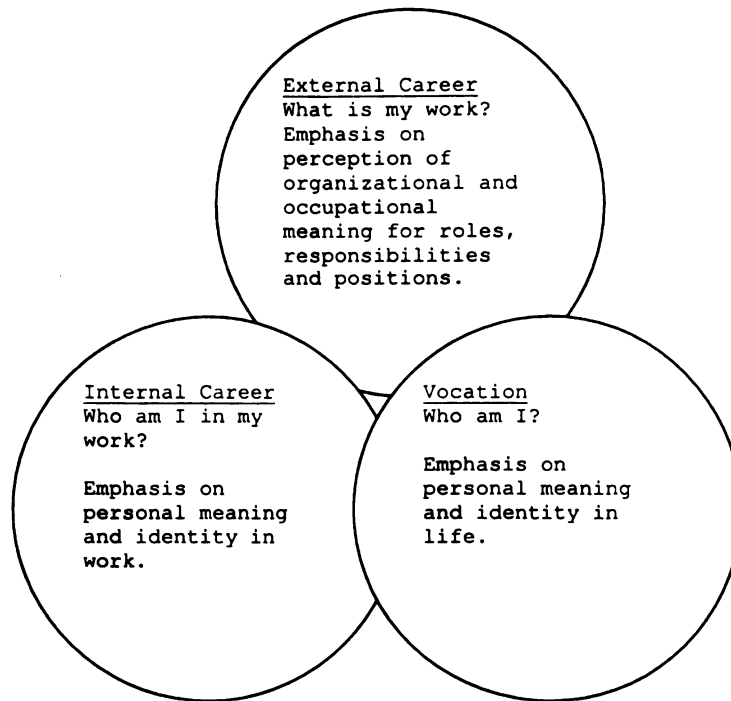
Summary of the External Career, Internal Career and Vocation

The external career is the perception of what's possible in an organization or occupation; the position, role and responsibilities. (Arthur, Hall and Lawrence, 1989) The internal career emphasizes the personal meaning and identity in work and careers. Vocation is the understanding and acting on your true self, the personal meaning and identity in life. These three interrelated concepts are illustrated in Figure 1.

The management of the external career; the skills, roles and positions, is often considered as career development. Career management may be important for a successful career but the more essential factor may be understanding and developing the internal career and vocation.

Figure 1

Concepts of the External Career,
Internal Career and Vocation.



To understand our vocation we are ask questions such as:
What are the needs that we want to address? What are the
talents or expertise that we can develop and share? What
is the need to which we feel we can respond? Clarifying
and understanding vocation contributes to the development
of careers which are satisfying and significant.

Career Development

There are various models and conceptions of career development. Some authors suggest that careers follow a developmental path. (Schuster and Wheeler and Associates, 1990) Each career stage; career entry, early career, midcareer, and late career, has different demands and challenges. "Most careers progress from an initial entry and establishment period to a period of growth and advancement. Eventually careers cease to expand; they level off to a stable plateau in a maintenance stage. Finally they move into a disengagement phase, during which people's involvement decreases in anticipation of retirement" (Baldwin, 1990, p. 24).

In a study of academic careers, Baldwin and Blackburn (1981) studied 106 male professors from 12 Midwest liberal arts colleges. Baldwin and Blackburn noted five career stages, which were delineated by position and time. The five career stages they described went from assistant professor in the first three years of teaching to full professor within five years of retirement. Baldwin and Blackburn (1981) randomly selected faculty within the disciplines of biology, chemistry, history, philosophy and

religion and found that career development was independent of academic discipline.

What constitutes career development for faculty and how is it defined? There are a number of definitions and descriptions of faculty development. Bledsoe (1993) notes that the scope and purpose of faculty development has been expanding. Jack Schuster and Dan Wheeler (1990) in *Enhancing Faculty Careers: Strategies for Development and Renewal* discuss ideas on faculty development. Career development is now emphasized and involves "three interrelated developments in the life of a faculty member" professional growth including teaching, scholarship, research and service; personal growth; and institutional growth. Institutional growth is the concept that as careers develop the institution develops as well. "A positive relationship should exist between the purpose and goals of the institution and those of the faculty member" (Bledsoe, 1993, p.44). "Faculty and institutional vitality" has replaced the narrower concept of "faculty development." (Bland and Schmitz, 1990, p.45)

The academic profession has been described as a calling or having a vocational nature. Wheeler (1990) notes that

becoming a faculty member has a vocational quality of being "called". There is a "one-life, one-career" imperative, which was described by Sarason in 1997 which dominates the academic profession. There is a sense that academic work is noble work to which one is called. Wheeler states, "Truly the well-socialized academic sees the professional "calling" as a life's work - one that often totally consumes professional and personal time and energy" (Wheeler, 1990, p. 84).

Some authors have argued that faculty development programs should help faculty redefine what it means to be a faculty member. They argue that the "one-life, one-career" imperative of the academy should be challenged to help find new ways to employ faculty. (Schuster, Wheeler and Associates, 1990) Other authors argue that many faculty find motivation in traditional academic values and community. Rice, notes, "Nowhere in the contemporary world do socially constructed fictions have more power than in the professions and there is no profession where a socially constructed, professional imagery dominates more thoroughly than among faculty. The socially constructed fictions in the academy include, "research is the primary focus of academic life, only in the academy can knowledge be pursued

for its own sake; an academic career is a lifetime calling" Bland and Schmitz, p.51). Buhl feels that these "academic assumptions and prevailing ethics significantly impact, both positively and negatively, faculty growth and development"(Bland and Schmitz, 1990, p.51).

The success of faculty development programs rests on a deep understanding of faculty. (Baldwin and Blackburn, 1981)

Faculty development requires an understanding of more than careers but also of vocations. Career management; the negotiation of positions, roles and skills, is necessary for a successful career but not sufficient. Faculty growth and development is shaped by the meaning that individuals seek in their work or that individuals feel is required in their work. People want their work to contribute something meaningful. People seek to express, if possible, their vocation through work. Traditional academic values have shaped the work and careers of academics in higher education.

Traditional academic careers have been described as five stages from assistant professor in the first three years of teaching to full professor within five years of retirement. Academic career development involves, "Three interrelated

developments in the life of a faculty member" professional growth including teaching, scholarship, research and service, personal growth and institutional growth. Traditional academic values have shaped the careers of faculty. Physical therapy education differs from traditional academic programs and can be characterized as professional health care education. How are careers and career development characterized for faculty in health care professional education?

Faculty Development in Health Care

Differences between traditional degree programs and professional education programs are described in the preamble of the Self Study Report Format for Education

Programs For The Preparation of Physical Therapists,

"Institutions must be committed to professional education and demonstrate awareness of the differences between professional education and traditional degree programs. Among the differences are the following: professional education requires the student to engage the entire body of knowledge related to the profession and to demonstrate accountability for the utilization of that knowledge; professional education is structured and focused on the knowledge and skills necessary for initial practice of the profession; emphasis is placed on socialization of the student into the profession, including the behavioral and ethical standards to be met; and, faculty are expected to serve as exemplary professional role models" (American Physical Therapy Association, 1997, p.2).

Burton Clark (1993) notes,

"More broadly, great differences in the academic life often appear between the letters and science departments and the many professional school domains in which a concern for the ways and needs of an outside profession must necessarily be combined with the pursuit of science and truth for its own sake" (p. 166). Bok (1986) discusses some of the issues that face academic faculty who teach in professional schools. He notes that everyone who teaches in the professions also belongs to a community of scholars. Bok states that, "these scholars share certain values, priorities, ways of defining excellence and status" (p.76). Bok notes that the highest values are placed on intellectual achievement especially if it is "abstract, theoretical, or interesting for its own sake" (p. 76). Bok notes that published research is the "common currency of academic achievement" and the "chief determinant of status within the guild" (p. 77).

Bok suggests that these priorities or values are subtly impressed in the academy by the way "they creep into conversations and collegial deliberations; they establish themselves in all the subtle ways by which communities confer status and establish hierarchies" (p. 77).

Professional school faculty do not want to be considered as "trade school teachers" and so Bok notes they must "manifest a respect for the regnant scholarly values" (p.78). At the same time practitioners in the profession value teaching over research and "favor attempts to teach the basic skills and habits of the mind directly relevant to practice" (p. 78).

In the health professions field, medicine has documented efforts and research on faculty and faculty development. Hitchcock, Hekelman, Monteriro and Snyder (1997) suggest that an academic career in medicine is "defined as a sequence of positions occupied by individuals during the course of their working life, is the product of one's values, goals, skills, sense of timing, and certain political and personal realities and circumstances"(p. 267). They note that institutional and organizational factors influence the careers of family medicine faculty.

Career management, Hitchcock, Hekelman, Monteriro and Snyder ((1997) suggest is an important skill for medical faculty members and they recommend a set of career management competencies. The career management competencies they recommend faculty possess include:

developing career plans for themselves, describing various rewards in academia and methods to achieve them, orienting themselves to the academic organization, negotiating academic roles and resources, and describing aspects of professional organizations relevant to their careers (Hitchcock, Hekelman, Monteriro and Snyder, 1997, p.267).

Faculty development programs in medicine have sought to develop professional academic skills in physicians. Necessary academic skills for health professionals or professional academic skills are "skills critical to the development and commitment of medical faculty to academic careers" (Hitchcock, Hekelman, Monteriro and Snyder, 1997 p. 266). Professional academic skills is a concept introduced by Bland et al in 1990. Professional academic skills suggested for medical faculty include 1) understanding academic values and ethics (generic values as well as in teaching, research and service; academic relationships) 2) academic relationships (ability to describe various types of collegial relationships, link collegial relationships to development and develop effective collegial relationships) and 3) career management skills (Hitchcock, Hekelman, Monteriro and Snyder, 1997).

Bland notes faculty developers in family medicine seek to instill academic ethics in their physician colleagues. A true belief in the academic ethic is important for those in faculty development according to Bland. One of the beliefs is that academic work is more than a job it is a calling. Holloway, Wilkerson, and Hejduck (1997) suggest that a true belief in the value of academic life undergirds the work of all faculty developers. They state, "The attribute required of most faculty development programs in the 1990s and beyond is to promote academic identity to enhance the vitality of both clinical and scholarly roles" (p.236). Individuals in faculty development seek to develop that sense of calling in physicians who still see themselves primarily as clinicians rather than academicians. Most physicians and health care faculty have established careers as clinicians. The "one-life, one career" academic ethic may not be viable for these clinicians. How do physicians and other health care faculty express vocation or calling in their academic work?

Evans (1995) discusses concepts of a successful career in academic medicine and faculty development issues in a changing academic and health care environment. Evans (1995) suggested this profile for the successful biomedical

academician in 1984 and suggests is still the "gold standard" by which most academic careers in medicine are measured,

- substantial involvement in research
- scientific productivity, as recognized by peers
- Active interaction with colleagues in field
- Mentor(s)
- Participation in the peer review system
(Evans, 1995, p.14)

Evans suggests however, changes in health care and the biomedical research worlds make this model of academic success "increasingly inadequate" and untenable" (Evans, 1995, pp.17-18). Evans asks, "What should be the contours of faculty roles, responsibilities, expectations, and rewards in a system that is neither purely academic and not purely market-driven, but an uneasy amalgam of the two?" (Evans,1995,p.19). Evans suggests that models for successful academic careers and for faculty development in medicine as well as for all health professions faculty need to be reconsidered.

Physical Therapy and Faculty Development

Models for successful academic careers in physical therapy have not been described in the literature. Relatively

little is known about the academic careers and work of individual faculty members who teach in physical therapy education programs. According to a survey of full time faculty in physical therapist education programs taken by the American Physical Therapy Association in 1995-6, 46.1% of full time faculty members in physical therapist education programs have been academic faculty 7 years or less and 63.7% have been at their current institution 7 years or less. 64.7% of full time faculty are women and 35.3% are men. 48% of full time faculty have a doctoral degree and 7.6% have a master's degree. The survey indicates that 37.4% of full time faculty have tenure and that 54.4% are on the tenure track. 40.5% of full time faculty are planning to apply for tenure (American Physical Therapy Association, 1996). In summary, the full time faculty members as a group appear to be relatively new to academe and to their current institution.

Physical therapy faculty, in addition to being relatively new to academe, are also in short supply. The American Physical Therapy Association (APTA) has recognized for a number of years that there is a shortage of qualified faculty to teach in physical therapy education programs. In 1985 the APTA convened a task force on the faculty

shortage in physical therapy. The task force noted in it's report of September, 1985 that "Physical therapy is faced with a critical shortage of faculty in absolute numbers and is further confronted with an inadequate number of faculty members qualified to teach, and to conduct and publish research" (American Physical Therapy Association, 1985, p.1). The 1985 report noted that 302 additional faculty members would be needed for the 102 current programs and to implement post-baccalaureate (a master's or doctorate degree in physical therapy) entry level education mandated by the American Physical Therapy Association. The report noted that this did not include faculty needed for new and developing programs nor did it account for faculty attrition.

The 1985 *Plan to Address the Faculty Shortage in Physical Therapy Education* was concerned not only with the shortage in numbers but also with the qualifications of the faculty. The 1985 report notes that in 1985 only 26% of full time faculty held a doctoral degree and 18% of full time faculty members were pursuing a doctoral degree. The report noted however that many were pursuing their doctoral degrees part time and as such this "limits the process of socialization

in the demands and rewards of a career as a scholar"(APTA, 1985, p.4). Concerns were also noted with the few number of faculty involved in doctoral work in physical therapy, the late entry into doctoral education which shortens the length of the academic career, and the small pool of individuals with scholarly interest given that entry level physical therapy education prepares individuals to be clinical practitioners. "Physical therapists are professionally socialized as practitioners, and although physical therapy education programs increasingly offer opportunities for faculty to engage in clinical practice, 64.7% of faculty surveyed in 1983 identified inadequate time for clinical practice as a stressful factor" (APTA, 1985, p.5).

The 1985 *Plan to Address the Faculty Shortage in Physical Therapy Education* recommended that funds be targeted for doctoral students, particularly those involved in physical therapy doctoral work, and for existing physical therapy doctoral programs. Stimulating interest in research, networking, and the exchange of ideas on research was also recommended. The 1985 Plan notes, "It is imperative that physical therapists be attracted to academic careers and socialized as research faculty members" (APTA, 1985, p.9).

Also suggested were helping program administrators share ideas about dealing with the reduction of stress on faculty and low salaries.

Calls to adequately socialize physical therapy education faculty members to their academic roles and to assist them in developing careers in the academy have continued. A 1993 research report by Radtka, *Predictors of Physical Therapy Faculty Job Turnover*, noted that faculty new to academe are most likely to quit. Radtka recommended "faculty recruitment and retention plans, job redesign strategies, and faculty development programs for new faculty" (Radtka, 1993, p. 250). Domholdt in her commentary on the article also noted, "Administrators and faculty colleagues need to look seriously at her suggestions to identify ways they can help new faculty members forge productive and satisfying careers within academic settings" (Radtka, 1993, p. 252).

A study published in *Physical Therapy* in 1990 on faculty development in physical therapy education programs found that less than half of the physical therapist education programs surveyed had formal faculty development programs. The study noted that many institutions had a commitment to

faculty development including support for development in research, teaching and service even if they did not have a formal faculty development plan. The study also found that programs used similar criteria to evaluate faculty for promotion or for annual review. The major evaluation criteria were related to teaching and scholarship with slightly less emphasis placed on professional, university and clinical activities. Only 22% of the institutions surveyed required faculty members to seek and receive outside grants (Rothman and Rinehart, 1990).

Patrick Ford (1990), at the time of his article on graduate professional education in physical therapy, was Dean of the Graduate School and Professor of Higher Education at Gonzaga University in Washington. He states that the principal issue in post-baccalaureate degree entry level education for physical therapy is, "a serious lack of understanding among many physical therapy educators of what it means to be a college or university faculty member" (Ford, 1990,p.5). His perception was that this orientation, to the role of a graduate faculty member, was not being done well. Ford suggested that new faculty need role models to help orient and socialize them to their roles, especially in regards to research, in the academy.

As of February, 1997 there were 222 accredited and developing physical therapy education programs (American Physical Therapy Association, 1996). The number of new and developing programs has more than doubled since 1985. The demand for physical therapy faculty has significantly increased given the number of new and expanding physical therapy education programs. Sherri Hayes, President of the American Physical Therapy Association Education Section notes, "the faculty shortage today is even worse than it was in 1984, which is a major problem for physical therapy education. We have not nurtured or developed enough doctorally prepared, research-oriented faculty members to teach in the academic setting" (Hayes, 1997, p.17).

Research Questions

An understanding of academic work and careers for faculty in physical therapy education programs is a pressing issue for physical therapy education. Current research does not address the academic careers or work of physical therapy faculty. It has been suggested, but not documented in the literature that, in general, physical therapists having been socialized originally as clinicians and practitioners, do not understand or appreciate the role of academic faculty; that part time doctoral students are not well

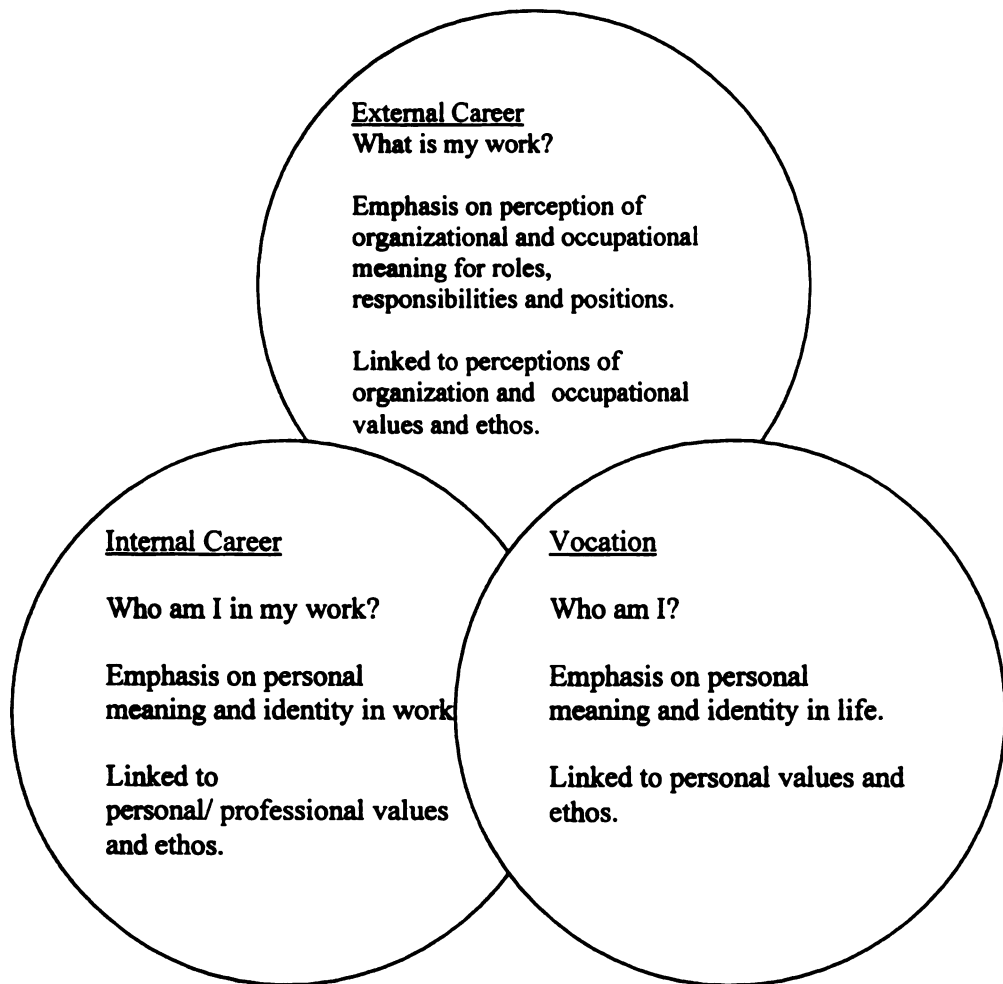
socialized to the academic role, and that faculty are not well oriented to or mentored in their academic roles, especially in regards to research. Given the shortage of physical therapists prepared for academic careers it is important to understand the academic work and careers of physical therapists that are faculty members. Understanding the academic work and careers of physical therapists may facilitate the preparation of physical therapists as faculty and help them develop successful careers in the academic setting.

The expression of vocation or meaning that academic work has for physical therapy faculty is important in understanding the careers of these faculty. The expression of vocation or meaning in academic work shapes faculty development. A strong belief in academic values and ethics such as the primacy of research in the academy and the academic career as a life-time calling has shaped the work of traditional academics. What is the expression of vocation or meaning for physical therapy faculty, which shapes their academic work?

The purpose of this research study was to describe and analyze the internal careers and vocation of full time

faculty in physical therapy education programs. The conceptual framework which emerged from the study was careers as three interrelated components; the external career, the internal career and vocation. See Figure 2 which illustrates these three interrelated components.

Figure 2 Careers and vocation link to values and ethos.



Chapter Two

Physical Therapy Practice and Education

The External Career

Many physical therapy faculty began their careers as physical therapy clinicians. Shepard and Jensen (1997) state, "The overwhelming preponderance of physical therapy educators have come directly from clinical settings, hold master's degrees, and have no well-developed areas of research" (p.26). This section describes aspects of the external career of the physical therapist clinician, the history of physical therapy education and concludes with a timeline of the history of physical therapy education.

The external or objective career is a series of positions, roles and responsibilities. The core of the external career is one's perception of the organizational and occupational context itself. The question that illuminates the external career is "What's possible and realistic in my organization and occupation, given my perceptions of the world of work?" (Derr and Laurent, 1989, p.456). What is the external career for the physical therapist clinician? What are the roles, responsibilities and professional ethos?

A physical therapist is, "A person who is a graduate of an accredited physical therapist education program and is licensed to practice physical therapy" (American Physical Therapy Association, 1997a, p. Appendix 1-3). The Guide to Physical Therapist Practice defines physical therapy as, "the care and services provided by or under the direction and supervision of a physical therapist" (American Physical Therapy Association, 1997a, p.1-1). In the Guide to Physical Therapist Practice the primary role of the physical therapist is described as that of the clinician or provider of direct patient care and services. Listed under "other roles" are consultation, education, critical inquiry, and administration (American Physical Therapy Association, 1997a, p.1-7 - 1-9).

Responsibilities of physical therapists are described in the Guide to Physical Therapist Practice (1997a) as follows:

- "*Provide services to patients/clients who have impairments, functional limitations, disabilities, or changes in physical function and health status resulting from injury, disease, or other causes.
- *Interact and practice in collaboration with a variety of professionals
- *Provide prevention and wellness services, including screening and health promotion
- *Consult, educate, engage in critical inquiry, and administrate
- *Direct and supervise physical therapy services, including support personnel" (pp.1-1 to 1-2).

The primary role and responsibility of the physical therapist than is that of clinician providing patient care and service in collaboration with other professionals.

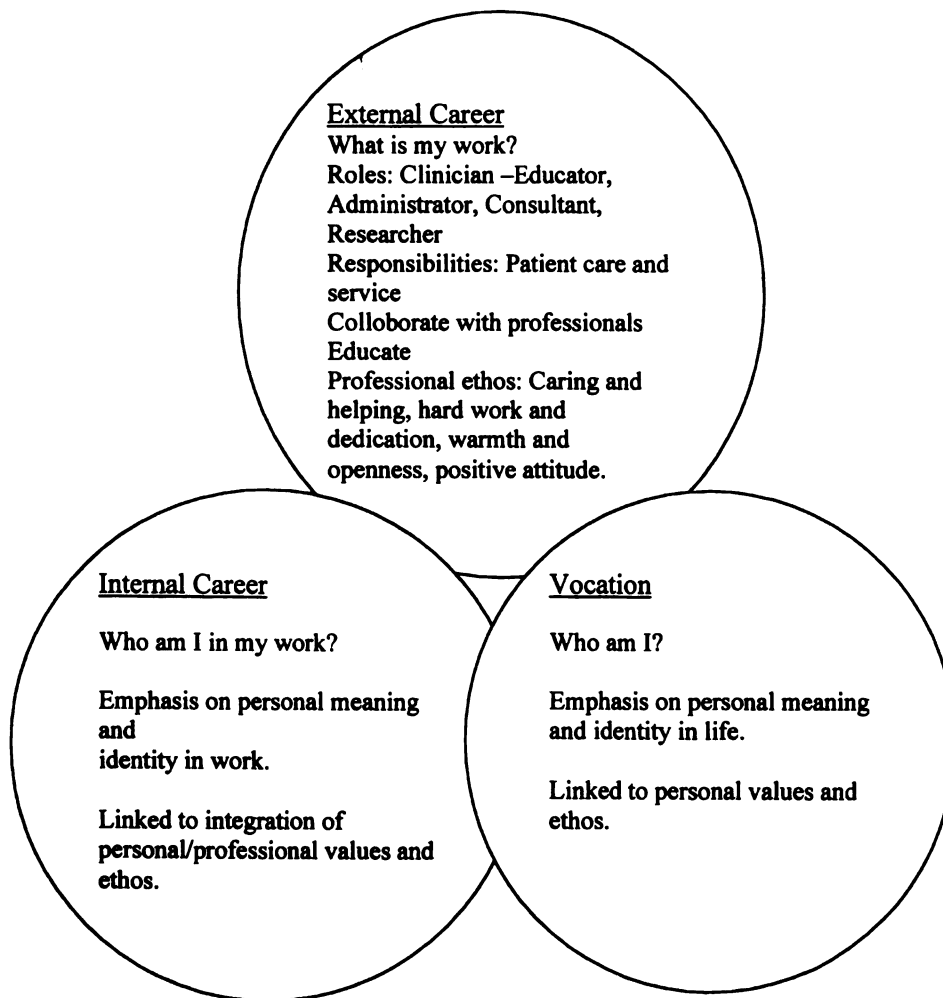
Stiller-Sermo (1998) in a recent study described the culture and professional ethos of physical therapy. The process of enculturation into a profession has been referred to as "attaining a professional ethos" (Tammivaara and Yarborough, 1984). Ethos may be defined as "The disposition, character, or fundamental values peculiar to a specific person, people, culture, or movement" (Houghton Mifflin, American Heritage Dictionary, 1992). Stiller-Sermo found that the professional ethos in physical therapy was characterized by several enduring traits. Those traits included "an emphasis on caring and helping, hard work and dedication, warmth and openness and positive attitude"(Stiller-Sermo, 1998, p.82). Stiller-Sermo suggests that one of the goals of professional education is to help students become members of the professional community by helping them internalize the ethos of the profession. Furthermore Stiller-Sermo argues that educators can assist students in this process of enculturation by providing them with opportunities to internalize the

professional ethos. Figure 3 depicts concepts of the external career for physical therapy clinicians.

Figure 3

**Physical Therapy Clinician Concepts of the
External Career, Internal Career and Vocation**

Adapted from Arthur, Hall and Lawrence, 1989; Charland, 1986;
Cochran, 1997; Palmer, 2000; Stiller-Sermo, 1998.



Clinicians entering the academy have operated in this external environment and have been socialized to the roles, responsibilities and professional ethos of physical therapy. Other historical factors, such as the world wars and epidemics, have influenced the profession and the education of physical therapists.

History of Physical Therapy Education

This is a brief history of physical therapy education in the United States. The history of the physical therapy profession and of physical therapy education is tied to the world wars and to epidemics, in particular the polio epidemic. A summary of some of the influences on the perceptions of academic faculty roles and responsibilities in physical therapy concludes the section. A timeline of key events in physical therapy education is included at the end of this section.

1921-1926 The Reconstruction Aides

The first physical therapists in the United States were "reconstruction aides". Graduate nurses and women with a physical education background underwent a four-month training program to become reconstruction aides. The early

physical education schools prepared women who were trained to be "medical gymnasts". Physical education programs offered schooling in anatomy, physiology and kinesiology (Murphy, 1995). The reconstruction aides were mobilized to treat men who had been wounded in World War I. The first physical therapy programs were at Reed College in Portland, Oregon and Walter Reed Hospital.

Physical therapy as a recognized medical specialty began during the 1920's with the reconstruction aides and their work with those injured during World War I. There were several reasons for the growth of physical therapy at this time. There was a growing recognition that people with disabilities; those wounded in the war should have an opportunity for a productive life. European rehabilitation methods were further along than those of America were and particularly the British, with the physiotherapeutic approach, were able to return soldiers to the field or to lives as productive citizens.

One of the early reconstruction aide and physical therapy educators was Mary McMillian who was an American citizen educated in physiotherapy techniques in London. War Emergency Training Centers were set up to train the

reconstruction aides and eventually there were 13 schools for "physical therapy" including Reed College in Portland. McMillian was on the faculty at Reed College, which set the standards for the War Emergency Training Centers. The curriculum at Reed consisted of "457 hours of classroom work including 112 in massage, 99 in anatomy using cadavers borrowed from the medical school, 66 in remedial exercise, 32 in physiology, 10 in hydrotherapy and electrotherapy combined, 23 in theory and practice of bandaging, 6 in kinesiology and 2 in ethics" (Murphy, 1995,p.54). Trainees also received ten hours of psychology and 163 hours of practical experience at Portland "reconstruction clinic" under Mary McMillian's supervision. Language courses in French were optional electives (Murphy, 1995).

The reconstruction aides work established physical therapy and the army was committed to providing physical and occupational therapy services to those wounded in the war. In 1922 a permanent four-month long physical therapy program was established at Walter Reed General Hospital. In 1921 Mary McMillian helped to establish the American Women's, Physiotherapeutic Association which was the forerunner of the professional association for physical

therapists, the American Physical Therapy Association (APTA).

1927-1936 Establishing Standards

The first accreditation standards for physical therapy programs were developed during this period. The American Physiotherapy Association (formerly the American Women's, Physiotherapeutic Association) asked the American Medical Association to help accredit physical therapy programs (Moffat, 1996). By 1934 fourteen schools in the United States met or exceeded these first standards and were approved by the AMA's Council on Medical Education and Hospitals. The recommended standards included nine months of instruction with 33 hours of physical therapy content per week for a total of 1,200 hours. Graduates of physical education or nursing programs were eligible for physical therapy coursework.

During this time period a physiotherapist, Lucile Grunewald, designed and implemented a "Study of Physiotherapy as a Vocation." Grunewald was an assistant director of the Department of Physical Education for Women at the University of California, Los Angeles. The purpose of her study was to "provide a rational basis by which UCLA

could develop its own program leading to a bachelor's degree in Physiotherapy" (Murphy, 1995, p. 84). Grunewald sent questionnaires to "successful" physiotherapists regarding their educational preparation and their subsequent professional development. She also interviewed physicians to determine how they worked with physical therapists. Finally Grunewald surveyed states and cities that legislated or controlled physical therapy practice. Grunewald found that in 1928 physical therapy education and practice could be characterized as "anything goes" (Murphy, 1995, p. 84).

Grunewald agreed with the American Physiotherapy Association that minimum educational standards needed to be set. However she felt that the current schools of physical education and nursing, which had additional coursework for physical therapy instruction, were not the appropriate environment for physical therapy education. She found that these schools had one or more of the following problems; the schools did not have fully qualified instructors, they did not teach the underlying actions of mechanical apparatus or they added the physiotherapy courses to the curriculum as an afterthought. Grunewald suggested that the most appropriate physical therapy education would be in

a university setting offering a four-year course of study in the "liberal arts, fundamental science courses, and specialized physio- therapy education" (Murphy, 1995, p.84). The editors of the Review, the journal of the APA, published Grunewald's findings but felt that a university degree was not feasible at this point for those in such a new profession. The editors characterized Grunewald's proposal for a university degree as "an encouragement and inspiration to all" (Murphy, 1995, p.84).

1937-1946 World War II and the Polio Epidemic

With the advent of World War II the Surgeon General's office estimated that the nation would need 6,000 physical therapists. At that time there were 1,077 physical therapy members in the APA and only 37 were with the military. APA determined that there were 135 physical therapy graduates per year. Given the projected shortages of physical therapists War Emergency Training Courses were once again established at several hospitals across the country. The physical therapy coursework was six months of concentrated didactic instruction and six months of supervised practice at a military hospital. The APA, the American Red Cross, the National Foundation for Infantile Paralysis and a number of other service organizations prepared posters,

magazine articles and pamphlets to recruit people into the physical therapy profession to serve their country. The government paid for the volunteer's coursework. Advances in physical therapy and the treatment of people with amputations, spinal cord injuries and neurological problems occurred during World War II.

During this period the country was also faced with the polio epidemic and it was of a major concern to physical therapy and the health professions. APA was involved in three of the major efforts to combat polio; 1) to develop a polio vaccine, 2) to understand the clinical course of polio and to find better methods of care and 3) to send medical personnel in "shock teams" to assist in areas with severe outbreaks.

There was not a standardized approach in physical therapy to care for people with polio. In fact physical therapy was in the center of a controversy over two approaches to polio care. The two approaches can be characterized as the traditional or conservative approach with bed rest and immobilization or splinting of acutely affected limbs and the approach of Sister Elizabeth Kenny, an Australian who arrived in the United States in 1940. Sister Kenny

promoted an aggressive physical therapy approach to the polio patient. Sister Kenny did not agree with splinting the limbs. Her patients received "hot wet packs" continuously and passive exercise and massage once or twice a day (Murphy, 1995,p. 123). This controversy over physical therapy treatment highlighted the need for research since much was still being on done on an anecdotal basis. The American Physical Therapy Association worked closely with the National Foundation for Infantile Paralysis (NFIP, later the March of Dimes) during the polio years. The NFIP was a major financial supporter of the APTA and physical therapy education.

