

The Participation Of Occupational Therapy Faculty In Clinical Practice

2005

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THE PARTICIPATION OF
OCCUPATIONAL THERAPY FACULTY
IN CLINICAL PRACTICE

by

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A dissertation submitted in partial fulfillment of the requirements
for the degree of Doctor of Education
in the Department of Educational Research, Technology and Leadership
in the College of Education
at the University of Central Florida
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ABSTRACT

The purpose of this research study was to examine the current use of clinical practice by full-time occupational therapy faculty members. Clinical practice, including faculty clinical practice and moonlighting were addressed. The seven research questions addressed were: (a) the perceived benefits of clinical practice as identified by occupational therapy faculty members; (b) the perceived barriers to clinical practice as identified by occupational therapy faculty; (c) if perceived benefits and barriers of clinical practice as identified by occupational therapy faculty differ as a function of their academic institution's Carnegie Classification (The Carnegie Foundation, 2000); (d) if perceived benefits and barriers of clinical practice differ among respondents according to tenure at the institution, tenure status, doctoral degree, rank, administrative duties, and gender; (e) the incidence of clinical practice in occupational therapy faculty members; (f) the relationship between participation in clinical practice and the Carnegie classification of the occupational therapy member's academic institution; (g) the characteristics (tenure status, doctoral degree, rank, administrative duties, and gender) of faculty members that participate in clinical practice either within or outside the faculty role; and (h) the characteristics of clinical practice as described by faculty members and how these differed if the clinical practice is conducted as part of the faculty role or outside the faculty role.

Data were collected using an on-line survey that contained 43 questions designed to elicit information that addressed the research questions. The surveys were electronically mailed to the population of full-time occupational therapy faculty members

obtained from a search of each academic program's website. A total of 224 responses were obtained. Descriptive statistics, ANOVAs, and Chi Square Test of Associations were used to analyze the data for the independent variables.

The results showed that 60 respondents indicated that they participated in some type of faculty clinical practice as part of their faculty role. Most of this work was in a facility that was associated with the academic institution. Most of these respondents were not tenured, did not have a doctoral degree, and did not participate in administrative tasks. Most of these respondents worked in Doctoral-Extensive universities and held the Assistant Professor rank. Most worked two to four hours per week and did not receive release time or financial benefits.

There were 99 respondents that indicated that they participated in moonlighting in a wide variety of settings. Most worked in their area of clinical expertise. Most of these respondents were not tenured and did not participate in administrative tasks. Only 37% had a doctoral degree. Over half had the rank of Assistant Professor. Almost 42% worked in Masters I academic institutions. Most worked less than 2 hours per week outside the faculty role and they received full financial benefits.

The top three benefits for participating in clinical practice were to maintain clinical skills, enhance teaching, and improve credibility with students. The top three barriers for participating in clinical practice were teaching responsibilities, not a component in tenure decisions, and the additional responsibilities of practice. There were no statistically significant differences between the benefits or barriers to clinical practice and the Carnegie Classification of the respondent's academic institution. One ANOVA

was significant between the barriers to clinical practice and if the respondent had a doctoral degree. There were no statistically significant differences between the benefits or barriers and tenure at the institution, the respondent's tenure status, the respondent's degree status, faculty rank, administrative duties, and gender except the respondents that had a doctoral degree had significantly higher barrier scores than those that did not have a doctoral degree. In general, less than five percent of the variance was explained by any of the independent variables.

None of the Chi Square analyses revealed any significant differences between the academic institution's Carnegie Classification and if clinical practice was required, if a faculty participated in faculty clinical practice, or if a faculty member participated in moonlighting.

In conclusion, although many faculty members recognize the benefits to participation in clinical practice, the barriers to clinical practice may be too great to outweigh the benefits for some faculty members. Most reported that clinical practice carried little weight in promotion or tenure decisions. In order for the scholarship of practice to flourish, active support from all academic institution administration is critical.

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CHAPTER 1

INTRODUCTION

Clinicians in the various health care settings frequently complain that academic faculty are removed from the issues of clinical practice (Budden, 1994; Peloquin & Abreu, 1996). Faculty may not be aware of “cutting edge” interventions. Therefore, students are not learning the necessary skills to survive in the clinic (Peloquin & Abreu, 1996; Richmond, Mossberg, & Rahr, 2001). To address this perceived gap, having occupational therapy faculty participate in clinical practice has been advocated.

Clinical practice occurs in two ways: faculty clinical practice and moonlighting. Faculty clinical practice (FCP) has been defined as “consulting or working in a clinical setting under the auspices of one’s role as a faculty member” (Scoggin, Gibson & Hanson, 2000, p. 533). Other faculty members may be employed outside of the academic setting, but their work is not part of their faculty role. This is referred to as moonlighting, which is usually an additional source of income for the faculty member (Budden, 1994).

Clinical practice has been advocated in nursing (Budden, 1994; Pohl, Duderstadt, Tolve-Schoeneberger, Uphold, & Hartig, 2002), public health (The Association of Schools of Public Health (ASPH), 2000), occupational therapy (Peloquin & Abreu, 1996; Scoggin et al., 2000), and in other health professions (Richmond et al., 2001). The purpose of clinical practice is to allow faculty to provide services or consultation for clients or organizations for which they may or may not receive financial reimbursement.

The ultimate outcome is to contribute to the faculty member's research agenda (Braveman, Helfrich, & Fisher, 2001; Budden, 1994).

Some types of clinical practice do not require a contract. However, clinical practice may be addressed in the faculty member's contract (Scoggin et al., 2000), or in a contract between the clinical setting and the academic institution (Gregg & Williams, 2001; Savage, Broski, & Olson, 1986). However, little research has focused on the benefits and barriers of participating in clinical practice in full-time occupational therapy faculty. The proposed study will examine the use and occurrence of clinical practice by full-time occupational therapy faculty members, including identification of the perceived benefits and barriers to clinical practice.

Benefits of Clinical Practice

Benefits of clinical practice have been identified for the institution and for the individual faculty member in the literature (Savage et al., 1986). From an institutional viewpoint, academic health centers have used FCP to provide additional revenue for their academic programs (Savage et al., 1986; Scoggin et al., 2000). Other benefits to the institution include maintaining currency in the curriculum, additional sites for student practice, research (Richmond et al., 2001; Scoggin et al., 2000), and better ties to the community (Richmond et al., 2001).

Benefits of clinical practice to faculty members include supplementing income, increasing opportunities for collaboration in scholarly endeavors with clinicians (Peloquin & Abreu, 1996; Richmond et al., 2001; Scoggin et al., 2000), personal

fulfillment, and enhanced believability with students (Scoggin et al., 2000). Faculty members that supervise students at a clinical site also have the benefit of bridging the gap between theory and practice (Baillie, 1994; Peloquin & Abreu, 1996). Faculty members also have the benefit of making important contacts in the field that may enhance their research agendas (Scoggin et al., 2000). Faculty members can also maintain their clinical skills needed for licensure (Budden, 1994).

Barriers to Clinical Practice

There are institutional barriers to participation in clinical practice. If faculty members want to establish a clinic within the academic institution, there is often a lack of adequate space for a clinic or inadequate funding for necessary equipment (Richmond et al., 2001; Savage et al., 1986). Space issues are important when clinical practice is part of the faculty role within the institution.

One of the biggest institutional barriers is the lack of recognition of clinical practice in the promotion and tenure process (Budden, 1994; Scoggin et al., 2000). Clinical practice was not considered in promotion or tenure decisions by 51% of the respondents in a survey of the National Organization of Nurse Practitioner Faculties (Pohl et al., 2002). In a small sample of occupational therapy department chairpersons, 71% reported that clinical practice contributed to the promotion and tenure process. However, the weighting of clinical practice in this process was not provided (Scoggin et al., 2000).

Some faculty members have become disinterested in clinical practice (Richmond et al., 2001) because the perceived rewards were not significant enough to offset the lack of institutional recognition (Scoggin et al., 2000). There is the perception that research production would be diminished when participating in clinical practice. However, this has not been an accurate assumption in the nursing field (Acorn, 1991). Another barrier to clinical practice for faculty members is difficulty juggling academic and practice duties. Time spent in the clinic is time that could be spent in meeting with students or revising course content, leading to decreased teaching effectiveness as perceived by students (Richmond et al., 2001). Academic colleagues or clinicians may also misperceive the role of the academic faculty member, thus not allowing the faculty member to meet his or her practice goals (Baillie, 1994; Peloquin & Abreu, 1996). Another barrier concerns junior faculty members. They would have difficulty in completing an advanced degree while maintaining clinical practice because of the time commitments for everything (Rodgers, 1986).

Occupational Therapy Faculty and Clinical Practice

Scoggin et al. (2000) surveyed all occupational therapy faculty members and occupational therapy department chairpersons in accredited occupational therapy programs on their perceptions of faculty clinical practice. Their definition of FCP included any agreement between the university and a clinic that allowed a faculty member to offer consultation or direct care for clients served by the clinic, with a focus on scholarly production for the faculty member. They used two surveys: one for

chairpersons that included yes or no or forced rankings and an open-ended survey for the faculty members. All data were analyzed by reporting the percentage of respondents that gave that answer. Each will be discussed individually.

Results from Occupational Therapy Department Chairpersons

Overall 59% of the respondents reported that their institution had faculty clinical practice. Faculty clinical practice was more common in public institutions (68%) than private institutions (43%). Institutions affiliated with an academic health center were more likely to have FCP (80%). Most chairpersons indicated that individual faculty members handled their FCP (13 of 19 programs) (Scoggin et al., 2000).

Department chairpersons were asked to rank order the perceived benefits of FCP. Fourteen chairpersons ranked benefits in the following order: (a) producing income for the department, (b) allowing the faculty member to maintain clinical skills, (c) increasing faculty income, (d) contributing to teaching skills, (e) allowing for contacts for research production, (f) training opportunities for students, and (g) meeting or exceeding promotion or tenure guidelines (Scoggin et al., 2000).

The barriers to FCP identified by 16 chairpersons included (a) a lack of institutional support for FCP; (b) a belief that teaching, not clinical practice, served the mission of the institution; (c) a lack of time due to requirements of the institution; (d) a focus on meeting tenure and promotion requirements; (e) difficulties in obtaining the necessary liability insurance; and (f) competition from acute-care therapists working in academic health centers (Scoggin et al., 2000).

Results from Occupational Therapy Faculty Members

Overall, 24% (n = 162) of the faculty member surveys, representing 46 academic programs, were returned. Only 32% of the respondents indicated that they had worked in FCP in the last year. Most respondents were in public institutions (64%). Respondents reported an average of 20 years in the occupational therapy profession, with an average of 9 years in teaching. Most of the respondents (68.4%) had master's degrees and 29.4% of the surveys were completed by tenured faculty members. Most respondents indicated that they worked in FCP between 4 and 8 hours per week (Scoggin et al., 2000).

The benefits of FCP as identified by the 44 faculty members that responded were (a) maintaining currency of practice (73%), (b) establishing and renewing contacts (36%), (c) individual satisfaction (41%) and (d) supplementing income (16%). One of the strongest reasons that faculty members gave for participating in FCP was the benefit for teaching and increased credibility with students. The respondents frequently commented on the benefits of having case examples to use during class to illustrate different principles (Scoggin et al., 2000).

Faculty members identified several barriers to clinical practice. These included: (a) lack of time (38%), (b) lack of support from the academic institution (35%), (c) lack of clinical practice as part of the job description (8%), (d) lack of opportunities within specific areas of practice expertise (5%), (e) a belief that education was the faculty member's area of clinical expertise (5%), and (f) individual preference (2%) (Scoggin et al., 2000).

Summary of Research on Clinical Practice

Clinical practice has been advocated to help faculty members remain current and to help bridge the theory-practice gap (Baillie, 1994; Peloquin & Abreu, 1996). The benefits and constraints of clinical practice for occupational therapy faculty identified by Scoggin et al. (2000) are consistent with those found in other literature. However, Scoggin et al.'s (2000) small return rate and narrow definition of faculty clinical practice may not accurately reflect the current state of clinical practice by occupational therapy faculty. In addition, their open-ended questions to faculty members may not have allowed the faculty member to fully express ideas because the respondent did not think of that answer. Forced-choice questions may help identify benefits and barriers more accurately.

Statement of the Problem

The following question guided this investigation: “What are the benefits, barriers, and characteristics of clinical practice to full-time occupational therapy faculty members in accredited occupational therapy academic programs?”

Purpose of the Study

The purpose of this study was to examine the current use of clinical practice by occupational therapy faculty. Clinical practice, including FCP and moonlighting, were addressed. Information that can be generalized to a broader population of occupational

therapy faculty is needed to identify the reasons, benefits, and constraints of participating in clinical practice.

Research Questions

The research questions for this study were:

1. What were the perceived benefits of clinical practice as identified by occupational therapy faculty members?
2. What were the perceived barriers to clinical practice as identified by occupational therapy faculty?
3. Do perceived benefits and barriers of clinical practice as identified by occupational therapy faculty differ as a function of their academic institution's Carnegie classification (The Carnegie Foundation, 2000)?
4. Do perceived benefits and barriers of clinical practice differ among respondents according to tenure at the institution, tenure status, doctoral degree, rank, administrative duties, and gender?
5. What was the incidence of clinical practice in occupational therapy faculty members? Is participation in clinical practice related to the Carnegie classification of the occupational therapy member's academic institution?
6. What were the characteristics (tenure status, doctoral degree, rank, administrative duties, and gender) of faculty members that participate in clinical practice either within or outside the faculty role?

7. What were the characteristics of clinical practice as described by faculty members and how do these differ if the clinical practice is conducted as part of the faculty role or outside the faculty role?

Definition of Terms

For the purpose of this study, the following operational definitions applied.

Perceived benefits - factors that are traditionally perceived as assisting the faculty member in meeting faculty role expectations.

Clinical practice - the provision of occupational therapy services to clients or organizations. This may include consultation, evaluation, intervention, or education. In most cases, clinical practice results in billing the client or organization for services rendered. Clinical practice may result in advancing the research agenda of the faculty member and may result in reimbursement to the faculty member for the services. There are two levels of clinical practice: moonlighting and faculty clinical practice.

Moonlighting - practice as an occupational therapist that is not part of a faculty role. This generally takes place outside of normal working hours. It may include working evenings or on the weekends. Services are generally billed by the faculty member or through an agency that is not affiliated with the academic institution or the occupational therapy program.

Faculty clinical practice - provision of clinical practice that is defined as part of the faculty role. This generally takes place during normal working hours. Services are generally billed through the academic institution or the occupational therapy program.

Occupational therapy faculty members - occupational therapists that are full-time faculty-line employees of the occupational therapy program within an academic institution.

Occupational therapy (OT) program - a program that is currently accredited by the Accrediting Council on Occupational Therapy Education (ACOTE) to provide an occupational therapy education program within an academic institution.

Carnegie classification - the academic institution's level based on the type of program and the number of degrees granted as determined by The Carnegie Foundation (2000). There were 6 levels for this study: (a) Doctoral/Research Universities - Extensive (Level 1), (b) Doctoral/Research Universities - Intensive (Level 2), (c) Master's Colleges and Universities I (Level 3), (d) Master's Colleges and Universities II (Level 4), (e) Baccalaureate Colleges (Level 5), and (f) Specialized Institutions (Level 6).

Doctoral/Research Universities - Extensive - the academic institution offers a wide variety of programs and awards a minimum of 50 doctoral degrees a year in at least 15 disciplines.

Doctoral/Research Universities - Intensive - the academic institution offers a wide variety of programs and awards a minimum of 20 doctoral degrees a year or at least 10 doctoral degrees in at least 3 disciplines.

Master's Colleges and Universities I - the academic institution offers a wide degree of baccalaureate programs and awards a minimum of 40 master's degrees in at least 3 disciplines.

Master's Colleges and Universities II - the academic institution offers a wide degree of baccalaureate programs and awards a minimum of 20 master's degrees.

Baccalaureate Colleges - the academic institution offers primarily a baccalaureate degree in liberal arts, general studies, or includes associate's degrees.

Specialized Institutions - the academic institution specializes in medicine, allied health, nursing, or other medical related specialties.

Characteristics of clinical practice - the respondent's reported level of participation in clinical practice. It includes (a) identification of the type of clinical practice (moonlighting or faculty clinical practice), (b) an indication whether the clinical practice is considered to be in the faculty member's clinical expertise area, (c) the type of clinical practice settings that are being used, (d) whether the clinical practice and release time is included in the faculty member's contract, (e) the number of hours per week that is spent in clinical practice, and (f) the financial implications of the clinical practice.

Assumptions

The following assumptions were made for this study:

1. Full-time occupational therapists that were occupational therapy faculty members at academic institutions participated in clinical practice, whether through an established faculty clinical practice plan through the academic institution, or through an independent arrangement with clients or organizations.
2. Occupational therapy faculty members had access to and used electronic mail through their academic institution.

3. Occupational therapy faculty members would complete an online survey.
4. Faculty listings on occupational therapy program websites were up-to-date.
5. Faculty members thoughtfully and honestly completed the online survey.

Limitations

The following limitations applied to this study:

1. This study was limited to occupational therapists that are employed full-time in occupational therapy programs as occupational therapy faculty members.
2. This study was limited to full-time occupational therapy faculty in graduate level programs.
3. The results from this study were limited to full-time occupational therapy faculty members that responded to the survey.
4. This study focused on the perceptions of clinical practice by occupational therapy faculty members.

Organization of the Study

Chapter 1 presents an introduction to the issues surrounding faculty practice and its benefits and barriers. Chapter 2 contains a review of the literature surrounding faculty practice. Chapter 3 contains the methodology used in the implementation of this study.