Catherine Worthingham, President of the APTA from 1940-44, was a member of the faculty of Stanford University and the first physical therapist to hold a doctoral degree. Her degree was in anatomy. During this period the Physical Therapy Schools began meeting as the "Schools Section" of the APTA. The Schools Section later became the Education Section and is the oldest special interest group in the APTA.

1947-1956 New Education Standards Approved

When World War II ended all of the army schools and two of the civilian schools were disbanded. There were 21 approved schools in the United States with 480 graduates per year. A shortage of physical therapists was predicted so APTA began to persuade universities and medical schools to start physical therapy programs. Efforts were also made to offer more graduate level education (Murphy, 1995).

In 1950 there were 31 accredited schools with 19 offering a four-year integrated bachelor's degree program and eight offering post-baccalaureate certification. That same year the APTA sponsored a conference of physical therapy program directors in French Lick Springs, Indiana. The issues discussed included, "vocational guidance, the lack of adequate laboratory and practice space at many schools, the chronic shortage of staff instructors, the difficulties of integrating physical therapy programs within established university programs, the need for internships as an extension of education, and what was generally perceived as a terribly outdated set of minimum curriculum standards which schools were using as their guide in designing coursework" (Murphy, 1995, p.138).

During this period the APTA's Department of Education and the Council of Physical Therapy School Directors met to determine a new set of recommendations for entry level education. In 1956 the AMA, which was accrediting physical therapy programs at that point, adopted a new set of standards recommended by a physical therapy task force chaired by Margaret Moore. Moore, a physical therapist, was the APTA staff educational consultant.

The baccalaureate degree was recommended as the minimum degree for entry level education. The new curricula recommended a 35% increase in the total number of class hours with an emphasis on understanding the rationale behind treatment and neurological principles. "No longer was it sufficient for the practitioner to be educated in basic anatomy and kineislogy and to have a mastered a series of basic procedures..."(Murphy, 1995, p.139). Up until this point physical therapists were often graduates of nursing, physical education or the biological sciences who had taken their physical therapy specialty courses in a hospital setting. Now physical therapists were more likely to be educated in a university setting with less of an opportunity for clinical experience and clinical teaching.

The APTA along with the NFIP began a recruiting campaign to attract students to physical therapy. Lois Ransom, APTA president in 1948 stated, "We have sold our profession as a service. We must now sell it as a career" (Murphy, 1995, p.139). The NFIP provided funds to subsidize an APTA education secretary, to write and print recruiting materials, to underwrite teaching fellowships for physical therapy instructors and to update instructional equipment and curricula. The NFIP also supported academic scholarships and funding for travel overseas. This support by the NFIP or March Dimes helped to grow the profession and to raise the level of education.

During the polio epidemic physical therapists provided emergency service. Physical therapists staffed polio centers and departments to help treat people with polio. APTA assisted in providing continuing education to physical therapists on polio treatment and care. Mobile teaching units were organized around a physical therapy school and consisted of a physician, nurse, and two physical therapists. These teams traveled from community to community to teach the latest treatment skills (Murphy, 1995). When the polio epidemic waned physical therapists were concerned about finding work and the APTA was

concerned about the potential loss of financial support from the March of Dimes.

1957-1977 Study of Physical Therapy Education

In 1962 the NFIP or March of Dimes ended its last support for the APTA and for professional education. The financial support of the NFIP was such that, "one in three of APTA's current members had received scholarships for their basic physical therapy education; thousands more had been helped to take continuing education courses, 100 members, comprising almost half of the current teaching faculty in schools of physical therapy, had received NFIP fellowships for advanced study that had made their academic careers possible" (Murphy, 1995, p.185). Former APTA President Catherine A. Worthingham, who had been director of Professional Education at the NFIP, was responsible for the strong support APTA had received from the NFIP.

After Worthingham left the NFIP she received a grant from the Office of Vocational Rehabilitation to undertake a study of physical therapy education. The six-part report was a significant document in the growth of the profession and was "comparable in its thoroughness and objectivity to the 1910 Abraham Flexner Report to the AMA that had led to

reforms of medical education in America" (Murphy, 1995, p.185).

Worthingham looked at all aspects of education to prepare for academic or clinical physical therapy careers. In her study she found that PT schools were not well funded because limited resources were put toward medical education. Physicians often determined the "direction and funding of physical therapy education" (Murphy, 1995, p.186). Physical therapy instructors tended not to have the advanced degrees, which were needed in the academic ranks. "Only 5 percent of faculty in physical therapy schools held doctoral degrees, of which not one was in the physical therapy field; of the 49 percent of faculty holding master's degrees, only half were in physical therapy studies" (Murphy, 1995, p.186). She found only 28 percent of instructors were conducting research. Although the report was likened to the Flexner report it did not lead to the overall reform of physical therapy education.

The first two-year graduate program was developed at Case Western Reserve University in 1960. This program included not only the traditional core of physical therapy education but also included more coursework on "public health

concerns, educational principles, administration and behavioral sciences" (Moffat, 1996, p. 124). The Case Western Reserve University program was phased out after 11 years due to cut backs in federal funding to universities during the 1970s. Case Western Reserve provided a high standard for new programs but also foreshadowed the problems and closing of the University of Pennsylvania and the Stanford programs. In 1973 New York University began offering the first post-professional Ph.D. program in physical therapy. Howard University became the first historically black college to offer a physical therapy program and in 1974 eight students graduated from the program. Physical therapist assistant programs, generally two years of community college education, were established during the 1970's.

1977-1986 The Move to Postbaccalaureate Education

Beginning in 1979 the APTA began to promote research presentations at Annual Conference and in the *Journal*. Up until that point original research papers had not been solicited for presentation at Annual Conference. Eugene Michaels, PT who served on the staff of APTA noted that this was important event because it gave physical therapists with PhDs, who had often left the field, an

opportunity to present their research. Faculty members at educational institutions also had an opportunity to produce and present research as would be expected of academic faculty.

Eugene Michaels, who was on the faculty at the University of Pennsylvania with the School of Allied Medical Professions, recognized the importance of establishing physical therapy research. The university administration closed the school having decided that "physical therapy offered insufficient intellectual content or scientific contributions to make it worth of an Ivy League imprimatur" (Murphy, 1995, p.189). Michaels joined APTA staff and assisted in developing the "Plan to Foster Clinical Research in Physical Therapy" which became a primary resource for physical therapy research efforts. The Foundation for Physical Therapy was established in 1979 to promote and fund physical therapy research. The Foundation awarded the first research grants in 1980.

Helen Hislop, Ph.D., PT recognized the importance of physical therapy research in her oft quoted and cited, 1975 Mary McMillian lecture entitled, *The Not So Impossible Dream*. In it Hislop notes,

"After 50 years the science of physical therapy is entering its infancy, The determination of the profession to retain a viable place in the health care system ... and to improve the quality of patient care must, for an indefinite future, necessitate a large continuing research and development enterprise. ... To convince others of our aptitude, we must prove to ourselves that our methods work. There are no scholarly professions today which do not have doctoral programs in their own discipline. The time is now to support doctoral education in pathokinesiology or physical therapy. In physical therapy, the advances in our field of endeavor are being made, not by us but by others, and in this state we are reduced to being mental pickpockets simply because we do not have organized program to develop our own science. ... Only when the science is established and proclaimed will physical therapy cease to be palliative, adjunctive, elective or an arena of last resort for the patient" (Hislop, 1975, p.1076)

In 1979 the American Physical Therapy Association (APTA) House of Delegates debated and ultimately passed a resolution which called for all entry-level physical therapy programs to be at the minimum of a the postbaccalaureate degree by December 31, 1990. Members in favor of raising the entry-level degree to a postbaccalaureate degree felt that physical therapists needed better educational preparation for autonomous or independent practice. The resolution to raise the entry-level degree to a postbaccalaureate degree caused a great deal of controversy. Members of the Schools of Allied Health Professions (ASAHP), which included many deans of schools that educate physical therapists, were very opposed to raising the entry-level degree requirement to post-

baccalaureate. ASAHP felt it might not be appropriate for APTA to accredit physical therapy programs but APTA has continued as the accrediting agency for physical therapy education programs (Murphy, 1995). In fact in 1977 the Council on Postsecondary Accreditation recognized APTA as a second accrediting agency along with the AMA. In 1983 APTA became the only accrediting agency for physical therapy programs.

There were other controversial issues with the resolution in favor of postbaccalaureate education such as the availability of funds to implement curriculum changes, the lack of qualified faculty, the possibility that students would not be interested in or able to afford a postbaccalaureate degree and finally a lack of consensus on an optimal curriculum for the postbaccalaureate degree. By 1995 half of the physical therapy programs were at the post-baccalaureate level (Murphy, 1995). In 2002 the Commission on the Accreditation in Physical Therapy Education (CAPTE) will accredit only physical therapist education programs which are at the post-baccalaureate level (American Physical Therapy Association, 1998b).

1987-1999 The Proliferation of Programs and the DPT

During this period the number of postbaccalaureate professional programs began to exceed the number of baccalaureate programs. The first physical therapist professional doctoral education programs (DPT) were established at Creighton University, the University of Southern California and Slippery Rock University (Moffat, 1996). These physical therapist professional doctoral programs include entry-level or professional programs as well as post-professional doctoral education programs for people who are already physical therapists. There are presently eight physical therapist doctoral education programs and fifteen programs, which have declared their intent to go to a professional physical therapist education doctoral program.

In 1993 the American Physical Therapy Association began a process to address important issues in physical therapy education. A series of five conferences were held between 1994 and 1996 to address curricular and noncurricular components of a normative model of physical therapy education. A series of working drafts of a normative model of physical therapy education were developed and shared with physical therapy education, practice and health care

constituents. In 1997 the American Physical Therapy Association Board of Directors and House of Delegates approved a Normative Model of Physical Therapy Education. One of the intentions of the *Normative Model of Physical Therapy Education* is to "serve as an expression of the profession's preferred prerogatives, perspectives, beliefs, and values relative to physical therapist professional education" (American Physical Therapy Association, 1997b). *Education* describes academic and clinical education curricular components as well as non-curricular components such as admissions requirements, prerequisites and qualifications of faculty (American Physical Therapy Association, 1997b).

There was a dramatic growth in the number of physical therapist and physical therapist education programs during this period. In 1986 there were 124 accredited and developing physical therapist education programs and 90 accredited and developing physical therapist assistant education programs, for a total of 204 programs. By 1997 the number of accredited and developing physical therapist education programs was 206 and the number of physical therapist assistant education programs was 294 accredited and developing, for a total of 500 programs. In 11 years

the number of physical therapist and physical therapist assistant education programs more than doubled.

As a result of this growth in programs there is currently a shortage of qualified academic and clinical faculty, an increasing scarcity of clinical education sites, changes in reimbursement for physical therapy and a projected surplus of physical therapists of 20 to 30% by 2005 (American Physical Therapy Association, 1998b). Given this situation the American Physical Therapy Association House of Delegates supported a resolution in June, 1999 which states, "The American Physical Therapy Association recommends against the development of new physical therapist and physical therapist assistant education programs and the expansion of existing programs until June 2002" (American Physical Therapy Association, 1999).

Issues in the External Career

In summary the history of physical therapy practice and education has been tied to wars and epidemics. Physical therapy education has been characterized by a variety of confusing options for entry-level professional education including certificate, baccalaureate, masters and now doctoral degrees. There has been a chronic shortage of

qualified academic faculty with few Ph.D. programs in physical therapy. Some research institutions closed physical therapy programs because they felt the programs lacked sufficient intellectual content. Up until recently there was a shortage of physical therapists and as a result there was a dramatic increase in the number of physical therapist education programs. The changes in health care, the increase in the number of physical therapist education programs and the predicted potential surplus of physical therapists in 2005 has created a chaotic environment for physical therapist education in the new millennium.

Physical therapists are primarily clinicians. They have been socialized into their roles and responsibilities as clinicians. The professional ethos for physical therapy has been characterized as caring and helping, hard working and dedicated, warmth and openness, and a positive attitude. Physical therapists who become faculty members move from the practice environment to the academic environment. As these clinicians enter the academic setting they encounter a very different set of positions, roles and responsibilities as characterized in the concept of the academic external career. They transition from positions as clinicians into the academic ranks of instructors and

professors; from primary roles in patient care and service in collaboration with professionals to academic roles of teaching, research and service; from a professional ethos in physical therapy characterized by caring and helping, hard working and dedicated, warmth and openness, and a positive attitude to an academic ethos described as one-life, one-career, research is the primary focus of academic life, only in the academy can knowledge be pursued for its own sake, and an academic career is a life time calling (Rice in Bland and Schmitz, 1990).

Leaders in physical therapy education as well as the professional organization, American Physical Therapy Association have described the "preferred physical therapist professional education faculty" as a blend of clinical specialists and doctorally prepared faculty that give evidence and demonstrate the following:

- postprofessional academic credentials consistent with the role and responsibilities, with a doctorate preferred
- postprofessional clinical credentials consistent with the role and responsibilities, with clinical specialization preferred
- scholarly activity, including research or clinical practice ...
- activity related to current and theoretically based approaches to teaching, the evaluation of teaching effectiveness, and student learning

- oral and written communication skills...
- interpersonal skills, including but not limited to, approachability, empathy, openness, personal and professional integrity, a concern for others and accountability
- professional ethical behavior
- commitment to lifelong learning
(American Physical Therapy Association, 1997b, p.198)

They call for faculty to have a Ph.D. or advanced postprofessional degree, to be socialized to their roles as academics or scholars, especially as regards research.

Rothman and Rinehart (1990) note, "physical therapy faculty members are expected to be competent across a wide and diverse spectrum of activities. These activities include teaching; research; scholarship; maintenance of clinical skills and expertise; improvement of academic qualifications and pursuit of an advanced degree; and community, professional, and university service" (p.310).

The focus of this research study is on the internal career and vocation of physical therapists transitioning into the academic setting. The focus is on their experiences of entering the academic setting, working in the academic setting and the meaning they make of their work. Figure 4 conceptualizes this transition and the contrast between the clinical and traditional academic careers. Figure 5

conceptualizes the transition and the contrast between the clinical and physical therapist faculty academic career.

Figure 4 Clinician - Traditional Academician

Concepts of the External Career,
Internal Career and Vocation

American Physical Therapy Association, 1997b;
Arthur, Hall and Lawrence, 1989; Charland, 1986;
Cochran, 1997; Palmer, 2000; Stiller-Sermo, 1998.

Practice Environment

Traditional Academic Environment

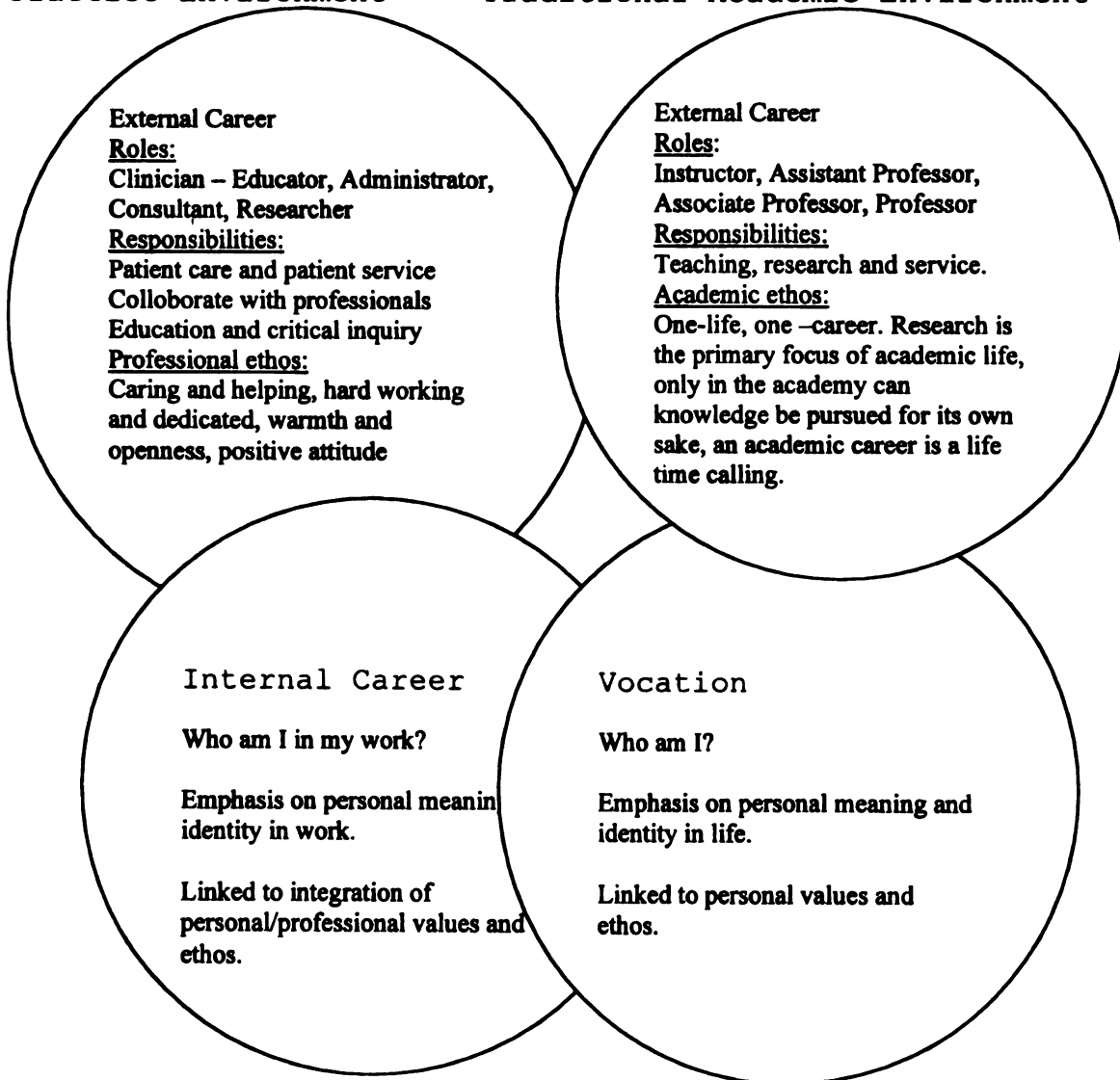


Figure 5 Clinician - Physical Therapist Academician

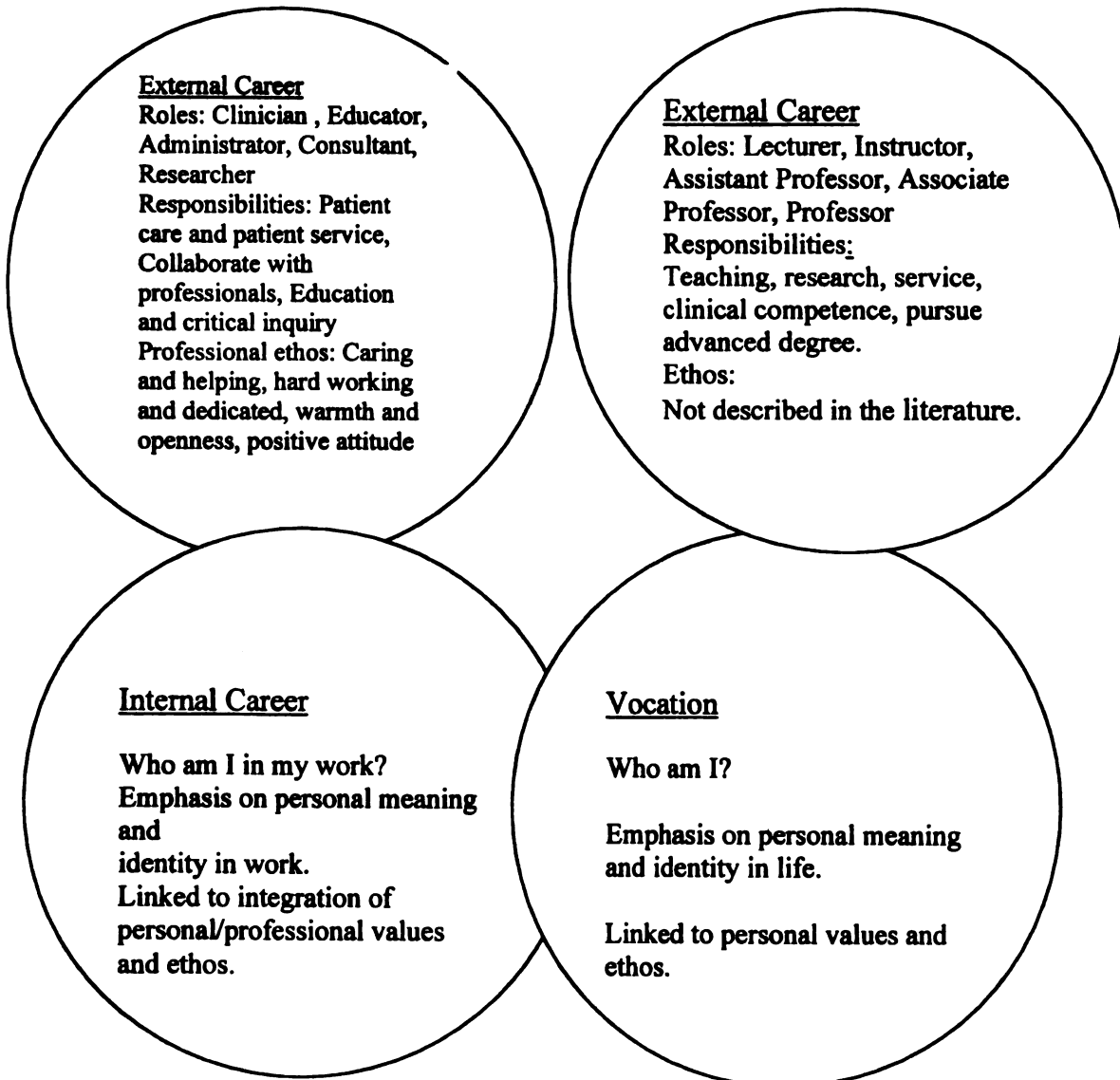
Concepts of the External Career,
Internal Career and Vocation

American Physical Therapy Association, 1997b; Arthur, Hall and Lawrence, 1989; Charland, 1986; Cochran, 1997; Palmer, 2000; Rothman and Rinehart, 1990; Stiller-Sermo, 1998.

Physical Therapy

Practice Environment

Professional Education Environment



Timeline of Physical Therapy in the United States

With a Focus on Education

- 1918** First Reconstruction Aides are trained. Walter Reed General Hospital program and Reed College are the first physical therapy programs. Thirteen programs follow.
- 1920** An organizational meeting for the American Women's Physiotherapeutic Association is held in New York. Mary McMillan is elected as the first President.
- 1927** New York University offers the first four year Bachelor of Science to physical therapists.
- 1928** Accreditation standards for physical therapy programs are developed. Most accredited programs are hospital based and award post-baccalaureate certificates. Lucile Grunewald, PT initiates study of the physical therapy education and the profession and publishes, "Study of Physiotherapy as a Vocation".
- 1934** AMA Council of Medical Education and Hospitals assumes responsibility for approving physical therapy schools. There are 14 approved schools of physical therapy.
- 1935** The American Registry is created to give physical therapists who pass the test the "registered" title.
- 1940** Physical therapy programs move from hospital based to university based.
- 1941** War Emergency Training Courses established at Walter Reed General Hospital. Courses consist of six months of didactic work and six months of supervised practice at a military hospital.
- 1942** The Physical Therapy Schools Section (later to become the Education Section) of the APTA begins to meet. The first continuing education programs are held at Stanford.
- 1944** Catherine Worthingham becomes the Director of Professional Education for the NFIP and leaves Stanford. Worthingham was the first physical therapist to hold a doctoral degree (anatomy).
- 1946** Army PT schools and two civilian schools are discontinuing. There are 21 approved schools of physical therapy with about 480 graduates annually.

- 1950** School of Allied Medical Professions (SAMP) at University of Pennsylvania becomes the first allied health school in the US. There are 31 accredited schools with 19 offering a four year integrated bachelor's degree and eight offering post-baccalaureate certification.
- 1954** A professional competency exam is developed by the APTA and the Professional Examination Service.
- 1955** APTA develops new set of recommendations for entry level PT education which are adopted by AMA, the accrediting body. Recommendations include a four year baccalaureate degree with major work in physical therapy.
- 1960** Case Western Reserve University starts a two year graduate program. The program is discontinued 11 years later.
- 1961** Catherine Worthingham is given a grant by the Office of Vocational Rehabilitation and begins an extensive study of physical therapy education.
- 1962** NFIP discontinues support for physical therapy professional education through the APTA.
- 1970's** Several physical therapy programs begin offering post professional Master's degrees.
- 1973** New York University begins the first Ph.D. program in physical therapy
- 1974** Helen Hislop, Ph.D., PT gives the Mary McMillian lectureship on the "Not So Impossible Dream"
- 1975** The APTA House of Delegates revises "Essentials of an Acceptable School of Physical Therapy"
- 1976** APTA becomes the second independent accrediting agency for physical therapy education along with the AMA.
- 1980** The APTA House of Delegates targets 1991 as the date for physical therapy programs to go to post-baccalaureate entry level education.
- 1983** APTA becomes the sole accrediting agency for physical therapy education. The Commission on Accreditation in Physical Therapy Education (CAPTE) is the accrediting agency.
- 1993** The first Impact conference on Postbaccalaureate Entry level curricula is held.
- 1993** Creighton University in Nebraska offers the first professional entry level Doctorate in Physical Therapy (D.P.T.)

- 1995** The 75th anniversary of APTA and the physical therapy profession in the US.
- 1998** CAPTE will accredit only post-baccalauarate programs in entry level education beginning in 2002.

Chapter 3

Methodology

Overview of the Study Design

This was a qualitative research study based on the in-depth interviewing method used and described by Irving Seidman (1998) in *Interviewing as Qualitative Research. A Guide for Researchers in Education and Social Services*. The use of a qualitative research design was appropriate for the purpose of this study which was to describe and analyze the internal careers and vocation in the academic work of full time faculty in physical therapy education programs. Polkinghorne (1990) suggests that human actions and career decisions are "best understood and explained through the use of a narrative perspective" (p. 104). This in-depth interviewing design has been used to study the careers of teachers, advisors, and faculty in higher education (Seidman, 1998). Previous studies of faculty career development (Baldwin and Blackburn, 1981; Boice, 1993; and Sorcinelli, 1992) have included interviewing and questionnaires.

There were four participants in the study. All four participants were physical therapists who are full time

faculty members in physical therapy education programs. A series of three in-depth interviews was conducted individually with each of the four participants. Each of the three interviews in the series focused on one of the three main research questions. The first interview focused on the coming to vocation in academic work: How and why did the person become an academic faculty member in a physical therapy education program? The second interview explored the description of vocation in academic work: What does the faculty member do in a physical therapy education program? The third interview was a reflection on academic work: What meaning does academic work have for the full time faculty member in a physical therapy education program and how is that meaning expressed in academic work?

Details of the focus of each interview are described in a subsequent section. The interview guides for each of the three interviews can be found in the Appendix C. Each participant completed a Participant Information Form. The Participant Information Forms include information such as the participant's name, address, phone number, academic rank, years of employment as a faculty member, tenure status, academic degrees and academic roles and

responsibilities. A copy of the Participant Information Form is in Appendix B.

The three interviews for each of the four participants were tape recorded and then transcribed by a transcriber. I listened to the tapes of the interviews and read the interviews. I then crafted profiles and vignettes from the interviews to describe the participant's expression of vocation in academic work and careers. I also analyzed the interviews to answer the three main research questions. Lastly, I interpreted the results of the study in light of the literature on vocation and academic faculty development. The interpretation also discusses the meaning of this research study.

Piloting the Study and Interview Guide

The study was submitted to the Michigan State University Committee on Research Involving Human Subjects (UCRIHS) and was approved in February 1999. The dissertation committee reviewed the initial interview guides and the changes they suggested were made. A colleague in my department interviewed me using a draft of the interview guides. After the interviews were completed changes were made in the interview guides. The revised interview guides were then

piloted on two full time physical therapy faculty members. The two full time faculty members were asked to be in the pilot study and they agreed to participate. The two faculty members signed the informed consent forms and completed the participant information forms.

The pilot interviews were conducted, as they would be with the participants. In the pilot study one set of interviews was conducted over three sessions and one set of interviews was conducted over two sessions. The set of three interviews appeared to work out better for the participant and myself, the interviewer. The set of two interviews was very lengthy and the participant and I tired. After piloting the interview guides the final versions of the interview guides were drafted. The focus of each of the three interviews is described below. Copies of the interview guides can be found in the Appendix C.

Interview Descriptions

Interview One: Coming to vocation in academic work: How and why did the participant become an academic faculty member in a physical therapy education program? The participants were asked to review how they became academic faculty

members in a physical therapy education program. The participants were asked to review personal, work and educational experiences that may have influenced their decision to become academic faculty members. They were asked about key people who may have influenced their decision to become faculty members. Participants were asked about their hopes and expectations of becoming faculty members as well as about the transition from clinician to academician or in the case of Mark of transitioning from academician to physical therapy clinician and academician.

Interview Two: The description of vocation in academic work. What does the participant do as an academic faculty member? Participants were asked to describe their work in teaching, research, service, advising, and patient care. Participants were asked with whom they worked. They were asked about their interactions with physical therapy faculty, other university faculty, staff and students. Participants were asked to describe a "typical" semester or year.

Interview Three: The reflection on vocation in academic work. What meaning does academic faculty work hold for

participants? Participants were asked to describe memorable, key or important events in their academic careers. Participants were asked to describe the rewards and satisfactions they found in academic work as well as the difficulties. They were asked about their strengths and their contributions. Participants were asked if they considered themselves to have a "life's work" and if so, to describe their life's work. They were asked to describe their future career plans.

Selection of Participants

I contacted four potential participants by telephone and or e-mail. I introduced myself, described the research project and explained the role of the participant in the project. The four participants fit the criteria for the study. They were physical therapists and full time faculty members teaching in physical therapy education programs. The participants were from two established physical therapy education programs. Each program has over 30 years in physical therapy education. There were two participants from each of the two programs for a total of four participants.

All four participants consented to participate in the study. The participants read and signed the informed consent forms. See Appendix A for the informed consent form. The participants were selected purposefully and presented with a range of characteristics. The participants varied on characteristics of gender, years of experience as a faculty member, academic degrees, and cultural background, work responsibilities and academic rank. Participants were selected with different characteristics as they might provide different perspectives on the expression of vocation in academic work. The characteristics of gender, years of experience as a faculty member, ethnicity and academic rank are related to career development as a faculty member (Schuster, Wheeler and Associates, 1990).

Participants included two men and two women. The range of experience for the participants as full time faculty members teaching in physical therapy education programs was three to five years. The range of experience for participants as adjunct, part-time or full time faculty members teaching in physical therapy education programs was five to twelve years experience.

Two of the participants had doctoral degrees. One participant was enrolled in a doctoral program and one participant had applied to a doctoral program but had not yet started. The two participants with the doctoral degrees were on tenure track. The other participants were not on a tenure track. Each participant is described below.

David

David is a Lecturer. He has been a physical therapist for twelve years and has been a full time faculty member for five years. He has been at his current institution for five years. David is currently enrolled in a Ph.D. program. He is not on a tenure track. His primary responsibilities in the physical therapy education program are teaching and service. He chooses to do patient care on his own time.

Carol

Carol is an Assistant Professor. She was a part time faculty member for seven years and has now been a full time faculty member for the past five years. She has a Ph.D. and is on a tenure track. Carol's primary responsibilities include teaching, research and service. She is not involved in patient care.

Susan

Susan is an Assistant Professor. She has been a full time faculty member at her current institution for four years. Prior to becoming a full time faculty member she was a part time faculty member at another institution for five years while she completed her Master's degree. Susan has been accepted to a doctoral degree program but has not started the program yet. Susan is on a clinical track that is not a tenure track. Susan's position is full time with the university but half of her time or twenty hours a week is spent in the clinic. Her primary responsibility at the university is teaching with some involvement in research and service. At the clinic she is involved in patient care, consulting, and staff and program development. Susan is from another country and came to the United States initially to work on her Master's degree.

Mark

Mark is an Associate Professor and he is on tenure track. He has a doctoral degree that he obtained more than ten years ago, prior to becoming a physical therapist. He completed a Master's in physical therapy three years ago. Mark has been a full time faculty member at his current institution for one year. Before he came to his current

institution he was a full time faculty member at another physical therapy education program for two years. He was a part time faculty member in a physical therapy education program for several years prior to getting his Master's degree in physical therapy. Mark also has experience as a faculty member in higher education in the field in which he obtained his doctoral degree. Mark's primary responsibilities are in research. He also teaches two courses a year. He is full time at the university but half of his time is in a research position at the clinic.

Participant Interviews

Each of the four participants completed the participant information form and a series of three in-depth interviews. See Appendix B for the participant information form and Appendix C for the interview guides. The four participants were individually interviewed and completed the series of interviews over a two - four week period. Interviews of all of the participants were completed over a period of three months.

Each interview was tape-recorded. I also took notes during the interviews. Following most interviews I wrote notes about my impression of the interview and noted any follow

up which was required. I offered to meet participants wherever it would be convenient for them. Interviews took place in the office of the participants or in an office in the physical therapy education department. Following the completion of the third interview I gave each participant a gift certificate to a bookstore.

A transcriber transcribed the tape-recorded interviews. The transcriber provided a written hard copy of each interview and a disc with all of the transcribed interviews.

Crafting a Profile or Vignette

Crafting a profile or vignette is using the material from the interviews to tell a story in the words of the participant. (Seidman, 1998) The stories of David, Susan, Carol and Mark are narrative profiles and vignettes I crafted from the three interviews of each participant. The profiles and vignettes are intended to address the main research questions of the study; 1) Coming to vocation in academic work: How and why did the participant become a faculty member? 2) The description of vocation in academic work: What does the faculty member do in a physical therapy

education program? 3) The reflection on vocation in academic work: What meaning does academic work have for the faculty member and how is that meaning expressed in academic work?

The profiles and vignettes were crafted by listening to the tapes of the interview and by reading the interview transcripts. I listened to the tapes while reading the transcribed interviews for one participant at a time. I corrected any mistakes or misinterpretations by the transcriber on the original interview transcript. For example, the transcriber had difficulty with some of the names of physical therapists in the field like Cyriax and Maitland. I had taken notes during all of the interviews so the notes were helpful in clarifying the transcribed interviews. Occasionally some phrases or parts of the tape were difficult to understand. In one instance, with Carol, about 30 minutes of the interview were not on tape. I have notes of the interview.

All of the words in the profile and vignettes are the participants except those in the brackets. Pseudonyms were used for the participants. Pseudonyms were also used for people mentioned by the participants. Fictitious names of

places such as the universities were used to help keep the identity of the participants confidential.

The profiles are about one-third of the total number of pages of the interview transcripts. The vignettes are about one-sixth of the total number of pages of the interview transcripts. The order in which the material came in the interviews has been changed in some cases so that the profile or vignette tells a story in a chronological order. Repetitions of speech and other idiosyncrasies have also been eliminated (Seidman, 1998).

Completed drafts of the profiles and vignettes were sent to the participants for their review. Participants were asked to review the drafts and for their consent to include the profiles and vignettes in the dissertation. All four of the participants agreed to have their profiles included in the dissertation. Two participants suggested a couple of minor word changes, for example application for acquisition. Two participants were concerned about grammar and suggested that their profiles be edited for grammatical changes. Some changes in grammar and repetitive phrases such as just or and were revised in the profiles.

Participant Analysis

After the profiles and vignettes were crafted I analyzed the interviews of each participants. The interviews were analyzed for each of the three research questions: 1) Coming to vocation in academic work: How and why did the person become an academic faculty member in a physical therapy education program? 2) The description of vocation in academic work: What does the faculty member do in a physical therapy education program? 3) The reflection on academic work: What meaning does academic work have for the full time faculty member in a physical therapy education program and how is that meaning expressed in academic work? The interviews were also analyzed across participants for common issues, concerns and themes in the external career, internal career and vocation of the participants.

Analysis and Interpretation

In this section I addressed the following questions. What are the common issues, concerns and themes in the external career, internal career and vocation of the participants? How are the participant's perceptions of vocation and vocation in academic work consistent or inconsistent with the literature? What are the implications for physical therapy faculty development? What are the implications for

professional education? What are the limitations of the study? What direction might future research on physical therapy academic career development take?

Chapter Four
The Stories of Physical Therapy Faculty
Academic Career Development

The External Academic Career of the Participants.

David

David is a Lecturer at C University. David has a Bachelor's degree in Health Science, and a Masters in Physical Therapy. For the past four years he has been working on his doctoral degree in education and is just completing his coursework. David has been at C University for five years as a full time faculty member. He indicates that Lecturer is not actually considered a faculty appointment by the university. Since he does not have a Ph.D. he is not currently on the tenure track. As a Lecturer the tenure clock does not start, which is one of the reasons he is a Lecturer. Lecturer is an annual appointment so David is up for reappointment each year.

As a Lecturer David's primary responsibilities are in teaching and he indicates that 70% of his time is devoted to teaching. He is responsible for six courses a year and teaches every semester. The remainder of his time is devoted to student advising (10%), to service responsibilities (9%), to committee responsibilities (8%)

and to research advising (3%). His committee responsibilities include committees at the department, school and university level. As a Lecturer there are some university wide committees that he is not able to serve on. He advises one - two student research groups and is a co-investigator with another faculty member in a research study. He is involved in community service, working with several groups. Patient care is not a part of his university responsibility but he does about ten hours a week of patient care on his own time.

Susan

Susan is an Assistant Professor at B University. She has been a physical therapy faculty member for nine years. She was at another university for five years and has been full time at B University for four years. Susan has a Bachelor's degree in physical therapy as well as two Masters Degrees. She is not currently working on a doctoral degree although she is planning on pursuing a doctoral degree in the future. Susan is a Clinical Specialist through the American Physical Therapy Association. Susan is not originally from the United States and came to study in this country several years ago.

Susan is on a clinical track as an Assistant Professor at B University. As a full time faculty member for B University 50% of her time is devoted to the University and 50% to the clinic. The clinic is part of a medical center and has an affiliation with the university. Susan indicates that at the university 60% of her time is devoted to teaching, 10 % to committee responsibilities, 10% to professional responsibilities and 5% each to research, advising, administration and service responsibilities. In the clinic 50% of her time is devoted to patient care, 40% to teaching, and 5% each for research and committee responsibilities. The patient care responsibilities have increased recently since there have been cutbacks and cost cutting measures implemented at the medical center.

Carol

Carol is an Assistant Professor at C University. She has been a faculty member for twelve years at C University. The last five years she has been a full time faculty member. Prior to becoming a full time faculty member she was a part time faculty member and was working on her doctoral degree. Carol has a Bachelor's degree in physical therapy; a Master's in Movement Science and a Ph.D. in Movement Science. She is on a tenure track at C University.

Carol's primary responsibilities are in committee work and teaching with some responsibility for research. Carol indicates that 40% of her responsibility is in committee work, 35% is in teaching, 15% is in research, 5% is in professional responsibility, 4% is in administration and 1% is in advising. Carol is very active in committee work at the department, school and university levels.

Mark

Mark is an Associate Professor at B University. Mark has a Ph.D. in Exercise Physiology and Master's degrees in Exercise Science and in Physical Therapy. Mark indicates that he has been a faculty member for eleven years. He has taught in exercise science and physical therapy programs. He was a part time faculty member, with a Ph.D. in exercise science, in a physical therapy program for several years. After getting a Masters in Physical Therapy he taught as a full time faculty member in a physical therapy education program for two years. He left that position and has been a full time faculty member at B University for one year.

Mark is on a tenure track at B University. He is a full time faculty member with a 50% appointment to the University and a 50% research appointment at a clinical

site affiliated with the university. Mark's primary responsibilities are in teaching and research. He indicates that 50% of his time is devoted to research, 25% of his time is devoted to teaching and 5% each to advising, committee responsibilities, service responsibilities and professional responsibilities.

The Internal Career

The profiles and vignettes of the participants; David, Susan, Carol and Mark are stories in their own words. They are stories of their transition into the academic setting. They are stories of their internal career development as physical therapy faculty. Internal or subjective career narratives are temporal and help people make sense of their lives. "Subjective careers evidenced themselves in the tales people told to lend coherence to the strands of their life. But most importantly, subjective careers changed with time as individuals shifted their social footing and reconstructed their past and future in order to come to terms with their present"(Faulkner and Strauss in Arthur, Hall, Lawrence, 1989, p.49). The stories of David, Susan, Carol and Mark are next in this section.

David
The Test Case

... I never had dreams of being an educator. But I've always had dreams about being a physical therapist. Once I understood what it was. I knew my idea, in my head as a child, I knew what I wanted to do but I didn't know the name. And it wasn't until I had the opportunity to interact with physical therapy that I was able to put a name with it and would say okay that's what it is, and changed majors.

When I think back and people talk to me about when I was a kid, I always had a sense of helping people who were in need. I never really jumped on the bandwagon of being in the in-crowd, I always hung out with the underdogs. I had a friend as a child and, I only recently found out what he really had, it was a tumor on his tibia and I was a kid, like five at the time. ... He was on a bedpan because he had a spica cast after removing the tumor and he was on bedrest. I remember taking the bedpan to him and playing games with him when he was in bed. And doing the bedpans and never thinking anything of it. I couldn't have been more than five or six at the time. And now I look back and

think a kid of five or six doing a bedpan and not being grossed out by it. And as I grew older I had an affinity for older folks. I just tended to help older people. I think it was probably because of my parents, really pushing to give respect to those people and holding them in a certain level of esteem that I just had an affinity for them.

As I got into college I decided I wanted to be an engineer. And that was strictly because of fiscal, nothing more than that. And then I knew it wasn't for me because I wasn't happy taking engineering courses. And then a friend of mine needed physical therapy and it kind of just fit into my schedule, I could take him to therapy between courses, courses that I was taking at the university, and I would watch because he was in therapy and that's when I was able to put a name to it. Oh, this is what I really want to do. And then I went back, spoke to an advisor and said okay, (laughs) how do I salvage what I've done to jump into here and we mapped out a one year plan for me to get my pre-reqs to make the jump from engineering to physical therapy.

... And so now when you say I'm a physical therapist, it was something that I had, who I was, it was my definition of

myself. (long pause) So then being an educator just evolved out of a self-concept, but it wasn't a primary self-concept. I didn't always think, oh I wanted to be a teacher.

A test case

... I was a test case. (laughs) I really was, the University (Central University) was looking for a person from the clinic to come on for one year, no strings attached. ... I guess they had been unsuccessful in the traditional methods of advertising. And it was at a time when teaching was at a height and clinical stuff was at a height so there weren't a lot of people interested in jumping into the academy. The letter came to my home, apparently for all members of the physical therapy association out in the clinic. They sent me a letter saying we're interested in seeing if a clinical faculty person wants to try their hand at the academy. I was about to switch jobs anyway from an administrative role and I said to my wife, "What do you think, should we try this?" I called Lois (a faculty member at Central University) because I had worked with her as a CI and an ACCE, academic, CCCE. ... And my wife and I said if it works out that's great, if it doesn't work, well that gives us just a year to explore something else and if need

be, it's easy to explain on a resume - I wanted to try something and it just didn't meet my needs.

I loved it. I was bad at it, but I loved it. (laughs)
Looking back I was so atrocious (slight pause) but it was absolutely a wonderful experience. And I really wanted to stay, I decided to interview for a full time position at once.

It was an opportunity and I think that really attracted me to it. It was not as threatening as saying okay, leave your job, jump into an arena that you are not familiar with, and try to make it a life career.

I called (Central University) and said I received this letter. It's intriguing but I need to know a little bit more. Are you expecting that I'm going to be teaching research? (laughs) teaching cardiopulmonary? (laughs), if it's something that I know perhaps I could, you know, it would make a lot more, it would be easier for me to say yes. If it would be something that is foreign to me, my stress level is going to go right through the ceiling.

So I was very curious to find out what was going to happen with that and when she said you would select what you want to teach, I was like, cool, I can live with that.

The biggest goal was to learn

The biggest goal was to learn, and for them to learn about me. ... and it was expressed because Chuck became my mentor and it was Chuck's role to shepherd me through that year, answering questions, helping me develop a lecture, helping me develop a philosophy. And looking back, it's one of the funniest things. Two of the people who were diametrically opposed in their views, well not views of life, excuse me, of academics. Chuck is so cognitively oriented and I am so psychomotor oriented, but I use him as a resource all the time because he gives me a perspective that I don't have. And I think that was a wonderful thing about him being my mentor. He still is my mentor.

It wasn't until recently actually that I've come to grips in my mind that this is the way I learn. Psychomotor meaning that I need to experience it. Clinically, I am an intuitive clinician.

I really just wanted to gain experience. I had no idea about the student evaluations. I had no idea of what I was even looking for in a student evaluation.

I really had very little expectations of myself. It was such uncharted territory for me that I didn't even know where to begin. (long pause) And I didn't have a philosophical framework, I was borrowing others.

Why I test, to what I test, to what I hope to achieve with a class. The concept of what it means to learn, what it means to teach.

The wonderful experience

The wonderful experience actually was the students and the faculty. The faculty had set the students up so they would be kind to me. They said to the students that this was an opportunity for you to teach as well as to learn at the same time. So the students saw their role as very collegial and in a different collegial way because I was so new they saw it as their job to help nurture me through this and be kind to me. As I made mistakes, to gently help me understand that I made a mistake.

There was a lot of discussion when I was introduced to the class about who I was, what I was here for, and what I was doing. They said exploring PT education and their reactions to me could really make or break the fact whether I would stay in education or not. So they gave me strong constructive feedback. They actually did a very nice job, looking back at that time. At the final evaluation they would write lengthy pieces of information, advice and counsel. I think that was because they didn't know me well enough to come up to me to talk to me about it.

They were kind in the classes as well as in the evaluations. They went pretty much like this: I had the potential; which was a nice thing to hear. Because I knew I didn't have it, but to hear someone say you have the potential to be a solid educator. It at least gave me the encouragement to keep trying. Had they said forget it, you're just not there; that probably would have had a much different impact on me.

The other (wonderful) thing was they (the faculty) all saw their role as helping me shepherd through this. Chuck was my official mentor, but everybody became my mentor. So they'd help you find out about this in a class or you might

want to try this out, this learning experience. It was unstructured, it just happened.

Chuck was structured. Chuck and I would have three or four meetings a week. To know Chuck is to love Chuck. (laughs) Chuck had his matrix and he had what I was going to learn each day and what was going to be covered, and how he would know I learned it. So he had his goals and objectives and assessment tools all laid out for me so I would know about the hierarchy of the university and what were the roles of the university. He had this all structured so by the end of the summer I was, in his mind, oriented to the university and ready to take on my role.

Adapting his philosophy

In addition, (Chuck was) trying to help me develop a philosophy for teaching. I really was adapting his philosophy. And, really, because I didn't have one, I just adopted his. Hindsight is 20-20. And not a good idea.

Chuck is Chuck. And Chuck is the only person who can get away with what Chuck does. No one else can do it and when you try to do it, it becomes disastrous. Chuck can sit and give an exam of umpteen questions and then meet with the

students after the exam and go over the exam and not have anyone argue with him. I thought that's a great idea. Teaching and learning. You give an exam and if they didn't know it coming into the exam, they'll know it on the way out. An excellent idea. In theory for someone at Chuck's level that works. For a new faculty member it didn't work. (laughs) I ended up getting test-giving anxiety (pause) when it came to giving exams. I would just make myself sick because I knew that every question was going to be an argument. It would be the ambiguity of the question, it was the answer, it was something. So it became an arduous test.

Back to some of the ways I was taught

I went back to some of the ways I was taught in school. I thought, okay, which faculty members did I like (pause) and most of them (pause) were very authoritarian in nature. They stood up in the class and you lectured. You lectured for the time and everybody sat there and took notes. Great idea in theory. (laughs) In practice for me that was disastrous, it literally was. Because I'm not linear on my thinking. I had to learn that.

I just talked to a friend the other night and he said he still, he talks a lot of my old classmates, and they still

thinks it's pretty funny that I actually went into education... being that I could never really see myself as an educator.

I think it was probably because of the style, the teaching style that I was in such a hierarchical environment. I remember being told by our director(of the physical therapy program David attended) at the time, I had to fight this traffic ticket that I didn't really deserve and I had a traffic court date and I was going to miss a class. The director said if you miss class I consider this to be unexcused and you will be put on probation. You couldn't miss class unless you had a reason that he felt was acceptable and he had a very small list of what was acceptable.

Actually he(the Director of David's physical therapy program) called the traffic court and had my date changed. They wouldn't let me change it, because I said, "I don't want this ticket." He (the program director) called the traffic department, the State Department of Transportation and said he (David) cannot attend this date and it will have to be rescheduled around his schedule. So it was such a hierarchical environment ..., although I learned in the

environment, I learned also that PT education was hierarchical and I just didn't see myself meeting my learning needs or fulfilling my plan as a person in that environment that was so opposite of whom I am.

As a student, you came in, you took your notes, everything was, here it is and you just do it. You don't have a voice, there wasn't a lot of growth and development. It was really, when I think about it, a lot of educators I had, although they were excellent educators and I hold them in high esteem, really didn't see their role as a nurturing role, but more as a role, more military-wise. It was you will do it because I tell you to do it and I remember in a practical, I started making a mistake about transferring one of my faculty members. She was supposed to be a spinal cord injured person. Instead of putting her in a chair with arms, I put her in a chair without arms and she just went into this role and was just getting worse and worse and worse.

I learned from it but she also really let me sink and what she ended up doing was destroying a lot of my confidence. I had to come back to build that confidence up again. I tell that as a very difficult way of teaching rather than okay,

What are we doing wrong here?, How do we do this differently?, and let's learn together. I would never be able to teach in that environment because it was so opposite. ...

I was at a crossroads

... During my second year(as a faculty member at Central U.)I probably realized that I was so tangential and students couldn't follow where I was going. I knew where I was going. And in a lecture when students are trying to take notes and you go okay and start lecturing down, and you get a thought and you go off on it. Then you come back to it and then you go how does this relate to that and you have to try to tie it all back together and in my mind it makes sense, and after I explained it, it made sense. But the students were all over the page and they didn't know where I was going. It really came to a head my second year. They were less kind. And then the second class that I taught was much more critical, (pause) they were very critical. At that point I was at a crossroads.

The first year gave me the halo and the grades and the encouragement to keep on. The second year said decide what you want to do with your life and do it. If you're going to

do the academy then do the academy; if you're going to do something else then do something else; (go back to the clinic) but don't do them both. That's when I decided I needed to learn how to teach.

You can't be in the academy, be in the clinic, be at school and try to be at home all together. It just doesn't work. There is a way to make it work, but at that point in time I was too much of a novice to realize what I was doing so poorly. And I was. Looking back at it, I was not doing what I should have been doing. I was struggling with a new philosophy, I was struggling with exploring philosophy. I didn't prepare the learners for that. That was one of the things I learned at South State. When you try something new you have to prepare your learners that you're trying something new. It's okay to explore and it's okay to engage. You just have to let them know that you're doing it because (if you don't) you look like you're shooting from the hip.

You know, I was preparing and spending hours at night preparing new ideas and it came in looking in like you just rolled out of bed with a thought in your head and you came through and just shot from the hip and I was like, oh man.

I owe them a lot because they (the students) really said wake up and smell the coffee.

As I look back and as we're talking, the students really played a very big role in my development. And this class in particular because I don't think any other class I've had would have been as brutally honest as this class. It was just a very honest, forthright class. And that's okay.

The plan

I hung in there because I really liked it. I still liked the academy and the faculty was very supportive at that time. Then I went to them and said help. I mean I went to Chuck and I went to Ruth (the physical therapy program director at Central University) and I said, "Okay, something's not happening here and I need help." I think because it was a safe environment I was able to walk up to somebody and say, "Here are my reviews, they're lousy, worse than ever the previous year. And I know I need help." The other nice thing was Ruth said, "You're not going to get fired.", which was a nice thing to know because here I'm getting these reviews from the clinic. you're used to getting positive accolades and positive strokes about what you're doing and the energy you bring to

a group and the innovations that you bring. You would automatically assume if you get something in the clinic someone's going to say to you perhaps this isn't the right place for you to be. Going to Ruth and having her say to me, "You're not going to get fired over this, it's okay. We just need to come up with a plan on how you can do what you're doing better. Is it a communication thing? Is it an education thing? What is it that was causing this to occur?" There's a big change if you think about it and say, "Well okay what was that?, What makes those changes?"

I think that was the first thing that everybody had to show me. That the numbers aren't as bad if you look at them individually. And then they could then have a place to springboard from. Okay, now that you're past the point of I'm lousy and I'm no good and I'm a terrible person, into okay now where do we go from here, what do we do. Yes, there's a plan.

Back to school

That's where the faculty really helped me make some decisions. At first I looked into South State. In my mind, I wanted to stay in the academy. So I started looking at South State and East U. as well. I was looking into schools

of education. I knew, and actually Chuck helped me make that decision as well. We looked at all the different areas that would be appropriate for me to get a Ph.D. in. Then we started to look at each one and saying, "Do you really want to do this?, Do you really want to get an advanced degree in neurology?, Do you want to get an advanced degree in anthropology?" I was looking down the list and saying no, no, no. And then education just seemed like the one that I needed to do. I didn't know how to teach. I didn't know what it meant to work in an educational arena. So it seemed like the most logical fit for me.

I had looked at movement science at East U. and their philosophy was so opposite of mine as far as what my role would be as a student in their program. I could never survive there. I might like a degree in movement science but not under these circumstances. Such an old, archaic model of what it means to be in the academy. At East U., their school of education, they couldn't understand why a physical therapist wanted a degree in education. They kept trying to convince me not to stay there.

No, (I did not apply at East U.) I interviewed them. I went down to interview the director to find out the

philosophy of the program, what it would take to get in and all those issues. After spending a couple of hours with their program, I knew their program was not for me.

They said they couldn't get past the fact I was a physical therapist saying, "Why would a physical therapist want a degree in education?, Why don't you just get a degree in a hard science? Or get a degree in physical therapy?" I kept saying I teach, I don't know how to teach, I need to learn. They just couldn't get it. They'd say, "Well, you're going to quit your job, right?" And I'd say no, and they'd say, "We don't think you can work full time and go to school full time here." I said I'd really like to go part time. And they said, "Oh, you think you can do that here?"

I was really disillusioned with South State, because I was doing this during the summer and I kept calling South State to try to set up an appointment with the director of the adult education program and I was getting very nervous. They'd say she'll be here in July and Susan, who was the director at that time, would call you. She would call and say, "This is not a good time, I'm very busy, maybe we could meet later." My stress level was going up because I really wanted to get into a program and I really wanted to

interview so I could find the right program, and they were just not making time for me. Finally at the end of August Susan said, "Let's meet." So I met with her and Denise Smith was in the same room with me at the same time. We spoke for a couple of hours at South State and they were just, we have physical therapists here, we love physical therapists here. They were going on and on and saying what are your goals. She (Susan) was circling courses in the education program and saying take this, and take this, and at the end of the meeting I said when can I start. She said all you need to do is go to the registration building and sign up for lifelong education and you take up to 9 credits for lifelong education and then you'll do your application and be in the program.

I was like, wow; they were just so focused. She said just take your prosem and don't worry about anything else. If you like prosem and then you can take some other courses. She just mapped it out for me in her office about the courses I would need to take. And now here I am ending with Susan in a class, it's like how funny to go full circle. I started with her and ended with her in full circle with Susan in a class. It just fit.

Developing a philosophy

I figured I at least needed to give it (teaching) two years. Because after the first year I applied for the position, the full-time position, permanent position and I was given the permanent position here at Central U. So I knew I had that permanent position but the critiquing from that class was so honest (long pause) that it really made me question what I was doing. But then, on the other hand, South State was giving me ideas about what I could do better. And so I had these two thoughts. One group saying if you're going to do this you have to do it better. And on the other hand there's another group saying here's how to do it better.

So it was easy to set a goal and achieve a goal when you had nowhere to go but up. So it was a nice way to look at that and that's part of the plan. Then there was some videotaping. Chuck said, "Do you want me to sit in a class with you?" and I said oh God, no. The thought of having to lecture with you sitting in the back is enough to make me sick. So we agreed to videotape and then together we would analyze the videotape of my lecture. We did a lot of those types of activities to try to get a handle on it. At the same time I started developing a philosophy at South State.

Recently I was talking to Ruth and I said my first two years were like wearing someone else's clothes. I was trying to be Chuck without his experience, without his influence. And that was problematic, almost disastrous. So therefore there was a time to say I had to develop my own voice. And South State was teaching me about my own voice, to explore my own voice. Stuff that Bill Wright's doing about reflection. Reflecting back, when you did something reflect back on it. It's all that transformational learning, Meizerow's transformational stuff, and Knowles. I mean, these became the people that became my mentors. I mean I was like reading this and going okay, this is who I am. Dewey, all these guys were who I am, and going okay, I'm these guys. How can I do what these guys are telling me in my class?

So once I started to see about those philosophical framework that wasn't me, I could then look at the curriculum and the courses I was teaching and the modules and say, of course if I stand up in front of a room for three hours and lecture I'm going to die. (laughs) I'm going to die because I'm tangential, because I don't do this. Doug's courses on experiential learning, it was like okay, this is who I am, this is how I learn. Then the

concept dawned on me during that summer that I needed to give the students an outline of my lecture before I lecture.

It served two purposes. First, it really forced me to be a day and a half ahead of my lecture because I had to send them to the copy shop to get them reprinted, to bring them back in the class to distribute them to the class. So when I knew I was lecturing on a Thursday, my weekend was preoccupied even though it was previously with reading and preparing. Now with reading and preparing and writing it down and getting it into a framework that flowed. And then the students having a hard copy, not of every word I was going to say but an outline. They could write into the outline those things they felt were most important from the lecture. Then they could see where I was going. So if I stopped and went tangential for a moment, they could bring me right back to where I stopped and say okay, we know where you stopped. Now get back to this and talk about this aspect. So they could stop listening to my little rant and rave or my clinical example, come back, and then continue along the outline. So they were happy. They liked the tangential part, they liked the clinical relevancy, they

just didn't like that they had no idea what to take from it. So that was a nice thing for them.

The courage to say to the faculty

I had a philosophy but I was not brave enough to do it. I didn't have the courage to say to the faculty okay, I'm going to teach a class where everybody's going to lay on the floor and do something or go out and just do anything. So, I had a philosophy, I just hadn't implemented it yet.

So the outlines helped a lot with the students understanding where I was coming from and going to. It also helped me to put things into perspective in my own mind in formulating thoughts and ideas. It enabled me to at least start to explore avenues plus, I think another big thing was that I gave up one class. We had brought another faculty member who assumed one of my teaching roles in the winter term which helped a great deal as well. My teaching duties were just that much a little bit less.

So instead of teaching three classes in winter term I was only teaching two. So it was more manageable and I could focus on those classes without trying to juggle three. So that was a little bit more manageable as well.

So overall it all turned out and this year the SEs(student evaluations) went right up. Not where I wanted them to be but they were much better, there was a lot more positive of students writing things on their own about the outlines and reinforcing those and reinforcing some of the things we were doing as a group.

That summer I went to the faculty and said I have an opportunity to take thirteen credits during the spring/summer semester at South State. I explained to them that this would mean I would cut almost a year and a half off of my time at South State bringing me closer to a Ph.D. This is something that was agreeable to the faculty. After they agreed to that and that became the moment when I had the ability, the courage to then say okay, in the fall these are the things I'm going to do. The main things. More of my own style and less someone else's style. That was really the transformational point for me.

I had taken a course in web site development in the summer of ... So when I dropped the course for my favorite, for the clinical neurology, a course that I taught which was basically the students were going to be putting things on a web site about their own thoughts, about their ideas of

clinical neurology. I came before the faculty in a faculty meeting in August. I developed the whole page by myself, put all the questions up there with, I went met with Information Technology Services and we were all ready to go. And just as FYI, not asking for permission but just saying hey, FYI, here's what I am doing. I said I've developed a web site, I'm putting it up. The faculty said when are you planning on doing this. I said September and their eyes got real big and they went, what do you mean you're going to do this in September and I said yeah, in September this is going live. They said okay, we need to look at it, we need to see it, we need to do this, and it was okay. I didn't mind the interaction. But the fact that I was able to go before them and say, with confidence and say here's the theory, I'm staying well within the guidelines of my course. Given the parameters of degrees of freedom which are - I can teach the course any way I see fit as long as I meet these objectives. This meets all the objectives, the course is designed around those, blah, blah, you know, the whole nine yards of all the criteria. I said I've met all them, I've developed it based on the criteria of the modules. Now I'm just going to take it and go live with it. And that was a big thing for them. And having Chuck in my corner as my mentor saying, "He's right."

These are the rules and he's playing by the rules, he's not breaking the rules, he's not doing anything differently. He's just doing what we've told him to do." (pause) Made a big difference.

Teaching students how to use the Internet, teaching students how to use web, having an instructor find their own voice. Which was the biggest thing for me. And moving away from exams. I still gave exams but they were take-home now. They were no longer classroom vague memorization. Which was another big thing for me because I was still having a problem with exams. Ambiguity, not really testing their knowledge. I didn't feel right about it. I didn't feel that exams, my philosophy was now starting to develop that exams don't prove knowledge. Just because you get an A on an exam doesn't equate to you have certain knowledge. You haven't internalized it.

So it gave me the confidence to start saying to my own class I will not be giving in-class exams, they are take-home. You have a week. You just can't work as a group. You can use your own books, you can open up anything you want, just don't share it with anybody else. And it has made big differences in my comfort zone with my teaching. Again it

showed in the SE's (student evaluations) that the students were thinking this is a nice idea. I also taught in the fall semester, it was a stressful semester of our program. The fall of the year four. And I would catch the brunt of their stress. They have very heavy loads.

The other thing was South State gave me the confidence to look at a class and make an assessment of a class. I think it enabled me to become more humanistic in my approach. That I wasn't an academician on the stage who was saying tough noggies pull up by your bootstraps and move on.

I remember once in that class I started the lecture and they were just blank stares and I stopped and I put down my notes and I sat on the edge of the table there and I said "Forget it, what's going on?" and they said, "We have a stats exam coming up right after your class." I said, "You know what, forget this. Go. We'll deal with this class at a later date. I could stand up here for the next time, waste your time, waste my time, and we're going to get nowhere. It's not worth it. Go, do what you need to do that will appease your own inner soul for the stats exam. If you need to cram some more, you need to go and get a drink, you need to go and do whatever you need to do, do it. As long as you

agree that we will find an alternate time to make this class up." Huge difference. Because they saw me as a different person.

I've finally got to a point where I'm comfortable and able to say something about what it means to learn. I want to share some of this with other people and learn some more.

For me, I think most memorable was the transformation. Because it represented making this job my own. I can almost pinpoint the day or date. It really occurred in the fall ..., I had just finished the 13 credits at South State. My mind was just racing with ideas. I really didn't share them, I just did them. I just wrapped it in the umbrella of or blanket of it's my prerogative because I was meeting the teaching objectives. As I told you earlier that this particular year was not a glowing one.

I guess I saw myself transforming from the prescribed role which I thought I should be doing and everybody else thought I should be doing to a much more ascribed role which I wanted to be. And I think and I really believe, and everybody wanted me to believe it, wanted me to do it too.

... I think that everybody really wanted me to come in to my own role. You're faced with okay, do I leave. Do I just live with this dissonance? What do I do with it? There's people to say oh no, this isn't okay. You have to do something about it.

The Life

I think (I see as my life's work) the exploration of both service and clinical relevancy. I see ... this grand meshing of two worlds. There's service, getting students involved. Getting myself involved. And doing it for the sake of doing it, not for personal gain.

... I think that camp (A camp David runs for people with disabilities), I think that what's through the PT students is done completely voluntarily. Students volunteer to serve. There's no money involved. There's no credit. It's just, "Do you want to have this experience?" Our students say to you it's the hardest job I've ever done and I'd do it again in a heartbeat. It makes it all worthwhile. Because they go in with their own reason for doing it and they come out with a gain that they never expected to happen.

A sense of seeing people with a disability in a whole new light. That they have merit and they have worth. Because we see them in conjunction to our level. Your client is an extension of me the physical therapist. So we're joined through therapy. In the camp, the Olympics, you're joined through the activity, through the events. Your clinical skills are second to a therapist in the big picture because you don't sit there and say okay, we'll do a full range of motion, full manual muscle testing, you don't. Because the premise is it's for them to be as functional as possible and we all gain by this.

There are no gait belts in camp because a gait belt will restrict their freedom. It will protect me from them getting hurt, but it restricts their freedom. So when a client's playing baseball and you're trying to figure out how to guard this person who does not have a gait belt, you can't figure it out. You really move beyond what is safe. You do what is functional and what is purposeful. And you're successful at it. Because when you challenge yourself, you think out of the box, so to speak. And they do. My students share that with me all the time. They'll say I think I am much better on my clinicals because of my personal skills because of camp. Because I can look at the

person beyond the person in the bed. I can look at the person beyond the person I see today. It's a reality check for them because these people had lives before their disability. I think it just grounds them a little bit on life, life has a way of just getting even. And you never know. Because this is real life. I think that's the most important thing that maybe that's really what I want them to learn. Is that your working with somebody's life. You need to consider that.

... Students leave with little bits of knowledge that just comes out of their ears. And they're so smart. They really are. I tell them all the time you guys are so smart. At camp you learn something that you can't learn in a book. It's beyond memorization, synthesizing, diagnostics. And it's all very important, and I know it is. But there's more to it. ... What do you think?, How successful do you think this person's going to be? Is it based on your diagnostic(exam)? Because if you look and say, "Oh 80% of the people get better.", well it isn't the 80% that you're dealing with. You've got to look beyond it. You've got to be willing to take the risk.

Why do this? Do you think they're not going to ambulate? Do you think they're just going to get worse and we should just make them comfortable now? and it's like, sometimes yes and sometimes no. I tell my students it's okay to be wrong, better to be wrong and shoot high than to be wrong and shoot low. If you shoot too high and you missed the mark, at least you put the person through a much better level than if you shot so low and they never really achieved anything. So I really want them to see the life. It's the problem of the (academic) institution that you don't want to see the life. You don't want to see the life of the students. You don't want to see the life...

But it's nice to now that there are people out there who see this and say you've got to see the life, you've got to see that there's more to this. And you're right. There are the Boards and you've got to pass the Boards and you've got to do these things.