Chapter 4 contains the analysis of the collected data. Chapter 5 contains a discussion of the findings, with conclusions and recommendations for further research.

CHAPTER 2

LITERATURE REVIEW

This chapter presents an overview of the literature on clinical practice. It begins by discussing faculty work outside of academia. Next is a discussion of the origins of clinical practice, followed by a section on clinical practice models. This is followed by a discussion of the benefits and the barriers to clinical practice. Next is a discussion of how clinical practice contributes to promotion and tenure within the academic institution. The final section focuses on occupational therapy, including accreditation standards and studies that have examined clinical practice.

Faculty Work Outside Academia

About one third of full-time faculty members in institutions of higher education participate in work experiences that are outside of their academic responsibilities. Many higher education institutions encourage, support, and, in some cases, require their faculty members to participate in these experiences. Faculty are usually given up to one day per week of reimbursable outside work, which is usually included in the faculty contract (Academic Leader, 2004).

There are supporters and detractors for outside work. Supporters believe that the individual, their academic program, and the academic institution all benefit because of the enhanced reputation of each. This reputation can be used as a marketing or recruitment tool for more faculty members, students, or financial support. Detractors

believe that faculty should focus on institutional needs, because outside work may interfere with quality assurance for the institution (Academic Leader, 2004).

For full-time faculty members in the health care fields, outside work is called clinical practice. Clinical practice services may be offered to outside agencies or organizations, or may be offered by the academic program as part of an on-site clinic. The clinical practice may be within the scope of the faculty member's role within the academic institution. This is called faculty clinical practice (FCP) (Scoggin, Gibson, & Hanson, 2000). The faculty member may also choose to work outside of the academic institution. This is called moonlighting (Budden, 1994).

Origins of Clinical Practice

Faculty clinical practice has its origins in medical schools. Medicine and its accompanying emphasis on medical specializations flourished after World War II. Medical schools were established in close ties with academic health centers. Funding was readily available into the 1960s. The roles of physician as researcher, faculty member, and primary care provider were overlapping. As physician faculty members trained medical students, they could also conduct research and see patients that were admitted into the health center (Reilly, 1984).

However, funding slowly decreased with the development of Medicare and Medicaid reimbursement programs in the mid 1960s. One of the implications of this reimbursement change was the movement toward identification of a primary physician. Medicare and Medicaid wanted a primary care physician identified. These programs did

not recognize the academic health center physician as researcher, faculty member, and primary care provider. These programs resulted in changes in funding for academic health centers. As a result, academic health centers and medical clinics began actively searching for different funding sources (Reilly, 1984).

One solution to the funding crisis was for physicians based in academic health centers that were in different specialty areas to band together to form different practice plans (Reilly, 1984). These plans replicated “primary-style medical care” (Richmond, Mossberg, & Rahr, 2001, p. 26). This allowed the faculty member to be identified as a primary care physician and accordingly, bill for services rendered. These plans generated enough revenue to pay the physician’s salaries (Relman, 1981).

Physician practice plans, also known as faculty practice plans, were widespread by 1970. Over the years, these plans have continued to flourish. Provision of clinical services allowed the faculty member to stay abreast of clinical practice needs, trends, and technologies. Provision of education as an academic faculty member allowed the faculty member to research and integrate information from a variety of sources. This combination of clinical services and access to knowledge assured “cutting edge” care for patients receiving clinical services (McNiel & Mackey, 1995).

Funding has also decreased in other health related programs in higher education. This has caused many higher education programs in the health professions to look for alternative funding sources (Savage, Broski, & Olson, 1986; Peloquin & Abreu, 1996; Richmond et al., 2001). One alternative funding option was to establish faculty practice plans similar to the physician practice plans. The concept of faculty practice plans,

known as faculty clinical practice (FCP), has carried over into nursing (Budden, 1994; McNiel & Mackey, 1995; Pohl, Duderstadt, Tolve-Schoeneberger, Uphold, & Hartig, 2002), public health (Aday & Quill, 2000; ASPH, 2000), other health professions (Richmond et al., 2001; Savage et al., 1986), and occupational therapy (Braveman, Helfrich, & Fisher, 2001; Peloquin & Abreu, 1996; Scoggin et al., 2000). All of these are practice-based professions that rely on contact with health care consumers.

Institutions of higher education have the option of allowing any, some, or no outside work opportunities or clinical practice for faculty members. For example, the institution may permit certain types of employment opportunities and exclude others, such as working for another academic institution. In other instances, departmental approval may be required before initiating outside work. Others may allow any type of work with the provision that faculty disclose the types and reimbursement of any outside work. Others may explicitly deny outside work opportunities for faculty members (Academic Leader, 2004).

Models of Clinical Practice

Several models of clinical practice are found in the literature: the unification model (Savage et al., 1986; Budden, 1994), the free standing clinic, contractual services, the joint faculty/clinical appointment (Savage et al., 1986) which is also called the collaboration model, the private practice model, the integration model, moonlighting (Budden, 1994), consulting, and education (Miller, Bleich, Hathaway, & Warren, 2004).

The unification model is seen in academic medical centers where the academic department and the department that serves patients in and outside the hospital are merged. The department chair in the academic department is also the director of the hospital-based program. The chair makes all human resource and budgeting decisions for both departments (Savage et al., 1986). Faculty members from the academic department may participate in patient care either in the hospital or in an outpatient clinic associated with the hospital (Scoggin et al., 2000).

In the free standing clinic, faculty members in the academic department provide outpatient services. These clinics may or may not be affiliated with the academic institution. Clinics that are associated with the academic institution are considered faculty clinical practice. The clinic may also be with an independent service provider that is in no way affiliated with the academic institution (Savage et al., 1986). This would be considered moonlighting (Budden, 1994).

In contractual services, the faculty member or the academic program establishes a contract with an outside agency or organization to provide necessary services. These services may be provided within the academic setting or in another location depending upon what is needed (Miller et al., 2004; Savage et al., 1986). For example, the work may involve a paper evaluation of services, conducting an audit, or reviewing outcomes. At other times, the faculty member may be providing direct intervention with clients or organizations (Braveman et al., 2001). If the contract is with the academic program, this model provides less risk to the academic program provided that the remuneration for the services covers the faculty member's income and benefits (Miller et al., 2004).

The joint faculty/clinical appointment model (Savage et al., 1986) is also called the collaboration model (Budden, 1994). The faculty member is partially funded through the academic department and through the clinic associated with the position (Savage et al., 1986). The faculty member in the joint appointment divides time between the clinical setting and the academic department. This is common in nursing programs (Budden, 1994).

The integration model includes students and faculty members working together to provide clinical services. This model is also common in nursing programs (Budden, 1994).

In private practice, the faculty member provides direct clinical services to clients. Students may or may not be involved. Sometimes a contract is established between the faculty member and the private practice setting to provide services. At other times, there are no formal arrangements (Budden, 1994).

In moonlighting, there is no formal agreement between the academic institution or program and the recipient of services. Instead, the faculty member agrees to provide clinical practice outside their role as a faculty member. The goal of moonlighting is usually financial. It does not advance the research agenda of the faculty member (Budden, 1994).

Consultation may or may not be part of a contractual obligation. It may include working with clients or working with organizations to examine immediate or long term needs or outcomes. Research may be one of the outcomes. If the academic program

develops a consultation model, various faculty members can work together to provide comprehensive services to an organization (Miller et al., 2004).

Education services include developing specific programs or seminars for clients or organizations. This may include developing Web-based learning opportunities, working with staff development in the outside workplace, or providing inservices on a given topic (Miller et al., 2004).

Benefits of Clinical Practice

Benefits of clinical practice have been identified for the institution, for the program, for the individual faculty member (Braveman et al., 2001; Hammel, Finlayson, Kielhofner, Helfrich, & Peterson, 2001; Savage et al., 1986) and for the outside organization in the literature (Braveman et al., 2001; Hammel et al., 2001). Each will be discussed individually.

Benefits of Clinical Practice for Institutions of Higher Education

Institutions of higher education that promote faculty participation in clinical practice are often recognized for their promotion of intellectual freedom. The reputation of the institution grows as the faculty member successfully works in the community. As the institutions' reputation spreads, more community and state organizations may want to pursue connections with the institution, leading to more funding opportunities for the institution, and more work opportunities for faculty (Academic Leader, 2004).

From an institutional viewpoint, academic health centers have used FCP to provide additional revenue for their academic programs because services are reimbursable through third party payors (Savage et al., 1986; Scoggin et al., 2000). Another benefit to the institution includes maintaining currency in the curriculums of the programs that have faculty members involved in clinical practice (Richmond et al., 2001).

Benefits of Clinical Practice for the Academic Program

The faculty member's academic program benefits from having faculty members work outside the institution just as the academic institution does. The program may be recognized for innovative program development or forward thinking. As more faculty members become involved, the status of the program within the academic institution and within the community grows (Braveman et al., 2001; Hammel et al., 2001). Grant funding to develop new programs or funding of research agendas may be more readily available as the program has a track record of successful implementation of programs through the efforts of individual faculty (Braveman et al., 2001). As outside funding sources increase, new full-time or adjunct faculty may be needed to help provide education to students (Copolillo, Peterson, & Helfrich, 2001).

Community organizations that are recipients of clinical practice can also help the program through curriculum development (Braveman et al., 2001; Peloquin & Abreu, 1996; Richmond et al., 2001). As agencies and organizations identify specific needs, the faculty member may translate those needs into specific assignments or into innovative

lines of research or service for the entire academic department (Braveman et al., 2001). The organization can also provide valuable learning opportunities in the classroom by having guest speakers come to speak with students (Peloquin & Abreu, 1996).

The academic program also benefits by having additional sites for its student placements for internship requirements. Opportunities for collaborative research between faculty members and clinical practice sites may also be more readily available (Richmond et al., 2001; Scoggin et al, 2000).

Benefits of Clinical Practice for Faculty Members

There are many benefits of clinical practice to faculty members. Faculty members may provide direct patient care, consult with and mentor clinicians, or serve as a consultant to clinics, organizations, or businesses. These consultations may focus on specific care issues or on programmatic issues (Peloquin & Abreu, 1996). Many faculty members feel that provision of clinical practice provides personal fulfillment (Scoggin et al., 2000) and allows an avenue to maintain their clinical skills needed for licensure (Budden, 1994).

Health care changes rapidly. Clinical practice helps the faculty member keep current with practice trends and medical innovations (Baillie, 1994; Budden, 1994) and to develop new skills and propose new programs as opportunities arise (Braveman et al., 2001). Health care advances also require faculty members and clinicians to understand both the science and its application. Within occupational therapy, a common theme is the perceived difference between the theory that is taught in the classroom and the realities of

clinical practice (Peloquin & Abreu, 1996). Doctoral-trained faculty members are uniquely able to bridge this gap if they participate in clinical practice and share their expertise with others in the clinic (Abreu & Neville-Jan, 1995).

Faculty members also have the benefit of sharing current clinical information with students to help bridge the gap between theory and practice (Baillie, 1994; Peloquin & Abreu, 1996). If faculty members provide services for outside agencies, awareness of resources in the community will increase. This can lead to more practical assignments for students, with “real life” examples of classroom teaching (Braveman et al., 2001). This will also provide enhanced believability with students because the faculty member practices what they preach (Scoggin et al, 2000).

Faculty members that participate in clinical practice also have the benefit of making important contacts in the field. This may enhance the faculty member’s research agenda (Scoggin et al., 2000) and increase opportunities for collaboration in scholarly endeavors with clinicians or organizations (Braveman et al., 2001; Hammel et al., 2001; Peloquin & Abreu, 1996; Richmond et al., 2001; Scoggin et al., 2000).

Many clinical practice positions, particularly moonlighting, are fee-for-service based. This results in supplemental income for the faculty member (Budden, 1994; Peloquin & Abreu, 1996; Richmond et al., 2001; Scoggin et al., 2000). However, some income may need to be returned to the academic program or institution based on contractual agreements with the faculty member (Gregg & Williams, 2001).

Benefits to the Community Organization

As faculty members talk with and provide clinical services to different organizations that are a match for the mission of the academic institution, contract relationships or partnerships may develop between the faculty member and that organization. These relationships benefit the organization because an experienced clinician provides consultative services to the organization. Initially, these services may be free or at a low cost. As the organization learns what the faculty member can do, and as the faculty member develops specific programs that meet the needs of the organization, a financial relationship is more apt to become a reality. In addition, the organization may help support alternative funding so that the occupational therapy services could be expanded (Braveman et al., 2001; Hammel et al., 2001).

Another benefit to organizations outside the academic institution that employ other occupational therapists is the mentoring that can occur between the faculty member and the staff occupational therapist (Peloquin & Abreu, 1996). Publications may also benefit both the faculty member and the organization (Braveman et al., 2001; Hammel et al., 2001; Peloquin & Abreu, 1996).

Benefits for Students

Faculty members that participate in clinical practice can influence student learning and increase student believability in what the faculty member says during class (Scoggin et al., 2000). Faculty members can share relevant clinical experiences with

students which serves to enhance student learning by linking theory and practice. Faculty members can also mentor students in the clinical setting (Peloquin & Abreu, 1996).

Students in nursing programs that participated in clinical practice with faculty members have been reported to have improved self-esteem and self-concept, a higher locus of control, better assimilation of the relationship between theory and practice, and more realistic workload expectations. Students can better integrate research into real life situations with clients and are more professional behaviors when working with faculty members (Budden, 1994).

Barriers to Clinical Practice

There are barriers to clinical practice that can be attributed to the institution or the department and to the faculty member. Each will be discussed individually.

Institution or Department Barriers to Clinical Practice

Some institutions do not allow any clinical practice. Others may limit the scope of practice possibilities by eliminating certain practice options such as working for another academic institution. Still other programs may require program director permission prior to faculty doing any clinical practice (Academic Leader, 2004).

Another issue is working out the details of any contractual requirements between the academic program and the contracting agency or between the faculty member and the contracting agency. Issues such as distribution of the percentage of net income must be

negotiated if it is not already set by the academic institution. Cost recovery issues for both the faculty member's salary and benefits must be addressed (Gregg & Williams, 2001).

If faculty members or academic departments want to pursue developing a clinic within the academic institution, there is often a lack of adequate space for a clinic or inadequate funding for necessary equipment (Richmond et al., 2001; Savage et al., 1986). Space issues are important when clinical practice is part of the faculty role within the institution. One of the biggest institutional barriers is the lack of recognition of clinical practice in the promotion and tenure process (Budden, 1994; Scoggin et al., 2000). This is discussed in the section after faculty barriers to clinical practice.

Faculty Barriers to Clinical Practice

Some faculty members have become disinterested in clinical practice (Richmond et al., 2001) because the perceived rewards were not significant enough to offset the lack of institutional recognition (Scoggin et al., 2000). There is the perception that research production would be diminished when participating in clinical practice. However, this has not been an accurate assumption (Acorn, 1991).

Academic colleagues or clinicians may misperceive the role of the academic faculty member. The academic colleagues may not appreciate faculty practice and only reward traditional scholarship activities. Therapists in the clinic may feel intimidated by the faculty member and thus not form collaborative working relationships. This may not

allow the faculty member to meet his or her practice goals (Baillie, 1994; Peloquin & Abreu, 1996).

Another barrier concerns junior faculty members. They would have difficulty in completing an advanced degree while maintaining clinical practice because of the time commitments for everything (Rodgers, 1986).

Another barrier to clinical practice for faculty members is difficulty juggling academic and practice duties. Time spent in the clinic is time that could be spent in meeting with students or revising course content, leading to decreased teaching effectiveness as perceived by students (Richmond et al., 2001).

Role strain has also been predicted for faculty members that work in joint appointments. Acorn (1991) examined the issues of role strain, role conflict, scholarly productivity and job satisfaction in 80 traditional nursing faculty members and 33 faculty members in joint appointments in nursing departments. There were no statistically significant differences between the groups in role conflict, role ambiguity, scholarly productivity, or job satisfaction, with all favoring the joint appointment faculty members. She did find a statistically significant relationship between role conflict, role ambiguity, and job satisfaction. Satisfaction was significantly negatively correlated with both role conflict and ambiguity ($r = -.51, p < .01$).

Finding release time for scholarly pursuits can be difficult. Academic programs that provide release time for faculty members to pursue clinical practice are preferred because of the time commitment involved (Braveman et al., 2001). Many OT programs rely on adjunct faculty to provide classroom teaching (AOTA, 1997; Copolillo et al.,

2001). Many of these adjunct faculty are employed at least part-time in clinical practice positions. Internal or external grant funds may be used to pay for the adjunct faculty to replace a full-time faculty member (Braveman et al., 2001). The intent is to allow the full-time person to pursue scholarly activity. Therefore, full-time faculty members in programs that use many adjunct faculty may not be participating in clinical practice because their time is devoted to other scholarly activity (Copolillo et al., 2001).

There are advantages of having adjunct faculty members in OT academic programs. If the adjunct faculty member works in the clinic, students are exposed to current practice. The adjunct can share current experiences and clinical stories with students. They can also share how the medical, social, and reimbursement systems are currently impacting the practice of OT (Copolillo et al., 2001).

However, adjunct faculty members do not have job security. The first year of teaching is very labor intensive, with no guarantee that the job will be available in future semesters. Receiving adequate and timely feedback to improve the course may not happen. Adjunct faculty members may not be familiar with the culture of the academic institution or may lack knowledge of how to design courses. All of these will negatively affect student perceptions of the academic program (Copolillo et al., 2001).

Clinical Practice and Promotion and Tenure Guidelines

A common problem in academic institutions is a lack of recognition of clinical practice in promotion and tenure decisions for the faculty member (Budden, 1994; Scoggin et al., 2000). Clinical practice was not considered in promotion or tenure

decisions by 51% of the respondents in a survey of the National Organization of Nurse Practitioner Faculties (Pohl et al., 2002). In a small sample of occupational therapy department chairpersons, 71% reported that clinical practice contributed to the promotion and tenure process. However, the weighting of clinical practice in this process was not provided (Scoggin et al., 2000).

Most academic institutions are still using the traditional definition of scholarly activity in awarding promotion and tenure to individual faculty members (Budden, 1994; Peloquin & Abreu, 1996; Pohl et al., 2002). Some (e.g., Aday & Quill, 2000; ASPH, 2000; Gregg & Williams, 2001; Richmond et al., 2001) have advocated using Boyer's (1990) definitions of scholarship which do provide a way to award clinical practice. The next section will examine Boyer's views of scholarship.

Boyer's View of Scholarship

Boyer (1990) advocated expanding the concept of scholarship to include four areas: the scholarship of discovery, scholarship of integration, scholarship of teaching, and scholarship of application. Each will be discussed individually.

The Scholarship of Discovery

The scholarship of discovery focuses on production of original research. The intent is to expand knowledge of given phenomena. Discovery has been the traditional focus of scholarly activity in higher education (Aday & Quill, 2000; ASPH, 2000; Boyer,

1990; Haertlein & Coppard, 2003) and has contributed to academic excellence for the faculty member and the academic institution (Boyer, 1990).

Individuals working in Carnegie I or II (The Carnegie Foundation, 2004) universities typically have high standards to meet in the scholarship of discovery. These universities are research intensive and offer many doctoral programs. However, most occupational therapy academic programs are not in doctoral intensive universities. This may be a contributing factor to the tendency for occupational therapy faculty members to produce less original research than many other professions (Haertlein & Coppard, 2003).

One of the problems with the scholarship of discovery is that clinically practicing therapists are unable to apply the new knowledge to the clinical setting, leading to a further rift between theory and practice or science and the clinician (Peloquin & Abreu, 1996). In addition, few OT faculty are actually contributing new knowledge to the field (Hammel et al., 2001).

The Scholarship of Integration

The scholarship of integration focuses on decoding, translating, and synthesizing original research to develop new views on previously explored phenomena. It includes finding and exploring links between research conducted by others. Integration occurs as the faculty member pulls together information from several sources (Aday & Quill, 2000; ASPH, 2000; Boyer, 1990). Occupational therapists that focus on the scholarship of integration are attempting to understand the meaning behind observed phenomena

(Haertlein & Coppard, 2003). Some OT faculty have published in this area (Hammel et al., 2001).

Integration is closely linked to the scholarship of discovery. The integrator helps synthesize knowledge from several sources, including discovery, to generate new ideas. If the integrator does not include discovery as one of the sources, then vital information that can change the viewpoint may never be included (Aday & Quill, 2000).

The Scholarship of Teaching

According to Boyer (1990), the scholarship of teaching focuses on examining how teachers teach. Boyer believed that teaching was a unique scholarly activity. It is an important area of scholarship because it has the “means to inspire future scholars in the classroom” (Boyer, 1992, p. 90). The descriptive aspect of the scholarship of teaching has focused on defining and categorizing what teachers do and how they do it (Trigwell & Shale, 2004). However, there has been controversy over what constitutes the scholarship of teaching (Kreber, 2002a; Trigwell & Shale, 2004).

All faculty members should teach well (Hutchings & Shulman, 1999). Faculty members that excel in the scholarship of teaching are excellent teachers. Scholarly teachers “share their knowledge and advance the knowledge of teaching and learning in the discipline in a way that can be peer-reviewed” (Kreber, 2002b, p. 18). The scholarly teacher uses a wider variety of sources to construct their knowledge than the excellent teacher. Both expert and scholarly teachers use self reflection and other methods to learn

about teaching. This increases their “declarative knowledge, procedural knowledge, and implicit knowledge of teaching and learning and the discipline” (p. 18).

The difference between the expert and scholarly teacher is that scholarly teachers make their knowledge available for public review (Kreber, 2002b). This public review provides a forum for others to evaluate and critique the scholarly work (Hutchings & Shulman, 1999). Therefore, the scholarly teacher is the highest level of teaching, followed by the expert teacher, then the excellent teacher (Kreber, 2002b).

Scholarly teachers also “know more about teaching” (Kreber, 2002b, p. 18). They seek out and use both personal and formal knowledge about how to teach. Scholarly teachers combine personal and formal knowledge with discipline specific knowledge “to construct pedagogical content knowledge” (p. 18). This pedagogical knowledge is further refined through the process of self reflection and public review (Badley, 2003; Kreber, 2002b).

Kreber (2002a) completed a Delphi study with 11 recognized experts in the scholarship of teaching in three phases. The purpose of this study was to reach consensus on the prominent characteristics of the scholarship of teaching and to identify unresolved issues that impact the scholarship of teaching. During the initial phase, each respondent answered questions related to the characteristics and to the unresolved issues. These answers were compiled, then sent to the same respondents again so they could complete a Likert scale ranking of each item. Kreber then compiled the information and identified the median point and interquartile range for the middle 50% of the responses. For the

final phase, she sent this information to the respondents to review their initial responses in view of the identified median and ranges.

Kreber (2002a) then compiled the information into two categories: those with a high degree of agreement and those with a low degree of agreement. She identified six factors with a high degree of agreement on what constituted the scholarship of teaching. The first factor was labeled “exploring relationships between teaching and learning, research, and integrating and applying knowledge” (p. 157). This implied that becoming an expert in the scholarship of teaching “involves curiosity, exploration, innovation, sharing, knowledge of how to conduct research as well as integrating and applying knowledge” (p. 157).

The second factor in Kreber’s (2002a) study was called “effective teaching through the wisdom of practice and standards of disciplinary scholarship” (p. 158). This implied that if effective teaching is the goal, the faculty member must realize that discipline specific knowledge, “learning about how students learn, and learning about the wisdom of practice” (p. 157) are all inter-related.

The third factor in Kreber’s (2002a) study was called “knowledge about teaching and learning through reflection on practice” (p. 158). This implied that experts believed that “reflection, preparation and inquiry” (p. 158) were important behaviors for the scholarship of teaching. The fourth factor was called “specific research skills, attitudes, and products” (p. 158). The focus of the scholarship of teaching is on assessment and research in the classroom to identify how teachers teach and students progress. Some type of publication is important in this factor.

Kreber's (2002a) fifth factor was called "development of pedagogical content knowledge through reflection" (p. 158). Discipline specific content knowledge is critical as is the need to constantly reflect on this while keeping in mind the context of teaching. The sixth factor was called "sharing and peer review of information and insight" (p. 159). This factor recognized the importance of contributing to the scholarship of teaching by designing, implementing, interpreting the use of various teaching methods and disseminating the information. Trigwell and Shale (2004) believed that putting these methods up for public review is an important component in the scholarship of teaching.

Trigwell and Shale (2004) also thought that the scholarship of teaching should focus on how students learn. Boyer did not include the concept of learning in his initial description of the scholarship of teaching (Badley, 2003). However, there is little distinction between the scholarship of teaching and the scholarship of discovery if the focus of scholarship of teaching focuses on knowledge about teaching. If the focus on scholarship in teaching is in teaching as opposed to about teaching, students and their experiences as the recipient of the teaching becomes a crucial part of the mix. Therefore, "the question of what links knowledge and learning" (Trigwell & Shale, 2004, p. 528) should be included in the scholarship of teaching.

Kreber (2002a) also identified four unresolved issues in her consensus study. First was "that the definition, criteria for assessment, and knowledge base for the scholarship of teaching are unclear" (p. 161). The second was that the process of acquiring knowledge about the discipline specific scholarship of teaching and what constitutes expert teaching are unknown. The third issue was that different terms have been used in

regards to teaching without a clear set of definitions. This has led to confusion and may contribute to the difficulty in having the scholarship of teaching recognized as a scholarly activity. The fourth issue was the uncertainty surrounding the use of new technologies and how these technologies will impact the scholarship of teaching. These issues will need to be addressed in the future.

Since occupational therapists are in academic programs, it is important that they study how their students learn about occupational therapy theory and practice methods (Haertlein & Coppard, 2003). This focus on learning is consistent with Badley's (2003) and Trigwell and Shale's (2004) emphasis on learning. In addition, students must complete a minimum of 24 weeks of supervised clinical experiences. Faculty may serve as the supervisor for these experiences. Thus, faculty need to be proficient at providing the right blend of experiences in the classroom and in the clinic to facilitate student learning (Haertlein & Coppard, 2003). This leads to the scholarship of application.

The Scholarship of Application

The scholarship of application provides the opportunity to link theory and practice (Boyer, 1990). Peterson (2000) agrees with Boyer's emphasis on theory and practice. However, he has carried Boyer's initial concept one step further by including links to research in with theory and practice. Research can and should be driven by practice needs, not just by theoretical or conceptual development (Kezar, 2000; Peterson, 2000).

For example, contextual issues that arise in practice arenas are important to study through systematic research (Peterson, 2000). Many important problems that need to be

addressed have been identified by clinicians. The clinicians and their organizations may lack the expertise to fully explore options. The faculty member that focuses on the scholarship of practice can be an excellent resource (Burgener, 2001). When links between faculty and clinicians are fully utilized, research results could be applied in real settings. As clinicians apply this knowledge, the researcher focusing on the scholarship of practice may generate new hypotheses that can then be tested by those focusing on the scholarship of discovery (Peloquin & Abreu, 1995). Unfortunately, many issues that clinicians believed to be significant have not been examined (Kezar, 2000).

The scholarship of application has also been called the scholarship of assessment or the scholarship of practice. The scholarship of assessment examines how the interpretation of information gained in the evaluation process is employed to modify behavior or the environment (Braveman et al., 2001; Haertlein & Coppard, 2003). The scholarship of practice emphasizes having faculty members develop innovative programs or participate in ongoing programs located in community settings (Aday & Quill, 2000; ASPH, 2000; Braveman et al., 2001; Haertlein & Coppard, 2003).

Burgener (2001) has offered suggestions on how to distinguish between the scholarship of practice and other areas of scholarship. The traditional research role assumes that the faculty member is the expert. To be successful in the scholarship of practice, the faculty member must either collaborate with or inspire others to action. There is an implied partnership. As problems develop, the faculty member must focus on the problem and on the needs of the individual or of the community.

Effective communication skills are a hallmark of the scholarship of practice (Boyer, 1990). The faculty member must avoid academic jargon because it contributes to an elitist attitude and separation from the individual and the community. The effective scholar must practice listen carefully to others individually or in groups, meet with others in their environments, and be sensitive to cultural issues (Burgener, 2001).

The faculty member participating in the scholarship of practice must have the knowledge and skills needed to meet the demands of the situation. This means that faculty members that work with clients or organizations must keep themselves educated about all clinical issues and the types of consumers (patients or family member) that face those issues. The importance of including the consumer's needs in research has been recognized by the National Institute of Health. They require researchers that are doing patient-oriented research to spend at least 25% of their time with the recipients of the service (Burgener, 2001).

Boyer (1990) emphasized showing significant results. Within the scholarship of practice, these results can be focused on the benefits to the recipients of the services. Health outcomes for individuals or communities are an especially important benefit to document in the health professions. This is different from statistical significance that has been emphasized in traditional research. However, the payoffs may be greater because there is real-world significance (Burgener, 2001).

On the other hand, sometimes programs or services do not work (Burgener, 2001). In traditional research, some hypotheses are rejected. In the real world, the researcher focusing on the scholarship of practice must deal with the repercussions if a

program or idea does not work. Sometimes clinicians or consumers are upset. The effective researcher must use clear and open communication with all to help maintain trust. The faculty member must remember that successful scholarship of practice involves collaboration. The researcher must be flexible and “be prepared to take detours along the way, venture into uncharted territory and go with the flow” (p. 51).

Dissemination of results via publications in peer-reviewed journals or professional presentations is another hallmark of research. In addition to the traditional sources, wider dissemination of results within the scholarship of practice may be appropriate. For example, using the local media to publicize findings is an excellent way to enlist community support. This information can also be shared with legislators, thus influencing public policy (Burgener, 2001).

Because there are many variables when dealing with real people in the practice setting, research findings may be more challenging to transfer to other settings. However, as new research findings are generated in different settings, patterns of commonalities may be identified. These commonalities provide support for new knowledge across settings, leading to new theories (Burgener, 2001).

As previously mentioned, the scholarship of application has strong links to teaching. The faculty member must be presenting current information in the classroom that may be gained through clinical practice. The faculty member also presents the theories that guide practice (Peloquin & Abreu, 1995). Academic programs that focus on professions such as medicine, education, communications, or business have helped forge links between theory and practice. The concept of being a reflective practitioner has been

used by these professions. Reflective practitioners are scholars that link theory with practice (Boyer, 1992).

Some OT academic programs have developed the scholarship of practice and integrated it such that both students and faculty members benefit (Braveman et al., 2001; Hammel et al., 2001; Kielhofner, Hammel, Finlayson, Helfrich, & Taylor, 2004). Faculty members approach outside agencies that could benefit from some form of OT, from direct client care to program evaluation. Once the faculty member is familiar with the setting, students participate in fieldwork I and II experiences under the supervision of the faculty member. Advanced master's degree and doctoral students also participate in the programs under the mentorship of the faculty member. These students' theses and dissertations also come from this practice. Over time, the faculty member's scholarship of discovery and integration directly benefit from the time spent in scholarship of application. In addition, all students get to see the bridge between theory and practice, as the faculty member generates and guides hypothesis development and empirical testing.

Outcomes research in occupational therapy has its basis in the scholarship of practice (Kielhofner et al., 2004). Outcomes research involves four processes. First is to accurately identify the client's needs. This is a critical step. Failure to accurately identify needs may lead to programs that are not wanted or utilized. Identifying needs may be accomplished by the faculty member either informally or more formally through needs assessment research.

The second step is to identify or create programs or services or processes that best meet those needs (Kielhofner et al., 2004). These services must be based on theoretical

principles as well as on evidence that demonstrates that these services are apt to be successful. The theoretical framework clarifies “(1) what characteristics are in an individual, group, or context are targeted for change . . . (2) how the proposed services will achieve the alterations in these characteristics, and (3) how the changes . . . lead to the targeted outcomes” (p. 16). The importance of this step is that if or as change happens in the practice setting, the researcher is also collecting evidence about the theory. The faculty member is perfectly suited for matching theory to program needs.

The emphasis on process in the second step is to thoroughly document service provision. For example, identifying factors that help clients participate in programs would be very important to ensure carryover from one client to another one. The emotional experiences of clients that receive services may provide valuable insight into the success of a program or service and thus be important to know for future programming or services (Kielhofner et al., 2004).

The third step in outcomes research is to collect detailed data on the services that were provided and its influence on individuals or other consumers such as the community. This is the process of “generating new evidence about service outcomes” (Kielhofner et al., 2004, p. 17). There are three possible strategies for the researcher. First is to evaluate a particular intervention method or tactic, which leads to improved strategies to use in the next setting. Second is to evaluate a particular program. This provides real world significance of the service. Third is to evaluate the contribution of a particular person or profession to the client or community. The emphasis here is on interdisciplinary care and the contribution of one component to the overall program.

The fourth step in outcomes research is to collect and evaluate the evidence that is accumulating. Steps one, two and three are all included in this step. A formal needs assessment sets the stage for appropriate service determination. The program must also be assessed for effectiveness as it is being implemented. If positive changes are not occurring, then changes can be made immediately to ensure better success. Evaluating a specific technique, an overall program, or one person's contribution to the program are all needed to add weight to the evidence that a program is effective (Kielhofner et al., 2004).

The Relationship Between the Scholarship of Application and Promotion and Tenure

A lack of objective measurements of the scholarship of application has hindered its acceptance into the promotion and tenure process. The promotion and tenure process at most institutions tends to emphasize scholarship of discovery or the scholarship of integration. In fact, many faculty members perceive that if they participate in the scholarship of practice, their research will be questioned (Kezar, 2000). Boyer (1990) advocated for the scholarship of application and including it in the promotion and tenure process. Those faculty members that spend more time in clinical practice should have more weight on the scholarship of practice than in any of the other areas during their promotion and tenure review (Aday & Quill, 2000).

Glassick, Huber, and Maeroff (1997) have developed a six step method that can be used to assess any of Boyer's (1990) levels of scholarship. First, the goals should be set such that the faculty member's responsibilities are clearly delineated and the

department chair has agreed to those goals. Second, new goals will require more preparation to develop unique documentation formats to show the scope of the scholarship. Third, methods to evaluate progress must be objective. Evaluation methods must ensure progress, not provide unnecessary road blocks (Aday & Quill, 2000; Glassick et al., 1997).

Fourth, participation in specific types of scholarship should result in intellectual stimulation and development for the faculty member. Fifth, presentation of the scholarship activity should be in an atmosphere that promotes openness. Sixth, the scholarship activity must meet expected norms, yet be flexible enough to adapt as new knowledge is gained (Aday & Quill, 2000; Glassick et al., 1997).

The faculty member also must possess certain characteristics that make participation in non-traditional areas of scholarship more successful. One characteristic is integrity. This implies that the faculty member is fair and ethical. Another characteristic is perseverance. The faculty member needs to stick with a line of scholarship long enough to determine if it is working adequately. This may take several years. The last characteristic is courage (Aday & Quill, 2000; Glassick et al., 1997). Participation in the scholarship of integration, teaching, or application is outside the normal scope of many universities, particularly those that are research intensive/doctoral institutions. Faculty members must have the courage and conviction to stand behind their line of scholarship if it is not well accepted by the academic institution.