I'll stop in the middle of a lecture, I'll say, "You know who that is?", I give you an outline because I'm tangential with my thinking. Because I will stop, come up with a topic and go on with a story. I'll tell my story and come back. Mostly they have no idea where I'm going. So I give

you the outline so you know when I've tripped off. It's really not what I had intended but it sort of came in my head. I will make these as personal as I can. Let me tell you about this guy, let me tell you what his life was, then let's talk about the disease that took his life.

Understand that this man was a full professor. Understand that this man was two weeks away from being a journeyman. His life was taken away from him. He's no longer the person he used to be.

I don't know. It made a difference to me. I guess if I hit one or two (students) that it makes a difference for it's better that I shoot high. ... I'll just do another one of my stories. It's hopefully a story with a purpose.

... Just recently, I had a student call in saying he was sick and would be out all week. Which is kind of unusual for you to know that you're sick and you won't be in for the whole week. Well, my response to it was, "I'm sorry to hear that you're not feeling well. When you're better come and talk to me so we'll catch you up and you can do what you have to do review." It wasn't if you're lying to me then we need to talk about the fact you're lying to me. Do I need to find out why you think you need to lie to me then you're not

going to be in my class. If you think it is a fluff class fine, then you think it is a fluff class. I'm not going to make it harder for you because you think it's a fluff class. But I think it's important to know, for the students to know that there isn't a punitive environment here. You're an adult, you made a choice. But in an email I said to him, recognize missing three classes in a short semester is like missing three weeks of a course. Because a lot of information is covered. Yes, I could be punitive and say your grade is going to suffer. First of all, really, they really care about their grade. But the reality is, their client will suffer. My goal is that they need to know all the information that they are supposed to know so their clients don't suffer. ...

We've conditioned them that this element might throw my grade out. You know, the exam comes by and you guys just go nuts because it's a matter of a grade and you can sit and sweat bullets over a point. Not whether or not you learn the information, it's about a point. So I say okay, here's the point. Now let's talk about it. Well, get beyond it. But I think so many of our colleague's hold this as a motivating tool, that it's the wrong motivational tool. So it's only corollary that there is to is money in the real

world. That's the wrong message to send to our profession. At least in my eyes it is. First of all, there isn't money there for it. Second of all, it's not what we're about. At least I don't think so.

I do think we're about service. There's no mistake that people that I, in our profession that I associate the most with are older. Chuck, Betty, Bill. If I could join the Prime Timers I probably would. They got into it for service. They all did. You can talk to each one of them and they'll tell you, when polio was cured they all thought they were out of jobs. There was no money in it, so they were doing it because people needed it. ... So, to hear the stories and say, it's incredible. You just saw the service and that guided your life.

And service. I'm big on service these days, I don't know why. I do think that's going to save our profession when we start to think about the orientation a student has towards service. Because we'll need a bigger voice to push out the voice that's right there now that's taking us down (the wrong) path ...

I think some of the thing when you start coming back to the service is to tell the people about what do you do, who do you treat, what do you see, what are you doing for your community. Because people will see us as being the good guys again. We still are the good guys, but we're not like, I mean when I first came out of school you were like seen as heaven on earth. You're going to make this person better, you're going to make him walk or you're going to make him do these things.

I am a clinician, PT first, foremost and always
I don't think I've made the full jump. I really think that being an academician has enhanced my clinical practice. I am a clinician, PT first, foremost and always. That's who I am. First thing, you ask me what I do, I'm a physical therapist, then I'm an academician. But I am a PT. It's how I define myself. (pause)

I see a lot of academicians who see their PT degree as a reason for being at the academy, not as a reason for why they went into being a PT. So they can readily give up that clinical practice and not have any sort of remorse if they don't treat anymore. It would be like cutting off my arm if I couldn't treat. Which is why I do it on my own time

Saturday morning on my way home from work. I leave here and I don't get home for another two hours because I have two clients on my way home.

Because it's so important for me as a clinician, I don't care if I don't get time for it. It doesn't make a difference to me; I would do it no matter what. I'd do it for free if I had to (pause) because it defines me. Maybe it gives me credibility. Maybe that's another reason.

Students see me as still practicing, which means you have more credibility. Maybe it's a safety net. I don't know, but it could be.

And because I am a PT, the time I spend treating clients is limited. It's precious to me so I find that being an academic really has enhanced my clinical skills because it makes each time I'm with a client is an opportunity for me to renew, those little perks you don't get all the time. Clients, they think you're wonderful. I mean, really, as academicians you don't get those. You don't get somebody coming up to you and saying you're just the best thing. As a clinician you get them all the time. Clients walk up to you and they give you a hug. When was the last time a student come up and say, "Oh thank you so much, it was a

great lecture." You don't get that. I don't think I need it from my students. But as a clinician it reaffirms who I am. Because I don't think I really have transformed to think I am an academician. ...

I definitely want to be better (as an academician). And not so much better, not better intellectually but more so, better from a human standpoint. I think that's where my strengths lie. That I can do the intellectual part but I'd much rather do the human. Making it real. Seeing the life, and understanding your voice.

I guess (I would want to be remembered) as a faculty member who really cared. I guess that's the most important thing to me. Chuck says sometimes I lead with my heart and not with my head. I think it's okay. It's not a bad way to lead. ... there's a price to pay everything that you do. I just think that he was just trying to warn me. He was saying be careful. You can lose yourself in the process. You become so you define yourself so much by the performance of others, you can tend to lose yourself in the process. So I think he just wants to be that warning for me and say, hey, be careful. ... for me if I didn't(care), I wouldn't be able to do the job.

Yes, I don't know what my role will be (in the academic setting), I'll have to wait and see. I know there will be something it's just a matter of when will that niche appear because it has to be a match, you can't force it.

Susan
When I Came Over to the United States

In a non-traditional setting

I started in education in a non-traditional setting in my country. I'd been (teaching) in a physical therapist assistant program in a hospital. It was a hospital-based program in a slightly different model than we have in the United States for the PTAs. So I had an interest in the education from that side. I didn't count that in the overall experience as a formal teaching experience. When I came over to the United States I was wanting to get some more experience in physical therapist assistant programs. I figured I would go back to my country and start a program there.

A position at a University

So I found a position at a university (Blue State) that had a physical therapist assistant program and was hired to start a distance education program there at the same time I was doing my Master's Degree. I started (teaching) in the PTA program and then gradually started teaching some of the labs in the Bachelors level curriculum. Then in the transition process into the Master's program I gradually

started teaching more and more in the entry level program, PT program, while I was still doing my Master's. At the point that I graduated and I took on more of the (teaching in the) PT program.

I was actually employed as a faculty member. They have an unusual situation where they have PTA, PT and post-graduate courses in the same department and there's no differentiation between the faculty members. All the faculty members are automatically faculty in the department so I just changed responsibilities more at that point.

I found that particularly at that point in time when I first came to the United States; I was working as a therapist in an acute care facility and then in a rehab facility which was very mundane and very repetitive in a lot of ways. There were very few opportunities to really stimulate the creative part of the job, which I don't think has to be the case. So that was one of the reasons (to go into academics).

A desire to teach

I've always had a desire to teach. When I first considered going into physical therapy my two choices were teaching,

as in high school teaching versus physical therapy. And for the first year I went to university I was considering becoming a teacher versus physical therapy. So I think I've always had an interest in it.

My mother was a teacher. I don't know whether that had any influence in my teaching methods, but it certainly does make a difference in terms of your choices as a career. I mean it's something that you're used to. High school teachers definitely had a big influence on my life; they really encouraged me to get into teaching. So the interest again was there. Friends have had an influence on it.

I had two friends in my country, one was involved in teaching and the other was a physician. The group of physicians that I was involved with at the hospital, when I was doing the PTA program, were very supportive. I think that that initial experience with the PTA program was so fulfilling that it definitely stimulated my need, desire for continuing in the teaching area. So if I had to say were there other people who influenced me, those students that I had in that initial PTA program were definitely motivators.

Not a conscious choice

Really, when I started teaching it wasn't a conscious choice that I was going to become an instructor full time. It was more I was doing it at the same time as my Master's. The Master's was my primary goal, the teaching, it was 50-50. I wanted the experience with the physical therapist assistant programs. But in my country there wasn't a need to choose between an academic career and a clinical career because the physical therapist assistant programs are in-house hospital training. At that point I was really serious about going back (to my country) and pursuing that option. It was a gradual transition.

I was employed (at Blue State). I would either have had to go on a full-time student visa or as an employee so I was employed which allowed me to stay in the country. I think as I got further into the teaching it also became the satisfaction of seeing the learning process. Not even the stimulation in terms of the pure knowledge or the personal stimulation that you get from having to prepare, but also the stimulation from finding the best way to enhance other people's learning. So although it was a different set of skills from the clinical skills, it parallels the clinical

skills in that you are always struggling to find the best way to assist the students with the learning.

You know, I do wonder about that first year of teaching. Here it is so hard and sometimes the students can be so negative because you're so inexperienced and they're very critical. I wonder how many people don't get past that first year because of it, but on the other hand I haven't seen that many people drop out the first year either.

It was hard. (the first year with the PTA program at Blue State) But there were multiple components to that, starting on the distance program, it was doing my Master's at the same time, it was moving, it was getting back into the academic environment and learning myself after having a break and not being used to going to the library. I wasn't computer literate at that point. Everything was learning. Every single thing. Plus the other difficulty that I found was that my educational background and educational system was different. I didn't know what a credit hour was. We don't have those in my country. I had no idea what the prerequisite courses were and basic content and things like American History or that type of thing that was totally foreign to me. So I had to learn all of that because we

were dealing with that type of thing when we were admitting students in the PTA program. I was just, learn it quickly. I read up for it. I asked.

Sometimes there were times when I didn't know that I didn't know something. Those were the hardest parts. When I took the group of students over to England; this was three years after I had been at the university, they (the students) started asking questions about the educational system (in England) and their hospital system. I started explaining what the difference was between the American system and the British system. And I came up with things like I didn't know what a credit hour was and she (the Blue State Physical Therapy Program Chair) had had no idea that I did not know what those kind of things were. So, it's automatically assumed in a homogeneous group that there are certain base lines that you know because you've been through the same system. When you haven't had the same background, I think that with some of the foreign PTs too, that there are times when they just don't really know and either they don't feel comfortable asking or they don't know enough that they don't know something. So that's an additional factor.

International environments

If I go back to some of the comparisons that I've had being in international environments, I think the international environments have really taught me a whole lot. One of the things that you really appreciate when you are there (is that) you see some of the patients that obviously can be helped by physical therapy and they are not receiving it. And it's an absolute shame. These people could be functioning. You realize how important PT is and how important it is to pass that knowledge on. Being a consultant allows me to pass on skills I have developed. Pass it on to 4,5 or 6 people and they can use it with their patients. Your impact is more than just treating 8 patients a day.

I mean, for example in Vietnam, they had a period of about twenty years where their original physical therapy program was run by a Swedish physical therapist. She went over about twenty years ago and trained one group of about eight people. They finished their training and then the program stopped. They left. Those same people became teachers in the schools so you had the same information, the same material, but no outside input. The only input that they were getting was from physical medicine specialists who

trained in Europe, in Eastern Europe in particular. You had this complete stagnation of the profession, as such.

They were literally years behind, complicated by the lack of translation of materials and academic books and things coming through. They only had one set of skills which can develop to a certain extent, but the more you have and the more outside input you are constantly putting in to the mixture, the faster it grows and the faster it evolves.

So taking it to a higher level and taking it to a situation where they have much more active thinking (is important). Part of that is cultural too. There is a strict hierarchy (in Vietnam). You do what you are told to do. The doctors are in charge but there are some cultural aspects, as well that a good portion of it was because they just didn't get the instruction. Now occasionally they had people coming through doing continuing education courses. But most of the continuing education courses were done on a technique.

So somebody would come over and teach PNF and somebody would come over and teach Bobath, or you'd have isolated techniques being taught and then the therapists didn't know how to use them or when to use them or they didn't have the

examples of good clinicians in the clinic that they would follow or ask. Jumpstarting a profession and comparing our situation here and the opportunities that you have both to learn and to practice with somebody who doesn't have it just to me was a very strong picture as to why we should be doing this and the importance of it. The teaching and the wealth of knowledge and experiences we have and why we should be passing it on in as many ways as possible.

And not only in an academic environment, but also in a clinical environment too. I think if I have to go back and look at the linkage between the clinical and the academic; I think something that has helped as well is that if I'm teaching or consulting in the clinic and working on skills with those therapists, those therapists are helping you out with your students both as clinical instructors and as lab instructors. You have more of a broad-based influence than just the one person does.

You can isolate your skills and keep them in the academic environment, but if you don't have back-up and you don't have people teaching the same thing or in the same way, it's not being used or reinforced. An example of that would be when I was in the Blue State area. Their skills had

been, in a way they had been fairly isolated, with the types of technique they had been taught because there was only one school in the area. Everybody coming out of that school, it was a very parochial environment, they'd stay in the area. The same material was being taught in the school and going into the environment. There was no cross-pollination from different areas, different books, and different ideas. If you start teaching new techniques in the academic environment and the students then go out to the clinic and the clinicians don't have those skills, they either don't let them practice them, they are threatened by it; or if they do let them practice them, they don't know how to correct them or help them or tell them what the next step is. And it's a waste, because they don't use them.

It really took starting post-graduate courses and training some of the clinicians in the same technique which takes a long time. Instead of just being three years with the students coming out you've got a generation of clinicians that you need to upgrade in their skills as well. It's going to be another six years or whatever before you're really able to make any changes in practice. That is a different situation to what we have here (at Clear State) because you have so many schools. Second of all, being an

urban, metropolitan area you get a lot of movement of people from different backgrounds, different environments, different training environments, and you have a lot of continuing education courses coming through. You do have far more variety and availability of education.

You also have the plus of an academic medical environment where the physicians are not just practicing one particular type of medicine. In some situations at Blue State there was the same thing, that you had family physicians who really didn't know anything about physical therapy. They wanted traction and that was it. Or traction and short wave diathermy. You had a responsibility to educate the physicians as well. You still have that here but the more (diversity of practice) there is the easier it is.

Partly because of my previous experience, partly because I feel I could really make a difference, I think there's a need for it (teaching in international environments). Sometimes you can do things here where you know if you don't do it, somebody else is going to pop in tomorrow. If you say no, they're going to find somebody tomorrow to fill your place whereas I guess in a way it's selfish, it gives you that feeling that you are needed. But it's more than

that. It's why I like the complex patients here and why I like the academic medical environment, you've got multiple problems. Sorting problems out gives me a lot of satisfaction. I can do it too, so if I'm to use my skills that's probably the area I should be moving towards.

Life's work

I think that in education it's very difficult to, when you say life's work I think one final product would be very difficult to have unless you had a very small life's work. So if you were going to build a department, one department and one small rural environment you could probably say this is what I want to do. I would prefer to look at a wide based spread of knowledge and skills and facilitating development of educational programs, of clinical programs and I think you avoid the word outcomes. What you're looking for and how you'd measure it is difficult. You could look at a number of people that received your services and look at the quality, but it's very difficult to quantify the quality and I think the quality is a very important part of it. You could look at satisfaction of the professionals in the area, which would be an issue. I think if you looked at functional outcomes of your clients, which again is difficult to quantify if you're using any of

your scores or your functional measures or something like that. But I couldn't say to you my aim would be to provide physical therapy services for a continent and all the amputees would be able to walk with prostheses or something like that. I couldn't really do that.

I don't really know where it's going to go. I'm in one of those situations where I know what I have to do to get to that eventual aim but I don't know how that eventual aim will work out. I have hit a stagnation point in my own career because dancing is my hobby. Without a doubt, the fact that I'm dancing right now put a definite stop on my professional growth and my professional involvement.

However, probably for the previous four years I overdid the professional part of it and I didn't have any personal part of it either so at some point there's got to be a balance. So for the moment while I'm still physically able to do this and pursue it, it (dancing) has definitely helped me in teaching and clinical work.

I guess if I have to be honest with myself, what I really want, what I want to do is to go back home and provide some impact or provide some support for assistants (physical therapist assistants) there (in my country). To provide

better rehabilitation services. It's strange, you don't think of these things very often. You should.

You used to think of it a lot, but you don't so much anymore. That's bad, because you get caught up with the day-to-day stuff and you don't think about the long-term issues. There isn't enough time to.

I think that's important. Because otherwise you choose the smallest things rather than the more important ones when it comes to making choices. Working towards a goal you should have an idea of what you want, but sometimes you can be diverted after the fact. I think one of my major problems is that I have too much going on, too many things and it's difficult to stay focused on one particular area.

Strongest memories

I guess one of my strongest memories or events that I think that I have of teaching is really one of my earliest. It was still teaching but it was a non-academic situation when I ran the physical therapist assistant program in my country which was in a rural environment and where I trained eight assistants over a fifteen month period. I guess just the appreciation and the satisfaction that they

got out of developing their skills. These were nursing assistants and in one case, a cleaner. A very bright, very capable woman but she was working as a cleaner in some tech and radiology section. Providing them with, or being able to provide them with, a situation where they developed enough skills so that they had some pride in who they were and what they were able to do, and the fact that they were able to help people. They were just basic techniques, but still, it helped them more than we could have done, and again we were leaving something behind. I was only there for two years but at least after I left there wasn't a complete void.

I guess it was extremely satisfying to me to see that you can make a difference. It was more satisfying to me than even making a difference with a patient. I was doing all the techniques. I was able to pass that along and the assistants would still continue to work in that area in their home environments. These were eight assistants from four of five different hospitals in the area, so it was much more widespread. It wasn't just from one hospital. I think that was really what stimulated my interest in teaching. I mean I've always been in interested in teaching, but what really pushed me towards wanting to

develop more skills in teaching and continuing with the teaching career rather than staying in the clinical environment alone. I guess that's probably, that was probably one of the most satisfying and I guess life-changing experiences.

It shaped a lot of things. I mean, when I came to the United States, when I came to travel, that shaped my desire to get more education and to go into my Masters. It shaped the fact that I wanted more experience in teaching physical therapist assistants. That's when I looked for the position at Blue State and I started teaching with the physical therapist assistant program in at Blue State. It shaped an interest in distance learning and different methods and means of providing education to different levels of professionals.

And for a long time that was really my goal and my dream in a way, I guess to develop enough expertise in an area in order to be able to go back to my country and really set up and establish programs for physical therapist assistants. And that kind of changed. I lost that. That was life changing too, not having that overall goal function or life goal as such. All of a sudden I was looking for something

else. Giving it up was, there was a lot of guilt associated with leaving a country and leaving any group of people, but not pursuing that, there's a lot of personal conflict for me.

Long term

Long term what I'd like to do; is I'd like to do more international consultanting in physical therapy. In a way, that would help me come to terms with not pursuing that same goal. To take it a little step further and look at maybe it wasn't just one country or the one area. I would be looking at and facilitating the spread of that knowledge into other international environments and that would be just as effective.

My involvement in the health volunteers overseas allowed me to move into a new environment; being involved in the Vietnam project has allowed me to take that broader scope. So I think long-term I would like to still be able to do that on a regular basis. I would like to be an international consultant. And teacher.

SUSAN
The Split Position

I didn't want to lose my clinical skills

The split position between the clinic and the university (at Clear State) was a big draw. When I started in the academic field I wanted to improve my knowledge and I wanted to be able to learn to teach. I didn't want to lose my clinical skills either. I found in the first couple of years when I was on the faculty full time (at Blue State) I really missed that (being in the clinic). I had tried to maintain my involvement in the clinic while I was there, the first university I was at by working with sports teams and treating some faculty members and students. I did do some contract work while I was there as well. But I found that I was missing it (the clinic setting), and missing the immediate feedback and the rewards. Rather than the prolonged changes that you see when you teach it. Which (wanting to be in the clinical setting) really stimulated the need to go and do the residency program or the second Master's Degree that I did which was a residency program rather than a pure academic program.

One (Master's Degree) is in orthopedic physical therapy, a sports-based course and the other (Master's), with an orthopedic residency, is in manual physical therapy. When I came here (to Clear State), the opportunity to do some of the clinical aspect of the developmental programs to me, working with clinicians and really working with consultants more than anything else seemed to be ideal. So that was a major drawing card and the metropolitan area and the fact that it was very multi-cultural and a large university with the resources around it were the main drives.

A shared position

I'm in a fairly unique job situation, but I have a shared position between The Clinic and Blue State. So 50% of my responsibilities are clinical and 50% of my responsibilities are teaching. My teaching responsibilities at Blue State include teaching Kinesiology 1, Kinesiology 2, Clinical Decision Making 1, Clinical Decision Making 2, and coordinating electives, in addition to faculty responsibilities with committee work and additional administrative work. The clinical portion is clinical teaching of the staff at The Clinic and mentoring, inservices and some program development work. Although that role has changed with the budget implications. I'm

expected to see four patients a day when I'm here (at The Clinic) and I'm here two and a half days a week and that's 12 codes.

I'm predominantly in outpatient right now. There is one other senior staff member there. We've split the staff and so we are responsible for the junior staff members. We set up times on a semi-formal basis. We tried to do it on a formal basis once a week at a specific time but it didn't work very well. Most of the time we set up times with the staff when they have difficult patients or a patient they need to work on with specific skills. And then you co-treat with the therapist or you can be called in just to consult on difficult patients in between (your own patients).

If I'm treating patients myself, I may be called in at the same time to see somebody when they have an evaluation or question. If you're in the environment and people see you treating the patients and have questions or if you see them treating patients and there's something specific that you see, you can just give them a few tips. We also do inservices for the outpatient area and for the performing arts program across system.

I'm asked to teach occasional inservices at some of the other sites or on the other floors, and I'm also working with the Spinal Cord Unit on occasion for mentoring there too. I am part of the faculty for the PMR (Physical Medicine and Rehabilitation) programs as well and adjunct faculty there, but I haven't done a whole lot. They haven't utilized me a whole lot within the teaching physician program. I have a feeling that now that we've had some of the physicians leave that there is going to be more responsibility in that area as well. We've had three or four major teaching faculty in the PMR program leave.

Faculty meetings

We have normal faculty meetings every two weeks and then the committee responsibility is divided up amongst all of us. I'm on the search committee and the student progress committee. I'm also on the departmental review committee right now. In the past I've been on the teaching awards committee and a globalization committee.

Those are the areas (the committees) that I find the most difficult to coordinate with my schedule. You know, only two and a half days a week isn't enough when you have

committee responsibilities and a patient is coming in. It's hard to schedule my committee work.

All the students are divided up amongst the faculty (for advising) so we can have approximately eight students per class that we are responsible for. In the past we have had research groups, which we have been supervising. I did ask to be excluded from that last year. Obviously it was too much.

It's not obligatory (research advising) but we were asked to do it, overall, and we were asked to include, or at least give the students topics relating to our own research. I just found that research overall has been less of a priority in my job description just because of the clinical involvement. Any of the clinical involvement in the research that I have done has been here at The Clinic with the clinicians or on a case study type basis. And so with the students it's that much more difficult because they also need help at different times and most of my time at the university has been filled with teaching and other responsibilities. It really is squeezing two jobs into one in which we end up having to cut some on both sides and that's been an area that I've looked at.

What's involved in the advising? It's most often when students have difficulties that we are involved. That might include disciplinary issues or behavioral issues or academic issues. The faculty is very collaborative with that type of thing. Sometimes we'll be called in to help with other students if somebody has a problem there might be two faculty that are involved with the program or development.

Priority

The teaching primarily because of the workload and because of the teaching load, the teaching responsibilities have to be fulfilled first. When I first started the job I was going back and forth trying to fit in everything at anytime and accommodating anybody who needed to have a meeting here and there. It was just inefficient, you were going back and forth from one place to another and getting in the car and getting out and leaving things in one place and then forgetting it. I try as much as possible to keep to the same schedule. That goes for across semesters too because on the clinical side if they set up a meeting it doesn't go by semesters. If you all of a sudden change your schedule, for example mentoring on specific days and they schedule their inservices on the dates that you're going to be here,

you can't just expect everybody to change because of you.
So I've tried to keep to that as much as I possibly can.

Other priorities are individualized so there might be times that I have a presentation or if I have any academic work that I'm working on where I'll need to do that as a priority for two weeks and work on that at the same time. So, the students' needs in terms of exams or remediation, those are usually fairly urgent and they take priority over anything else at that particular point. The grading responsibilities and your grading very often takes priority sometimes even over preparation.

I think sometimes the lowest priority and things that get pushed down to the bottom of the pile are just because of the workload is your programmatic development and working with some of the other faculty members. Things you would really like to do for the curriculum or furthering the curriculum. We try to do as much of that as possible and with the accreditation taking place over the past couple of years we've been forced to get into curriculum development with everything else. I think accreditation has a vital role in doing that because otherwise you just put it off.

Expectations

Already having been involved in that academic environment, I think there are some different expectations that come from just the organization environment, the previous university that I was at had a very large faculty. They had an established program, they had three different programs, and they were applying for a doctoral program too. They had a very dynamic leadership both in the dean and the faculty chair. I started as junior faculty member and so your roles and responsibilities and your status or your position is already defined for you. You have to fight every step of the way to get anything new. It's a very different hierarchy here.

Actually when I came here there was far less of that (strict hierarchy), so that was a very pleasant change. The program was starting up again (transitioning from a Bachelor's to a Master's entry-level degree program) so it was a different situation from the previous university. I probably had more experience than some of other the instructors, not all of them but some of them. I was changing my role in a way because I was really working alongside with, in one case with one faculty member who had no experience with teaching. Seeing her go through the new phase was interesting. And having more input in the entire

faculty structure and committee situation was different.
But I expected that too.

I knew that when I was coming in that it was a new and growing (Master's) program and it wasn't really established and I was looking forward to that. I felt that I had something to contribute rather than the previous place. There were strengths from the people around you that you really gained from the number of people with all their expertise and having all the wealth of knowledge and wealth of opinions around you. But this was a different way to go and I found that that part of the expectations were already there when I came here. The shaping of the curriculum was something also that I expected. It hasn't been different except for two things that possibly changed.

One, that we have not had the number of new faculty members that they promised us initially. And, two, that I have found that the split position, as exciting as it is, it can detract some from your responsibilities within your department. Your curriculum development or anything new or anything that is outside your normal allocated responsibilities is going to take second place just because you haven't got the time to do it. So that I think has

changed from last year, but part of it could change if we got more faculty members. What else is different? I think the interpersonal dynamics is always different in a new environment. That changes how you function as a faculty member to a large extent.

I think the only thing that I did not expect was, I would have liked to have been more involved in some situations and have not been able to because of the time constraints. When you're in the clinic two and a half days a week, just the organization of meetings is just an absolute bear. There are some limitations, yes. Organization and time are the two big ones. Having the two offices, two computers, and two sets of messages, people not being able to get hold of you at one place versus the other. It's hard, I mean things like faculty meetings, when do you have faculty meetings because everybody is all over the place.

On a clinical track

I'm on a clinical track here. We're very lucky at Clear State. We have two completely separate tracks, a clinical track and a tenure track. In a tenure track you're expected to do research. In the clinical track you're expected to work on academic professional endeavors. But

it doesn't have to be pure research. It can be a research component, but it can be case studies, it can be development. Your promotion and salary adjustments can be based on book chapters or educational materials that you develop for your courses or presentations, anything that is going to lead to professional development but doesn't have to be pure research.

I have been involved in some research projects, collaborative work with other faculty members or members of other departments. I find sometimes the nitty-gritty of the actual research is difficult to organize with the time constraints. Getting the subjects or making sure that everything is tested out. Up until recently with all the changes in the clinic, I was able to do more research in the clinic than I have been even in the academic environment. I've had far more teaching responsibilities here and less time in the academic environment than I have in the clinic. That's just changed in the last few months ago.

But this environment has everything that makes it possible. There is no excuse, if you want to get involved with it (research) you can. You've got the statistics support,

you've got the dean of research who is very supportive in research endeavors and I'm now working on a project with him and a whole team of people. That's one of the advantages of being in a large academic environment and in a research institution that not only stimulates and supports the research but also provides the wealth of people. You've just got so many people here who've got so much expertise that you don't have to do anything by yourself. That makes it easier. We've also got an enormous amount of equipment available and it's just sitting there waiting for us to use. We don't use it fully though.

At the Clinic

Initially when I started at The Clinic my responsibilities were mentoring staff, teaching programs, continuing education, in-servicing, development of programs and patient care was not a primary responsibility. We're still trying to work on what my roles and responsibility are right now. I had been treating patients before now, it's just that now I have the productivity expectation. I'm treating patients approximately 50% of the time. There is less time available for the staff to be involved in education, and before I had time to pursue my own academic

components. A lot of the presentations that I've done have been done on case studies with staff members at The Clinic. I've had the opportunity to work on those and to do the research. There's a lot less time to do that right now.

I've had some things that have been unexpected. I've had a lot more opportunity to travel, which I think is one of the attractions. Professional meetings and continued education courses and those kind of things. I've also had an opportunity with my involvement with the international physical therapy education and through two mechanisms. One through a volunteer organization for physical therapy overseas, and doing some international workshops through them. They've been supported through both universities that I've been at, so they've given me time off to go and do those types of things. And the other mechanism which was at the previous university and I haven't really been able to pursue here, but it's becoming a priority within Clear State, is stimulation of the international physical therapy educational students. I've taken two groups of students overseas, one to England and one to Canada—it's on the same continent. I never really expected that when I first started in the academic environment. But it's very

definitely a reason for me to stay involved in the academic arena.

Status and stigma

The status and the stigma. (of being a clinical or professional person in the academic environment) At times, yes it's difficult. It's a difficult marriage at times and it depends on the environment and the institutions you're at. I think in some places it's more difficult than others. I think that one of the main reasons I chose this particular job was because it is accepted more than in a lot of other places. In my previous job I did not feel accepted or that I was on the right track. Unless you fitted in with their rules and regulations and expectations. More than rules and regulations, expectations to at least have the Ph.D. Even though the Ph.D. and the research, pure research, scientific research did not have to be there. The pure research and scientific research did not have to be there. The Ph.D. had to be there.

That role (professional) and identity is so important in your profession, and if you're going to stay an academic you need to have that role and identity. If you're

constantly fighting to be, just for your identity, it detracts from what you should be doing. It makes you feel like you should be doing something else with your time. ... I know that there have been people who tended to go toward that area (the Ph.D.) only because of that reason, because they felt that they had to do it and they had to be involved with it. And they are less than somebody else if you didn't do it (get the Ph.D.). Rather than concentrating on the really important part of your own growth, but also of what you can give to the students and the people around you.

Functioning as a clinician and teaching

I'm able to use a case for the students and give it to them off the top of my head. I hadn't actually prepared it up front but I was able to use that picture that I had in my mind of that patient to cover that situation because I needed to, for that lecture. I hadn't anticipated that I might need that but it was fresh in my mind. So, in a way, the clinical environment gives me preparation time that doesn't have to come from books. I mean every single day I'm seeing these patients. It's not like I've seen this patient ten years ago, or I've never seen this patient type before. Whereas I think some academicians are in that

situation. I've seen a lot of academicians who come from other professions or come from a research background and then decide to do a physical therapy degree because they need to be more marketable and have a professional component to their teaching, or they want to use the health care environment for their research. When they start teaching they do it from the book. So they only have the material that they were taught in the physical therapy program or what they could read up in a book. Plus, the theoretical knowledge. They don't have the practical picture to be able to use with it.

Some of the skills that you develop, for example, I had a question from one of the students yesterday. We were talking about how you re-educate movement. What are the best ways to teach someone how to do a new movement pattern or to change a compensation? He asked what book there was where you could learn those kinds of factors, because he was weight lifting. (The student said) "There are a lot of people around here giving instructions, and they're difficult to understand, is there any way to read up on it." I had to say to him "No, that there is nothing after that gives you the absolutely right way. You have to have to develop that. The more you do it yourself, the more

that you're exposed to other people's teaching, and the more that you try the different methods, the easier it becomes." I think it's the same thing when you're teaching students. If you don't do it yourself on a regular basis, it's very hard to fine tune. Not the base line level, I think when they reach the high level or really being able to keep the students interested in why you are doing this, it (being in the clinic) can make a difference. I don't think it's the only way but for me it has worked very well.

I know a lot of people out there who have come have come from the clinics and gone to academics and moved into traditional academics and they are doing a lot of additional research in their specialist area. They become very knowledgeable and have become extremely well versed with the material in that specialist content. Being in the clinic I probably don't get as much of that. Also, the function that I'm doing as a consultant doesn't allow me really to narrow down my focus absolutely to one area. I'm exposed to anything and everything from neurological conditions to orthopedic conditions to multiple pathology and so that makes it ideal for content that I'm teaching in clinical decision-making. And somewhat in the basic sciences too, and I'm really pleased with the way my

teaching content has developed. I've taught a lot of courses.

I taught a lot at the previous university which, if I had to go back and look for my primary interest area or content area, I've developed more clinical skills and the baseline, underlying material and I think that's partly because of maintaining my clinical involvement then say rather than just doing one type of patient. It allowed me to act as a consultant rather than just providing patient care. It's putting everything together. So that's a component of the split position and where it is in the academic medical center.

Susan
Learning to Teach

Trial and Error

Learning how to teach, this was something I didn't expect when I first started, nobody teaches you how to teach. You're just thrown in and it's trial and error. I don't know if it would have been different if I had taken some education courses as part of my Master's or if the degree was in education. A lot of the time you gleaned bits and pieces from the faculty members around you. But most of it's trial and error and feedback from your students or just the mistakes that you've made. And so I think having to learn yourself in whatever environment it is, is really important...