Summary of Clinical Practice and Promotion and Tenure Guidelines

The implications for clinical practice for occupational therapists vary among the different levels of scholarship. The scholarship of discovery may be difficult for many occupational therapy faculty members, particularly if they are not working in research intensive/doctoral granting universities. Clinical practice may not be possible for those in research universities because of the time commitment necessary for discovery. The scholarship of integration focuses on pulling many pieces of information together to modify knowledge. Clinical practice may be available to this person as they apply old information or methods to different situations to generate new solutions.

The scholarship of teaching offers clinical practice opportunities because of the requirements for supervision of students during fieldwork experiences. Faculty members may choose to make themselves available in the clinic so that students can complete Level I or Level II fieldwork experiences under the faculty member's supervision.

The scholarship of application offers the best opportunities for clinical practice. Through its links to practice and assessment, the OT faculty member has the opportunity to develop programs that fit the needs of the community and its consumers. Several OT faculty members have developed programs in various settings. Some of these programs also provided student supervision opportunities (Braveman et al., 2001; Cohn, Dooley, & Simmons, 2001; Fleming, Christenson, Franz, & Letourneau, 1996; Hammel et al., 2001; Peloquin & Abreu, 1996; Rydeen, Kautzmann, Cowan, & Benzing, 1994; Shordike & Howell, 2001).

Occupational Therapy and Clinical Practice

Clinical practice for full-time occupational therapy faculty members is valued by many academicians (Braveman et al., 2001; Peloquin & Abreu, 1996). Accreditation standards and promotion and tenure guidelines for faculty members influence the use of clinical practice in the academic setting.

Accreditation Standards

All occupational therapy (OT) programs located in institutions of higher education are accredited by the Accreditation Council for Occupational Therapy Education (ACOTE). ACOTE addresses the standards for OT faculty members in the Academic Resources section of the ACOTE Standards for an Accredited Education Program (ACOTE, 1998). Faculty members “must possess the necessary academic and experiential qualifications and backgrounds . . . appropriate to meet program objectives” (p. 2). The interpretation for this standard indicates that the OT program must document that individual “faculty member’s expertise in their area(s) of teaching responsibility” (ACOTE, 2004, p. 4).

No specific standard states that faculty must participate in clinical practice. However, other standards state that “faculty responsibilities shall be consistent with the mission of the institution” (p. 5) and that “each full-time faculty member shall have a written continuing professional growth and development plan” (p. 5). Clinical practice is one method that may be used to show continuing professional growth.

Student clinical experiences are also a requirement in the Standards. Fieldwork I experiences occur while the student is enrolled in classes. Typically, they are one or two days a week experiences that last for at least part of a semester or trimester. The student may or may not be supervised by occupational therapists. The purpose of Fieldwork I is to expose the student to a variety of settings in order to develop their observation skills and to begin to participate in the OT process (ACOTE, 1998).

Some OT programs have developed on-site clinics that are supervised by OT faculty members (K. Howell, personal communication, September 7, 2004; P. Marvin, personal communication, September 7, 2004). Other programs have developed relationships with outside agencies. These agencies may contract with the academic program to have a faculty member come and provide clinical practice and/or to supervise OT students (Braveman et al., 2001; Rydeen et al., 1995; Schmalz, Flores, & Hadlock, 1997). Both the on-site clinic and the outside agency contract provide Fieldwork I experiences to students.

Fieldwork II experiences generally take place upon completion of the didactic portion of the OT academic program. Students are required to complete a minimum of 24 weeks of full-time fieldwork experience. The student's supervisor must be an occupational therapist with a minimum of one year of experience. This supervisor may be employed full-time or part-time by the site or may be contracted full-time or part-time to the site by the academic OT program. If the supervisor is part-time, a minimum of six hours a week of supervision by an occupational therapist is mandatory (ACOTE, 1998). Different OT academic programs have developed part-time supervision models using OT

faculty members to provide the necessary supervision (Braveman et al., 2001; Cohn et al., 2001; Fleming et al., 1996; Shordike & Howell, 2001).

Occupational Therapy Faculty and Clinical Practice

Scoggin et al. (2000) surveyed all occupational therapy faculty members and occupational therapy department chairpersons in accredited occupational therapy programs on their perceptions of faculty clinical practice. They used a narrow definition of FCP:

An arrangement (formal or informal) that exists between a clinical setting and a university that allows faculty to consult and deliver client care resulting in research and scholarly outcomes. Although it is not a prerequisite, revenue is often generated by the FCP. FCP is generally not considered part of the faculty member's teaching and research responsibilities; however, it can be part of the academic contract. FCP is sanctioned by the college of university. (p. 535).

They used two surveys: one for the chairpersons and an open-ended survey for the faculty members. Each will be discussed individually.

Results from Occupational Therapy Department Chairpersons

Forty four questions on the chairperson's survey addressed the time that faculty spent in clinical practice, how the practice was administered, the clientele that was serviced, and how the faculty member was compensated. Most of these questions were yes or no or forced rankings. The survey concluded with a section for the chairperson to express his or her opinion (Scoggin et al., 2000). Due to a low return rate, data was analyzed by reporting the percentage of respondents for each question.

Overall, 44% (n = 39) of the chairperson surveys were returned, with 59% of these chairpersons reporting that their institution had faculty clinical practice. However, not all respondents answered every question, making it difficult to interpret the results. The chairperson surveys collected demographic information about the program. Chairpersons reported that more public institutions (68%) had FCP than private institutions (43%). Institutions affiliated with an academic health center were more likely to have FCP (80%). Most chairpersons indicated that individual faculty members handled their FCP (13 of 19 programs). Most institutions did not include FCP in the faculty member's contract (3 of 16 programs). In examining FCP and promotion and tenure, 15 of 21 programs reported that FCP contributed to decisions. Release time for FCP was reported by 19 of 20 chairpersons. Only 6 of 17 programs reported full monetary compensation for the faculty member, with most reporting that the department received at least partial compensation (Scoggin et al., 2000).

The department chairpersons were asked to rank order the perceived benefits of FCP. Fourteen chairpersons ranked benefits in the following order: (a) producing income for the department, (b) allowing the faculty member to maintain clinical skills, (c) increasing faculty income, (d) contributing to teaching skills, (e) allowing for contacts for research production, (f) training opportunities for students, and (g) meeting or exceeding promotion or tenure guidelines (Scoggin et al., 2000).

The barriers to FCP identified by 16 chairpersons included (a) a lack of institutional support for FCP; (b) a belief that teaching, not clinical practice, served the mission of the institution; (c) a lack of time due to requirements of the institution; (d) a

focus on meeting tenure and promotion requirements; (e) difficulties in obtaining the necessary liability insurance; and (f) competition from acute-care therapists working in academic health centers (Scoggin et al., 2000).

Results from Occupational Therapy Faculty Members

This survey focused on 24 open-ended questions, with the respondents reporting their ideas and opinions about faculty clinical practice and moonlighting. These questions elicited the respondent's opinions on (a) why the faculty member did or did not engage in FCP, (b) the perceived benefits and constraints of participating in FCP, (c) the administrative structure of the FCP, and (d) why the faculty member engaged in moonlighting (Scoggin et al., 2000). Due to the low return rate, all data were analyzed by reporting the percentage of respondents that gave that answer.

Respondents also provided demographic information. Overall, 24% (n = 162) of the faculty member surveys, representing 46 academic programs, were returned. Only 32% of the respondents indicated that they had worked in FCP in the last year. Most respondents were in public institutions (64%). Respondents reported an average of 20 years in the occupational therapy profession, with an average of 9 years in teaching. Most of the respondents (68.4%) had master's degrees and 29.4% of the surveys were completed by tenured faculty members. Most respondents indicated that they worked in FCP between 4 and 8 hours per week (Scoggin et al., 2000).

The benefits of FCP as identified by the 44 faculty members that responded were (a) maintaining currency of practice (73%), (b) establishing and renewing contacts

(36%), (c) individual satisfaction (41%) and (d) supplementing income (16%). One of the strongest reasons that faculty members gave for participating in FCP was the benefit for teaching and increased credibility with students. The respondents frequently commented on the benefits of having case examples to use during class to illustrate different principles (Scoggin et al., 2000).

Faculty members identified several barriers to clinical practice. These included: (a) lack of time (38%), (b) lack of support from the academic institution (35%), (c) lack of clinical practice as part of the job description (8%), (d) lack of opportunities within specific areas of practice expertise (5%), (e) a belief that education was the faculty member's area of clinical expertise (5%), and (f) individual preference (2%) (Scoggin et al., 2000).

Summary of Occupational Therapy and Clinical Practice

Occupational therapy is a practice profession. Accreditation standards require OT faculty members to have clinical experiences in the areas they teach. There are no standards that state that faculty must maintain these skills, although it is implied that the faculty member will stay up-to-date on the latest trends in clinical practice. Supervision of students in the clinical setting has been used to both educate students and to provide clinical practice opportunities for faculty.

This section concluded with a description of one study that has focused on occupational therapy faculty members and clinical practice (Scoggin et al., 2000). They surveyed both faculty and department chairpersons. Their low return rates, narrow

definition of clinical practice, and the use of open-ended questions provided support for the need for this study. Information that could be generalized to all occupational therapy faculty is needed to identify the benefits and barriers to participation in clinical practice. A description of the characteristics of practice for those that do participate is also needed to document which models of practice are being utilized and to provide a more accurate view of how many are participating in clinical practice.

Summary

The review of literature in Chapter 2 focused on the different aspects of clinical practice. The focus of this study was to investigate the benefits, barriers, and characteristics of clinical practice for full-time occupational therapy faculty members and to examine if there were differences in these three factors in academic institutions classified by Carnegie level.

Chapter 2 was divided into seven sections, including an introduction and a summary. Section two began with an introduction to faculty work outside of the academic setting. The definition of clinical practice was presented, including faculty clinical practice and moonlighting.

The third section discussed the origins of clinical practice in the medical field and the impact that federal legislation had on it. A discussion of the different models of clinical practice was included in the third section. These models included the unification model, the free standing clinic, contractual services, the joint faculty/clinical appointment, the integration model, moonlighting, consulting, and education. Different

models of clinical practice have been used by occupational therapy faculty members, but little is known about the incidence of the various types of models.

The third section continued with a discussion of the benefits of clinical practice to the institution, to the academic program, to the faculty member, to the community organization, and to students. The barriers to clinical practice for the institution, the academic program, and for the faculty member completed the discussion of clinical practice.

The fourth section reviewed clinical practice and promotion and tenure guidelines at the academic institution. Many academic institutions still define scholarship as research. This section reviewed Boyer's concepts of the scholarship of discovery, the scholarship of integration, the scholarship of teaching, and the scholarship of application, also called the scholarship of practice. The close relationship between the scholarship of teaching and scholarship of practice was presented, with an emphasis on the scholarship of practice. The implications of the scholarship of practice for promotion and tenure and a method to assess scholarship in general concluded this section.

The fifth section reviewed occupational therapy and clinical practice. Accreditation standards set by the accrediting body for occupational therapy education were included as the foundation for clinical practice. The section concluded with a description of a study that has been completed on clinical practice in occupational therapy.

Clinical practice is a desired behavior in practice professions. Many occupational therapy programs emphasize teaching. However, the institution requires a focus on the

scholarship of discovery. There are many benefits to participation in clinical practice. There are also many barriers that may outweigh the benefits. These barriers cause a gap between the benefits and the participation in clinical practice. A carefully designed practice plan will allow the occupational therapy faculty member to link teaching to participation in the scholarship of practice and develop that practice into the scholarship of discovery and the scholarship of integration.

CHAPTER 3

METHODOLOGY

The methods used to conduct this research are described in Chapter 3. This chapter includes a statement of the problem, a description of the population, a description of the data collection instrument, the data collection procedures used, the statistical analysis used, and a summary.

The primary method used was a descriptive survey of occupational therapy faculty members perceptions of clinical practice. A survey to measure these perceptions was developed and utilized to identify benefits, barriers, and characteristics of clinical practice in full-time occupational therapy faculty.

Statement of the Problem

The following question guided this investigation: “What are the benefits, barriers, and characteristics of clinical practice to full-time occupational therapy faculty members in accredited occupational therapy academic programs?”

The purpose of this study was to examine the current use of clinical practice by full-time occupational therapy faculty members. Clinical practice, including FCP and moonlighting, were addressed. The following research questions guided this study:

1. What were the perceived benefits of clinical practice as identified by occupational therapy faculty members?

2. What were the perceived barriers to clinical practice as identified by occupational therapy faculty?
3. Do perceived benefits and barriers of clinical practice as identified by occupational therapy faculty differ as a function of their academic institution's Carnegie classification (The Carnegie Foundation, 2000)?
4. Do perceived benefits and barriers of clinical practice differ among respondents according to tenure at the institution, tenure status, doctoral degree, rank, administrative duties, and gender?
5. What was the incidence of clinical practice in occupational therapy faculty members? Is participation in clinical practice related to the Carnegie classification of the occupational therapy member's academic institution?
6. What were the characteristics (tenure status, doctoral degree, rank, administrative duties, and gender) of faculty members that participate in clinical practice either within or outside the faculty role?
7. What were the characteristics of clinical practice as described by faculty members and how do these differ if the clinical practice is conducted as part of the faculty role or outside the faculty role?

Population

The population for this study was occupational therapists who were full-time occupational therapy faculty members in entry-level graduate degree occupational therapy programs in the United States that were accredited by the Accrediting Council for

Occupational Therapy Education (ACOTE) at the time of the study. Of the 149 accredited occupational therapy programs, 134 institutions offered the entry-level graduate degree (AOTA, 2004).

Only full-time faculty members in occupational therapy programs who were occupational therapists were eligible to participate in this research study. Occupational therapy faculty members who were part-time, adjunct, or who were not occupational therapists were excluded from participation. Emeritus faculty were also excluded.

To obtain the names and electronic addresses (e-mail) of the faculty members, a search of each program's website was conducted. All full-time faculty members that were listed on the website were included in the sample. A master list including the academic institution's name and the faculty members' names and e-mail addresses was generated based on the website search. A total of 957 occupational therapy faculty members were eligible for participation based on the search of each program's website.

The eligible number of full-time occupational therapy faculty members for each academic institution's Carnegie classification was also determined. There were 6 levels of classification used in this study. The number of faculty members within each classification is presented in Table 1.

Table 1

Initial Description of the Population by Carnegie Classification

Carnegie Classification	Number of OT Programs	Number of Faculty Members from the Website
1	33	272
2	20	164
3	43	296
4	13	80
5	13	62
6	12	83
Totals	134	957

Note: Carnegie Classification: 1 = Doctoral/Research Universities - Extensive; 2 = Doctoral/Research Universities - Intensive; 3 = Master's Colleges and Universities I; 4 = Master's Colleges and Universities II; 5 = Baccalaureate Colleges; 6 = Specialized Institutions

Instrumentation

A survey developed by the researcher was the primary instrument used for data collection. The survey (Appendix A) was designed to identify the benefits, barriers, and characteristics of clinical practice. There were four sections in the survey. The first section addressed the perceived benefits and barriers to participation in clinical practice. There were 22 statements in this section: 12 statements on benefits and 10 on barriers. The survey items for the benefits and barriers questions were based on a five-point Likert scale containing answers coded as strongly disagree, disagree, neither agree nor disagree, agree, and strongly agree.

The second section identified specific characteristics of the clinical practice, both within and outside the faculty role. There were 15 questions in this section, 8 addressing characteristics of faculty clinical practice and 7 addressing characteristics of

moonlighting. These questions were either yes/no, forced choice, or fill in the blank.

Room for comments was provided on appropriate questions. The third section included demographic information about the respondent and included seven questions. The final section requested the name of the academic institution for coding purposes for the Carnegie classification.

For clarification, Table 2 matches the research question to the questions on the survey.

Table 2

Study Construct to Survey Item Relationship

Research Question	Survey Items
1. What were the perceived benefits of clinical practice as identified by occupational therapy faculty members?	1 through 12
2. What were the perceived barriers to clinical practice as identified by occupational therapy faculty?	13 through 22
3. Do perceived benefits and barriers of clinical practice as identified by occupational therapy faculty differ as a function of their academic institution's Carnegie classification (The Carnegie Foundation, 2000)?	1 through 22 and 42 and the Carnegie Classification
4. Do perceived benefits and barriers of clinical practice differ among respondents according to tenure at the institution, tenure status, doctoral degree, rank, administrative duties, and gender?	1 through 22, 38 through 42
5. What was the incidence of clinical practice in occupational therapy faculty members? Is participation in clinical practice related to the Carnegie classification of the occupational therapy member's academic institution?	23, 24, 31 and the Carnegie Classification
6. What were the characteristics (tenure status, doctoral degree, rank, administrative duties, and gender) of faculty members that participate in clinical practice either within or outside the faculty role?	24, 31, and 39 through 42
7. What were the characteristics of clinical practice as described by faculty members and how do these differ if the clinical practice is conducted as part of the faculty role or outside the faculty role?	23 through 37

Validity of the Survey

Content validity of the survey was established by thoroughly reviewing the literature to identify those factors that have been identified as benefits or barriers to participation in clinical practice. Clinical practice characteristics, including faculty clinical practice and moonlighting, were also included based on the literature review. Content validity was further established by having four occupational therapists that are

employed as full-time occupational therapy faculty members review the survey. Their average length of time as a full-time occupational therapy faculty member was 16 years, with a range of 4 years to 25 years. One of the four is currently a program director and another one has previously served as a program director at a different institution.

The faculty reviewers focused on wording of specific items and accuracy to make sure that the statements addressed the constructs of benefits, barriers, and characteristics of clinical practice. Based on their feedback, the survey items were revised and a new survey was developed for pilot testing (see Appendix A).

Reliability of the Survey

Reliability of the survey was established by completing a pilot study with the full-time occupational therapy faculty members in seven occupational therapy programs located in Florida. Forty eight occupational therapy faculty members were identified through a search of each occupational therapy program's website. An e-mail (Appendix B) was sent to each faculty member asking them to participate in a reliability study for the survey, with a link included to the survey instrument. Five e-mails were returned as unknown, and two respondents indicated that they were not full-time, leaving 41 full-time occupational therapy faculty members eligible to participate. A follow-up telephone call was made to all 41 faculty members to thank them for their participation and to remind those that had not responded to please do so.

Thirty two full-time occupational therapy faculty members participated in the pilot study. A Cronbach alpha coefficient was completed to test the internal consistency

of the instrument. Respondents ratings for the survey were judged to have high reliability, with a reliability coefficient of .81 for the Likert scale items. All items were positively correlated. Therefore, no questions were removed from the survey.

Individual reliability coefficients for the benefits section of the survey (questions 1 - 12) were highly correlated, with a reliability coefficient of .84. All of the items were positively correlated. The reliability coefficients for the barriers section of the survey (questions 13 - 22) were modestly correlated, with a reliability coefficient of .71. All of the items were positively correlated.

Procedures

This research was approved by the Institutional Review Board at the University of Central Florida (Appendix C). Informed consent was included on the survey instrument. This study used a web-based survey for data collection purposes. The initial survey was converted into HTML format by an experienced computer programmer. Buttons were positioned below each Likert scale item or to the left of the items on the characteristics and demographic sections.

The survey was available on a website that respondents could access from the hyperlink provided in the initial e-mail. Respondents were asked to read each item and click on the button that corresponded to their choice. At the bottom of the form was a box for the respondent to click to submit the completed form. The survey was linked to a database such that once respondents submitted their answers, they were coded in the database. The database did not contain any identifying information about the respondent

other than what the respondent had placed in the appropriate boxes of the survey. Thus all answers were anonymous.

As mentioned previously, 957 faculty e-mail addresses were obtained through a website search of the 134 occupational therapy programs. Three programs did not include their faculty member's e-mail address on the website. A telephone call was made to the occupational therapy program director to obtain these addresses. One of the three program directors or their designee responded with the appropriate e-mails. The other two directors did not respond.

Electronic addresses that were not deliverable were removed from the list as this indicated that the person was not working at that academic institution ($n = 85$). This resulted in a population of 872 occupational therapy faculty members. Table 3 indicates the number of failed e-mails for each Carnegie Classification and the revised total available in the population.

Table 3

Description of the Revised Population by Carnegie Classification

Carnegie Classification	Number of Faculty from the Website	Number of Failed E-mails	Final Population Size
1	272	19	253
2	164	16	148
3	296	26	270
4	80	6	74
5	62	6	56
6	83	12	71
Totals	957	85	872

Note: Carnegie Classification: 1 = Doctoral/Research Universities - Extensive; 2 = Doctoral/Research Universities - Intensive; 3 = Master's Colleges and Universities I; 4 = Master's Colleges and Universities II; 5 = Baccalaureate Colleges; 6 = Specialized Institutions

A series of three e-mails was sent to each faculty member. An initial e-mail (Appendix D) was sent in early 2005 to each faculty member requesting their participation in the study. The researcher's e-mail, address, and a contact telephone number were included on the survey instrument so respondents could contact the researcher with any questions.

Within 2 days it became apparent that there was a problem with submitting the survey. Many respondents tried to submit the survey but encountered an error message. None of these responses were recorded in the database. However, many others had no problems submitting their responses. The computer programmer was contacted to fix the problem. However, the problem was not fixed immediately.

Other respondents had replied that although they were full-time faculty, they did not believe that they should participate since they were not participating in clinical

practice at this time. Both of these issues (error messages and not in clinical practice) resulted in the next e-mail to respondents two days after the first e-mail (Appendix E).

After the survey technical problem was fixed, a new e-mail (Appendix F) was sent to the respondents. It apologized for the problems with the initial survey, thanked those that had responded, asked those that received an error message to please re-submit, and asked those that had not responded to please do so. A final e-mail was sent to elicit as many responses as possible (Appendix G).

Because all responses were anonymous, all faculty members on the list received every e-mail. The list was revised after every e-mail based on undeliverable addresses, if the respondent indicated that they did not meet the sampling criteria, or if the respondent did not wish to participate.

Each occupational therapy program faculty member received the survey via e-mail. Of the 872 e-mails, 61 respondents indicated that they did not meet the inclusion criteria for participation. This left 811 potential respondents for the survey. Table 4 identifies the number of e-mails that were sent to the population, the number of respondents that indicated they did not meet the inclusion criteria, and the total number left in the population after removal of those that did not meet the inclusion criteria by the Carnegie Classification of the academic institution.

Table 4

Description of the Final Population by Carnegie Classification

Carnegie Classification	Total E-mail Contacts*	Not in Population	Total N
1	253	17	236
2	148	10	138
3	270	21	249
4	74	5	70
5	56	5	51
6	71	3	69
Totals	872	61	811

Note: Carnegie Classification: 1 = Doctoral/Research Universities - Extensive; 2 = Doctoral/Research Universities - Intensive; 3 = Master's Colleges and Universities I; 4 = Master's Colleges and Universities II; 5 = Baccalaureate Colleges; 6 = Specialized Institutions

*Total e-mail contacts is the number of usable e-mail addresses that received the survey.

The total number and percentage of respondents by Carnegie Classification is in Table 5. For example, of the 33 programs in Carnegie Classification 1, respondents represented 26 (78.8%) of the programs. There were 253 possible faculty member respondents, with 47 (18.6%) that completed the survey. Four other individuals (1.6%) refused to participate, leaving a total of 51 (20.2%) respondents from Carnegie Classification 1.

Two people identified their academic institution's Carnegie Classification, but did not list their academic institution. Therefore, it is not known if they represent a unique academic institution or if it is a duplication of another institution. Overall, 224 faculty members (27.6%) responded to the survey. However, 45 respondents did not answer any questions and were therefore removed from the data analysis, leaving 181 respondents

(22.2%) in the data analysis. Seven respondents did not provide their academic institution, but did complete the survey.

Table 5

Total Number of Respondents by Carnegie Classification

Carnegie Classification	Respondent's OT Programs/Possible (%)	Number of Respondents/N(%)	Refusals(%)	Total Responding (%)
1	26/33 (78.8%)*	47/253 (18.6%)	4 (1.6%)	51 (20.2%)
2	15/20 (75%)	27/148 (18.2%)	1 (0.7%)	28 (18.9%)
3	34/43 (79.1%)	62/270 (23%)	1 (0.4%)	63 (23.3%)
4	9/13 (69.2%)*	12/74 (16.2%)	1 (1.4%)	13 (17.6%)
5	7/13 (53.8%)	14/56 (25%)	2 (3.4%)	16 (28.6%)
6	7/12 (58%)	12/71 (16.9%)	1 (1.4%)	13 (18.3%)
Unknown**		7/872 (0.8%)	35 (4.0%)	42 (4.8%)
Totals	98/134 (73%)	181/811 (22.2%)	45 (5.5%)	224 (27.6%)

Note: Carnegie Classification: 1 = Doctoral/Research Universities - Extensive; 2 = Doctoral/Research Universities - Intensive; 3 = Master's Colleges and Universities I; 4 = Master's Colleges and Universities II; 5 = Baccalaureate Colleges; 6 = Specialized Institutions

* One respondent did not specify the name of the academic institution.

** Unknown respondents did not specify their academic institution and could not be placed into the Carnegie Classification.

The highest percentage of respondents were in Baccalaureate Colleges (Carnegie Classification 5), followed by Master's Colleges and Universities I (Classification 3) and Doctoral/Research Universities - Extensive (Classification 1). The lowest percentage of respondents were in Master's Colleges and Universities II (Classification 4) and

Specialized Institutions (Classification 6). However, those respondents that did not indicate their academic institution may affect these results.

Statistical Analysis

The Statistical Package for the Social Sciences (SPSS), Version 11.5 was used for all analyses. The level of significance was set at $p < .05$. An item-by-item analysis of responses was determined through the use of descriptive statistics for the barriers (research question 1), benefits (research question 2), clinical practice characteristics (research question 5), clinical practice demographics (research question 6), and clinical practice characteristics (research question 7).

For research questions 3 and 4, a one-way analysis of variance (ANOVA) was used with the Carnegie classification as the independent variable for question 3; tenure at the institution, tenure status, doctoral degree, rank, administrative duties, and gender as the independent variables for question 4; and the barriers and benefits or gender, rank, and tenure status as the dependent variables for both questions. For research question 5, a Chi Square Test of Association was also used to examine the relationship of clinical practice occurrence to Carnegie classification. Table 6 contains the research question, the survey question numbers, and the statistical analysis method for each question.

Table 6

Comparison of Research Question, Survey Question Numbers and Statistical Analysis

Research Question	Survey Questions	Type of Statistical Analysis
1: What are the perceived benefits of clinical practice as identified by occupational therapy faculty members?	1-12	Descriptive statistics were used, including frequency counts, response median and mode. Responses were rank ordered.
2: What are the perceived barriers to clinical practice as identified by occupational therapy faculty?	13-22	Descriptive statistics were used, including frequency counts, response median and mode. Responses were rank ordered.
3: How do the perceived benefits and barriers of clinical practice as identified by occupational therapy faculty relate to their academic institution's Carnegie classification?	1-22 and the Carnegie classification	Two one-way ANOVAs were used to examine differences between barriers and benefits and the Carnegie classification of the institution. The independent variable was Carnegie classification and the dependent variables were the benefits and barriers.
4: How do the perceived benefits and barriers of clinical practice differ among respondents according to selected demographic variables (tenure for the institution, tenure status, doctoral degree, rank, administrative duties, and gender)?	1-22, 38-43	One-way ANOVA was used to examine differences between barriers and benefits and the demographic variables. The independent variables were each of the demographic variables. The dependent variables were the benefits and barriers.
5: What is the incidence of clinical practice in occupational therapy faculty members and are there any significant differences based on the academic institution's Carnegie classification?	23, 24, 31 and the Carnegie classification	Descriptive statistics were used to calculate the occurrence of clinical practice. A Chi Square Test of Association was used to examine the relationship of clinical practice occurrence to Carnegie classification.
6: What are the characteristics (gender, earned degree, rank, tenure status, years as a faculty member, and gender) of faculty members that participate in clinical practice either within or outside the faculty role?	24, 31, 39-43	Descriptive statistics were used, including a frequency count of responses.
7: What are the characteristics of clinical practice as described by faculty members and how do these differ if the clinical practice is conducted as part of the faculty role or outside the faculty role?	24-37	Descriptive statistics were used, including a frequency count of responses.

Summary

The methods used in the data collection and analysis process of this research project have been presented in Chapter 3. This chapter presented the statement of the problem and the research questions. The population and procedures for inclusion were described. The methods used to develop the survey instrument and to ensure its reliability and validity were discussed. The data collection method and the respondents were described and the data analysis methods were presented.

CHAPTER 4

ANALYSIS OF DATA

The purpose of this study was to identify the benefits, barriers, and characteristics of clinical practice by full-time occupational therapy faculty members. Clinical practice, faculty clinical practice (FCP) and moonlighting, were addressed. Chapter 4 presents the analysis of the data collected for this study for each of the research questions. The chapter concludes with a brief summary of the study's results.

Research Question 1

What were the perceived benefits of clinical practice as identified by occupational therapy faculty members? The data used in evaluating Research Question 1 were collected from the responses to the first 12 survey statements from Section I (see Appendix A).

Respondents were asked to rate their level of agreement for statements 1-12 using a 5-point Likert scale. Frequency counts for each of the levels from the Likert scale, the response median, mode, mean, and standard deviation were completed for each of the benefit statements and are presented in Table 7. Higher mean scores indicate more agreement that the statement is a benefit.

Table 7

Response Frequencies for Benefits to Clinical Practice Statements

Survey Item	Response Frequencies					Median	Mode	<i>M</i>	<i>SD</i>
	1	2	3	4	5				
1. Clinical practice allows me to maintain my clinical skills.	1	1	6	54	119	5	5	4.6	.639
2. Clinical practice supplements my income.	14	16	43	56	52	4	4	3.64	1.21
3. Clinical practice allows me to supervise students in the clinical setting.	13	26	47	61	34	4	4	3.43	1.16
4. Clinical practice enhances collaboration for clinical research.	4	9	27	86	55	4	4	3.99	.925
5. Clinical practice enhances my teaching.	1	3	11	58	108	5	5	4.49	.735
6. Clinical practice provides data for my research interests.	8	20	43	71	39	4	4	3.62	1.08
7. Clinical practice fits with the mission of our OT program.	8	19	44	61	49	4	4	3.69	1.11
8. Clinical practice is a source of personal satisfaction.	2	7	16	64	92	5	5	4.31	.87
9. Clinical practice improves my credibility with students.	1	4	10	65	101	5	5	4.44	.748
10. Clinical practice offers opportunities to network with others.	2	4	13	79	83	4	5	4.31	.790
11. Clinical practice helps me maintain my professional identity.	5	14	33	55	74	4	5	3.99	1.08
12. Clinical practice produces revenue for our department.	77	34	39	25	6	2	1	2.17	1.21

Note: *N* = 181; *M* = Mean; *SD* = standard deviation

Rating: 1=Strongly Disagree; 2=Disagree; 3=Neither Agree or Disagree; 4=Agree; 5=Strongly Agree

The highest percentage of agreement or strong agreement (95.6%) was with Statement 1: Clinical practice allows me to maintain my clinical skills ($M = 4.6$). The second highest level of agreement (91.7%) was a tie between Statement 5: Clinical practice enhances my teaching ($M = 4.49$) and Statement 9: Clinical practice improves my credibility with students ($M = 4.44$). Two other statements also had agreement levels above 85%: Statement 10 (89.5%): Clinical practice offers opportunities to network with others ($M = 4.31$), and Statement 8 (86.2%): Clinical practice is a source of personal satisfaction ($M = 4.31$).

The highest percentage of disagreement or strong disagreement (61.3%) was with Statement 12: Clinical practice produces revenue for our department ($M = 2.17$). The next highest level of disagreement (21.5%) was with Statement 3: Clinical practice allows me to supervise students in the clinical setting ($M = 3.43$). However, 52.5% agreed or strongly agreed with the statement. The third highest level of disagreement (16.6%) was with Statement 2: Clinical practice supplements my income ($M = 3.64$). However, 59.7% agreed or strongly agreed with this statement.

Responses for Research Question 1 were rank ordered for all of the benefit statements based on the percentage of agreement or strong agreement with each statement. These rankings are in Table 8. The top ranked benefits were Statements 1 (maintain clinical skills, $M = 4.6$), 5 (source of personal satisfaction, $M = 4.49$), and 9 (improves credibility with students, $M = 4.44$), while the lowest ranked items were Statements 2 (supplements income, $M = 3.64$), 3 (supervise students in the clinic, $M = 3.43$), and 12 (produces revenue for department, $M = 2.17$). Statements 3 (improves

credibility with students, $M = 3.43$), 7 (fits mission of OT program, $M = 3.69$), 6 (data for research interests, $M = 3.62$), 2 (supplements income, $M = 3.64$), and 12 (produces revenue for department, $M = 2.17$) had at least 25% of the respondents rating the statement as neither agree nor disagree, indicating that those respondents did not perceive those statements to be a benefit or a barrier to clinical practice.

Table 8

Rank Ordering of Benefits to Clinical Practice

Rank number	Statement Number/Item	Agree	Strongly Agree
1	1. Maintain clinical skills	54	119
2*	5. Enhances teaching	58	108
3*	9. Improves credibility with students	65	101
4	10. Opportunities to network	79	83
5	8. Source of personal satisfaction	64	92
6	4. Collaborate for clinical research	86	55
7	11. Maintain professional identity	55	74
8*	7. Fits mission of OT program	61	49
9*	6. Data for research interests	71	39
10	2. Supplements income	56	52
11	3. Supervise students in the clinic	61	34
12.	12. Produces revenue for department	25	6

* Ranked by level of agreement or strong agreement. Ties between rank 2 and 3 and 8 and 9, with the number indicating strong agreement as the tie breaker.

Research Question 2

What were the perceived barriers to clinical practice as identified by occupational therapy faculty? The data used in evaluating Research Question 2 were collected from the responses to survey statements 13 - 22 from Section I (see Appendix A). Respondents were asked to rate their level of agreement for each barrier statement using a 5-point Likert scale. Frequency counts for each of the levels from the Likert scale, the response

median, mode, mean, and standard deviation were completed for each of the barrier statements and are presented in Table 9. Higher mean scores indicate more agreement that the statement is a barrier.

The highest percentage of agreement or strong agreement about barriers to clinical practice (85%) was with Statement 21: Clinical practice is limited because of teaching responsibilities ($M = 4.20$). Two statements had the second highest agreement (81.2%): Statement 17: Clinical practice would be an additional responsibility ($M = 4.01$) and Statement 20: Clinical practice is not a component of tenure expectations ($M = 4.20$). These statements were followed by Statement 19: Clinical practice is not a component of faculty promotion expectations (80.1%, $M = 4.11$).

The highest level of disagreement or strong disagreement (82.9%) was with Statement 22: My OT clinical specialty is not needed in the area ($M = 1.70$). The next highest level of disagreement (63.5%, $M = 2.40$) was with Statement 15: Clinical practice is not supported by the Department Chairperson, followed by Statement 16 (53%, $M = 2.61$): Clinical practice is not supported by the Dean.