I've done some teaching workshops. I think I've learned as much from the faculty members around me and from the instructors that taught my Masters courses. I had some senior mentors in the previous university that taught me a lot, two people in particular, and about the methodology as well as the content. The environment that I was in there as a junior faculty member was very good, both from the structural and administrative type aspects to the pure

teaching methodology. The dean was very helpful with some of the methodologies and two of the other senior faculty members helped me a lot. They were people that I co-taught courses with or were of my advanced Master's instructors. It was a very close-knit faculty so people talked about experiences they had and methods they used and what works and what didn't work and I think that that helps.

They would help me with things like, if I was doing a presentation I would get them to sit in on a dry run and they would help with that. They brought you in on academic work, co-authors on projects. Some of the research projects you worked together with the other faculty members.

I've taught a lot of classes. A lot of different classes. It was one of those things that as each program was evolving and they needed more people to teach and things were being moved around and shifted and my role changed. I was moving from PTA to PT to graduate (teaching). I was constantly preparing new courses, taking on new courses, taking on new content, which had pluses and minuses. I mean I would see what had been done before or where it fit in within the curriculum. It meant I was doing a lot of

preparation every time, but I got a much broader sense of the whole curriculum, where everything fit in and how to fit one course with the other. I was also involved in distance education program, a PTA program which I was administering, was at a place about 2-1/2 hours away. So I was responsible for both organizing the courses, getting the instructors from the area, making sure that everything was working and the curriculum development with it. It's all the same PTA program, but because it was on an evening weekend format it had to be fitted in. I had a lot of trial by fire and I was just thrown into it right up front.

Shaping the knowledge

Working with different personalities, working with groups that have different personalities because each group has a different flavor to it. Shaping the knowledge, sometimes anticipating what they do or they don't know. It's all very well having the syllabus and the content laid out, but sometimes just having an anticipation of what the concepts are that they may not understand and emphasizing those concepts. It's something that you can't just put on a piece of paper. Especially when you're teaching movement or you're teaching three-dimensional skills or anything where you can have a one-two-three-four-five list, but it

never explains to you exactly how to teach it effectively. And using the visualization, using demonstrations, using descriptions of how to do it, how to demonstrate it, or how to show a student physically what to do. All the different options that you have to be able to teach the same skill.

I think we usually go back to the way we were taught to start with and then as you develop as a faculty member you start picking up different ways of doing things. Again, take it back to the dancing options, I've had numerous coaches teach in different ways so I've picked up little bits and pieces from them, and when it actually comes to teaching movement in a practical sense. Now that brings up something very different. That is something else that I didn't expect and only really came up as an issue last year.

Carol and I did a personality survey on some of her students. I did not realize that some of the personality traits that our students have are so different from my own. So that what I perceive as being the thinking styles, the learning styles that you need to have to be able to get into the clinic, and things that I value, are sometimes not the personality styles that the students have. It is one

area in the educational realm that I would like to get a lot more knowledge and expertise in is how you best shape your teaching for the different learning styles without necessarily compromising on what you want to achieve at the end.

Well, I had two components (for support). I had the experienced people that I could always go and ask. And then I had people who were going through it at the same time and that helped just to have somebody going through it. You see them making mistakes as well and not feeling quite as bad about it. I think all of that helped.

Expectations of your students

I think sometimes when you come in as a clinician you have higher expectations of your students. You don't really understand where they are in their learning process. I do see that in someone else too, new lab instructors or new instructors coming in. You expect them (the students) to achieve what you know rather than understanding that they don't have the skills and knowledge to be able to give 100%. They're only at 25% or 50%. I think when you base your expectations on your framework there are times when you are closed to other options.

I'm talking about things like specific techniques or specific philosophies in the physical therapy environment where if you've been taught Maitland techniques or you've been taught Cyriax techniques or whatever it happens to be. You teach that set of skills instead of offering options with it. It can be a good thing or it can be a bad thing. I mean it can confuse people terribly if you give them too many options too. But coming to some sort of consensus about what you want to teach and having both the consensus across the faculty members too because if you don't you'll end up confusing them or having conflicts between your classes.

I think something else that comes in to that, especially because when I first started I was 27. I don't think there was one class that I had that I was teaching where there wasn't somebody or quite a few people who were older than me. You are dealing with some of those peer-related issues, so what do you hope for? It's difficult to separate yourself sometimes when you first get in as a faculty member. You still look at yourself as being the same age or in the same environment even if you're in a different role. You don't quite get the objectivity to be able to say (to the students) you need to be able to

achieve this, this and this. You can take things as a little more personally as well.

What else do you hope for from your students? I think there's more of an expectation that everybody in the class is going to achieve what you want them to achieve. And there's a lot more pressure that if somebody is not making it that it's your fault. On the other hand, I think I was a lot stricter when I first started as well. But my expectations were a lot higher. And part of that came from my personal background where our grading system was very different. An A was 75 or above and all our exams were essay-type questions. So there was a lot more room for error. Even in the practical exams I think a fail was 50%.

But there was more room for error and the emphasis in my country's system is that you're there for corrections, not for the achievement, not to see how good you are. I found that a lot of the American students were very much into I've got to get an A. I've had an A, I'm coming with an A average, I need to get an A. They were quibbling about a .5 on this and .5 on that and I just had absolutely no understanding of that whatsoever at that point. It caused me a lot of grief on both my student evaluations and

personally. Before I started bending a little bit. Yes, I did have higher expectations, and I'm not sure whether that was normal for a new faculty member or if it was my previous educational background which caused it.

Teaching is easier

I think things have gotten easier as I've gone on. I don't find teaching difficult now. I don't find the content difficult. I don't find the actual delivery difficult at all. Even the discipline I don't find as difficult as I initially did. I think that was one of the hardest things at the start.

The priority of organization and juggling of the time is probably my most difficult. Just to get everything done. And specifically to get everything the way that you'd like to have it done. I mean you can get it done but it's not always to your own satisfaction because you're running around and trying to get things sorted out. The other thing that I do find difficult in my particular position is that you don't have enough time to be able to; you don't have any fluff time, you don't have any spare time. So if something goes wrong, if you have students who are having difficulty or if you happen to run out of time on a

particular class and you need to schedule another full day, there's very little leeway. You have to be very accurate in your planning out and economical in use of your own time. Other difficulties I think really are more, within our own system right now. We need more faculty members.

There's more teaching and more student-related issues that take the time. And occasionally just administration issues. Things like, we don't have enough clerical support and administrative help. So it's stupid things like filing all the exams and having everything set up for you. If you had a good clerical support system, "I need you to do this for me now." You end up doing that much more. You know, having the computer resources is always feasible and available, but it would be nice just to have somebody there and say "Go and do my copying for me." It's such a waste of time (doing it yourself).

I do find timewise, too, that because of the lack of faculty or the load that you carry, you tend not to be able to prepare as far in advance. And because you're not doing that you can't be as efficient either because if you had sufficient support staff and enough time to prepare ahead then you could be handing off some of the tasks to other

people. But instead you end up doing your copies the day before or just before class and then you end up having to do it instead of sending it to the print shop or getting it to the bookstore and overall it becomes, I think, more costly financially.

I think the other things that suffer are your own academic work. I've been pretty productive over the last couple of years except possibly the last year when my workload really increased. In my case I'm lucky because the clinical portions allowed me to do that here. But now with my productivity expectations increasing that's going to go by the by. I can see that having to be all outside normal hours.

Teaching isn't as difficult

I know the material. I've been through the material enough to know what the important parts are and where they fit within the curriculum. Plus after teaching for three years you think less curriculum, you not only know what everybody else is fitting in, but you know which parts are the parts that the students have difficulty. So you're able to introduce that at the beginning and reinforce it along the

way rather than finding at the end all of a sudden that someone doesn't understand the concept.

I'm teaching far more on concept than I am on material and the more I develop my own teaching skills in that area, teaching how to think and how to problem-solve, the easier it becomes. I think one area that I've developed my own skills in is how the individual personalities of the students affect how they process material and how best to learn the thought processes of the critical thinking skills that they need to have. I also do think that having a clinical involvement really helps me too.

I'm constantly being challenged by the patient treatment to think of different ways of doing things. Problem-solving myself through patient problems. So I don't get stale with what I'm teaching because of being backed up by my own personal experience. I think practically when I'm teaching, and we talked about this before, but I think that my dance has helped that as well.

A learning curve

The fact that I'm in a learning curve (with my dance) and that I'm going through a learning curve myself, I'm going

through the frustrations of not being able to do something or having somebody explain something in a way which doesn't make any sense. It points out the good and the bad and the way I should be teaching. I think all of that has made me a better teacher and it certainly has made me a lot more sympathetic. But my students might not think so.

I think anticipating where your problems are going to be. Being able to start off from the beginning of each semester and putting down a couple of basic rules and sticking to them so that you don't end up having unexpected problems coming up later on. I've eased up on my discipline. I think I used to be too heavy with my discipline.

Perception of the work

My perception of the work itself. I think the teaching portion, I think what my goal is with it, in terms of not my perception of evaluating why I do it or how I do it, but my goal of what I'd like to be doing with my teaching is I would like to be teaching material, but more than teaching just the content I'd like to be teaching students how to think through a process. And mixing everything together with the why's and the how's and the reasons for tests or

for treatment techniques and the reasons for making choices, rather than just delivering content.

I guess that's more a teaching philosophy but that's really what I would like to achieve in the end. Students would be able to grasp or to develop a full process that allows them to take any material, no matter what it is, and apply it to their patient populations with an inquiring mind about why it's happening and then utilize that information to, if they don't have the background knowledge, to find it, put it all together and develop a plan. Then constantly re evaluate at the same time what the results are.

Even though I'm teaching some of the basic course work in the kinesiology courses. I'm trying to build that concept in even at that stage so that when you're looking at the structure of the body. You are thinking about the reasons that it's even developed in that way or how a normal structure can facilitate normal functions and if it deviates from that then it would be a reason for development of pathology, abnormal functions. If I look at my work as such, the whole package is such an integral part I don't think I can really separate out the clinical, the

teaching and the professional development part of it because they play such an important part in each other.

When I'm teaching, in a way I'm developing my own thought processes constantly at the same time that I'm working with students so that enhances my own clinical skills. When I'm in the clinic I'm going through that thought process and I'm able to transfer those thought processes to my teaching. So, the teaching part on an undergraduate level, I feel that I would like to prepare the students to be able to function in the new environment that we're dealing with, which requires a very quick process, which requires an immediacy in development of your skills rather than having to get into the clinic and just build it by experience and time and more just the fact that you've done it for a long time.

Developing into an expert can be enhanced or the speed of which you develop that can be jump started if the preparation work is solid, and there's already the process there rather than having to develop the process. Not just having the solid knowledge placed and not the tertiary thinking skills. In a lot of ways it's like being a coach. It's being able to stand outside the development of

students but also being constantly thinking where they are and what they're doing. I perceive my work as an academician, I think there is a responsibility to be constantly improving your own skills and knowledge base. And that's one of the reasons that I got into this.

Once that the questions are not there, you just function as a clinician. But there's also a time when as a senior you either push more towards administration or leadership in another form and that's not the area that I wanted to go. I like the clinical component with the public, I like functioning as a consultant, and I like doing the difficult cases, and being involved in that process gives me a satisfaction as well. Perhaps because I'm able to work through something itself and have a constant stimulation of finding new answers. Not necessarily new, mostly it's just working through the problem. And by the assisting of others you are constantly reshaping your own skills. And then along with that, the academic environment has provided for the direction or opportunities for growth that were not in the clinical environment.

You are around other people with an inquiring attitude and people who question on a regular basis of what you're

doing, of what you are teaching. You are having a dialogue with other academicians around you so by questioning each other you also question yourself. And that's not done quite as much in the clinic as the academic environment. There are so many other situations that you are put in as an academician the expectations that you are going to perform the classical academic work whether it's research or education. I didn't expect initially to be interested in that area when I started doing it, I really do like it. The end product is very satisfying and the process of doing it is extremely enriching.

Carol
The Collegial Experience

Recruited

My first experience (teaching) was when I was a Master's student and I was a TA for a movement science bio-mechanic course. That was just for one semester and I helped with the labs and just one or two lectures. I worked part-time as a physical therapist and went to school part-time. I was at an acute care hospital doing inpatient and outpatient.

And then Tom talked to me. They really were desperate for faculty up here. He actually had talked to me when I started my Master's degree and tried to hire me then. I had declined at that time because I didn't feel like I knew that much more than the people I would have been teaching. When he talked to me again I was just completing my Master's degree and felt a little more comfortable with that. So he recruited me to a half-time position here. I started out as an adjunct half-time and then after a couple of years that became a regular half-time position.

I would be taking a half-time teaching load and minimal committee work, mostly internal with the department.

The reason I went to grad school is because I knew I didn't know enough. There were some clinical problems that I didn't know the answer to. I wanted to expand my knowledge. I worked at United Cerebral Palsy and while I was there they had some type of team, an athletic team for the clients. I wasn't really participating. I stayed after a couple of nights just to observe. What I observed was strength training and things that were really antithetical to the training I had received about NDT (neurodevelopmental treatment) and things.

It really made me question the training I had as a PT. I kept saying to myself, no, (the strength training) this is going to increase their spasticity and not knowing even how to go about getting information. It really stimulated me to go back to grad school and find out more. So that is the reason why I went back. I figured in order to serve patients I needed more education.

I found, as I was going to school, I found academic life very interesting and at the same time I found some aspects of PT practice rather repetitive. I really enjoyed being intellectually stimulated and challenged. I think if I had been in a more challenging clinical setting I might not

have felt the disparity so much. But I wasn't in a real challenging clinical setting and so I didn't feel challenged there and I did in academe. So, it wasn't an issue I struggled with. It just kind of flowed naturally. To just try it out and continue.

Looking ahead career-wise, I figured I could either go into more administrative work in the clinic or go into education. I really didn't have that much interest in administration in the clinic. I wanted to try out academia as a real potential career. So at the same time I took the position I started my Ph.D. I knew I was going to go on. Even though I wasn't absolutely sure when I started my Ph.D. that I would go on in academia, I knew I still wanted that knowledge base.

In terms of expectations I really needed to see if it was right for me. I anticipated it would be a good fit, but I wasn't totally sure. And I needed a job. Tom said they really needed somebody. Tom's philosophy at the time, which has changed, was that any PT could teach any course. I think he's changed his tune more recently. He made me feel comfortable that I could actually teach and benefit the

students. It certainly wasn't the salary that attracted me. Or the working hours.

I come from a family of educators and I always had that background. I was trying to build the future and provide education for others. I also get excited about research and I knew that would fit there. I really like to learn things. And to me working in the field of education allows you the opportunity or the indulgence of continual learning as a component of your job and I don't think that that time is always available in other settings.

Hired on

When I was hired on we did our teaching loads differently. The teaching load I had half-time is equivalent to what I currently have full time. I was teaching a lot. Before we used to divide teaching hours based on number of courses you taught. Now we teach it divided based on contact hours. It just happened I was teaching heavy contact hour courses. So while there was flexibility in the hours, there were just a lot of hours. Trying to do it with the Ph.D. work was difficult.

I gradually over the years increased to a three-quarter-time position and then when a tenure track position became available I applied for it before I had my Ph.D. in hand. I received that position and at that point the expectation was definitely that I get my Ph.D. done. They were able to give me that position without the clock starting. So I was a lecturer cum assistant professor which just meant that once I got my Ph.D. the clock started. I really enjoyed it from the start so I don't think there was ever a doubt in my mind after that first year that that wasn't what I wanted to do.

I think, and this is true, as I've observed other faculty come on, that you (initially) think of academic life as teaching and maybe a meeting here or there. You don't realize all the administrative functions that go on. You don't realize what it takes to pull a curriculum together, how to manage students, the stressors and time involved in doing that. You just have no concept of faculty governance in terms of the committee load. I think the other thing, at least here, as people progress to be more senior; there's much more responsibility in terms of guiding student research. That was another big component I hadn't foreseen as much.

Learn the ropes

I was real young age-wise. I was only 27. Which meant I had students older than me in the classroom and I was just really young age-wise. One of the struggles I faced, and therefore, one of my hopes to overcome was to deal with that. It just took time for me to learn the role of the teacher versus being a colleague. And even though we work in a collegial model there still has to be some separation. I found it more difficult at that age because I was the same age as the students. That was difficult to deal with. Now I'm older so it doesn't matter. It took a couple of years to get comfortable with that and learn the ropes in terms of separating. You know, being a mentor to students and being a buddy to students. I have a much clearer view of that now.

I don't try to socialize with students. I really think while I want to be supportive and friendly, in our collegial model you get to know students really well, you're still a faculty member and you have those responsibilities. If you start socializing out of the classroom with students it's hard to do some of the things you need to do as a faculty member. When I first became a faculty member students would invite me to parties and

things like that. While I never went, I considered going. Now I would never consider going. Although I do have relationships with some of my students after they graduate which has been very rewarding. It's a fine line and I feel more comfortable now than I did back then.

In a clinic you get a lot of positive feedback. In academia you don't. Especially that first year. Your first year I don't think is ever your best year because you're working against time to get your lectures done and everything else. So some of the criticism is probably well deserved, but also you get very little positive. And when you're used to it on a daily basis, I found that very difficult. So that was difficult.

I only got four hours of sleep at night that year. I was taking two or three courses a semester and then teaching. Well, it was half-time but like I said, what we would now consider a full-time load. It was just extremely difficult. The course preparation primarily (was time consuming). I was on a limited number of committees that really didn't involve too much time. There were faculty meetings and things, but really it was the course load, developing it.

The carpool

Commuting with the carpool. The carpool was Tom, Roger at that time. No, Roger wasn't here my first year, he came after that. Lisa, maybe it was Roger. Anyway, the carpool was an educational system. I really got an orientation to faculty life through that. And to the collegial model. I had a place to ask questions because we spent an hour back and forth everyday. We couldn't always commute together. But that was a wonderful education for new faculty (who commuted).

It's a positive environment to work in. It's an enjoyable place to work. If you're running into trouble there is always somebody to talk to. I think I mentioned before they have workshops for teaching and learning. I went to a couple of those my first year or two here and they were helpful. So there were resources around to help on the teaching side. And faculty volunteered to come in and sit in on your class if you needed feedback.

The elements of good teaching and engaging students in critical thinking are still central to what I want to do teaching-wise. Another component that I've added to teaching is that I want to make my students good

communicators both orally and in writing, and that's become an element of all my courses. So those are kind of teaching things. Another component, I don't know if you would call it teaching or whatever is helping students develop as professionals, as having good behaviors, professional behaviors. It's certainly another student expectation I've added and tried to facilitate.

When I came on I did not (have expectations for research) because I was hired purely for teaching and that was the expectation the department had of me at that time. That's changed. But at that time there was no expectation I would do research. Even our student research wasn't quite as developed as it is now. There wasn't even an expectation that I would really participate in student research.

When I first came on research wasn't part of my thing. I was doing that as part of my dissertation. I saw that as separate or part of my doctoral work when I came on. I have a lot of research connections in terms of people who are NIH funded and things, and I am a consultant on a NIH grant. Even a few years ago when I was heavy into my dissertation things I thought of myself as going on and applying for a NIH grant. In the last year, since I have

my Ph.D., I really have begun to reassess what I want to do. I have some administrative goals that I haven't addressed yet which would not be consistent with going after an NIH grant time-wise.

But I really enjoy doing research and I need that stimulation. So I look at research more as going after some grants, but much smaller, maybe just some foundations and things. I think sometimes faculty members go after these huge grants and get so wrapped in getting the grants they forget about the purpose of their research. To me the purpose of research in physical therapy is to help the patients out there. I think you can do that without \$500,000. And so I have a line of research that I've developed and I'm continuing to develop, and I'd like to keep pursuing that.

I've been involving students in that because it's a nice match to get them research experience in a meaningful research project. It also helps me because then I don't have to do all the data collecting. It's been a really nice match. So I guess my research aim has been brought down, I don't think in terms of the quality of the research but in terms of going out for the big funding.

But I have discovered by getting forced onto committees and things university-wise in the last few years that I really do have some talent in that area (administrative) and that I can serve the department well by doing that. So, that's a very much more recent goal or hope that I have and so my hope now is to learn more, developing better skills so that when the time comes then I'll be able to take on that (administrative) challenge. The committee work has been helpful in helping me discover my skills. It has also given me some stature in the university so that when that happens (taking on a more administrative role) nobody's going to talk.

The other thing in terms of hopes and goals, before I always just thought of the PT department in terms of hopes and goals, but serving on the university-wide committees I have been pushing for more university-wide gain. For instance, I'm the chair of the distance education task force this year, which is just a task force with a specific task, that is a short-lived task force hopefully. But really, in terms of seeing my role and my hopes, I see them beyond the department now. I look at the health of the university and what we need to succeed at the university. It will directly benefit PT because we have some internal

departmental goals related to distance learning. But I guess I see my role and hope to serve not only my department, but also the university. I think the other hope in the faculty position at this point is to be able to serve the profession through some work with APTA sections and that type of thing. I've always had an interest in promoting research in the state and I've done some work on that. And in promoting research, I just got on a research committee for an APTA section.

I swore I'd never go into education. My father was an educational administrator; my mother was a librarian for a school system. And they would come home and talk about education and administrative issues, and so I swore I would never go into education. That's why I went into the medical field. But I don't think you can deny who you are.

I also had no intention to go in any administrative direction either. Oh well. I think the values of education were instilled in me. And the values of serving. And serving in a public institution was certainly part of my upbringing.

The collegial model

Yes, (my Ph.D. is) in movement science. The education (in my Ph.D. program) was very different in terms of orientation to education, and not one that I appreciate or value. I think that's why it was important to have, how do I say this? I think that if I had not had an experience in physical therapy teaching, where there really is a concern about the student, and trying to provide top quality education, ... I think if I had not had that experience, I may not have continued with grad school. I may not have ended up in PT education or education at all because I was very disillusioned.

My department that I got my degree in was very poorly run and not student-centered at all. I knew there were other departments where it was better. But it was, in terms of providing an experience that would make people want to go into education at that level, it was not an experience that would promote that.

It (getting the Ph.D.) really helped me develop critical thinking. I think that was the central part. In terms of research skills, I gained maybe half of those in movement science and half up here on the job. Certainly in terms of

content, I feel very comfortable in my content area and so it gave me that knowledge base. I think educationally, you can make a sound educational program. It's just that the experience in terms of learning about academe and how to be a good professor and things, I would not look back on my department that I came out of (in graduate school) as a model or as a motivator for that.

Really all the faculty here (stimulated an interest in education) because we work so closely together. Janice took me on. Lisa helped over the years. Karen Hall. Probably those four would be the key people. You know, in terms of going into education it wouldn't be anybody external to this department.

I think that my values, in terms of my personal values, are very consistent with the collegial model that we have here. There's a real sense of caring for students and for not only their academic development but also their professional and social development. Part of the mentoring was all the discussions we have about those issues with our faculty. Being able to see those issues more clearly and how some of those core concepts get translated to how you work in a classroom and interact with a student I think.

There were specific mentoring things on how you might teach a class, tips here and there and those types of things, but I think the real mentoring comes around at the faculty table or in private discussions where you talk about how you develop these things in students. We can all teach. Well, not everybody can teach effectively, but if you have the basic skills for teaching you can teach.

But in order to engage students or develop those other things I think it has to be consistent with how you view the world. And then if it is consistent then the mentoring is just, "Okay, how can we get this to work in this specific case?" and develop skills in the students and so on. That's the kind of mentoring that I value. Because the other can come from lots of different people, how to put an overhead up and so forth, you can get that from anywhere.

Respecting students as humans and as colleagues (is the collegial model). Then figuring how to make them good PTs. An outsider could probably see it (the collegial model) better than I do because I might be used to it.

I think that was collegial

This semester I'm teaching a research course and I have a student group. They have to do presentations. They have to prepare a literature review and present it in the class. I really push them to have this be the literature review that will be the start of the proposal for their research, so they don't have to do it again. I had a student group in this class that really hit zero. There was no research on their topic and it didn't look very productive.

They finally came to this conclusion a week before they were supposed to present their research. I look at it, instead of just being a course in which they receive a grade, I look at it as trying to help them develop their learning and help facilitate them through the research process. I said to them in late February, because we started presenting in March, I told them that it was alright with me to present the last day of class, which was the last week. All we had to do was ask their fellow students if they would stay late after class for half an hour on the last day of class so that we could have them present.

They did that, and I think that was collegial on my part to them, because I understood where they were at and that they needed time. It was also collegial on the part of their fellow students because there was not one complaint from a student about having to spend an extra half-hour in class on the last day of classes. In fact, they were all very attentive and supportive.

Other (collegial) times have been when students had difficulty. We've had some students who've had difficulty in terms of their social behavior. If we observe something inappropriate in the classroom I've taken that student aside and worked with them. In another classroom setting that might just slip by or the student might not be held accountable. But part of that collegial model is responsibility and that responsibility comes from students and it also comes from faculty.

A year or two ago we had a student who was really having social problems. One thing you don't want is to graduate somebody who is going to have these same problems out in the clinic if you think it will disrupt patients' treatment. And we had a student where we thought that would be a problem. I happened to be the student's

advisor. It was my role in this kind of (collegial) model to work with this student, address the issues, invite her to go into therapy or do something to try to change the behavior. And when she refused, to try to get her, to counsel her out of the program. That's just a responsibility. That's part of the collegial model that you would never see in a department like movement science or some other department.

But in that process there was also a mentoring. I was the person responsible but I had Tom, who's a counselor, and everybody else's support and help in working with that student. And certainly Marcia as director has played a big role too. There's a very supportive environment here.

A very good fit

I think that there isn't a better job in the world for me. It's a very good fit because it's a job where you're continuously learning and continuously challenged. I've found that very rewarding.

I feel good about it. I think, I wish I had more time to dedicate to the teaching aspect of it because there are some things that I would like to do and to experiment with

in terms of teaching modalities and some technology, just revisions in course structure, that type of thing. They take time to develop and I wish I had more of that to devote to the teaching. The administrative part is good and I happen to enjoy that. But I really enjoy the teaching part too. I kind of resent sometimes when the administrative part takes so much time that I can't do what I feel I should be doing, teaching and learning.

Teach students how to critically think (is the most important work I do). For example when I teach about balance, testing or training, I have a logarithm thing that I go through that I've developed to give them a thinking framework. Sometimes it's not a logarithm. Sometimes it's more a series of questions they need to ask themselves or ask the patients or something so they can work through a problem and try to analyze it as a problem instead of taking the easiest way out in saying, "Oh, this person has low back pain that must be x so I'll treat with y ." Really to develop them as problem solvers, investigators.

My primary line of research is something that nobody else is researching right now in physical therapy, and I think it's something that physical therapists have kind of

forgotten. I feel good about that. I know sometimes on research you can kind of go with the fad and I figure other people are doing that. I'm going to do what I think needs to be done and to be beneficial to patients as well. I feel good about that.

I'm looking at proprioception and whether improving proprioception will then improve motor function. Because most of the therapeutic approaches to improving motor function don't really pay attention to trying to improve the sensory side of things. Or if they do say something about the sensory side, it's giving sensory input but not necessarily looking at sensory learning, which is different than just providing sensory feedback or input.

I think in the generic sense, I think that I'm good at facilitating communications and so that's something I feel good about generically across of all the committees I work on. And also getting things achieved. In a university setting sometimes there are committees where nothing ever gets done and it drives me nuts. So I bring a task-oriented approach to try and get things done within the university, which is sometimes difficult, but it is possible. In terms of what I feel good about in a more

specific sense, I've been working on this distance learning stuff very intensely this past year. Even before that, trying to push for somebody to deal with it on the campus and something is finally starting to happen. It's kind of nice to see something come from all that really intense and very controversial work.

I'm a solid faculty member. I don't know. I'm a good teacher. I'm trustworthy in terms of being responsible with committee work. I contribute in terms of research advising and all of that. I don't think any one thing stands out above the rest, but I think just being a well-rounded contributor to the faculty with a vested interest in the future of the faculty.

Watching them (the students) walk across the stage when they graduate (is satisfying). Other than that obvious one, I find it real satisfying more in one-on-one contacts with students where you sit down, you explain something to them and they "Oh", you see the light go on for them and they finally understand something. Even if a student might not be your brightest student, but somebody who has been struggling with an idea; if you can describe it for them in a different way or do something that makes it click, I find

that very satisfying. I put a lot of work into those students and look, they're all graduating and they look great. They're going to be successful. It's just a good feeling.

Delayed gratification. (comparison of satisfaction as a clinician to academician) It takes three years to get there. It's just, I think that the rewards are far between compared to clinical experiences. I think the level of satisfaction perhaps, I don't know. I tend to look at life pretty positively so, I wouldn't say one is better than the other. They're both good.

The way that the position can monopolize your private time (is what is difficult). I'm raising a family and my value systems are, my preference would be to work part-time and spend the rest of the time home with my kids. Given my personal circumstances that just isn't going to be the way it is. And professionally that wouldn't be all that wonderful. But I would rather spend more time home with my kids.

The work load and in part the overall work load, the committee work and things (overflow into homelife). The

teaching load isn't too bad but the committee work, if you have a sense of responsibility about that it, means it takes time. But then the other part is just the distribution of the workload. Because when you're in class teaching 18-20 hours one semester and then one hour the next semester, you know you just have to work every weekend when you're in class so much. If the distribution were more even it would help.

I think getting my Ph.D. (was a key event and) made a difference in terms of the expectations by the faculty. In terms of being expected to do certain committee work, take on more responsibility. In terms of other significant factors, I think, too, I had been working part-time for awhile and going up to full time(work)made a difference. When you're physically present you get more work because you get the students who need a letter of recommendation written right away. You get, just that extra stuff that happens when you're around and somebody else isn't. There is more of a sense of ownership with it went I went full-time; the department, the curriculum.

Certainly there has been a lot of mentoring that was absolutely crucial to my development (and has been

meaningful). I road in the carpool for four years and became educated about professional and scholarly life by my senior faculty. When I came on there wasn't a formal mentoring system like they have now, but certainly there was an informal system. And there remains an informal system now. I still go to Tom or Marcia, our senior faculty, when I have all this committee work and stuff that I've been doing on campus. There are political issues that are just new to me. I go to them for input and mentoring on those. In terms of forming a philosophy about teaching and being a faculty member that is probably the single most important factor in this department, probably for any of us, the mentoring.

The being somewhat flexible in time so I can go on a weekday afternoon to help in my kids' class (is a reward). If I were in the clinic I wouldn't necessarily be able to do that. You have contacts in the community and I've been invited to be on some advisory boards that I wouldn't otherwise probably have had the opportunity to do, and I enjoy those kinds of service to the community. You get to set your own schedule. I don't know if these are rewards or just that I would list them as advantages.

My life's work is...

It has nothing to do with my job. My life's work is to make this world a better place for children to live. Indirectly (it's related to academic work) because you have to provide a good environment for the students. I happen to teach our development course. We were talking about social responsibility and things within that context. And certainly I teach some of the pediatric content in terms of treatment and certain things so that would affect children. But in my life I am a Christian first and a PT faculty member second. I see my responsibilities in that order. And Sunday school teacher and I do that kind of stuff. That's how I value myself in the work.

I think of working with children more as a life's work, but if I were to broaden it out and just think about quality of life for people, absolutely (my values are reflected in my work as an academic faculty). That's one of the reasons I've been involved in trying to recruit minorities in our department. In the many times we have student issues come before us my value system is to look back and say what's good and right for this individual independent of what's good and right for the institution. And while you have to be mindful of the institution, everybody has to make that

choice sometimes, you do what's right for the institution or you do what's right for the individual and I would tend to side with the individual. I think that certainly my personal value system has affected decisions I've made, how I vote in faculty meetings.

My value system is much more consistent with this department and how it operates. It was not consistent with the department in which I got my Ph.D. I would easily leave (if there wasn't consistency between my personal value system and the value system here).

I think (I would like to be remembered) as someone who made students think, going back to the critical thinking. So that would be how I would like to be remembered by students. I guess it's still my hope that they (the students) would learn how to think. I think sometimes, it's even more a problem today than back in the '80s when I started teaching, that you can get information overload. In terms of developing my teaching style I really wanted to be able to develop students' ability to critically think. To try to give them a frame work on which they can hang information.

And (remembered) by faculty I think two things. One thing I feel good about is that I have really been able to bring in my area of expertise in movement science and integrate it into our curriculum because I have that background and nobody else on our faculty does. So I think that's a good thing. Students wouldn't know that because they don't know what the old was but faculty would.

But then (remembered) in terms of the faculty for providing leadership. So I'm assuming that would be after I've assumed a more administrative role. Certainly right now I do provide some leadership in terms of chairing some of the key committees or task forces in the department and trying to formulate things in terms of when problems arise with students and things. So that would be maybe now than more in the future. I think (I would like to be remembered by colleagues) as somebody who speaks honestly and is interested in the best interest of the university as a whole and not just my department.

After I go up for tenure and I am successful I anticipate that the same year I will (take on a more administrative role). I think that will be a challenging time for our department. We will hopefully have launched a Ph.D.

program and opened a health center. There's going to have to be some reshuffling in the department; really work on the value system to see with all these new endeavors, how we can make (the value system work). I am interested in maintaining the current value system but I think it will be more of a challenge in the future. There should be some departmental growth and we're looking at the whole issue of clinical faculty versus academic faculty. Trying to keep that all in mind, I think that's going to be a real challenge. And just working in an environment of physical therapy, I think we've kind of come to the end of the golden years in physical therapy in some regards. Leading a department in an era when it's declined from the golden years I think it's more of a challenge.