Responses for Research Question 2 were rank ordered for all of the barrier statements based on the percentage of agreement or strong agreement with each statement. These are presented in Table 10. The top ranked barriers were Statements 21 (limited due to teaching responsibilities, $M = 4.2$), 20 (not a component for tenure, $M = 4.2$), 17 (an additional responsibility, $M = 4.01$), and 19 (not a component for promotion, $M = 4.11$). The lowest ranking items were Statements 13 (interferes with research

production, $M = 3.0$), 15 (not supported by department chair, $M = 2.40$), and 22 (clinical specialty not needed in area, $M = 1.7$)

Table 9

Response Frequencies for Barriers to Clinical Practice Statements

Survey Item	Response Frequencies					Median	Mode	M	SD
	1	2	3	4	5				
13. Clinical practice interferes with my research production.	22	45	46	47	21	3	4	3.00	1.21
14. Clinical practice interferes with my success in the academic setting.	45	54	40	28	14	2	2	2.51	1.24
15. Clinical practice is not supported by the Department Chairperson.	43	72	31	21	14	2	2	2.4	1.19
16. Clinical practice is not supported by the Dean.	43	72	31	21	14	2	2	2.61	1.20
17. Clinical practice would be an additional responsibility.	33	63	43	25	17	4	4	4.01	1.04
18. Academicians outside the OT department do not value clinical practice.	7	14	13	84	63	3	2	3.06	1.17
19. Clinical practice is not a component of faculty promotion expectations.	15	50	49	44	23	4	5	4.11	.98
20. Clinical practice is not a component of tenure expectations.	3	13	20	70	75	4	5	4.2	.94
21. Clinical practice is limited because of teaching responsibilities.	2	10	22	62	85	4	4	4.2	.87
22. My OT clinical specialty area is not needed in this locale.	2	8	17	79	75	1	1	1.7	.93

Note: $N = 181$

Rating: 1=Strongly Disagree; 2=Disagree; 3=Neither Agree or Disagree; 4=Agree; 5=Strongly Agree

Table 10

Rank Ordering of Barriers to Clinical Practice

Rank Number	Statement Number/Item	Agree	Strongly Agree
1	21 Limited due to teaching responsibilities	79	75
2*	20 Not a component for tenure	62	85
3*	17 An additional responsibility	84	63
4	19 Not a component for promotion	70	75
5	18 Academicians do not value clinical practice	44	23
6*	16 Not supported by the Dean	25	17
7*	14 Interferes with academic success	28	14
8	13 Interferes with research production	47	21
9	15 Not supported by department chair	21	14
10	22. Clinical specialty not needed in area	6	3

* Ranked by level of agreement or strong agreement. Ties between rank 2 and 3 and 6 and 7, with the number indicating strong agreement as the tie breaker.

Research Question 3

Do perceived benefits and barriers of clinical practice as identified by occupational therapy faculty differ as a function of their academic institution's Carnegie Classification (The Carnegie Foundation, 2000)? The data used in evaluating Research Question 3 were collected from the responses to the first 22 statements in Section I (see Appendix A). The first 12 statements were the benefits and the next 10 were the barriers to clinical practice. The scores from the benefit statements were summed for each respondent to obtain the total benefit score. The scores from the barrier statements were also added together to obtain the total barrier score.

The respondent's academic institution was coded into one of six Carnegie Classification levels as follows: Carnegie Level 1 was Doctoral/Research Universities - Extensive; Level 2 was Doctoral/Research Universities - Intensive; Level 3 was Master's

Colleges and Universities I; Level 4 was Master's Colleges and Universities II; Level 5 was Baccalaureate Colleges; and Level 6 was Specialized Institutions.

A one-way analysis of variance (ANOVA) was used to examine the differences between barriers and benefits and the Carnegie Classification of the institution. The independent variable was the Carnegie Classification. The dependent variables were the benefits summed score or the barriers summed score. The Tukey/Kramer test (Tukey's-b) was used for all post-hoc comparisons because of unequal sample sizes in the different groups.

Carnegie Classification and Benefits of Clinical Practice

The Levene's Test for Equality of Error Variance (Levene's test) was not significant $F(5, 168) = 1.433, p = .215$. The assumption of equal variances was met, so ANOVA was an appropriate statistical procedure to use to analyze the data.

The ANOVA result approached significance but was not statistically significant. Benefits to clinical practice did not differ, on average, as a result of Carnegie Classification. This suggests that the null hypothesis cannot be rejected $F(5,168) = 2.188, p = .058$. Table 11 contains the ANOVA results.

The Doctoral II group had the highest mean scores on the benefits to practice ($M = 49.93$) while the Masters II group had the lowest mean scores ($M = 44.92$). However, these differences were not statistically significant. Inspection of the effect size (partial Eta squared = .061) indicates that there is a slight difference between the groups. Only

6% of the variance in benefits is accounted for by the Carnegie Classification. Table 12 contains the mean benefit scores of the different Carnegie Classifications.

Table 11

Analysis of Variance for Carnegie Classification

Source	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>	Partial Eta Squared
Between	475.519	5	95.104	2.188	.058	.061
Within	7302.940	168	43.470			

Note: *df* = degrees of freedom

Table 12

Mean Benefit Score by Carnegie Classification Level

Carnegie Classification	<i>M</i>	<i>SD</i>	<i>n</i>
Doctoral I	44.98	6.462	47
Doctoral II	49.93	4.891	27
Masters I	47.10	6.457	62
Masters II	44.92	4.757	12
Bachelors	46.71	5.770	14
Special	45.92	11.813	12
Total	46.70	6.705	174

Carnegie Classification and Barriers to Clinical Practice

The Levene's test was not significant $F(5, 168) = 2.013, p = .079$. The assumption of equal variances was met, so ANOVA was an appropriate statistical procedure to use to analyze the data.

The ANOVA result showed no statistically significant difference. This suggests that the null hypothesis cannot be rejected $F(5, 168) = 1.335, p = .252$. There is not enough evidence to suggest that barriers to clinical practice differ, on average, as a function of Carnegie classification. Table 13 contains the ANOVA results.

Table 13

Analysis of Variance for Carnegie Classification

Source	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>	Partial Eta Squared
Between	281.791	5	56.358	1.335	.252	.038
Within	7090.071	168	42.203			

The Doctoral I group had the highest mean scores on the barriers to practice ($M = 33.34$) while the Doctoral II group had the lowest mean scores ($M = 30.04$). However, these differences were not statistically significant. Inspection of the effect size (partial Eta squared = .038) indicates that there is a slight difference between the groups. Only 3.8% of the variance in benefits is accounted for by the Carnegie Classification. Table 14 contains the mean barrier scores of the different Carnegie Classifications.

Table 14

Mean Barrier Score by Carnegie Classification Level

Carnegie Classification	<i>M</i>	<i>SD</i>	<i>n</i>
Doctoral I	33.34	7.417	47
Doctoral II	30.04	7.455	27
Masters I	30.89	5.466	62
Masters II	32.67	7.050	12
Bachelors	31.57	6.284	14
Special	33.25	4.595	12
Total	31.76	6.528	174

Research Question 4

Do perceived benefits and barriers of clinical practice differ among respondents according to tenure for the institution, tenure status, doctoral degree, rank, administrative duties, and gender? The data used in evaluating Research Question 4 were collected from the responses to the first 22 statements in Section I and questions 38 - 43 from Section III (see Appendix A).

A one-way ANOVA was used to examine differences between barriers and benefits and each of the demographic variables. The independent variables were the demographic variables (tenure, tenure status, degree, faculty rank, administrative duties, and gender). The dependent variables were the benefits and the barriers to clinical practice. Because of using six ANOVAs for each independent variable, the Bonferroni adjustment was applied. The level of significance was set at .008 (.05/6) to reduce the risk of a Type I error.

Tenure at the Institution and Benefits of Clinical Practice

Overall, 157 (87.2%) respondents indicated that their academic institution had tenure, while 23 did not. The Levene's test was not significant $F(1, 178)=.553, p = .458$. The assumption of equal variances was met, thus ANOVA was an appropriate statistical procedure to use to analyze the data.

The ANOVA result showed no statistically significant difference between those institutions that had tenure from those that did not on the benefits of clinical practice, on average. This suggests that the null hypothesis cannot be rejected $F(1, 178) = 1.102, p = .295$. Table 15 contains the ANOVA results.

Table 15

Analysis of Variance for Tenure at the Institution

Source	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>	Partial Eta Squared
Between	49.183	1	49.183	1.102	.295	.006
Within	7944.128	178	44.630			

The mean benefits score was 46.48 ($SD = 6.779$) for those that had tenure at the institution and 48.04 ($s.d. = 5.935$) for those that did not. Inspection of the effect size (partial Eta squared = .006) indicates that there is no practical difference between the groups. Only .6% of the variance in benefits is accounted for by having tenure available at the institution.

Respondent's Tenure Status and Benefits of Clinical Practice

Overall, 31 (17.2%) of the 180 respondents indicated that they were tenured at their academic institution. The Levene's test was not significant $F(1, 178) = .553, p = .458$. The assumption of equal variances was met, thus ANOVA was an appropriate statistical procedure to use to analyze the data.

The ANOVA result showed no statistically significant difference between respondents that had tenure from those that did not on the benefits of clinical practice, on average. This suggests that the null hypothesis cannot be rejected $F(1,178) = .000, p = .988$. The mean benefit score for those that have tenure is 45.61 ($SD = 6.80$) and 46.90 ($SD = 6.659$) for those that are not tenured. Inspection of the effect size (partial Eta squared = .005) indicates that there is no practical difference between the groups. Table 16 contains the ANOVA results.

Table 16

Analysis of Variance for Tenure Status

Source	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>	Partial Eta Squared
Between	42.466	1	42.466	.951	.331	.005
Within	7950.845	178	44.668			

Doctoral Degree and Benefits of Clinical Practice

Overall, 93 (51.4%) of the 181 respondents indicated that they had a doctoral degree. The Levene's test was not significant $F(1, 179) = .146, p = .702$. The assumption of equal variances was met, thus ANOVA was an appropriate statistical procedure to use to analyze the data.

The ANOVA result approached significance but was not statistically significant. Benefits of clinical practice did not differ, on average, as a result of having or not having a doctoral degree. This suggests that the null hypothesis cannot be rejected $F(1,179) = 6.189, p = .014$. Individuals that did not have a doctoral degree had higher benefits for clinical practice scores ($M = 47.90, SD = 6.664$) than those that did have a doctoral degree ($M = 45.46, SD = 6.505$) although the difference was not statistically significant. Inspection of the effect size (partial Eta squared = .033) indicates that there is a slight difference between the groups. Only 3% of the variance in benefits is accounted for by having a doctoral degree. Table 17 contains the ANOVA results.

Table 17

Analysis of Variance for Doctoral Degree

Source	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>	Partial Eta Squared
Between	268.172	1	268.172	6.188	.014	.033
Within	7757.198	179	43.336			

Faculty Rank and Benefits of Clinical Practice

Fourteen respondents (7.9%) indicated that their rank was Instructor, 79 (44.6%) had a rank of Assistant Professor, 70 (39.5%) had a rank of Associate Professor, and 8 (4.5%) had a rank of Professor. Six others indicated that they had other ranks, including four (2.3%) at the rank of Assistant Clinical Faculty, one (.6%) Visiting Assistant Professor, and one (.6%) Distinguished Professor. The Levene's test was not significant $F(4, 172) = .436, p = .782$. The assumption of equal variances was met, thus ANOVA was an appropriate statistical procedure to use to analyze the data.

The ANOVA result approached significance but was not statistically significant. Benefits of clinical practice did not differ, on average, as a result of faculty rank. This suggests that the null hypothesis cannot be rejected $F(4,172) = 2.553, p = .041$. There is not a statistically significant difference in the benefits of clinical importance based on faculty rank on average. Table 18 contains the ANOVA results.

There were no statistically significant differences between the faculty ranks. Those at the rank of Other had the highest mean score, followed by the rank of Instructor. Those at the rank of Professor had the lowest mean. The mean score and standard deviation for each rank are in Table 19. Inspection of the effect size (partial Eta squared = .056) indicates that there is a slight difference between the groups. Only 5% of the variance in the benefits score is accounted for by the faculty member's rank.

Table 18

Analysis of Variance for Faculty Rank

Source	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>	Partial Eta Squared
Between	436.699	4	109.175	2.553	.041	.056
Within	7355.945	172	42.767			

Table 19

Mean Benefit Score by Faculty Rank

Faculty Rank	<i>M</i>	<i>SD</i>	<i>n</i>
Instructor	49.57	5.140	14
Assistant Professor	46.75	7.037	79
Associate Professor	46.04	6.342	70
Professor	42.63	6.739	8
Other	51.83	3.371	6
Total	46.68	6.654	177

Administrative Duties and Benefits of Clinical Practice

Of the 177 respondents, 18 (10.27%) indicated that they were a Program Director and 16 (9%) indicated that they were a Department Chair. Academic Fieldwork Coordinators accounted for 25 (14.1%) of the respondents. Most of the respondents ($n = 80$, 49.7%) did not report any administrative duties other than those included as part of being a full-time faculty member such as serving on committees or providing advisement for students.

Other administrative duties were identified by 38 (21.5%) respondents. These other categories included serving as the Graduate Degree Program Chair or Director ($n = 7$), Clinic or Lab Coordinator or Director ($n = 4$), Graduate Program Advisor ($n = 19$), or a Director of a Grant ($n = 2$). Other duties mentioned by one person included Semester Leader, Academic Coordinator, Program Coordinator, Assistant Director, Program Director for a bachelor of health science program but not an OT program, and serving as an Academic Dean.

The Levene's test was not significant $F(4,172) = 1.208, p = .309$. The assumption of equal variances was met, thus ANOVA was an appropriate statistical procedure to use to analyze the data. The ANOVA result approached significance but was not statistically significant. Benefits of clinical practice did not differ, on average, as a result of administrative duties. This suggests that the null hypothesis cannot be rejected $F(4,172) = 2.625, p = .036$. Table 20 contains the ANOVA results.

Table 20

Analysis of Variance for Administrative Duties

Source	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>	Partial Eta Squared
Between	451.578	4	112.894	2.625	.036	.058
Within	7396.976	172	43.006			

Academic Fieldwork Coordinators rated benefits of clinical practice higher than the program directors but the difference was not statistically significant. Table 21

contains the benefit means for each of the administrative duties groups. Inspection of the effect size (partial Eta squared = .058) indicates that there is a slight difference between the groups. Administrative duties accounted for 5% of the variance in benefits scores.

Table 21

Mean Benefit Score by Administrative Duty

Administrative Duty	<i>M</i>	<i>SD</i>	<i>n</i>
Program Director	43.39	7.180	18
Department Chair	48.31	5.747	16
Academic Fieldwork Coordinator	49.40	3.862	25
Other	47.18	5.599	38
None	46.18	7.554	80
Total	46.76	6.676	177

Gender and Benefits of Clinical Practice

Most of the respondents were female ($n = 166, 93.3\%$). The Levene's test was not significant $F(1,176) = 1.113, p = .293$. The assumption of equal variances was met, thus ANOVA was an appropriate statistical procedure to use to analyze the data. The ANOVA result showed no statistically significant difference between the gender of the respondents on the average benefits of clinical practice. This suggests that the null hypothesis cannot be rejected $F(1,176) = .073, p = .788$. The mean benefit score was 47.17 ($SD = 4.687$) for men and 46.63 ($SD = 6.819$) for women. Inspection of the effect size (partial Eta squared $< .001$) indicates that there is no practical difference between the groups. Table 22 contains the ANOVA results.

Table 22

Analysis of Variance for Gender

Source	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>	Partial Eta Squared
Between	3.265	1	3.265	.073	.788	.000
Within	7914.510	176	44.969			

Tenure at the Institution and Barriers to Clinical Practice

The Levene's test was not significant $F(1, 178) = 301, p = .584$. The assumption of equal variances was met, thus ANOVA was an appropriate statistical procedure to use to analyze the data. The ANOVA result showed no statistically significant difference between those institutions that had tenure from those that did not on the barriers to clinical practice. This suggests that the null hypothesis cannot be rejected $F(1,178) = 1.167, p = .281$. The mean barrier score for those that had tenure at the institution was 32.03 ($SD = 6.559$) and 30.43 ($SD = 7.044$) for those that did not. Inspection of the effect size (partial Eta squared = .007) indicates that there is no practical difference between the groups. Only .7% of the variance in barriers is accounted for by having tenure at the institution. Table 23 contains the ANOVA results.

Table 23

Analysis of Variance for Tenure at the Institution

Source	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>	Partial Eta Squared
Between	51.168	1	51.168	1.167	.281	.007
Within	7802.493	178	43.834			

Respondent's Tenure Status and Barriers to Clinical Practice

The Levene's test was not significant $F(1,178) = 0.00, p = .992$. The assumption of equal variances was met, thus ANOVA was an appropriate statistical procedure to use to analyze the data. The ANOVA result showed no statistically significant difference between those individuals that had tenure from those that did not on the barriers to clinical practice on average. This suggests that the null hypothesis cannot be rejected $F(1,178) = .569, p = .452$. The mean barrier score for those with tenure was 32.65 ($SD = 6.741$) and 31.66 ($SD = 6.61$) for those that did not. Inspection of the effect size (partial Eta squared = .003) indicates that there is no practical difference between the groups. Only .3% of the variance in barriers is accounted for by the respondent's tenure status. Table 24 contains the ANOVA results.

Table 24

Analysis of Variance for Tenure Status

Source	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>	Partial Eta Squared
Between	25.021	1	25.021	.569	.452	.003
Within	7828.640	178	43.981			

Doctoral Degree and Barriers to Clinical Practice

The Levene's test was significant $F(1,179) = 8.001, p = .005$. The assumption of equal variances was not met. However "the effect of the violation seems to be small with equal or nearly equal *ns* across the groups (nearly equal *ns* might be defined as a maximum ratio of the largest *n* to smallest *n* of 1.5)" (Lomax, 2001, p. 286). In this study, there were 93 that had a doctoral degree and 88 that did not. Thus ANOVA was an appropriate statistical procedure to use to analyze the data.

The ANOVA result was statistically significant between having a doctoral degree and barriers to clinical practice. This suggests that the null hypothesis can be rejected $F(1,179) = 8.480, p = .004$. Those respondents that reported having a doctoral degree had significantly higher barrier scores ($M = 33.16, SD = 7.246$) than those that do not have a doctoral degree ($M = 30.35, SD = 5.571$). Inspection of the effect size (partial Eta squared = .045) indicates that there is a slight difference between the groups. Only 5% of the variance in barriers is accounted for by doctoral degree status. Table 25 contains the ANOVA results.

Table 25

Analysis of Variance for Doctoral Degree

Source	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>	Partial Eta Squared
Between	356.776	1	356.776	8.480	.004	.045
Within	7530.660	179	42.071			

Faculty Rank and Barriers to Clinical Practice

The Levene's test was not statistically significant $F(4,172) = 1.406, p = .234$. The assumption of equal variances was met, thus ANOVA was an appropriate statistical procedure to use to analyze the data. The ANOVA result showed no statistically significant difference between individuals at the different faculty ranks on the barriers to clinical practice on average. This suggests that the null hypothesis cannot be rejected $F(4,172) = 1.353, p = .252$. Table 26 contains the ANOVA results.

The mean barrier score was highest for those at the rank of Professor, followed by the rank of Other. The lowest mean barrier score was for those at the rank of Instructor. Inspection of the effect size (partial Eta squared = .030) indicates that there is a slight difference between the groups. Only 3% of the variance in the barrier scores is accounted for by rank of the respondent. Table 27 contains the mean barrier score and standard deviations for the different faculty ranks.

Table 26

Analysis of Variance for Faculty Rank

Source	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>	Partial Eta Squared
Between	238.846	4	59.711	1.353	.252	.030
Within	7592.623	172	44.143			

Table 27

Mean Barrier Score by Faculty Rank

Faculty Rank	<i>M</i>	<i>SD</i>	<i>n</i>
Instructor	30.50	6.309	14
Assistant Professor	31.34	6.197	79
Associate Professor	31.93	6.939	70
Professor	36.63	9.319	8
Other	33.17	5.456	6
Total	31.81	6.671	177

Administrative Duties and Barriers to Clinical Practice

The Levene's test was statistically significant $F(4, 172) = 3.007, p = .020$. The assumption of equal variances was not met. There was a large difference between the *ns* in the smallest ($n = 16$) and the largest ($n = 80$) group, thus ANOVA was not an appropriate statistical procedure to use to analyze the data. The Kruskal-Wallis Test was used instead because nonparametric procedures are "less sensitive to unequal variances" (Lomax, 2001, p. 287). The Kruskal-Wallis Test indicated that there was no statistically significant differences between the means, $\chi^2(4, N = 149) = 7.058, p = .133$.

Table 28 contains the means and standard deviations for the different administrative duty levels. The highest mean barrier score was from respondents that did not have any administrative duties, followed by those that reported other administrative duties. The lowest mean barrier score was from Academic Fieldwork Coordinators.

Table 28
Mean Barrier Score by Administrative Duty

Administrative Duty	<i>M</i>	<i>SD</i>	<i>n</i>
Program Director	31.28	8.615	18
Department Chair	31.38	8.884	16
Academic Fieldwork Coordinator	29.72	4.016	25
Other	31.95	6.290	38
None	32.67	6.490	80
Total	31.84	6.658	177

Because there were five levels of the independent variable administrative duties, the data were condensed into two levels to see if the data met the assumptions of the ANOVA. The two levels were: yes, the respondent had administrative duties or no, the respondent did not have administrative duties. The Levene's test was not statistically significant $F(1, 175) = .111, p = .739$. The assumption of equal variances was met, thus ANOVA was an appropriate statistical procedure to use to analyze the condensed data.

The ANOVA result was not statistically significant in examining the difference between administrative duties (yes or no) and the barriers to clinical practice. This suggests that the null hypothesis cannot be rejected $F(1,175) = 2.086, p = .150$. Those that did not have administrative duties had higher barrier scores ($M = 32.57, SD = 6.386$)

than those that did ($M = 31.13$, $SD = 6.872$). Inspection of the effect size (partial Eta squared = .012) indicates that there is little practical difference between the groups. Table 29 contains the ANOVA results.

Table 29

Analysis of Variance for Administrative Duties

Source	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>	Partial Eta Squared
Between	91.906	1	91.906	2.086	.150	.012
Within	7709.664	175	44.055			

Gender and Barriers to Clinical Practice

The Levene's test was not statistically significant $F(1, 176) = .174$, $p = .677$. The assumption of equal variances was met, thus ANOVA was an appropriate statistical procedure to use to analyze the data. The ANOVA result approached significance but was not statistically significant. Barriers to clinical practice did not differ, on average, as a result of gender. This suggests that the null hypothesis cannot be rejected $F(1,176) = 3.123$, $p = .079$. Inspection of the means of response to the barrier statements revealed that women tended to rate the barriers higher ($n = 166$; $M = 31.96$, $SD = 6.510$) than men ($n = 12$, $M = 28.50$, $SD = 7.217$), but the difference was not statistically significant. Inspection of the effect size (partial Eta squared = .012) indicates that there is little difference between the groups. Only 1% of the variance in barriers is accounted for by gender. Table 30 contains the ANOVA results.

Table 30

Analysis of Variance for Gender

Source	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>p</i>	Partial Eta Squared
Between	134.273	1	134.273	3.123	.079	.017
Within	7566.783	176	42.993			

Research Question 5

What was the incidence of clinical practice in occupational therapy faculty members and are there any significant differences based on the academic institution's Carnegie classification? The data used in evaluating Research Question 5 were collected from the Carnegie Classification and responses to questions 23, 24, and 31 on Section II on the survey (see Appendix A).

Descriptive statistics were used to calculate the occurrence of clinical practice. There were 179 respondents for these questions. Most respondents indicated that clinical practice was not required by their academic institution or program. However, respondents in 15 (8.4%) academic institutions indicated that clinical practice was required (Question 23). Overall, 60 (33.5%) respondents indicated that they participated in faculty clinical practice that was part of their faculty role while 119 (66.5%) did not (Question 24). Of these respondents, 1 (0.6%) worked in an academic health center, 7 (3.9%) worked in a clinic located in the occupational therapy department at the academic institution, 7 (3.9%) worked in an outpatient clinic that was owned or operated by the academic institution,

and 45 (25.1%) worked in other facilities. In examining Question 31, 99 (54.6%) of the respondents participated in some form of moonlighting.

To examine the relationship between requiring clinical practice, participation in faculty clinical practice, and moonlighting to the academic institution's Carnegie Classification, a Chi Square Test of Association was used. Faculty clinical practice had five levels: (a) yes, in an academic health center; (b) yes, in a clinic located in the OT department at the academic institution; (c) yes, in an outpatient clinic owned or operated by the academic institution; (d) yes, in another setting; and (e) no. The Carnegie Classifications were as follows: Level 1 are Doctoral/Research Universities - Extensive; Level 2 are Doctoral/Research Universities - Intensive; Level 3 are Master's Colleges and Universities I; Level 4 are Master's Colleges and Universities II; Level 5 are Baccalaureate Colleges; and Level 6 are Specialized Institutions. Moonlighting was classified as yes or no.

A two way contingency table analysis was conducted to evaluate the relationship between the academic institution requiring clinical practice (yes or no) (Question 23) and the Carnegie Classification (3 levels). There were 173 respondents for this question. During the initial analysis, five cells came back with an expected count of less than five. The six levels of the Carnegie Classification were collapsed into three levels: (a) Level 1 included both the Doctoral Research Universities - Extensive and Intensive; (b) Level 2 included the Master's Colleges and Universities II; and (c) Level 3 included Master's and Colleges and Universities II, Baccalaureate Colleges and Specialized Institutions. This last classification had the lowest number of possible and actual respondents.

A two-way contingency table analysis was repeated using the three levels of Carnegie Classification and if the institution required clinical practice (yes or no). One cell (level 3) came back with an actual and expected count of less than five. The three levels of the Carnegie Classification were collapsed into two levels: (a) Level 1 included both the Doctoral Research Universities - Extensive and Intensive and (b) Level 2 included the Master's Colleges and Universities II, the Master's and Colleges and Universities II, Baccalaureate Colleges and Specialized Institutions. This last classification had the lowest number of possible and actual respondents.

A two-way contingency table analysis was repeated using the two levels of Carnegie Classification and if the institution required clinical practice. The results were not statistically significant in examining this relationship. This suggests that the null hypothesis cannot be rejected $\text{Pearson } \chi^2(1, N = 173) = .135, p = .714$, Cramer's $V = .028, p = .714$. There is no statistically significant difference between the Carnegie Classification and if the institution requires tenure. Table 31 contains the number and percentage of respondents in the four categories.

Table 31

Crosstabulation Table for Clinical Practice

Clinical Practice is Required	Carnegie Classification		Total
	1	2	
Yes	7 (4.0%)	8 (4.6%)	15 (8.7%)
No	66 (38.2%)	92(53.2%)	158(91.3%)
Total	73 (42.2%)	199(57.8%)	173 (100%)

Note: Carnegie classifications: 1 = Doctoral Extensive and Doctoral Intensive Institutions; 2 = All other classifications

There were 173 respondents included in examining FCP (Question 24) and Carnegie Classification. During the initial analysis, 21 cells came back with an expected count of less than 5. The five levels of FCP were collapsed into 2 levels: yes they participated in FCP or no they did not. This analysis yielded three cells with an expected count less than five. The six levels of the Carnegie Classification were collapsed into three levels: (a) Level 1 included both the Doctoral Research Universities - Extensive and Intensive; (b) Level 2 included the Master's Colleges and Universities II; and (c) Level 3 included Master's and Colleges and Universities II, Baccalaureate Colleges and Specialized Institutions. This last classification had the lowest number of possible and actual respondents.

A three-way contingency table was conducted to evaluate the relationship between the Carnegie Classification and participation in FCP. The results were not statistically significant. This suggests that the null hypothesis cannot be rejected, Pearson $\chi^2(2, N = 173) = 3.488, p = .175$, Cramer's $V = .142, p = .175$. There is a small effect size, indicating that 14% of the variance in participation in faculty clinical practice is accounted for by the Carnegie Classification. Table 32 contains the number and percentage of respondents in the four categories.

A two way contingency table analysis was conducted to evaluate the relationship between participation in moonlighting (Question 31) and the Carnegie Classification. The results were not statistically significant in examining this relationship. This suggests that the null hypothesis is true Pearson $\chi^2(5, N = 173) = 5.474, p = .340$, Cramer's $V = .178, p = .361$. There is a small effect size, indicating that 18% of the variance in participation

in moonlighting is accounted for by the Carnegie Classification. Table 33 contains the number and percentage of respondents in the four categories.

Table 32

Crosstabulation Table for Faculty Clinical Practice

Respondent Participated in FCP	Carnegie Classification			Total
	1	2	3	
Yes <i>n</i> (%)	30 (17.3%)	16 (9.2%)	13 (7.5%)	59(34.1%)
No <i>n</i> (%)	43 (24.9%)	46 (26.6%)	25(14.5%)	114(65.9%)
Total <i>n</i> (%)	73 (42.2%)	62 (35.8%)	38(22.0%)	173(100%)

Note: Carnegie Classification: 1 = Doctoral Research Universities Extensive and Intensive; 2 = Master's Colleges and Universities II; 3 = All other Carnegie Classifications

Table 33

Crosstabulation Table for Moonlighting

Respondent Participated in Moonlighting	Carnegie Classification						Total
	1	2	3	4	5	6	
Yes <i>n</i>	22	17	41	6	8	5	99
Percent	12.7%	9.8%	23.7%	3.5%	4.6%	2.9%	57.2%
No <i>n</i>	24	10	21	6	6	7	74
Percent	13.9%	5.8%	12.1%	3.5%	3.5%	4.0%	42.8%
Total <i>n</i>	46	27	62	12	14	12	173
Percent	26.6%	15.6%	35.8%	6.9%	8.1%	6.9%	100%

Note: Carnegie Classification: 1 = Doctoral Research Universities - Extensive; 2 = Doctoral Research Universities - Intensive; 3 = Master's Colleges and Universities I; 4 = Master's Colleges and Universities II; 5 = Baccalaureate Colleges; 6 = Specialized Institutions.

Research Question 6

What were the characteristics (tenure status, doctoral degree, rank, administrative duties, and gender) of faculty members that participate in clinical practice either within or

outside the faculty role? The data used in evaluating Research Question 6 were collected from questions 24 and 31 on Section II and from the clinical demographic questions in Section III (see Appendix A).

Descriptive statistics were used to analyze the data. There were 60 (33.3%) respondents that indicated they participated in some form of FCP as part of their faculty role. Of these respondents, 1 (1.7%) worked in an academic health center, 7 (11.7%) worked in a clinic located in the occupational therapy department at the academic institution, 7 (11.7%) worked in an outpatient clinic that was owned or operated by the academic institution, and 45 (75%) worked in other facilities. All but 5 (8.3%) of the respondents that participated in FCP were women.

Most of the respondents that participated in FCP were not tenured ($n = 48$, 80%). Most did not have a doctoral degree ($n = 34$, 56.7%); however, four of these respondents indicated that they were working on their dissertations. Of those that had a doctoral degree, 16 (61.5%) had Doctor of Philosophy (PhD) degrees in various fields, 4 (15.4%) had Doctorates in Occupational Therapy (OTD), 2 (7.7%) had Doctor of Education (EdD) degrees, 1 (3.8%) had a Doctor of Science (ScD), 1 (3.8%) had a Doctor of Public Administration (DPA) and 2 (7.7%) did not specify their type of doctoral degree.

The respondents that participated in FCP were typically at the Assistant Professor ($n = 25$, 41.7%) or Associate Professor ($n = 20$, 33.3%) rank. Instructors ($n = 10$, 16.7%), full Professors ($n = 1$, 1.7%), and other ($n = 3$, 5%) were also participating in FCP. The other category included clinical faculty line positions and teaching assistants.

Most of the respondents in FCP ($n = 22$, 36.7%) did not have administrative duties. Eight (13.3%) were program directors, 4 (6.7%) were department chairpersons, 7 (11.7%) were academic fieldwork coordinators, and 18 (30%) were doing other administrative duties. These administrative duties included serving as the graduate program chair or graduate program advisor, entry level program coordinators, director of a clinic, academic coordinator, director of general education for the university, and a coordinator for bachelor's level programs (not in OT).

The largest number of respondents ($n = 18$, 30%) that participate in FCP work in a Doctoral-Extensive I university. This was followed by 16 (26.7%) that work in Masters I institutions, and 12 (20%) that work in Doctoral-Intensive II institutions. Four (6.7%) work in both the Masters II and the Bachelor's institutions, and five (8.3%) work in Specialized institutions.

Slightly over half ($n = 99$, 54.7%) of the respondents to the survey indicated that they participated in moonlighting over the past year. Nine (17%) of these respondents reported that they were tenured and 6.1% ($n = 6$) were males. Doctoral degrees were reported by 37.4% ($n = 37$) of the respondents. For those with the doctorate, the PhD was the most common degree ($n = 17$, 44.7%), then OTD ($n = 4$, 10.8%), EdD ($n = 2$, 5.4%), ScD ($n = 1$, 2.7%), DPA ($n = 1$, 2.7%), and unknown ($n = 1$, 2.7%). Four additional respondents indicated that they were working on their dissertation.

The most common faculty rank for participants in moonlighting was Assistant Professor ($n = 52$, 52.5%), followed by Associate Professor ($n = 30$, 30.3%), Instructor ($n = 7$, 7.1%), and Professor ($n = 3$, 3.0%). Other ranks included clinical faculty members

and teaching assistants ($n = 4$, 4.8%). Another three respondents (3.0%) did not specify their rank.

Most of the respondents indicating that they participated in moonlighting did not have administrative duties ($n = 46$, 46.5%). Five respondents (5.1%) were Program Directors and five were Department Chairpersons. Fifteen respondents (15.2%) were academic fieldwork coordinators. Other administrative duties were selected by 26 respondents (26.3%). These included duties such as serving on committees, advising graduate students, serving as graduate chair, and serving as grant administrators.

The highest number of respondents that participated in moonlighting work in Masters I Carnegie Classification programs ($n = 41$, 41.4%). This was followed by Doctoral - Intensive I programs ($n = 22$, 22.2%), and Masters I ($n = 17$, 17.2%) programs. The lowest numbers of respondents were in Special Institutions ($n = 4$, 4%), Masters II ($n = 6$, 6.1%), and Bachelor's programs ($n = 8$, 8.1%). Two individuals did not provide the name of their academic institution and were unable to be placed in the Carnegie Classification.

Overall, 38 (21%) respondents reported that they participated in both FCP and moonlighting in the past year. This represents 63.3% of the people that participated in FCP and 38.3% of the respondents that participated in moonlighting.

Research Question 7

What were the characteristics of clinical practice as described by faculty members and how do these differ if the clinical practice is conducted as part of the faculty role or

outside the faculty role? The data used in evaluating Research Question 7 were collected from questions 24-37 on Section II of the survey (see Appendix A).

Respondents answered both questions 24 and 31. If the response to question 24 (did the respondent participate in FCP?) was yes, the respondent was asked to answer questions 25-30. If the respondent answered no to question 24, the respondent was instructed to go to question 31. If the response to question 31 (did the respondent participate in moonlighting?) was yes, the respondent was asked to answer questions 32-27. If the respondent answered no to question 31, the respondent was instructed to go to question 38. All of the answers to these questions, except question 33, were yes/no or forced choice. Room for written responses to allow clarification of responses was provided for questions 24, 28, 30, 33, 35, and 37.