I think the larger you get, the harder it is because you really have to know your colleagues well. You have to be able to work together and, just like calling a committee meeting, the more people you get the harder it is to call a meeting. So I don't know how much longer we are going to be able to have faculty meetings; meetings that are mandatory for everyone. It really is an integral part of making the collegial model work (and I hope they will continue).

I have a dream, I don't know if it's reasonable or not. Because I've been so involved in distance learning things on campus, I would like to offer a distance learning class to other PT schools in the area of development or human growth and development; something that other schools need and where we have a nationwide faculty shortage it might be beneficial to other schools to do something like that. I was thinking of calling Jody Gandy to see what she thought about it, but that's something I might want to play with. I guess in terms of goals it's just to keep current, in terms of content and to constantly change. In terms of teaching format to keep experimenting with new things. I don't want to get in a rut.

Don't go into teaching unless you want to. It's nothing you go into for the pay or the hours. It's something you have to be really committed to do.

I think people who even teach a lecture have no concept of what being a faculty member is. Those who teach a class have a little bit better concept of a teaching workload but they still don't understand the other aspects of being a faculty member. I think you could understand if you got on part-time or something where you had some of the other

responsibilities or sat in on faculty meetings. I think that departments that have faculty meetings, at least in this department, it is key to understanding what a faculty position is.

In our faculty meetings that's where we discuss student performance and student behavioral issues, and all of those things that students would not know that goes on. We keep track in that way and it also helps in terms of getting the bigger picture. We're having accreditation going on and you're seeing all the work involved in that. And things around faculty governance, when issues come up where we need to make recommendations to what our code should be for our school, for developing a new code. Sometimes that goes down from faculty to department to make decisions on it. Just all the politics. How should you approach something? If you want to get something done in the university you have discussions about, "Well is it appropriate for the department? Or should we do this or that." There's a lot of education that goes on and you really see the complexity of the faculty role. The bigger picture.

Mark
Special Populations

Twenty years ago

My Ph.D. (in exercise physiology) was obtained almost 20 years ago. I finished in 1981 but I started that work in 1976 and went for a couple of years, 1976 through 1978. I did course work, got the dissertation topic approved, collected some data and then I got a job because we had our first child in 1977. In 1978 through 1980 I was just working on the writing of the dissertation and then in 1980 I defended it. In late 1980 and 1981 was granted the degree.

The first one (job) was at, actually two spots. I was at South State University for one year and then I spent two years at West State. So it was a three-year junior faculty status I guess you'd call it. I didn't have a doctorate; I was ABD so to speak. And my roles in either department were pretty much teaching. At South State I had to do a clinical role as well as an academic role. The academic role was teaching. I had one activity course in the physical education department. I also had a more didactic course and I think it was the pediatric adolescent years, which is ironic for me because I really don't do much of

that now. I kind of traced the development and looked at development activity-wise with the students. ... I had a fair amount of a load because I was young and they pile a lot on people who are not on a tenure track and I wasn't because I didn't have a doctorate. I was writing up my data.

A 30% appointment

And then I went ahead through a lot of clinical jobs through 1981, actually in 1980 I took a job in Town ... I had defended the dissertation at that point but I got the degree early in 1981. I was in Town, at that time I was at the Hospital. And that was strictly a clinical role with their cardiac rehab (department) developing kind of a sports medicine emphasis, which was really my first connection with PT. If I trace it back, that would be it. In 1982 I worked with a physical therapist at the Hospital who is still there doing some of the same things, ... And I started to develop a sports medicine (program) with him and a physician. And that went on until late '82. In '82 I was contacted by the head of the PT Department, which had just formed with the College. Bill was the chairperson at that point; he started in '81. ... You know that cardiopulmonary course is usually later on in the (course) sequence. Well, it was second year students. And he wanted

to know if I wanted to help with it, they had a faculty member (Kate) who was a PT who would do the main part of the cardiopulmonary aspects. I would conduct the exercise portion of that because she didn't feel she had the expertise in that. So we team-taught that. And then we're onto 1987-88 we team-taught that.

Kate is chairperson right now. I guess I did a decent job (teaching cardiopulmonary) so Bill said you can put together a 30% appointment. I dropped back a little bit from the Hospital to 30% of that so-called 100%. By then it wasn't just cardiopulmonary. I did the research methods, just one research course which now we have three. I know we have at least two here. The third job I had at the College was (helping) students conducting independent study, actually carry it through ... And that went on until '87, and then I didn't teach in '88 or the rest of '89. Mary came in as chairperson of the (Physical Therapy) department of the College. ...

A PT student

The faculty at that point, it was '87 or '88, four or five of them (the faculty) simply said, "You know, you're a member of our department, you're a nice guy, but we don't

think you should be a (PT) student (here). You know, being a teacher if you're a student. There's going to be a conflict. And plus you should go full time (to PT school)." There were really two arguments that they had. And I guess I can't argue with the former, the latter going full time... I suppose I should have been full time (going to school as a physical therapy student). ...

So Mary came in '89. But Mary's attitude was, "Gee, we're in the late 80's, we need more doctoral people, you've been teaching in this department for several years, you know the curriculum." And I did for the most part. She said, "You don't have a license. You haven't gone through the other components of the curriculum. How would you like to do that?" I said, "Hey, that's what I've been wanting to do. Let's put a plan together." And we did. And it worked as long as she (Mary) was there but she left about '91. She had some problems with trying to get too much done too quickly. And there was some resistance. And those resistant people kind of ganged up and said, "You better go." and that was that. Maybe that is a tactful way of saying what happened and she left.

Anyway, I had some courses at that point. And I was going to continue but now with some of the same faculty, Bill was gone, Jay was gone, Matt was gone, and some of the other (faculty) said, "This is not a good idea." (going through the program while being a faculty member). And basically wanted me to take courses that I had taught like research methods and cardiopulmonary and I was against that. I thought that was kind of a waste of my time. The person teaching research methods said you (Mark) should go to the library for a tour. And so anyway to make that story short we had a parting of the ways and I was going to just drop out and not continue with it (PT school).

(Mark went to another physical therapy program, was able to go part time and to complete a Master's in Physical Therapy. He discusses his conversation with Susan, the program director at the school where he was able to complete the Physical Therapy degree.)

I think... that Susan thought that it (his career as a physical therapist) would be more academic related because I think her idea was 'Yes, we do what we can. If you want to do it part-time and if you've taken research, which I'm sure, did tie in, we would do something with that.' She did

a lot in that (research) area. Her attitude was we'll do this because you have a Ph.D. already in an area somewhat related. Therefore, you would be an asset to the profession. She stopped at that, I think the next word might have been academic application. What's the word I'm looking for, academic application more than a clinical application.

Gold University

What occurred is that Don was a former student back in the '80s who has now been out 12 years as a PT, really is well-respected and orthopedically as a PT in Town. Don had mentioned to the chairperson (Cheryl Church of the Gold University Physical Therapy Program)... that there was a guy who had done that (taught a cardiopulmonary course). Cheryl Church, the chairperson, contacted me and said, "Would you like to do this (teach the cardiopulmonary course) for the summer of '96?" and I said, "Sure!". Somehow she didn't know that I was just finishing up with (my physical therapy degree). I mentioned it to Don and Cheryl said, "I heard you also have a Ph.D. degree and almost have a PT degree." I said, "Yes". She said, "We have some other courses, and we have a faculty position open too this fall, fall of '96, would you like to consider that?" and I said, "Okay". So

that's how that evolved. It was kind of like she (Cheryl) presented it was just that one course they wanted but then the faculty position of course got into a whole bunch (of courses); a couple of eval courses, electro course, problems course, cardiopulmonary course...

It was really a lot of courses. More than what I wanted at my age ... I was on a tenure track for associate professor. And they gave me that more so because of the Ph.D. Some of the things that I'd done were relevant to physical therapy - cardiopulmonary research, but not obviously so much on electro or physical agents.

Fine University

A student of mine, he's now a physician, a physiatrist over at the Clinical Site, and another physician, Rick; both of them had been at the College back in the late '80s, early '90s. When they came up here they kind of lobbied for me to come up when I told them I wasn't satisfied where I was (at Gold University). And Lisa Toth (one of the Fine University faculty members), she had at least one course (that I had taught) and I made an impression on Lisa. She liked me in the course. Or maybe she had an ulterior motive. I just found out an hour ago, because she's

working on her doctorate, that she wanted me to be on her committee.

She's been working with me this summer. She likes the area we're dealing with immune function, cardiopulmonary tie-ins, physiology with spinal cord injury, and she wants to pursue that. But anyway, Lisa was responsible for that, so she told me about the position and she admitted that she was kind of the indirect, behind-the-scenes recruiter. John (the chairperson of the PT Department at Fine University) wanted to talk with me and (he asked) "Would I be interested?", and I said "Sure". This was over a year ago I'd say late '97. I had only been a little over a year at Gold U. but I could see by the end of the first year it was just too much teaching. That's basically why I left there (Gold U.) and came here, the teaching load was much more manageable. And secondarily, just professional contacts.

Leaving Gold University

What I liked about Fine was that I could teach the things that I felt good with and I knew a lot about, whether it was because of my former background or my more recent background since (completing the physical therapy program). The (faculty) here, they're good about that. They said they

want me to do research and do that for the department. At Gold it was strictly a teaching curriculum, not a research curriculum, and therefore teach as much as you can, and I did. And that was okay. I guess in a way that year or two, actually two years down there was good because I was just a new PT and sometimes to get immersed in a curriculum you become better at it whether you want to or not, or whether you're interested or not because you want to stay ahead of the students at least ...

The other part of it I suppose was I was hoping to do some writing and I was going to do it, but they (Gold University) obviously weren't requiring that. I still have data from when I had a grant (earlier) and I'm still publishing some of that. So I was going to write up some of that. So it wasn't so much collecting the data as just having some time to write it; other than midnight or one in the morning, which I had done that when I was younger, and my wife would say, "It would be good if you'd come to bed once in awhile." So at any rate, so I just did it (write) during the day and didn't have enough time to do any of that or even Sundays or evenings to write. There were so many things we teachers had to do.

I really had little or no time because I was just a new PT anyway and I really had to get into these courses. Whereas some other person, maybe a senior PT who was coming to academia from some clinical aspect wouldn't have to prepare quite as much, but I did. So I lost a lot of time preparing and sort of more preparation time, not as much writing time.

Of course, that made me feel not as good as I wanted to feel self-esteem wise. Because you sort of attach certain parts of yourself to what you're doing. You're not doing those for a couple of years and that could have an impact. And I wasn't being asked to talk anymore to different groups... I was just teaching period. There was so much course work that had to be done. That was about the extent of it.

I was doing, as I said, some clinical work. I had eight hours. I usually saw patients. I did eight hours at a hospital and I did a few hours with some cardiopulmonary patients. So I was doing that and that was nice, but there was an aspect missing.

Hopes at Fine State

We had talked really since '97 with Lisa, John and others and I really felt comfortable with everyone here. I really was kind of like, well they know me, I know them and I knew people at the Clinical Site. Where at Gold I didn't know anyone, Don kind of pulled me down there. So I knew everybody here for the most part and not down there. So my hopes and expectations were almost one, that I expected that I would not teach a lot but would be required to get a research program going and some grants and such. And that's what it's been; it's all kind of jived nicely. As a matter of fact, I've said to my wife several times it's one of the best jobs I've had as far as people sticking to their word. We agreed on these goals and objectives a year ago and they've just kind of flowed the last year.

At Fine State

I teach and do research. Those are the two main areas. I have the primary responsibility as a course instructor and coordinator, (for one course on) health promotion and problem prevention, which is kind of like an advanced therapeutic exercise course. The other course is just called therapeutic exercise, which is supposed to be a basic exercise therapeutic course. Those are the two

primary ones. The other ones I've been assisting in have been cardiopulmonary, with helping Lisa do some labs; and also in electrotherapy, helping with some labs and a couple lectures. And the third course I've helped a little bit in has been Tim's course, and I believe that's called clinical decision making two. And then I've helped a little bit with the basic Intro course to PT,

The two primary clinical groups that I've been researching are with the spinal cord area and the traumatic brain injury area. And presently we've got about three or four different studies in the spinal cord area. The first one really is in two parts, it's looking at the effects of a drug, at rest and during exercise. It's really two separate studies on the same drug. And the second spinal cord area of research has been the immune function, and that one's just about ready to go. The third spinal cord research topic area has been ongoing the last few weeks. It's looking at the relationship of aerobic capacity with the functional independence measure. And the traumatic brain injury we are at creating norms for folks who are probably Rancho Los Amigos five or six. They're there but they're not too agitated. They are not too confused but they need a little bit of motivation and probably directions being

spelled out very closely and precisely so that, that has been going on too, the last few weeks.

I present things well

I think I present things well to groups of people that have an interest but not a great understanding of the area. I do well talking to groups whether they're nursing groups, perhaps from an understanding of say spinal cord injury complications... I've done that for recreational therapists who need some advice on therapy exercise. I wouldn't call that teaching as much as maybe information proliferation; to the extent that it's understandable and they can use it, at least a couple points of it, and take it back to their respective patients or centers. I guess I did a fair amount in the '80s when I was on a consultant basis with a group in Washington. ...

I would fly around every other weekend, at least in the summer, the entire weekend. It was six weekends in the summer. I did some of that and I enjoyed that. It differed from teaching because you're not evaluating their performance, which I've always struggled with. I've struggled with; Am I really evaluating what the objectives say I should? Am I evaluating my teaching or their

learning? I've always struggled with that; Do I have the right questions? Are they worded correctly? So, I didn't have to do any of that when I've done some of these things (speaking to groups) over the years.

And so they come up with their feedback after you're done talking... and that has been rewarding. I think working with patients, I'm going into a second area that I enjoy, or subjects getting back to doing some of the benchmark testing or bench testing. Because most of these people are really interested. As a matter of fact, some are coming in and not getting paid... you can see they're really enjoying it or they're picking up and absorbing what's going on.

I guess presenting the findings, that has to be number one (in terms of being rewarding), but where I don't have to try to test it, put it in a syllabus, score it. I did so much of it the two years I was at Gold University. We had short courses so it seems like every other week we were testing. Testing, writing tests, testing.

I have a few degrees and I've been through an educational component of how to do all that (testing). But still, it was many years ago. I bet still today that there really

isn't a formula yet where you could put one test together and feel totally good; well here's a test that I know of and it's exactly what you should have in class. And I think everyone wrestles with that. I think if you don't you're probably not evaluating yourself as critically as you should when you teach a course.

Special Populations

I really feel (what I have to offer) it's what I bring forth in the special population's area and the research I have done and want to continue doing after being off for a few years with it. Bringing that back, because like I mentioned a few minutes ago, I think they could find somebody else to do some of the teaching I'm doing. And in basic therapeutic exercise you're not going to bring in a lot of that special population type of angle. But in the other course, the one in the fall, I have brought that in and will probably bring in a little bit more. But irregardless of the two courses, my claim to fame so to speak here has been some of the special population's interest I bring and expertise. I think that's what my main contribution is thus far. It would be nice to say there's some money involved too, (in terms of bringing in

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grant dollars) although that's looking better now. That one grant I think is about 99% approved by NIH.

Most important work

Probably, I could go two routes bringing any awareness that leads, and hopefully more independence, awareness, independence and self-sufficiency; maybe throw those terms in for individuals who've had some of the things we've been talking about, chronic illnesses and diseases. And then somewhere too, in terms of training or helping assisting with the training of students and faculty to provide some of the same services and care for some of the individuals. Even though some of that has been research or has been clinical, it's still been people involved. There's been, I believe, some benefits obtained by some of the people or at least they say there is. They've told me, whether the study is concluding or whether they've told me a year later, they've enjoyed it. So I think there's that awareness and independence that these individuals thought, this is neat, I got something out of this, I know how to do this myself and I can do this better now and I know why. ...

Most satisfying

I guess really (most satisfying) it would be students who come back and say I really got a lot out of helping you with that... And of course those that helped you with studies and have gone on and done well in their own right as far as publishing things. Whether it's just something that's non peer-reviewed or a peer-reviewed publication, I really enjoy seeing that.

For instance, Skip Todd, who's done a lot of work, more than me at this point, used to be a student of mine in the mid '80s. He was a student in the sense I helped him with his clinicals, I was his clinical instructor in exercise physiology back in Town. He was at the University at the time, working on his doctorate and he got hooked up with me for about six months. He's done a lot of good work through the '90s in spinal cord (research). As a matter of fact he has a research job at the Miami project in which they're trying to eradicate spinal cord injury itself. So, that's satisfying to see individuals like those do things.

But just somebody who's coming, even if they're not semi-famous like he is now, just coming back and saying that course was good or it helped me do this later on and such

and so on. So, it would be the students, whether they're research students or just regular students, class students coming back and recognizing some of the things they might have bitched and complained about in class, 'I don't want to do that', etc.

When I did teach back in the '80s, back in the college, one of them (my students) sent me a card when he graduated this last year from UT, got a Masters in Medical Science. I couldn't remember his face but I might remember his name. He said that he felt that the cardiopulmonary (course) was one of the key courses he had in realizing that he needed to know much more about physiological mechanisms for PT and he eventually got a Masters in that and said I was responsible for him pursuing that, and he wanted me to know that.

I thought it was kind of nice to know the good things. You know I've had a couple of those along the way, ... so those kinds of things are nice. And maybe some others don't send a card, they hopefully think it (the teaching or research assistance is helpful) and I'm sure some don't at all. That's kind of what is rewarding.

Most difficult

Probably trying to prioritize. There are other things ... some meetings... You know, you sit at some of these meetings and I think I could be doing this. Especially if there's a lull or some other talk where a point goes off in a tangent as at a meeting sometimes they do. You think I could be doing this and I wish I were. ... But it goes along with the job so you do it, and try to do a good job. I try to do it efficiently. I sure don't do it for the love of the meetings ...

Memorable

Probably it would be, from a higher education standpoint first, getting into a physical therapy program (and teaching) as a non-PT. It's significant in the sense that there hadn't been a lot of that done yet because most of the PT curriculum, back in the early '80s had PTs teaching PTs, and if there were any outside people it was in a science course. Whereas cardiopulmonary PT wasn't that, it had some science aspects obviously but was a clinical course. So being involved in that as a non-PT and then taking more of the research part of it too and doing some physical therapy, shall we say, writing, research writing with students had to be the most memorable because it got

my interest going about the profession of physical therapy and how really similar it was to what I had just gotten a doctorate in a couple of years earlier with respect to at least the exercise portion of it.

When I was at the College, ... I was helping with a cardiopulmonary course and eventually took more of that That's the most memorable I would say at this point, especially as it relates to physical therapy.

Some good memories back in the late 1970s when I was a youngster doing things at West State as a faculty member there, and South State where I was for awhile as well. Those were short jobs, a couple of years each, getting some experience. I guess the memories there were more of when you're young and don't have a doctorate yet, you really get a lot thrown at you, a lot is expected of you, and so that would be the memory, a lot of expectations, not much authority or privileges. How is that for a summary of that memory? But yet it was a good experience. You build yourself on your experiences and that's kind of where that was.

Rewards

The intrinsic versus extrinsic are probably what I've been alluding to are where I feel satisfaction in seeing a student, even just one from a class who'll want to do good things, you hope you see several. There's various degrees of good things whether you hear about them in the clinic or read about them, that they're doing this or that, or whether you see articles published and you see them presenting a paper, these are good feelings which have, you hope you had something to do with that, especially I mentioned the intrinsic part of being a faculty member.

Probably the second thing would be, I would hope, is from a service aspect giving one's expertise and time to projects that better the clinic and/or the clinic services. We're trying to do it over at the Clinical Site right now for anyone with chronic disease or illness, that type of aspect where you have the expertise and they rely upon you to provide some direction and leadership. Whether it's as a consultant or they want you to get more involved. That's a rewarding aspect because they come and find you and seek you out.

This reporter called me the other day about *Living Healthy* and people seeking you out to get your opinion which usually means there's some value of your opinion from an academic perspective and clinical obviously too. Extrinsic, well, just for one, PT faculties get more money than exercise physiology faculty does. That's really being crass but, hey

Life's work

My definition would be something that you really have a passion and interest in that you will, above all else, pursue. I'd have to go back to the special populations' area because it's really been something that I did for awhile and then didn't do. Actually you could put HIV in there because in a way they're included in that by the way. I mean that's an obviously progressive disease and it's one that's chronic. ... I'd say that's probably been my life's work to look at the optimal physical functioning of persons with these chronic illnesses and diseases. My life over the last twenty years has I suppose been really geared toward that. I suppose when you throw in the cardiopulmonary aspect it really is. So that would be it, optimal physical functioning of individuals or persons with

chronic illnesses and diseases, and trying to make it optimum in terms of research or service provided.

I think if we look at physical therapy, especially at a Masters level, I mean not so much at the Baccalaureate, there needs to be more of a pursuit of both the cognitive, psychomotor, just overall knowledge of how to best treat individuals with these conditions. As you're well aware, some of the courses will get to that in the latter part of the curriculum and do a decent job, maybe could do a better job, maybe there should be more involved there because there will be people who go out and work in these areas and basically do some on-the-job training. Not that you're going to, even by adding a couple of extra courses, to provide all that they're going to know for that job, but at least they'll feel more comfortable and be more aware.

The future

I hope to pursue some of the research that we've gotten involved in out here. If all holds true, I'm hoping in five years we've determined that this drug or the combinations provide the best basis for cardiac output to relieve the fatigue and visual disturbances and dizziness and lightheadedness, that some of the folks have,

especially with tetraplegic injuries. And looking at other aspects of immune function where we see if that can be beneficial because there are increased levels of urinary tract infections, pressure sores that lead to some real bad ulcerations. All that needs to be dealt with and it can be somewhat from a standpoint of just better blood flow through an area. That can be through pharmacologic mechanisms and/or a combination of the assists from perhaps e-stim or magnetics from different binders with different types of exercise; we'll try to look at all that.

I probably will (go for tenure). I hope to be around long enough to do that. I'll see if I'm here. I hope it's before the six or seven year point. I'll examine that, or not only examine but pursue it, start to take it up seriously in two years and by the third year from now, which is four years in July I've been here, actually try to obtain that (tenure), assuming it's still available.

To be remembered

Someone who cared about the welfare of the student with respect to how that student was able to relate to the patient and provide the best care for the patient, whether it's obviously education of the patients or they could do a

home program. And obviously the proper quality and quantity of exercises if they're getting exercise here. ... I'm hoping they (the students) say, "Yes, he really hammered home those points. I got tired of hearing him but he made some sense." That's kind of like what I hope some of them would say. I guess the other aspect would be that some of them moved on with research or some would say I really got a lot out of that, it led me to wanting to pursue more of this on my own.

The way the budgets have been (in the physical therapy departments) there probably isn't a lot of time that people are getting to work on individual (research) projects. At least I sense that either they'll (the physical therapy staff) probably want to say we're busy enough or we're not interested. We may have to do this but we're just too busy with other things that need to get done day in and day out than to (do research). First off, you can't get any time off for a couple of hours to work with you, and secondly, they don't want to stay there any longer than they need to. But then a lot of times they're staying later anyway to finish notes. So unfortunately that has been how things have gone the last at least six months. I can see there hasn't been a lot of interest in doing any research. It's

not to say they're not interested overall, it's just right now it's not a good time.

Starting out

I almost have three Masters degrees; physical therapy, exercise science, and I almost have a third one, one course short in special education. My first job, I had just been married was in a state run school having to do with visual impairments but most of the children and adults there were multi-impaired. Well I shouldn't say most, but up to at least 30% and the other were sensory impairments or physical impairments. I had just a couple courses in that area prior to taking that job. So at any rate, that's really where I guess the interest (in special populations) started. And then I let that lay for awhile and then went for a doctorate, but then when I was in Town I got re-involved in 1982, 1983 with special populations...

I was called a recreational therapist. I think now most of the people are certified...(It was many years ago...) So it really was a program that was along with the physical education program and the physical therapy program. We all three of us kind of met- the PT, that's when I really got involved with PT, the PE instructor and myself had planned

out a curriculum basically for the physical betterment of the individuals there. Since it was state run, these kids lived there. So it wasn't just an 8:00 to 3:00 program. I basically had programs that were after school, in the evening, and I had regular day in the afternoon somewhat. Obviously I didn't have programs in the mornings or I would be there like 14 hours, it felt like some days anyway. So, that's how that came about really. This was my first professional job.

I had a baccalaureate degree that was in physical education and biology. I took a double major so the physical education part I took advantage of. I had two adapted PE courses, I think they were called. And I was there (at the state run school) for about three years.

It was an interesting experience with some good instructors. Obviously individuals who were really into special education. It was kind of a new thing back in the '70s. This mainstreaming concept started coming about so there needed to be individuals who could educate, so to speak, whether it was English or whatever, in this case, movement, physical education in ways which could be implemented and still get the most out of the student and

not get them too far from the mainstream so to speak. That was kind of the whole approach to it.

I guess it was beneficial. I haven't reflected in a lot of years. It was beneficial because that led to a lot of things in the '80s I got involved in a three-year grant at the handicapped center in Town- that was in '83, '84, '85, and '86. And that led to some publications and the consultant role I had with the National Association of Handicap Sports & Recreation. And it led to Tom Bright and led to him coming to work with me. And I got here. The whole thing it's linked. So it goes back to special populations. See how it's all woven itself together?

Chapter Five

Analysis and Interpretation

Introduction

Physical therapy education is undergoing a number of changes that impact the external career or faculty roles and responsibilities of physical therapy faculty members. Faculty are now expected to be doctorally educated, to be socialized as a graduate faculty, to teach, conduct research, perform service and maintain clinical competence (Rothman, 1990). Issues in the external career impact and frame issues in the internal career. The focus of this study was on understanding physical therapy faculty from their perspective through their internal careers and vocation. In this section issues, themes and concepts (Schmoll, 1993) in the external career, the internal career and the vocation of the participants will be described and discussed. Implications for physical therapy faculty development and for professional education are discussed. The study is summarized at the end of this section. In conclusion the limitations of the study and suggestions for future research are outlined.

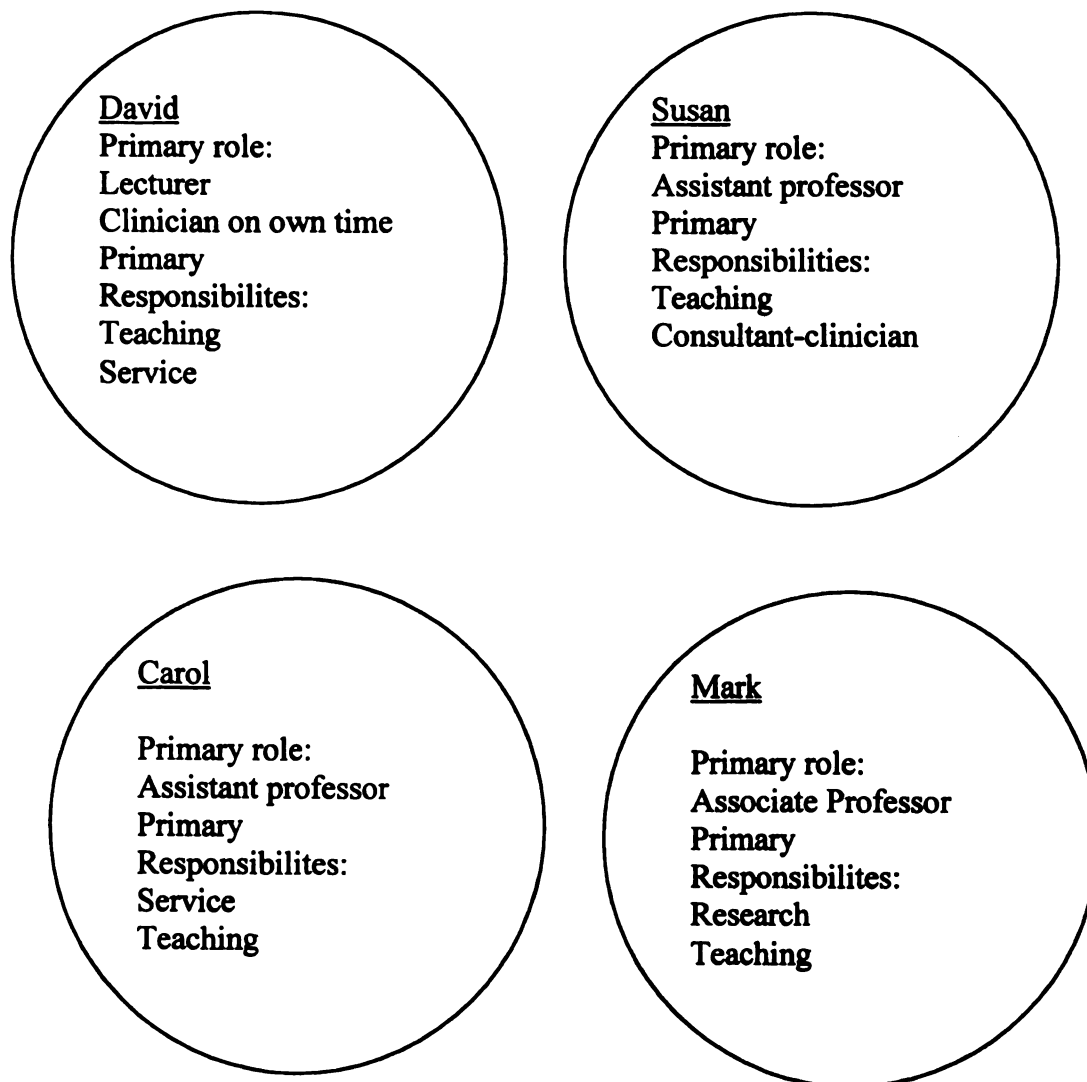
The External Career for the Participants

The external career is expressed in the position, roles and responsibilities held by the individual. The core of the

external career is the individual's perception of what is possible in the organizational and occupational context.

(Arthur, Hall and Lawrence, 1989) See Figure 6 for the roles and responsibilities of the four participants.

Figure 6 External Academic Careers of the Participants



The interviews and stories of the participants revealed issues with which they struggled or had to deal with in their academic roles and responsibilities. Four issues related to entering the academy as clinicians and teaching in a professional education program are discussed. The four issues include obtaining a doctoral degree, the clinical role in the academy, perceptions of possibilities in the academic setting, and responsibilities in professional education.

Obtaining a doctoral degree

Given the transition of entry level physical therapy programs to master's degree entry level by 2002, and in some programs to the clinical doctorate in physical therapy degree (DPT), there is a shortage of doctorally prepared faculty (Hayes, 1997; Rothstein, 1999). Physical therapy faculty are aware of this need to be doctorally prepared and many are pursuing a doctoral degree while they are on faculty in physical therapy education programs.

David and Susan had to choose whether or not they wanted to pursue a doctoral degree. There are several doctoral degree options available to physical therapy faculty. For example faculty may choose an academic degree such as the doctor of

philosophy or a clinical degree such as the doctor of physical therapy (DPT). David and Susan both struggled with deciding to go for a doctoral degree, the type of degree to pursue, and where to pursue a degree.

Clinical role

One of the primary issues for all of the participants was managing the clinical or patient care role as an academic. Only one of the participants, Susan, actually had a clinical appointment as an explicit role in her academic position. Even though Susan has a clinical role she expresses the difficulty of maintaining two offices and of managing responsibilities at both the university and the clinical site. David, Carol and Mark did not have a clinical role or patient care as part of their roles as academics. Each of the participants managed the clinical role differently. David felt that he had to treat patients and maintain a clinical role. He states,

"I see a lot of academicians who see their PT degree as a reason for being at the academy, not as a reason for why they went into being a PT. So they can readily give up that clinical practice and not have any sort of remorse if they don't treat anymore. It would be like cutting off my arm if I couldn't treat. Which is why I do it on my own time Saturday morning, on my way home from work. I leave here and I don't get home for another two hours because I have two clients on my way home. Because it's so important for me as a clinician, I don't care if I don't get time for

it. It doesn't make a difference to me; I would do it no matter what. I'd do it for free if I had to (pause) because it defines me" (David: The Test Case).

Both David and Susan discussed several reasons why they felt it was important for them to continue to treat patients. David feels that treating patients gives him credibility with the students and perhaps acts as a safety net. David sees himself as a clinician, "first, foremost and always." He feels that being a clinician defines him.

Susan sees the clinical work, teaching, and professional development as very interrelated and difficult to separate out. She states,

"I don't think I can really separate out the clinical, the teaching and the professional development part of it because they play such an important part in each other.

When I'm teaching, in a way I'm developing my own thought processes constantly at the same time that I'm working with students so that enhances my own clinical skills. When I'm in the clinic I'm going through that thought process and I'm able to transfer those thought processes to my teaching" (Susan: Learning to Teach).

Both David and Susan were somewhat critical of academicians who are not treating patients. David is critical of academicians who see their physical therapy degree as a reason for being in the academy, not as a reason for why they went into being a physical therapist. David feels

people who get physical therapy degrees should not do so just to go into the academy.

Carol, when asked about patient care activities abruptly answered that she didn't have time. Mark would like to be involved in patient care but hasn't been able to find a part time position. The American Physical Therapy Association 1983 survey of faculty identified that inadequate time for clinical practice was a stressful factor for physical therapy faculty members (American Physical Therapy Association, 1985). Shepard and Jensen (1997) note that it is difficult for faculty to develop and maintain expertise in teaching, research, service and patient care. Managing a clinical role or making the decision not to be involved in patient care seemed to be stressful for the participants. There also appeared to be tension between those academics who maintained a clinical role and those who did not.

Perceptions of possibilities

The external career is not just the roles, responsibilities and positions but also the perception of what is possible in the organizational and occupational context. Another issue for the participants was defining their work as well

as evaluating their work in the academic setting. David receives what he perceives to be negative student reviews and states,

"And you're used to getting positive accolades and positive strokes about what you're doing and the energy you bring to a group and the innovations that you bring. And you would automatically assume if you get something in the clinic (like the negative student evals) someone's going to say to you perhaps this isn't the right place for you to be" (David: The Test Case).

David's frame of reference for interpreting his performance in the academic setting is the clinic frame of reference. He needs the assistance of the experienced faculty to put his performance in perspective and to come up with a plan to improve his teaching. David felt he was more successful in the clinic and had difficulty understanding why he wasn't more "successful" in the university setting.

Carol sums up the limited perceptions that people sometimes have of the faculty role. She states her initial perception of being a faculty member was that it was teaching with a few meetings. She relates that faculty meetings provide a broader perspective about issues related to student problems, accreditation, faculty governance and university politics. Carol also found that as she became involved in committees university wide, through the insistence of her

mentors, that she developed a greater appreciation for the health of the university and it's relationship to the physical therapy department.

Susan's initial expectations and perceptions were influenced not only from having been a clinician before she came to the academy but also from being from another culture. Susan explains,

"Plus the other difficulty that I found was that my educational background and educational system was different. I didn't know what a credit hour was. We don't have those in my country. I had no idea what the prerequisite courses were and basic content and things like American History or that type of thing that was totally foreign to me. So I had to learn all of that ..." (Susan: When I Came Over to the United States).

The American grading system also caused her difficulty with her students. Susan relates,

"... the emphasis in my country's system is that you're there for corrections, not for the achievement, not to see how good you are. I found that a lot of the American students were very much into I've got to get an A. I've had an A, I'm coming with an A average, I need to get an A. They were quibbling about a .5 on this and .5 on that and I just had absolutely no understanding of that whatsoever at that point. It caused me a lot of grief on both my student evaluations and personally. Before I started bending a little bit. Yes, I did have higher expectations, and I'm not sure whether that was normal for a new faculty member or if it was my previous educational background which caused it" (Susan: Learning to Teach).

All of the participants mentioned that the lack of feedback and the negative feedback from students was difficult to

deal with especially since they were used to getting positive feedback from their patients.

Responsibilities in professional education

Responsibilities of physical therapy faculty, who are involved in the professional education of students, include being a professional role model for students and socializing students to the profession. Each of the four participants, to differing degrees, recognized these responsibilities and undertook to fulfill them with the students.

David and Susan both participated in patient care activities and were role models for patient care activities. David talked to the students about their professional responsibilities and service. He involved students in the camp for people with disabilities. Carol talked about educating the "whole person" and being responsible for student's personal and professional development. Carol states, "There's a real sense of caring for students and for not only their academic development but also their professional and social development" (Carol: The Collegial Experience).

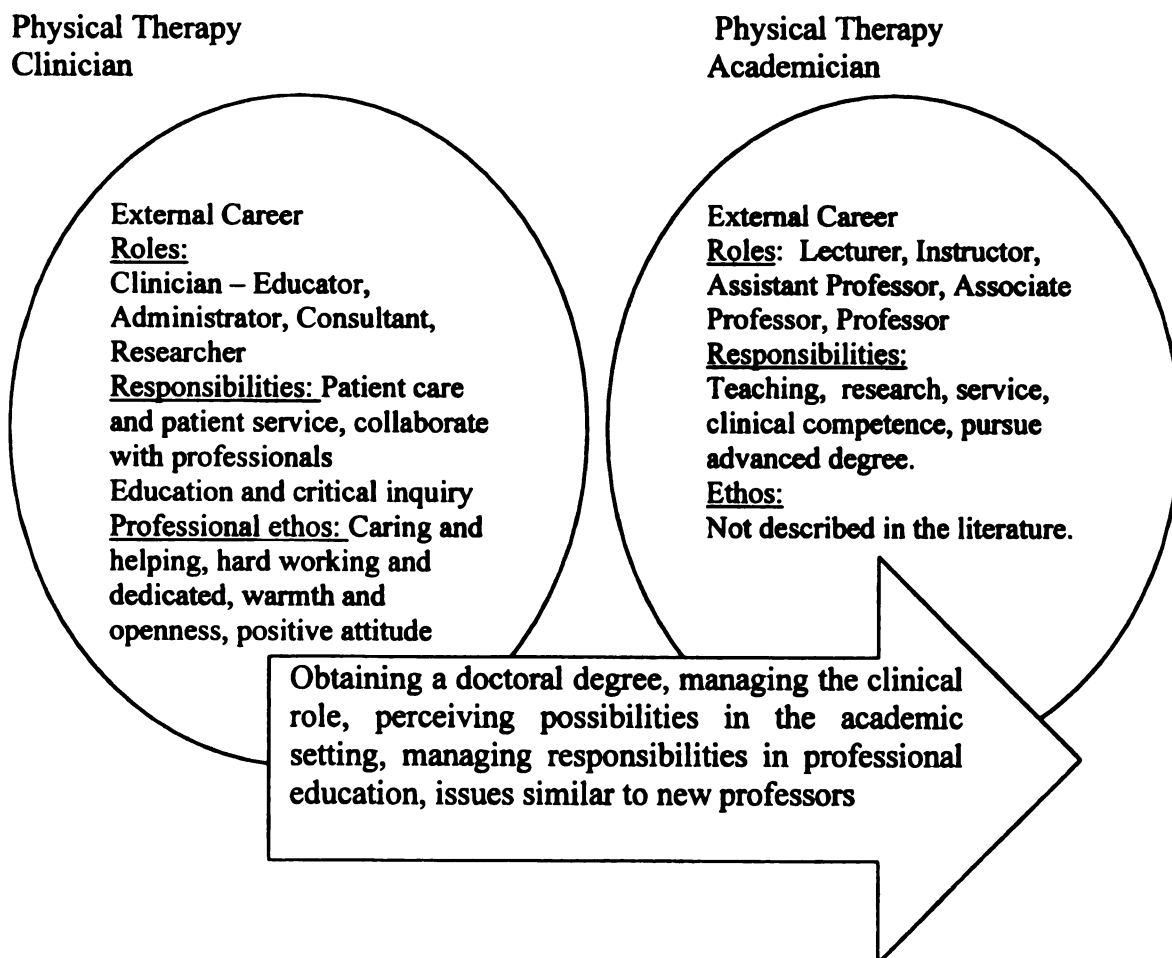
One of the major responsibilities that each of the participants mentioned in their role as faculty was ensuring that the students treated patients appropriately and did not harm the patients. The participants wanted to be sure that students were knowledgeable and competent. David sums up this responsibility after a student has missed class, "And yes, I could be punitive and say your grade is going to suffer. First of all, really, they really care about their grade. But the reality is, their client will suffer. And my goal is that they need to know all the information that they are supposed to know so their clients don't suffer" (David: The Test Case).

Issues similar to new professors

Many of the issues expressed in the stories of these participants are similar to issues encountered by new professors. Those issues experienced by the participants and documented in the literature as well, include time constraints, difficulty managing multiple priorities, feeling unprepared for the various roles in academe, infrequent feedback, and work life spilling over into personal life (Millis, 1994; Reynolds, 1992; Sorcinelli, 1994). In summary the four issues in the external career, which were highlighted in the stories of

these participants as they entered the academic setting, included obtaining a doctoral degree, managing the clinical role in the academy, perceiving possibilities in the academic setting, and undertaking responsibilities in professional education. Figure 7 depicts the issues in the external career transition from physical therapy clinician to physical therapy academician.

Figure 7 Issues in the External Career Transition from
Physical Therapy Clinician to Physical Therapy Academician



The Internal Career for the Participants

The internal career is the "way personal meanings are formed and lived out in a career- emphasizes identity rather than social roles" (Cochran, 1997 p. 140). An important personal question regarding the internal career is "What do I want from work, given my perceptions of who I am and what's possible?" (Derr and Laurent, 1989, p.456) If the external career is the perception of what is possible then the internal career is what is possible for me. The internal career is who we are in our work. The internal career is making the work one's own. The internal career is expressed in the stories of the participants.

The internal career for the participants

These stories of coming into an academic career and early academic career development are stories of developing personal meaning and identity in academic work. It is important to realize that these stories are temporal and are a reflection of where the participants are at a particular point in time and place in their careers. As several authors have noted, "Subjective careers evidenced themselves in the tales people told to lend coherence to the strands of their life. But most importantly, subjective careers changed with time as individuals shifted

their social footing and reconstructed their past and future in order to come to terms with their present"(Faulkner, Strauss, as cited in Barley, 1989,p.49). Themes in the personal meaning and the identity of the participants are discussed in the following sections.

Personal meaning

All four of the participants expressed two common themes, the "patient" and the physical therapy professional ethos, in their stories. The "patient" and the expression of the professional ethos appeared to be meaningful to each of the participants in their academic work. Each of the participants also found personal meaning in their work which was unique to them.

The centrality of patients

One of the themes expressed by the participants is the centrality of patients in their academic work as physical therapy faculty members. The centrality of patients is expressed in their teaching, research, service and patient care. For example, all of the participants were concerned that students have the information and skills they need to treat patients and that the students not harm the patients. David states, "And my goal is that they need to know all

the information that they are supposed to know so their clients don't suffer" (David: The Test Case). Carol states, "A year or two ago we had a student who was really having social problems. One thing you don't want is to graduate somebody who is going to have these same problems out in the clinic if you think it will disrupt patients' treatment" (Carol: The Collegial Experience). David also mentioned the importance of helping the students to see the patients as real people with real lives.

Mark and Carol both mention having a positive impact on patient's or clients through their research. Mark states in regards to the objective of his work, "So that would be it, optimal physical functioning of individuals or persons with chronic illnesses and diseases, and trying to make it optimum in terms of research or service provided" (Mark: Special Populations). Carol relates, " I know sometimes in research you can kind of go with the fad and I figure other people are doing that. I'm going to do what I think needs to be done and to be beneficial to patients as well. I feel good about that" (Carol: The Collegial Experience).

All four of the participants mentioned service to patients as part of their work. Susan discusses what she has learned from her international service experience,

"One of the things that you really appreciate when you are there (is that) you see some of the patients that obviously can be helped by physical therapy and they are not receiving it. And it's an absolute shame. These people could be functioning. You realize how important PT is and how important it is to pass that knowledge on. Being a consultant allows me to pass on skills I have developed. Pass it on to 4,5 or 6 people and they can use it with their patients. Your impact is more than just treating 8 patients a day" (Susan: When I Came Over to the United States).

Mark states he would like to be remembered as, "Someone who cared about the welfare of the student with respect to how that student was able to relate to the patient and provide the best care for the patient, ..." (Mark: Special Populations). Patients, improving the care of patients, and the preparation of students to care for patients appeared to be meaningful and central to the academic work of the four participants. The professional ethos in physical therapy was also meaningful to the participants in their academic work.

Professional ethos

The professional ethos in physical therapy has been described as, "an emphasis on caring and helping, hard work

and dedication, warmth and openness and positive attitude"(Stiller-Sermo, 1998, p.82). The four participants demonstrated this professional ethos in their work. Even if the participants were not directly treating patients there is a way that the professional ethos and their identity as physical therapists is expressed in their academic work. The professional values and ethos that the participants ascribe to was frequently reflected in their teaching, service, research and patient care.

For example, all of the participants described helping or service to patients as an important part of their academic work. This was reflected in their teaching, research and service activities. Teaching activities were undertaken so that students would not harm patients, would have the knowledge they need to treat patients, would critically reflect on patient care and clinical decision making and would understand the lives of their patients. Research activities were designed and implemented to service and benefit patients. All four of the participants were directly involved in service activities to benefit patients including camps, overseas work, committee work, writing and presentations.

Caring, which is another aspect of the professional ethos, was important to the participants. The participants mentioned caring for students and patients or clients. Carol discussed the importance of caring for the whole student and facilitating their academic, professional and personal growth. She states, "There's a real sense of caring for students and for not only their academic development but also their professional and social development" (Carol: The Collegial Experience).

Warmth and openness are also part of the professional ethos. The participants were concerned about their working relationships with their colleagues and working together well with their colleagues. Collegiality was mentioned as being important to the participants. Susan states, "What's involved in the advising? It's most often when students have difficulties that we are involved. That might include disciplinary issues or behavioral issues or academic issues. The faculty is very collaborative with that type of thing" (Susan: The Split Position).

The academic ethos has been described as one-life, one-career, research is the primary focus of academic life, only in the academy can knowledge be pursued for its own

sake, and an academic career is a life time calling (Rice in Bland and Schmitz, 1990). Faculty developers in medicine have noted that part of their responsibility is to "instill" the academic ethos. There are significant differences between the professional ethos and the academic ethos. These differences appear to be difficult for the participants to resolve or are a source of tension for the participants.

For example, David wants to be a more humane faculty member. He states, "I definitely want to be better (as an academician). And not so much better, not better intellectually but more so, better from a human standpoint. I think that's where my strengths lie. That I can do the intellectual part but I'd much rather do the human" (David, The Test Case).

Carol discusses the difficulty or tension in the program where she received her doctoral degree. She states,

"I think that if I had not had an experience in physical therapy teaching, where there really is a concern about the student, and trying to provide top quality education, ... I think if I had not had that experience, I may not have continued with grad school. And I may not have ended up in PT education or education at all because I was very disillusioned. My department that I got my degree in was very poorly run and not student-centered at all" (Carol: The Collegial Experience).

Susan discusses the difficulty of maintaining a professional identity and the pressure for obtaining a doctoral degree. She states,

"That role (professional) and identity is so important in your profession, and if you're going to stay an academic you need to have that role and identity. If you're constantly fighting to be, just for your identity, it detracts from what you should be doing. It makes you feel like you should be doing something else with your time. ... I know that there have been people who tended to go toward that area (the Ph.D.) only because of that reason, because they felt that they had to do it and they had to be involved with it. And they are less than somebody else if you didn't do it (get the Ph.D.). Rather than concentrating on the really important part of your own growth, but also of what you can give to the students and the people around you" (Susan: The Split Position).

For most of these participants research is not the primary focus of academic life, they have not had the one life-one career in the academy and the focus of their research and knowledge generation is more applied. Mark is primarily a researcher and was in the academic setting before he became a physical therapist. He sees himself as a researcher and appears to be more closely aligned with the academic ethos. He struggles to establish his credibility with students and physical therapy faculty as a knowledgeable physical therapist.

A study by Reynolds (1992) on socialization and acculturation to the academy found that entering the

academy can also be a choice of values. Nancy, a new faculty member and one of the participants in the study explains, "I think coming here ... wasn't just a change of jobs. It was a real choice of values, and I think it is likely to affect what I am as a human being, and part of my ambivalence about coming here is because I think the environment you put yourself in does affect the kind of person you become. I think I will become - I probably already am - a different person than I would have been had I stayed at[my former college]" (p. 650). The four participants in this study also found that choosing an academic career was also a real choice of values and that their personal and professional values differed at times from those of the academy.

This tension or difference in the professional and academic ethos raises questions regarding faculty development. Are these physical therapy members "poorly socialized" to the academy? Is this a "lack of socialization"? How does this "socialization" or acculturation to the academic ethos affect physical therapy faculty members roles, responsibilities, and teaching as physical therapists? What is the "ethos" or culture for academic physical therapy faculty who have roles and responsibilities in both

the academic and professional or clinical worlds? Is there or can there be an ethos for faculty which blends or recognizes this reality? When are you the physical therapist and when are you the academic? Barley (1989) notes,

"When people belong to multiple social systems that offer competing interpretations of one's fate, it is quite likely that subcultural forces of institutional change will arise. For instance, when employees are simultaneously members of organizational and occupational cultures, competing schemes for understanding one's work and one's career are generally available. Resolution in favor of one institution or the other is rarely a foregone conclusion" (p. 57).

Physical therapy faculty members belong to more than one "social system". They are in a university or organizational culture with an academic ethos. Physical therapy faculty members are also in physical therapy with an occupational culture and a professional ethos. The differences between these two cultures and the two ethos appear to be a source of tension to the participants. Have these competing schemes for understanding work and careers as physical therapy faculty members given rise to change in academic settings? This is a question for further study.

Personal meaning

In addition to the centrality patients and the expression of the professional ethos each of the participants

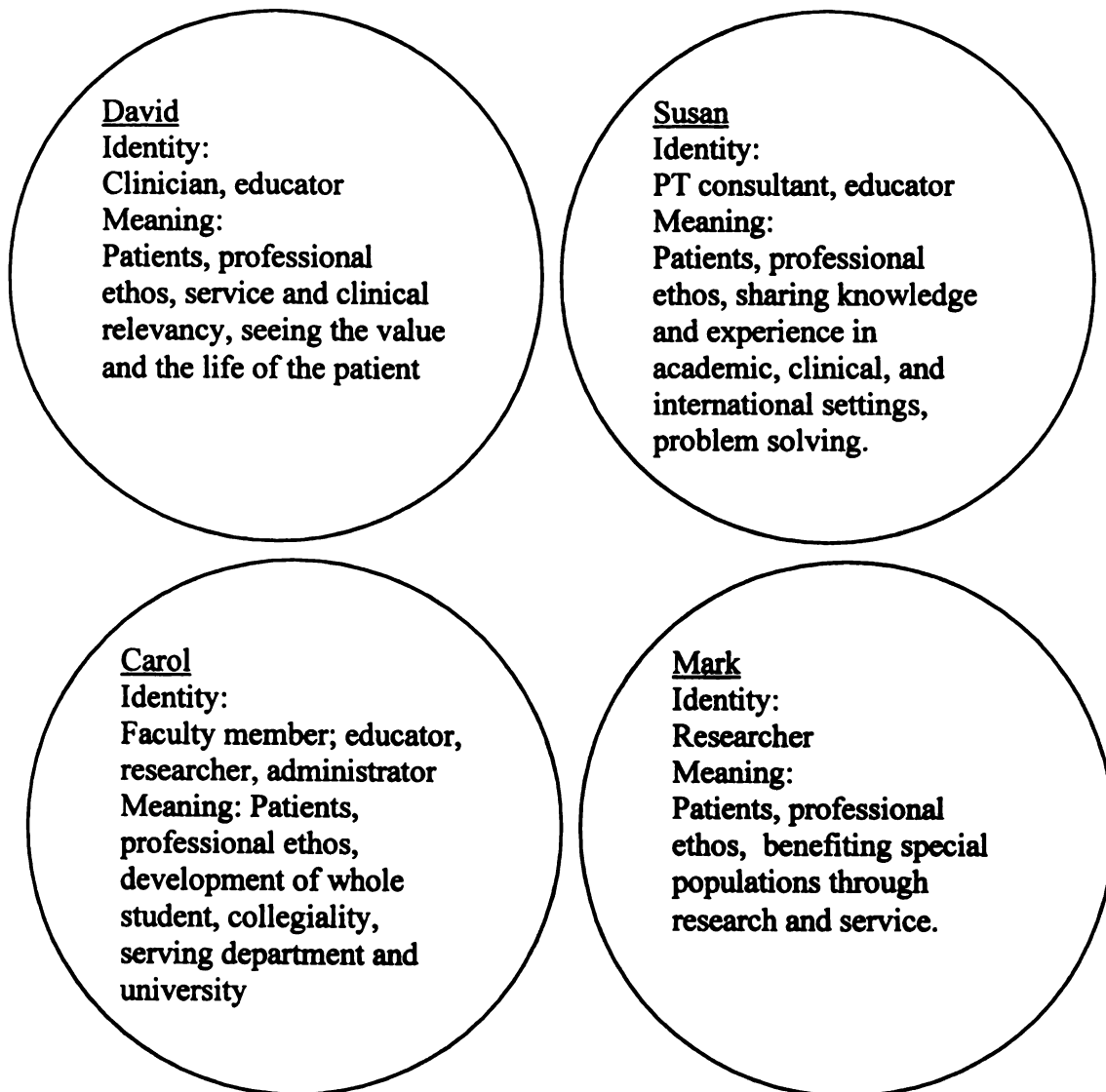
expressed a unique personal meaning in their academic work. David is clearly concerned about service and clinical relevancy. He takes the students to camp. Susan is an international consultant in physical therapy and takes students abroad. Carol is concerned about the "whole" student and the quality of life for people. Mark is concerned about special populations in his research and service. This unique personal meaning is related to the participant's identity and to their vocation or who they are as people.

Identity

The identity and personal meaning that the participants derive from their work appears to be linked to their external career; their roles and responsibility and to their values and vocation. The participants discussed their work and linked it to their identity. For example, David sees his primary identity as that of a clinician. He feels that it is imperative for him personally to treat patients and to maintain his role as a clinician. Carol realizes that she can't deny who she is and that teaching, public service, and administration are part of her identity. Susan describes the struggle of maintaining a professional identity in the academic setting. Mark relates

that a piece of himself is missing when he is not involved in research. The participants faced different issues related to developing identity and personal meaning in their work as faculty. See Figure 8, which depicts the internal career of the participants.

Figure 8 The Internal Academic Career of the Participants



Identity in the career transition

"Substantial changes in a person's self-image, attitudes, and aspirations can occur during the early years of a career" (Baldwin, 1990, p.25). Exploring, learning and developing an academic identity were key themes for all of the participants in their transition to an academic career. Elements of these key themes are discussed below.

Exploring

In the initial career transition participants discussed exploring the faculty member role and responsibilities. The participants explored the position to see if there was a "fit". David and Carol both expressed this exploration in their stories. In fact David relates that he had not actively considered an academic career until he received the letter from Central University. He states, "I learned also that PT education was hierarchical and I just didn't see myself meeting my learning needs or fulfilling my plan as a person in that environment that was so opposite of whom I am" (David: The Test Case).

David was interested in exploring and learning about the faculty position. He states, "I called (Central University) and said I received this letter. It's intriguing but I

need to know a little bit more. Are you expecting that I'm going to be teaching research? (laughs) teaching cardiopulmonary? ... The biggest goal was to learn, and for them to learn about me. ... I really had very little expectations of myself. It was such uncharted territory for me that I didn't even know where to begin" (David: The Test Case). Carol also discusses exploration of the faculty role and looking for a fit. She states, "In terms of expectations I really needed to see if it was right for me. I anticipated it would be a good fit, but I wasn't totally sure (Carol: The Collegial Experience).

Questions of identity arose for these participants as they made the transition from clinician to faculty member. This is most clearly expressed with David. His story relates how he came and is coming into his identity as an educator.

David states,

"And recently I was talking to Ruth and I said my first two years were like wearing someone else's clothes. I was trying to be Chuck without his experience, without his influence. And that was problematic, almost disastrous. So therefore there was a time to say I had to develop my own voice.... Doug's courses on experiential learning, it was like okay, this is who I am, this is how I learn" (David, The Test Case).

Susan relates her struggle for identity as a physical therapist in an academic setting. She states, "That role

(professional) and identity is so important in your profession, and if you're going to stay an academic you need to have that role and identity. If you're constantly fighting to be, just for your identity, it detracts from what you should be doing. It makes you feel like you should be doing something else with your time" (Susan: The Split Position).

Learning as a faculty member

All of the faculty members expressed that there was a lot of learning in the transition process. Susan relates,

"It was hard. (the first year with the PTA program at Blue State) But there were multiple components to that, starting on the distance program, it was doing my Master's at the same time, it was moving, it was getting back into the academic environment and learning myself after having a break and not being used to going to the library. I wasn't computer literate at that point. Everything was learning. Every single thing" (Susan: When I Came Over to the United States).

David says in regards to the his goal for the first year, "The biggest goal was to learn, and for them to learn about me. ..." (David: The Test Case). Experiential learning and learning from others, staff, students, junior and senior faculty was important for all of the participants.

Development as a faculty member

Mentoring by senior faculty played a role in the development of all of the participants. Participants also felt that students, staff and junior faculty were an important part of their academic career development. Participants valued mentoring by senior faculty which addressed philosophical issues or ways of thinking about students and their development versus mentoring which was related to skill development. Carol says,

"But in order to engage students or develop those other things I think it has to be consistent with how you view the world. And then if it is consistent then the mentoring is just, "Okay, how can we get this to work in this specific case?" and develop skills in the students and so on. That's the kind of mentoring that I value. Because the other can come from lots of different people, how to put an overhead up and so forth, you can get that from anywhere" (Carol: The Collegial Experience)

All of the participants struggled initially with issues related to discipling students, establishing appropriate relationships with students, and testing. Key questions for the participants as they developed in their academic careers included, Who am I as an educator? What are my values as an educator? What is my relationship to students? What do I believe about disciplining students? About testing students? Who am I as a researcher?

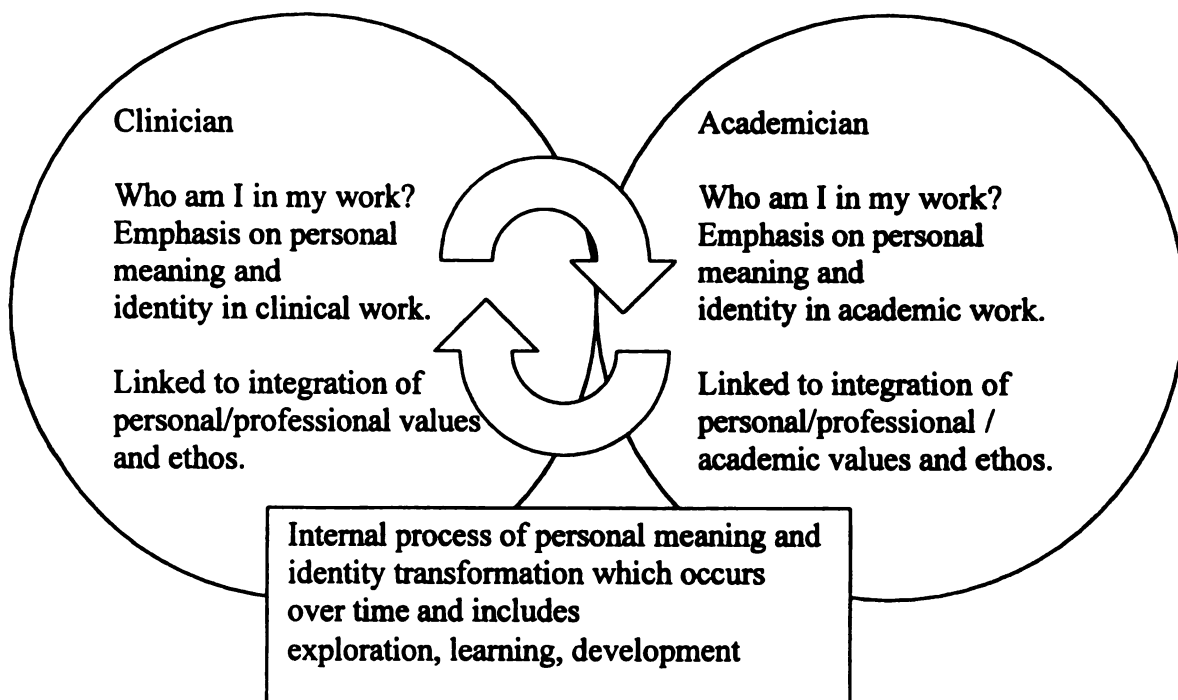
The internal career concept

The transition into an academic career is not just a change in roles and responsibilities or change in the external career. As C. Wright Mills has noted, career transitions involve more than just "learning the ropes". They also involve what Mills calls a "vocabulary of motive". Mills as cited in Barley (1989) relates, "A vocabulary of motive is rhetoric typical of the occupants of a specific status. Such rhetoric provide an idiom for justifying one's action, for signaling one's status, and for convincing oneself of the justice of ones fate and the fate of others" (Barley, 1989, pp. 55). Foote as cited in Barley (1989) notes, "the vocabularies that accompany career transitions act as seed crystals for the formation of an occupational identity"(p. 55)

Participants expressed an internal career of personal meaning and identity through their stories. Moving from a clinical role into an academic position as a physical therapy faculty member is expressed in the internal career and is characterized by a career transition where personal meaning and identity may be transformed through exploration, learning and development. It is an internal process that occurs over time. It is not a linear process

and requires attention and reflection. Senior faculty, junior faculty, staff, and students play key roles. Participants also reflected back on previous teachers, parents, family, friends, and their own values and experiences. The transition into an academic career is a transformative process of making the work your own. See Figure 9, which depicts the internal career transition from physical therapy clinician to physical therapy academician.

Figure 9 The Internal Career Transition from Physical Therapy Clinician to Physical Therapy Academician



The internal career is an internal and private process.

David describes the transformation point of making the job his own when he describes what has been most significant or memorable for him in his academic career. He states,

"For me, I think most memorable was the transformation. Because it represented making this job my own. I can almost pinpoint the day or date. I guess I saw myself transforming from the professor role which I thought I should be doing and everybody else thought I should be doing to a much more ascribed role which I wanted to be. And I think and I really believe, and everybody wanted me to believe it, wanted me to do it too" "it really was an internal response... I was so energized by it... (David, The Test Case)

The internal career is making one's career one's own.

Vocation is central to making one's work and career one's own.

The Vocation of the Participants

The participants did not express that they were "called" to teach before beginning their academic careers. David expressed that he never saw himself in the academic setting until he received the letter and decided to try it out.

Carol tried to avoid the education setting because she did not want to do what her parents had done. Susan was interested in teaching and physical therapy. She wanted to further her own education to go back home to teach physical therapist assistants. Mark had a doctoral degree in an

area of practice related to physical therapy and was approached to teach in a physical therapy program. There was a need for physical therapy faculty and a shortage of faculty brought David, Carol and Mark into the academic setting.

Three of the participants expressed having a vocation linked directly to their work as physical therapists. David, Susan and Mark expressed that they saw their vocations linked to physical therapy. In part they are able to express their vocation through their academic work. However they also undertake projects which reflect their vocation on their own time. Their vocation is a part of their academic work but not all of it. Carol felt that her vocation was not directly related to her work although she stated if she expanded her definition of her vocation there was an overlap with her work. As Hansen (1995) found with his study of vocation, teachers and teaching, there is still a lot of academic work which needs to be done that is not related to the expression of vocation. The vocation of the participants is described below and depicted in Figure 10.

David sees his vocation as physical therapy service and clinical relevancy. David is a humanist. He is dedicated to helping students see the patients as real and worthwhile people. He tells stories about the patients in his class to help the students see the patients as real people. He involves the students in a camp outside the academic setting so that the students have an opportunity to serve and to work with patients in a real setting.

Susan sees her vocation as teaching and consultanting to expand the knowledge of physical therapy in international settings. Susan is interested in teaching and consultanting as a physical therapist in international settings. She takes students abroad. Susan has worked and volunteered in overseas. She chooses to work as a faculty member in a culturally diverse setting. Through her international experiences she has seen the value of physical therapy education and teaching.

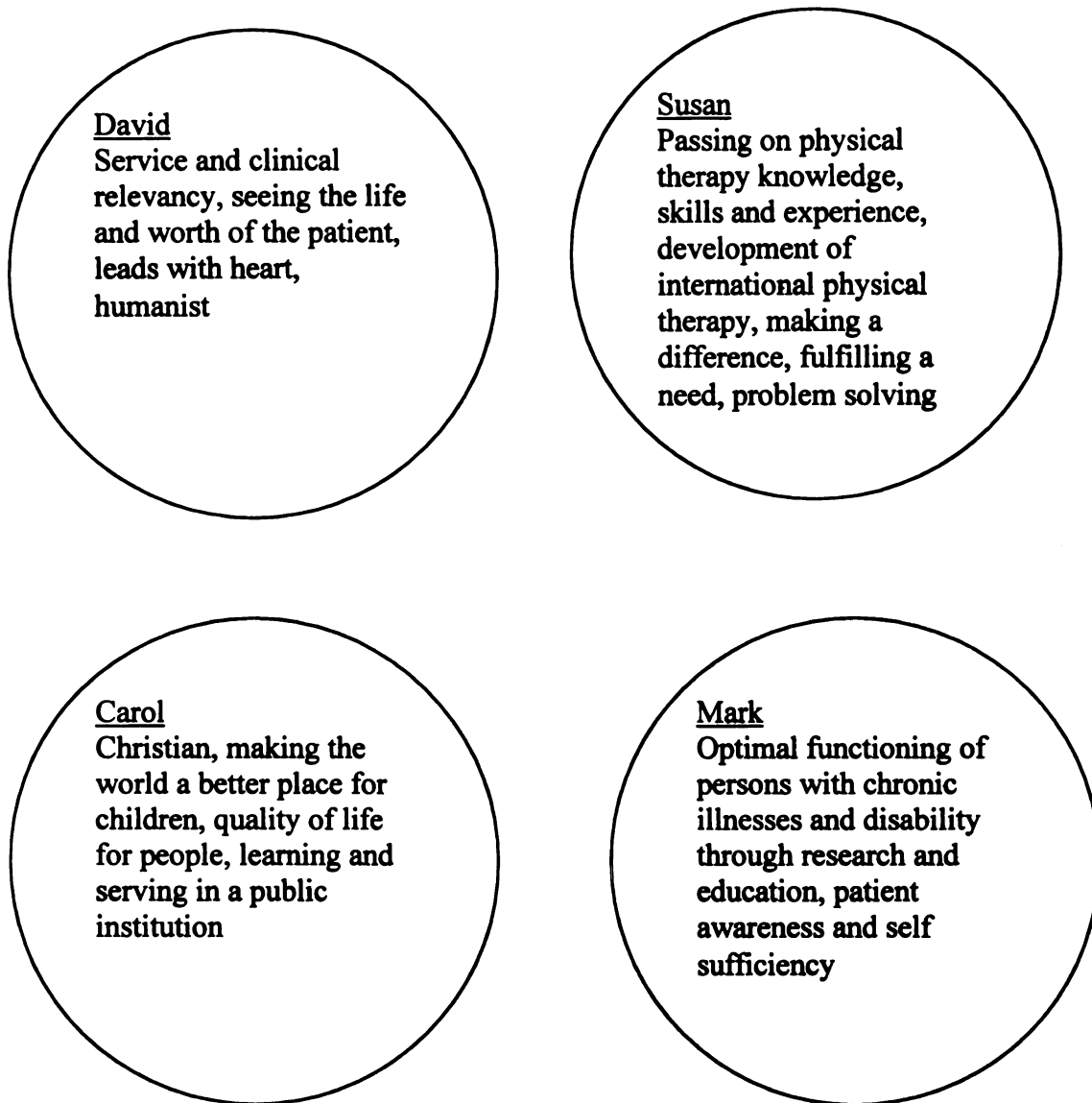
Mark sees his vocation as working with special populations in research and service. Mark is concerned with the optimal functioning of people with chronic disease and illnesses. He involves students and patients in research. He teaches

students about special populations and people with chronic disease and illness.

Carol expressed her vocation as outside of her academic work. She feels her vocation is making the world a better place for children. However she felt that if she expanded her definition of her vocation to caring about the quality of life for people than her vocation is expressed through her academic work. Carol valued collegiality. She is concerned for the "whole" student and their personal and professional growth. It is important to her that her personal values are consistent with the values in her work setting. She values education and serving in a public institution. Figure 10 illustrates the vocation of the participants.

For these participants vocation is not necessarily synonymous with paid work. There is some overlap with paid work although the participants also undertake to fulfill their vocations on their own time and through their own projects. It appears that it is important to the participants that their personal values are consistent with work values.

Figure 10 Vocation of the Participants



Vocation can be a difficult or a burden. For example Susan discusses that finding her vocation, teaching the physical therapist assistants in her country was life changing. But losing that vocation was life changing too. Susan relates that she had a lot of guilt about not going back to her country. She had to find something else, such as

consultanting in other countries that was meaningful to her.

It takes time to develop and recognize a vocation. Susan comments on the importance of reflecting on the bigger or meaningful values. Palmer (2000) notes that developing vocation takes time and requires listening and reflection. Developing a vocation also requires nurturing. Gustafson (1982) notes that bureaucratization in organizations and over specialization in occupations can stifle a calling. Burton Clark (1993) notes that burnout and teaching overload can also dampen a sense of calling.

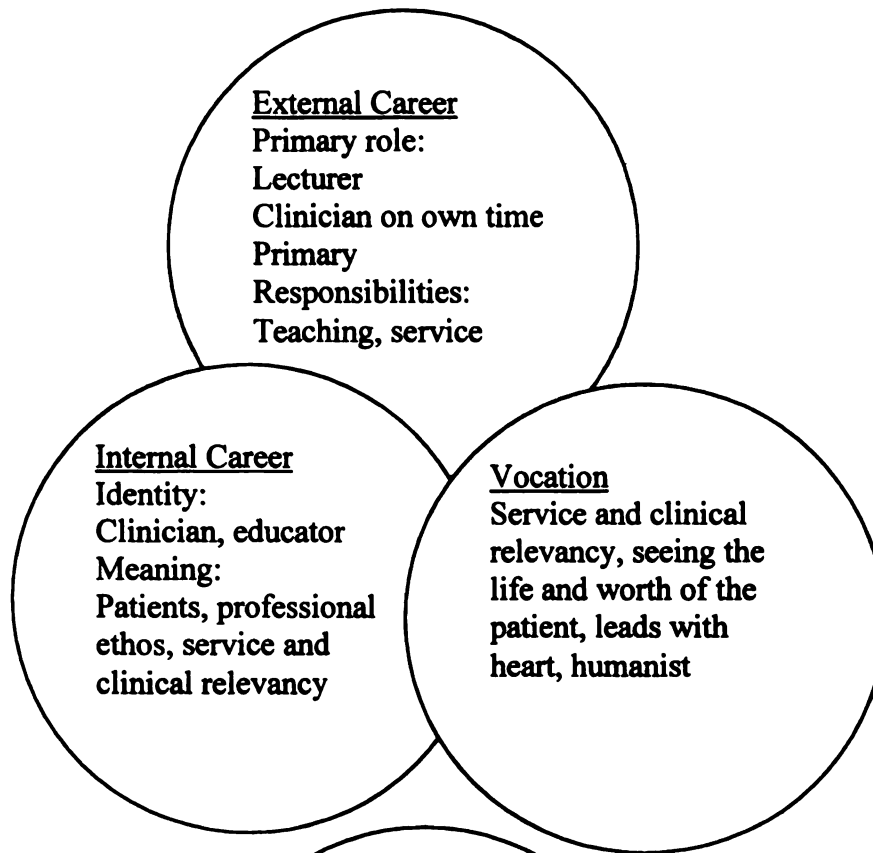
Summary of the Study

The purpose of this study was to describe and analyze the internal careers and vocation of physical therapy faculty as they entered into academic careers. Careers were conceptualized as having three interrelated components; the external career, the internal career and vocation. In-depth interviews were conducted with four participants, David, Susan, Carol and Mark, who are physical therapy faculty members. The stories of the participants revealed that there were four common issues in the external careers of

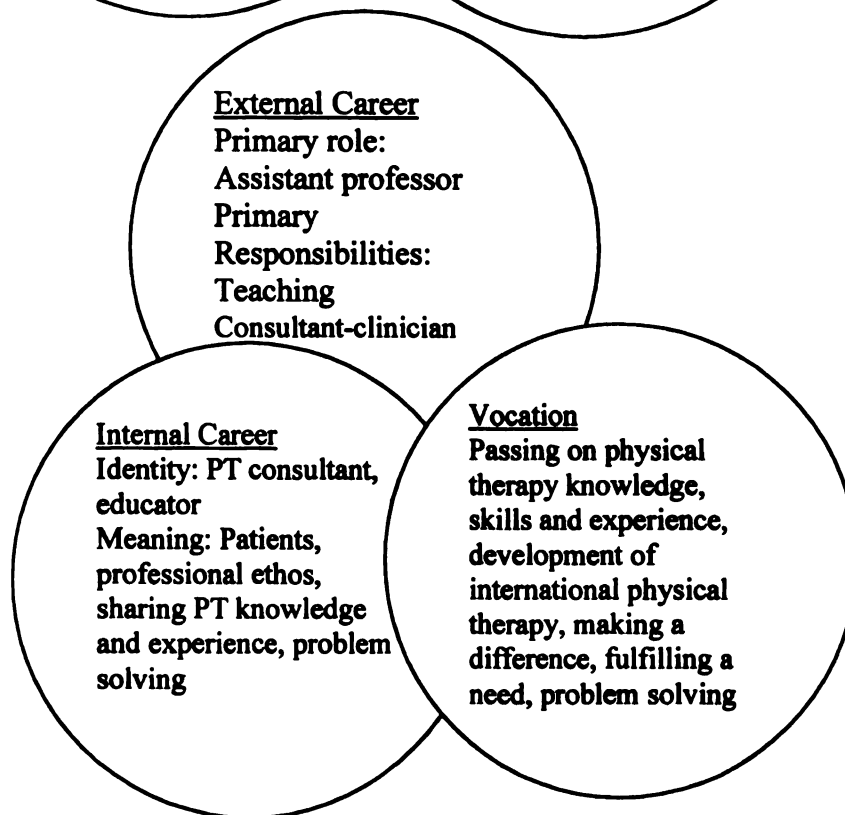
the participants as they transitioned into academic careers.

Those four issues, in addition to issues new faculty usually face, included obtaining a doctoral degree, managing a clinical role, perceiving possibilities in an academic setting and managing responsibilities in professional education. Participants described two common themes in their internal careers that were meaningful to them, the centrality of patients and the expression of the professional ethos in physical therapy. Participants also described personal meaning related to their vocations in their internal careers. See Figure 11, which depicts the external career, internal career, and vocation for each of the participants. Figure 12 summarizes the transition process.

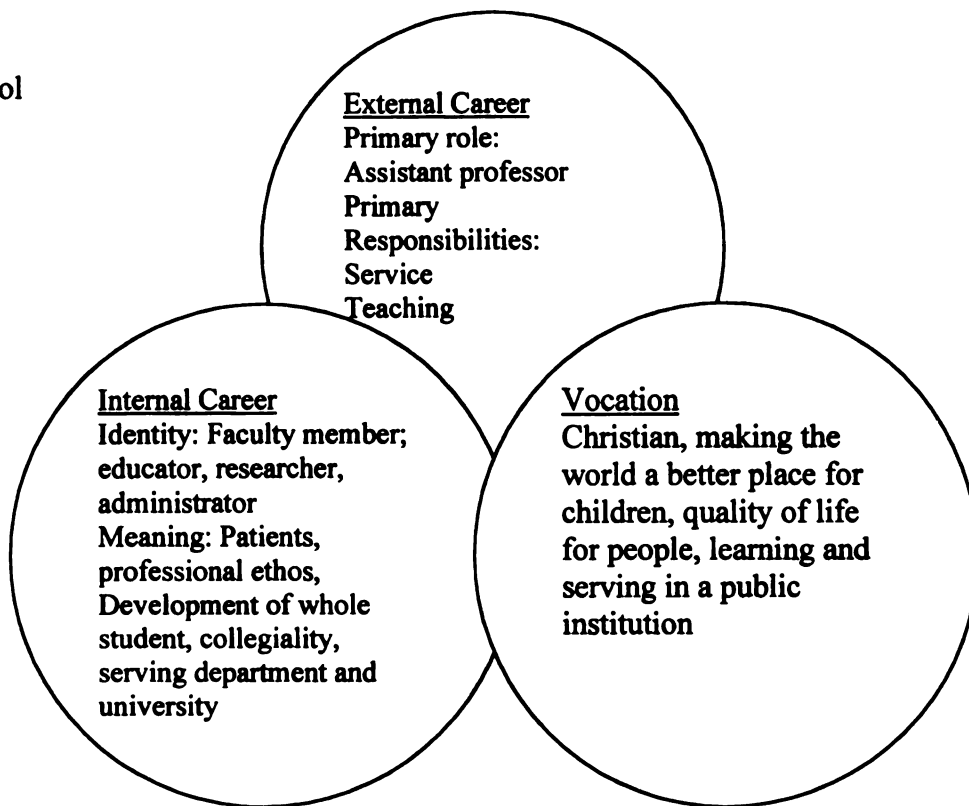
Figure 11 The External Career, Internal Career and Vocation of the Participants
David



Susan



Carol



Mark

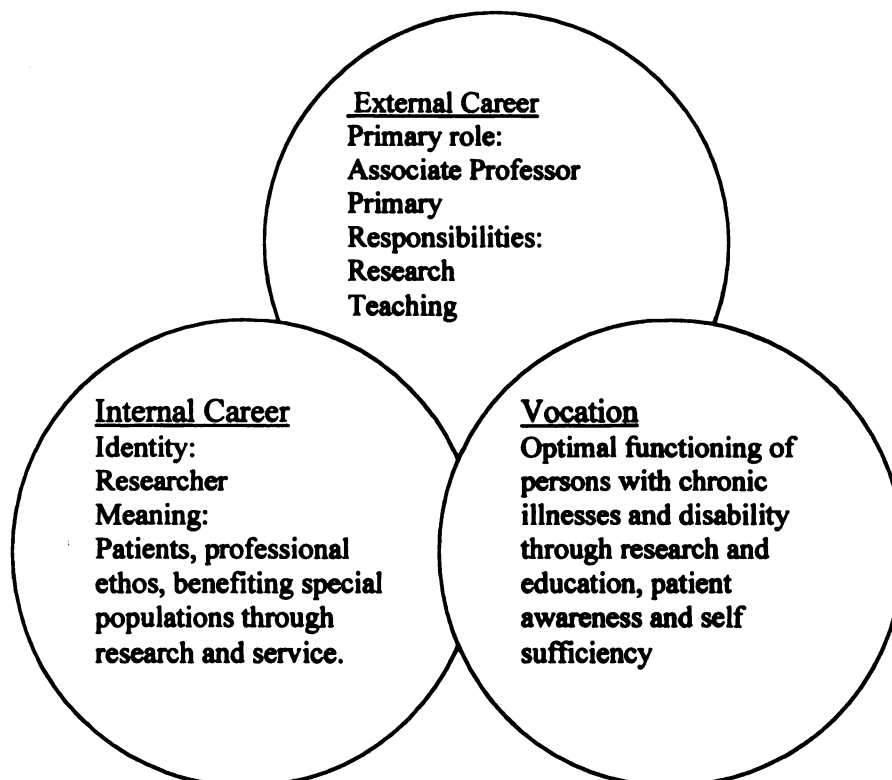
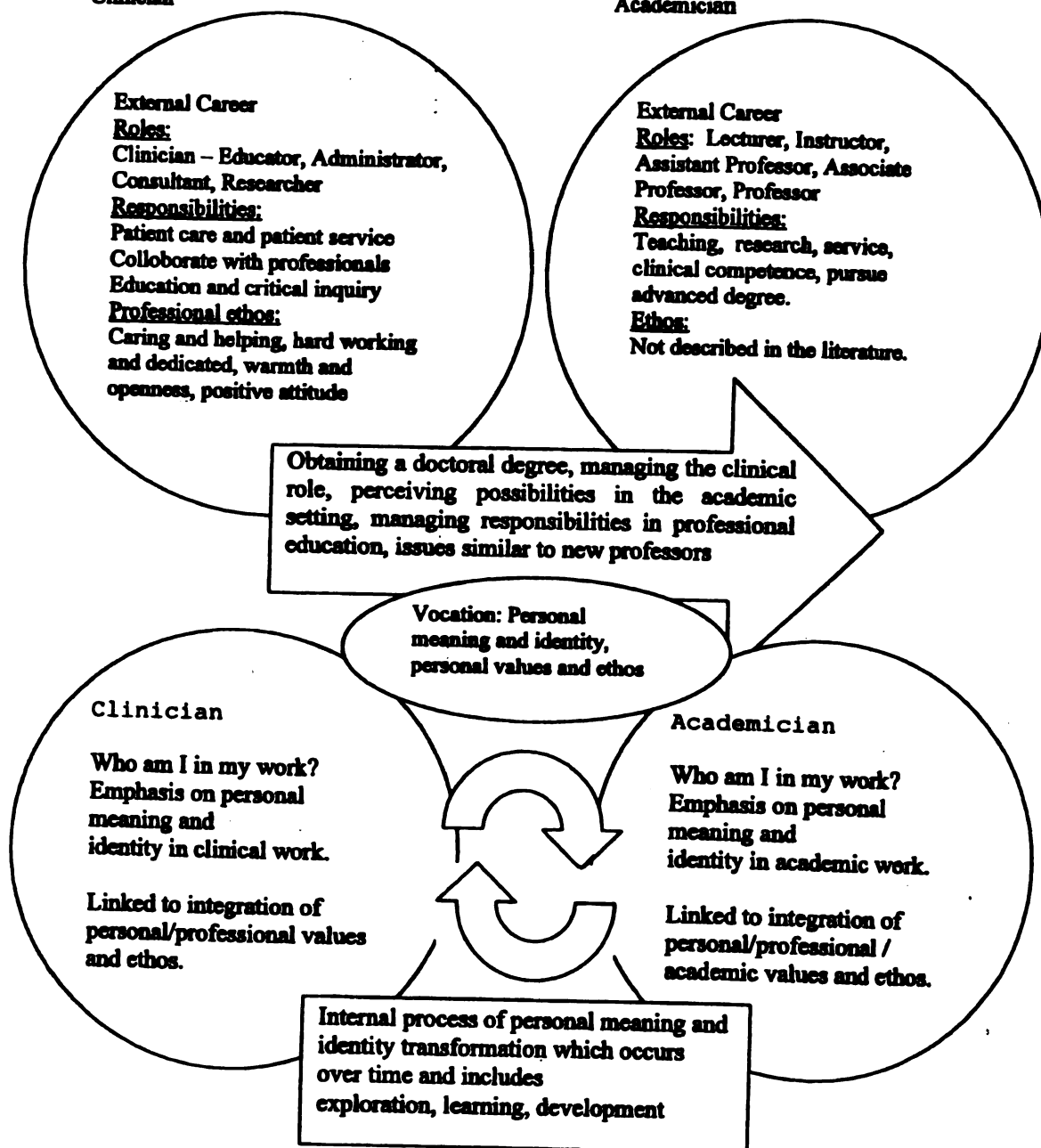


Figure 12 **The Career Transition Physical Therapy Clinician to Academician**



Implications for Physical Therapy Faculty Academic Career Development

Physical therapy faculty members are expected to fulfill a number of responsibilities as academic faculty including teaching, research, scholarship, service, obtaining an advanced degree and maintaining clinical competence (Rothman and Rinehart, 1990). As many physical therapy faculty come from the clinical ranks there is a need for strong faculty development programs. Faculty development programs should not only address skills needed to undertake these responsibilities but should also address issues in the internal career.

Faculty development programs can help faculty to address issues of personal meaning and identity transformation by recognizing that there is an internal career that emphasizes personal meaning and identity. The internal career transition is an internal process of personal meaning and identity transformation that occurs over time and includes exploration, learning and development. There are several approaches to faculty development that might facilitate this internal development process.

Reading narratives or stories of physical therapy faculty may be useful in this process (Arthur and Rousseau, 1996; Merriam and Caffarella, 1999). Using narratives makes the internal career more explicit. Making the internal career more explicit might impact on the perceptions of the external career. The use of reflection and journal writing in understanding internal career development may be helpful as it is a personal and internal process. Developing a personal narrative or story about how and why one became a faculty member might be helpful to faculty. As one of the participants' commented it is necessary to think about the important things, such as your vocation or life work, because otherwise you tend to lose focus.

On going and life long learning is critical to success in academic careers. The participants in the study felt that learning by experience and being able to learn by experience was an important component of their development as faculty members. A development program that helped faculty to effectively learn from their experiences is important. One form of learning from experience suggested in the adult education literature is reflective practice (Merriam and Caffarella, 1999).

Reflective practice includes reflection-on-action and reflection-in-action. Reflection-on-action might include portfolio development, journal writing and critical reflection. The important component in these activities is to "frame critical observations and questions" (Merriam and Caffarella, 1999, p. 236). Issues of personal meaning and identity in the internal career could be addressed and clarified through reflective practice.

Rachel C. Livsey in collaboration with Parker Palmer has authored a guide which suggests a variety of ways for teachers to "explore the inner landscape of a teacher's life" (Livsey and Palmer, 1999, p.1). This guide could be used as a basis for faculty development on the internal career. There are two parts to the guide. The first part prepares the reader for the process of reflection and the second part suggests "issues about self and colleagues, students and subjects that can help teacher reflect on their vocation" (Livsey and Palmer, 1999, p.3). The guide can be used by individuals or by a group of faculty.

Reflection-in-action is thinking while you are doing. Schön has described reflection-in-action as, "what we are doing while we are doing it" (Schön as cited in Merriam and

Caffarella, 1999, p. 236). Reflection-in-action requires that we pay attention and focus our mind's energy.

Reflection-in-action is critical to a reflective life.

Using narratives, reflection and journal writing would stimulate a discussion on professional academic values.

Discussion and the use of narratives might facilitate the development of a professional/academic ethos in physical therapy education. The development of an ethos for physicians teaching in academic and clinical settings has been suggested for medicine. Hitchcock, Hekelman, Monteiro and Snyder (1997) note,

"Physicians are taught the ethics of medical practice as part of their preparatory training. However, no one teaches physicians the values and ethics of academic life when they become faculty. In fact, to date the values and behavior codes of academic medicine have remained largely unwritten. ... the absence of a comprehensive definition of academic values and ethical codes in medical education provides a tenuous environment for faculty. What are the standards of conduct appropriate in classrooms, ward rounds, clinical consultations, departmental faculty meetings, grading students, and evaluating colleagues? Answers to these questions must, at present, be extrapolated from the general education literature. Perhaps, it is time to construct such a description to assist family medicine faculty" (p. 266-267).

Faculty in physical therapy would also benefit from exploring and developing values and an ethos which would guide their academic efforts.

Implications for Professional Education

Burton Clark (1993) notes that professional education differs from a liberal education. He also notes that the discipline and the institution are important in the actions of academics. Clark states,

"Disciplinary locations and institutional locations together compose the primary matrix of induced and enforced similarities and differences among American academics. These two internal features of the system itself are more important than such background characteristics as class, race, religion, and gender in determining the thought and behavior of academics" (p.164).

It is important to examine the factors in the external career, internal career and vocation of faculty in professional education given the difference in professional education from liberal education and that disciplinary influence is critical to understanding the behavior of faculty.

Faculty development involves more than skill development in faculty roles and responsibilities. Making the internal career of academic faculty who are involved in professional education more explicit is important. Sharing the experiences; the stories of personal meaning and identity transformation may influence perceptions of the external career. Faculty may have a clearer or more realistic idea

of what is possible in an academic career and more accurate perceptions of the external career. Faculty involved in professional education also need an understanding of their professional ethos and to explore the relationship between the professional and academic ethos.

Limitations and Suggestions for Future Study

There were several limitations in this qualitative study. There were a limited number of participants who were purposefully selected from two physical therapy programs. The participants were selected with different characteristics but were not intended to be a representative sample of all junior physical therapy members. The sample size and the method of selection limits the generalizability of the results to the larger population of physical therapy faculty. However the value of narrative, qualitative studies does not necessarily lie in their ability to be generalized. Polkinghorne (1990) suggests research efforts on careers should be focused on generating case histories of career development in individual lives. The emphasis he suggests should be on developing rich, deep narratives about particular people. Polkinghorne suggests that narratives produce knowledge

that is suggestive rather than predictive and shares the creative and unique characteristics of human beings.

The study focused on two aspects of careers, the internal career and vocation. There are other factors which influence careers and their development such as environmental factors and factors in the external career. There appears to be a relationship between external, internal careers and vocation. The other factors and their relationships might be explored in future studies.

Seidman (1998) suggests that in-depth interviewers can address the validity of the study by asking the question of whether or not the participants comments are valid (p.17) He suggests checking for internal consistency of the participants comments in this study appear to be consistent over the set of three interviews. The participants all read and reviewed the profiles for accuracy.

The researcher is recognized in qualitative studies as being part of the interviewing and meaning making process (Seidman, 1998). I was the only researcher in this study and I am also a physical therapy faculty member. My background and experience as a physical therapist and

physical therapy faculty member influenced the results. I could relate to many of the experiences that the participants discussed in their stories. The analysis and interpretation of their stories are also what makes sense to me in terms of my background and experience.

Future study

Physical therapy faculty members are involved in professional education. Professional education of necessity differs from traditional liberal arts education. There is a need for understanding the careers; external internal, and vocation of professional faculty to undertake effective faculty development efforts.

Future research efforts might focus on exploring the components of careers as well as the organizational and occupational environment in which the careers are located. What is the relationship between external careers, internal careers and vocation? Future research efforts might also address questions raised earlier in the study such as, What is the "ethos" or culture for academic physical therapy faculty who have roles and responsibilities in both the academic and professional or clinical worlds? Is there or can there be an ethos for faculty which blends or

recognizes this reality? How does "socialization" or acculturation to the academic ethos affect physical therapy faculty members roles, responsibilities, and teaching as physical therapists? When are you the physical therapist and when are you the academic? When are you the physical therapist role model and when are you the academic? How does this relate to the socialization of students into the profession? How does the expression of the ethos relate to the students learning? Is there an underlying set of values, a professional ethos for physical therapy faculty?

Burton Clark (1993) notes, "Under all the strengths and weaknesses of American academic life, we can sense the persistent problem of the professional calling. A calling transmutes narrow self-interest into other-regarding and ideal-regarding interests: one is linked to fellow workers and to a version of a larger common good. The calling has moral content, it contributes to civic virtue" (p.176). The study of personal meaning and vocation in academic work can help to contribute to more satisfying and significant efforts in faculty development and in professional education.

APPENDIX A

PARTICIPANT INFORMED CONSENT FORM

PARTICIPANT INFORMED CONSENT FORM

Vocation in Academic Careers: A Qualitative Study of Physical Therapist Faculty

I am conducting a study to describe and understand the academic work of faculty members in physical therapist education programs. The study will examine how and why physical therapists become academic faculty members, the roles and responsibilities of physical therapist faculty members and the meaning academic work has for physical therapist faculty members. I am a physical therapist on the faculty of a physical therapist education program. This study is being conducted as partial fulfillment of the requirements for my Ph.D. in education administration at Michigan State University.

Your participation in this study will provide valuable information about vocation and the meaning of academic work for physical therapist faculty members. You qualify for participation in this study if you are 1) a physical therapist, and 2) a full time faculty member and 3) in a physical therapist education program. You will be asked to participate in a series of three, ninety minute interviews scheduled over a period of one to four weeks. The interviews will be tape recorded and transcribed. You will also be asked to complete a questionnaire regarding your academic work and academic career. The questionnaire will take about 15 minutes.

The names of the participants will be kept confidential. Pseudonyms will be used in reporting the results of the study. Participation in this study is completely voluntary. You may withdraw from the study at any time. You may refuse to answer any questions and ask to have the tape recorder turned off at any time.

Interview data will be used in the dissertation. Interview data may also be used in publications and presentations. Quotes, profiles or vignettes may be used in the dissertation, publications and/or presentations. Profiles and vignettes are more lengthy excerpts from the interview transcripts of one person. If a profile or vignette is developed from your interview transcripts you will have the opportunity to review the profile or vignette. If you choose to review the profile or vignette you may choose to delete some or all of the material.

There is limited psychological risk in reviewing your academic career and activities. This study will contribute to an understanding of academic work and career development, especially the development of physical therapist educators. There is no remuneration for participation in this study.

If you have questions regarding this study you may contact the committee chairperson, Dr. Steve Weiland at Michigan State University, (517) 355-2395, 410 Erickson Hall, Michigan State University, E. Lansing Michigan 48824 or the Chairperson of the UCRIHS at Michigan State University, Dr. David E. Wright, (517) 355-2180.

Your signature on this consent form indicates that you have read and understand this form and that you consent to participate in this study.

Thank you for your assistance.

Investigator:

Kris Thompson, MPH, PT
(248) 540-8321 (h)
(248) 370-4096 (w)
thomp156@pilot.msu.edu

20094 Carriage Lane
Beverly Hills MI 48025

Participant:

Date

Name (Please print)

Signature

APPENDIX B

PARTICIPANT INFORMATION FORM

PARTICIPANT INFORMATION FORM

Vocation in Academic Careers: A Qualitative Study of Physical Therapy Faculty

Instructions: Please complete the following questions. Thank you.

Name: _____

Address: _____

Phone number: _____

Fax number: _____

E-mail: _____

1. Gender: (Please check one) _____ Female _____ Male
2. Are you a physical therapist?
(Please check one) _____ Yes _____ No
3. Are you employed full time as a faculty member in a physical therapist education program? (Please check one) _____ Yes _____ No
4. In what month and year did you begin employment at your current institution? _____
5. How many years, including all of your faculty positions, have you been a faculty member? _____
6. What is your current academic rank? _____
7. Are you tenured? _____ Yes _____ No. If no,
are you on a tenure track? _____ Yes _____ No.

8. In what areas are your earned degrees? If you are currently enrolled in a degree program indicate the degree that you are pursuing.
Please complete all that apply.

Year received

Bachelor _____

Master _____

Doctoral _____

9. Please indicate any other certifications you have such as American Physical Therapy Association Clinical Specialist.

Year received

Year received

- 10.a. Please estimate the total number of hours you work each week.

- b. Please indicate the percentage of time that you spend as a faculty member on these activities in an academic year.

<u>Activity</u>	<u>Percentage of Time</u>
A. Teaching	_____
B. Research	_____
C. Advising	_____
D. Administration	_____
E. Patient Care	_____
F. Committee Responsibilities	_____
G. Service Responsibilities	_____
H. Professional Responsibilities	_____

Thank you.

APPENDIX C

PARTICIPANT INTERVIEW GUIDE

PARTICIPANT INTERVIEW GUIDE

Interview One: Coming to vocation in academic work

Introduction by the interviewer.

This is the first of three interviews that we have scheduled. In this interview I will be asking you to tell me how you became an academic faculty member in a physical therapist education program.

(State date, time, interview number one and name of the participant.)

Questions for the participant.

- 1. How did you become an academic faculty member in a physical therapist education program?**
- 2. Why did you become an academic faculty member?**
- 3. What were your expectations of academic work?
of being a faculty member?**
- 4. What were you hoping to do when you became a faculty member?
How has that changed over time?**
- 5. What work experiences have you had that led to your becoming an academic faculty member? Can you tell me about them?**
- 6. Can you tell me about your education or schooling to become a physical therapist faculty member?**

- 7. Can you tell me about the key people who have an an influence on you becoming a faculty member?**
family members? friends? colleagues? mentors? others?
- 8. Tell me about making the transition from clinician to educator.**
What, if anything did you find difficult in making the transition?
Was there anyone or anything that you found helpful in making the transition?
What did you find surprising?
- 9. Is there anything else you would like to tell me about how you became an academic faculty member?**

Interview Two: The description of vocation in academic work

Introduction by the interviewer.

This is the second of three interviews that we have scheduled. Today I am going to ask you to describe your academic work experiences.

(State date, time, interview number two, and the name of the participant.) Any comments or thoughts from the first interview?

Questions for the participant.

- 1. What do you do as an academic faculty member?**

Questions for exploration.

Do you teach? Tell me about your teaching.

Do you do research? Tell me about your research.

Do you advise students? Describe your advising activities .

Are you involved in service activities?

Tell me about those service activities.

Are you involved in patient care?

Tell me about your involvement in patient care?

What do you find difficult?

How do you prioritize your work as an academic faculty member?

What do you think you do best?

How has your work changed over time?

- 2. With whom do you work?**

Questions for exploration.

Tell me about your work and interaction with other faculty in the physical therapy department.

Tell me about your work and interaction with staff.

Tell me about your work and interaction with students.

What about your work and interaction with faculty outside the physical therapy department?

Exploration:

How are the interactions characterized by the participant?

What are the levels or frequency of interaction (none, low, moderate, high)

How satisfying are the interactions?

How are the interactions the same or different from those as a clinician?

3. Describe your current appointment? How are you reappointed? What are expectations for promotion and tenure?

.4 What is a typical "week" like?

What is a typical "semester" like?

5. Is there anything else that you would like to tell me about your work as an academic faculty member?

Interview Three: The reflection on vocation in academic work

Introduction by the interviewer.

This is the third of three interviews that we have scheduled. We have talked about how you became an academic faculty member and the work that you do as an academic faculty member. In this interview I will be asking you to reflect on your work as an academic faculty member. I will be asking you what you see yourself doing in the future.

(State date, time, interview number three and name of participant.)

Questions for the participant.

- 1. You have talked about the work that you do as an academic faculty member. (Briefly review from the previous interview). What is your perception of the work that you do as an academic faculty member?**
- 2. What do you think is the most important work that you do as an academic faculty member?**
Explore teaching, research, service, patient care.
- 3. What do you think is your most significant contribution as an academic faculty member?**
To students, to program,, to faculty, to university, to profession?
- 4. What gives you the most satisfaction as an academic faculty member?**
- 5. What do you find most difficult as an academic faculty member?**

6. As you consider your academic work, describe what have been the most important or key events for you? Why? What has the impact been on your work?
What has been most memorable?
What has been most meaningful or significant?
7. What rewards does academic faculty work hold for you?
How are the rewards the same or different from your work as a clinician or in patient care?
8. How would you hope to be remembered as a faculty member?
9. Have you heard the term life's work? How do you define the term life's work? Do you consider yourself to have a life's work? Can you tell me about your life's work?
10. What do you see yourself doing in the future?
Questions for exploration.
What do you see yourself doing in your academic work?
in research?
in teaching?
in service?
in patient care?
11. Is there anything else you would like to tell me about yourself as an academic faculty member in a physical therapist education program?

APPENDIX D

PARTICIPANT DESCRIPTION TABLES

PARTICIPANT DESCRIPTION TABLES

Table 1 PARTICIPANT GENDER, UNIVERSITY, RANK AND YEARS AS FACULTY

Name	Gender	University	Rank	Years as Faculty (Full time, part time, adjunct)	Years as full time PT faculty	Years as full time faculty at current institution
Susan	Female	B	Assistant Professor	9	4	4
David	Male	C	Lecturer	5	5	5
Carol	Female	C	Assistant Professor	12	5	5
Mark	Male	B	Associate Professor	11	3	1

Table 2 PARTICIPANT TENURE, DEGREES AND CERTIFICATION

Name	Tenured	On Tenure Track	Highest Degree	Working on Doctoral Degree	Specialist Certification
Susan	No	No	Two Masters	No	APTA: Certified Specialist
David	No	No	Masters in Physical Therapy	Yes, Education	No
Carol	No	Yes	Ph.D., Movement Science	N/A	No
Mark	No	Yes	Ph.D., Exercise Physiology	N/A	ACSM: Ex.Program Director , Clinical

Table 3 PARTICIPANT PRIMARY RESPONSIBILITIES

Name	Primary Responsibilities
Susan	Teaching and clinical work
David	Teaching
Carol	Committee work and teaching
Mark	Research and teaching

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