Descriptive statistics were used to analyze the data. Sixty people reported that they participated in FCP. For a description of the general settings, please see the results of Research Question 5. Other facilities where FCP occurred included community education programs, serving as a consultant, working in a school district, having a contract set with an acute care facility or with a skilled nursing facility, working in outpatient private practices, completing ergonomic assessments, supervising students in different clinical experiences as part of their fieldwork requirements, consultation with agencies or families, working with non-profit agencies, providing mental health services, and working as part of a grant.

Only four respondents indicated that they had a joint appointment (6.7%), the rest did not. On average, the respondent that participates in FCP does so in their area of

clinical expertise ($n = 51$, 85%). The faculty member's contract did not specifically address FCP most of the time ($n = 47$, 78%). However, respondents indicated that there was flexibility within their contract that allowed them to meet the needs of the department or institution.

Most ($n = 27$, 45%) reported that they participated in FCP less than two hours a week. Others reported spending 2-4 hours per week ($n = 10$, 16.7%) or 5-8 hours per week ($n = 12$, 20%). Those reporting 8 or more hours per week in FCP reported 10 to 36 hours per week in clinical practice. They also reported that the exact time in FCP depended upon the teaching schedule and the time of year. Most spent more time in FCP during the summer.

Slightly more than half ($n = 31$, 51.7%) reported that they did not receive release time for participation in FCP, while the remaining respondents did receive release time. Slightly more than half ($n = 36$, 60%) also do not receive financial benefits from the FCP. For those that did receive financial benefit, 11 reported that they received full benefit, 6 reported that they had to turn in a portion to the department or college, and 7 indicated other financial arrangements, but did not specify what these were. For those that had to turn in a portion of their income, one reported returning 6% and one reported 10%, two reported returning 40%, one returned 50% to the department or the academic institution.

In looking at moonlighting, 99 respondents indicated that they participated in moonlighting. Most (94.9%) were working in their area of clinical expertise. Clinical release time for moonlighting was not a part of the faculty contract most (90.9%) of the

time, with respondents commenting that moonlighting was usually not done during faculty work hours, so it was not included in the contract.

Most reported working less than 8 hours per week in moonlighting. Specifically, respondents reported working less than 2 hours per week ($n = 31, 31.3\%$), 2-4 hours ($n = 29, 29.3\%$) or 5-8 hours ($n = 25, 25.3\%$) per week. Eleven people (11.1%) indicated that they averaged more than 8 hours per week in moonlighting. These hours ranged from 12 to 20 hours per week. Some respondents indicated that these higher hours occurred during off-contract times (for those on a 9 month contract). Three other respondents did not indicate how much time was spent in moonlighting.

Most ($n = 77, 77.8\%$) reported that they received full financial benefits for participation in moonlighting. One reported returning 10% of the financial compensation to the academic institution. One reported using the financial benefits toward the respondent's research efforts. Another one reported using the financial benefits toward a sabbatical leave. Four respondents did not respond to this question. The rest did not receive any extra financial benefits.

Respondents indicated a wide variety of settings for their moonlighting. Adult physical dysfunction, including rehabilitation, acute care, home health, and gerontology settings had the highest number of respondents. This was closely followed by working in pediatrics, including early intervention, home based, outpatient clinics, and school settings. Work with orthopedic clients and completing work hardening or functional capacity evaluations were also frequently mentioned. Other respondents indicated that they provided a wide variety of consultation services to individuals and to organizations.

CHAPTER 5

SUMMARY, DISCUSSION, AND RECOMMENDATIONS

Chapter 5 presents a summary of the first four chapters and a review of the data analysis from Chapter 4. A summary of the chapters, a summary and discussion of the statistical findings for each research question, conclusions and recommendations for future research are also presented.

Summary of Chapters

In Chapter 1, the researcher presented a framework for the variables investigated in this study. The following question guided this investigation: What are the benefits, barriers, and characteristics of clinical practice to full-time occupational therapy faculty members in accredited occupational therapy academic programs? Chapter 1 presented the purpose of the study, the research questions, definitions of terms used in the study, the study assumptions, the study limitations, and the organization of the study.

The review of relevant literature on clinical practice was presented in Chapter 2. The section was an introduction, followed by a discussion of faculty work outside of the academic setting. The definition of clinical practice was presented, including faculty clinical practice and moonlighting. Next was a discussion of the origins of clinical practice in the medical field and the impact that federal legislation had on it. This was followed by a section on clinical practice models.

The third section continued with a discussion of the benefits of clinical practice to the institution, to the academic program, to the faculty member, to the community organization, and to students. The barriers to clinical practice for the institution, the academic program, and for the faculty member completed the discussion of clinical practice. The fourth section reviewed clinical practice and promotion and tenure guidelines at the academic institution, including Boyer's concepts of scholarship. The fifth section reviewed occupational therapy and clinical practice. Accreditation standards set by the accrediting body for occupational therapy education were included as the foundation for clinical practice. The section concluded with a description of a study that has been completed on clinical practice in occupational therapy.

Chapter 3 presented the methodology used in this study. This chapter presented the statement of the problem and the research questions, the population and sampling procedures, methods used to develop the survey instrument, data collection procedures, and the data analysis methods were presented.

This study was conducted via an Internet-based survey of full-time occupational therapy faculty members in accredited occupational therapy programs. All full-time faculty members who were occupational therapists who had accessible e-mail addresses were eligible to participate ($N = 872$). Individuals with non-valid e-mail addresses were removed leaving a final population of 811. The survey was developed by this researcher and a pilot study was conducted prior to the research study. The survey instrument contained 43 questions. Overall, 224 faculty members (27.6%) responded to the survey, with 181 respondents completing the survey instrument.

In Chapter 4, an analysis of the data collected for this study was presented. Data analyses were based upon responses to the survey. This chapter was divided into nine sections, including an introduction, the seven research questions, and a summary.

Discussion

The purpose of this study was to identify the benefits, barriers, and characteristics of clinical practice as identified by the population of occupational therapists who were employed full-time as faculty members in the occupational therapy departments of academic institutions. Occupational therapy faculty members were identified for participation in this study via a web-based search of each academic institution's occupational therapy web pages. Electronic mail addresses were identified for each full-time occupational therapist that worked in the academic institution. A total of 872 valid e-mail addresses were obtained.

A survey, developed by the researcher, was sent to each full-time occupational therapy faculty member via e-mail. Overall, 224 faculty members responded, with 181 respondents providing sufficient information to be included in the data analysis. Technical problems with the database that occurred after the first e-mails went out may have limited participation. When some potential respondents tried to submit the survey, an error message occurred. The end result was that those responses were not included in the database.

A follow-up e-mail asked respondents to wait until the technical problems were fixed. Once the technical problems were fixed, another e-mail was sent to all of the

population asking those that had received an error message to please re-submit. However, some respondents may not have wanted to do this, thus limiting the number of respondents.

Some faculty members may not have been included on the institution's website. Therefore, they would not have received the survey. Other faculty members may never read their e-mails. In looking at Scoggin et al.'s (2000) study, they had a return rate for their mailed study of 24%, with 46 academic programs included. They did not limit their study to full-time faculty members and they did not report how many were full-time in their results. In looking at the response rate for this study, 27.6% of the full-time faculty members responded. This response rate is comparable to that of Scoggin et al.'s study. These respondents represented 98 different academic programs. A discussion of the results related to each research question follows.

Research Question 1

What were the perceived benefits of clinical practice as identified by occupational therapy faculty members? The data for analyzing this question came from the first 12 statements in Section I on the survey (Appendix A). Respondents were asked to rate their level of agreement with each statement on a five point Likert scale (strongly disagree, disagree, neither agree or disagree, agree, and strongly agree). These statements were designed to identify potential benefits of participating in clinical practice. The frequency of response on the Likert scale, median, mode, mean, standard deviation, and a ranking of responses were identified for each of the benefits statements.

The results showed that Statement 1 Clinical practice allows me to maintain my clinical skills, was the most important reason to pursue clinical practice. It was ranked number one of the benefits statements. Maintaining clinical skills is also related to Statement 8 Clinical practice is a source of personal satisfaction (ranked number five) and Statement 11 Clinical practice helps me maintain my professional identity (ranked number 6). Clinical practice skills are associated with practice professions. The high ranking for maintenance of clinical skills may reflect the importance of maintaining professional standards of practice. Clinical practice also serves as a source of self fulfillment (statement 8) as reflected in maintaining ones' professional identity (statement 11).

As indicted by this study, clinical practice also enhances teaching (Statement 5) and improves credibility with students (Statement 9). Enhancement of teaching was ranked number two and improving credibility with students was ranked number three. It is not surprising that these two statements were closely ranked. Teaching frequently involves using clinical examples to illustrate theoretical points (Peloquin & Abreu, 1996). Faculty must be sure to include state of the art practice in their examples (Peloquin & Abreu, 1996; Richmond et al., 2001).

Inclusion of state of the art practice in teaching enhances the faculty member's ability to present concepts and theories to students. Students generally respond well to clinical examples because it allows them to see the application of theoretical principles. Therefore, clinical skills enhance both teaching and credibility with students. The process of linking clinical examples and theory to teaching is consistent with the scholarship of

teaching and contributes to the faculty member's pedagogical knowledge (Kreber, 2002b).

Opportunities for networking (Statement 10, rank number 4) and collaboration for research (Statement 4, rank number 6) are also closely related. Some occupational therapy programs have successfully established community networks that have directly led to collaborative research (Braveman et al., 2001; Fleming et al., 1996; Hammel et al., 2001). This also benefits the faculty member's research interests (ranked number 10), and can increase personal satisfaction (Statement 8).

The highest level of disagreement or strong disagreement (lowest ranking) for the benefits to clinical practice was with Statement 12 Clinical practice produces revenue for our department. The disagreement with this statement indicates that clinical practice was not used to generate income for most of the respondent's academic departments. However, 31 respondents agreed or strongly agreed with this statement, suggesting that some faculty members are required to share any reimbursement from clinical practice with their academic department.

The next lowest ranking was with Statement 3 Clinical practice allows me to supervise students in the clinical setting. Only 52.5% agreed or strongly agreed with this statement. This indicates that almost half of the full-time faculty members that responded do not supervise students in the clinical setting.

The next lowest ranking was with Statement 2 Clinical practice supplements my income. While most (59.7%) agreed or strongly agreed that clinical practice supplemented their income, 16.6% indicated that it did not. In examining this issue

further, many faculty members that participated in clinical practice indicated that they do not receive any supplemental income for this participation. Instead, they participate to maintain their clinical skills or for personal satisfaction.

The results of the ranked benefits are slightly different than those obtained by Scoggin et al. (2000) in their survey of faculty members. Scoggin et al. identified staying current, making contacts and networking, maintaining professional identity, enhancing teaching, personal income, and departmental expectations as the rank order of benefits. This study identified maintaining clinical skills, enhancing teaching, improving credibility with students, networking, person satisfaction, maintaining professional identity, collaboration for clinical research, fitting the mission of the OT program, supplementing income, pursuing research interests, supervising students in the clinic, and producing revenue as the order of benefits (see Table 8).

This study was based on 181 respondents. Scoggin et al.'s (2000) study of faculty members was based on 44 respondents. This study also used an objective format for respondents to rate their level of agreement with the benefits statements. Scoggin et al. used open ended questions to elicit information. These differences in methodology may account for the disparities in the ranked items.

Scoggin et al. (2000) also surveyed occupational therapy department chairpersons. They ranked production of income for the department as the top benefit. Respondents in this study ranked production of income last, indicating that many faculty members do not have to contribute any income earned during clinical practice to the

department. The other benefits ranked by the department chairpersons in Scoggin et al.'s study are consistent with the results of this study.

Research Question 2

What were the perceived barriers to clinical practice as identified by occupational therapy faculty? The data for analyzing this question came from statements 13-22 on Section I of the survey. Respondents were asked to rate their level of agreement with each statement on a five-point Likert scale (strongly disagree, disagree, neither agree or disagree, agree, and strongly agree). These statements were designed to identify potential barriers to participating in clinical practice. Response frequencies, median, mode, and a rank order were identified for each of the barrier statements.

The results showed that the biggest barriers to participation in clinical practice are interrelated. Teaching responsibilities (Statement 21, ranked number 1) were perceived to be high enough such that any other task, such as participation in clinical practice, would be perceived of as an additional responsibility (Statement 17, ranked number 3). With little to no recognition in the awarding of tenure (Statement 20, ranked number 2) or promotion (Statement 19, ranked number 4) for participation in clinical practice, there is little incentive for faculty to participate in clinical practice. The extra workload to support clinical practice was not justified by many respondents.

Inspection of the disagreements with the barrier statements revealed that an overwhelming majority (89.2%) believed that there was a need for their clinical specialty in their locale (Statement 22). This indicates that there is a need for the faculty member to

participate in clinical practice. However, time commitments to the academic institution and a lack of recognition for clinical practice in the promotion and tenure process were such that the respondent could not participate fully in clinical practice.

The department chairperson (Statement 15, 61%) and dean (Statement 16, 51%) were supportive of clinical practice. However, in the comments section, several indicated that while the department chairperson or dean verbally supported clinical practice, no release time was given for this endeavor. Still others indicated that they were strongly discouraged from participating in clinical practice by their department chairperson or dean because it would interfere with research and grant production. This was also found in Scoggin et al.'s (2000) survey of faculty. They found that a lack of institutional support was the number one identified barrier to clinical practice. This is in direct contrast to Boyer's (1990) work advocating the recognition of other scholarly endeavors, such as the scholarship of teaching or scholarship of practice, in consideration for promotion and tenure decisions.

The barriers identified in this study are similar to those identified by faculty members in Scoggin et al.'s (2000) study. They identified a lack of time and a lack of arrangements within the academic institution as the biggest barriers to clinical practice. The lack of time for clinical practice is related to teaching responsibilities (Statement 21) and to research production (Statement 13) as identified in this study.

Scoggin et al. (2000) also identified personal choice and having specialties that were not considered clinical practice as reasons for not participating in clinical practice. This was confirmed from several e-mails that this researcher received from respondents

that did not have time to complete the survey. These respondents (n=15) indicated that research was their practice area or that the definitions of clinical practice, faculty clinical practice, and moonlighting used in this survey were too limited to describe their practice.

Other respondents to this study indicated that their occupational therapy programs had specific lines for clinical faculty versus tenure track faculty. Clinical faculty were expected to teach and to participate in faculty clinical practice or in moonlighting. Tenure-track faculty were expected to participate in traditional forms of research and grant writing. Tenure-track faculty were actively discouraged from participating in clinical practice.

Research Question 3

Do perceived benefits and barriers of clinical practice as identified by occupational therapy faculty differ as a function of their academic institution's Carnegie Classification? The data for analyzing this question came from the first 22 statements in Section I on the survey and the academic institution's Carnegie Classification. An ANOVA was used to examine the relationship between the barriers and the benefits and the Carnegie Classification.

The independent variable was the Carnegie Classification and the dependent variables were the benefits and the barriers to clinical practice. Neither benefits nor barriers were statistically significantly related to the Carnegie Classification. The ANOVA examining the relationship between benefits and Carnegie Classification was approaching significance ($F(5,168) = 2.188, p = .058$).

An examination of the benefit mean scores for the different Carnegie Classifications indicated that respondents from the Doctoral Intensive II group had the highest mean score (49.93), followed by the Masters I (47.10). Respondents in the Masters II institutions had the lowest mean benefit score (44.92) followed by the Doctoral Extensive I institutions (44.98). While these differences were not statistically significant, they show a trend. This trend may indicate that respondents in the Doctoral Intensive II institutions and the Masters I institutions are better at combining clinical practice with their research agendas. This could indicate appropriate use of the scholarship of practice with these two groups. A larger sample may clarify this relationship.

The comparison between the Carnegie Classification and the barriers to clinical practice had similar results. The ANOVA was also not statistically significant. The trend was for respondents from Doctoral I institutions to report more barriers on average than the other groups ($M = 33.34$), with individuals from Doctoral II ($M = 30.04$) and Masters I ($M = 30.89$) reporting fewer barriers. None of these differences were significant. However, they fit with the trends seen in the benefits section. Both the respondents in the Doctoral II and Masters I groups indicated more benefits and fewer barriers than the respondents in Doctoral I institutions.

No other research was found comparing Carnegie Classifications to the benefits or barriers to clinical practice.

Research Question 4

How do the perceived benefits and barriers of clinical practice differ among respondents according to selected demographic variables (tenure for the institution, tenure status, doctoral degree, rank, administrative duties and gender)? The data for analyzing this question came from the first 22 statements in Section I on the survey and questions 38-43 in Section III (see Appendix A). An ANOVA was used to examine the relationship between the barriers and the benefits and each of the demographic variables. The independent variables were the demographic variables (tenure, tenure status, degree, faculty rank, administrative duties, and gender). The dependent variables were the benefits and the barriers to clinical practice.

Benefits of Clinical Practice and Demographic Variables

There were no statistically significant relationships between the benefits of clinical practice and availability of tenure at the institution, the respondent's tenure status, or the respondent's gender. Three ANOVAs approached significance, but were not statistically significant. They were between benefits and doctoral degree ($F(1,179) = 6.189, p = .014.$); benefits and faculty rank ($F(4, 172) = 2.553, p = .041$); and benefits and administrative duties ($F(4,172) = 2.625, p = .036$). No other studies could be identified that examined the benefits of clinical practice to if the institution had tenure, or the respondent's tenure status, faculty rank, administrative duties, or gender.

A closer inspection of the benefits and doctoral degree suggested that respondents with doctoral degrees ($n = 93$, $M = 45.46$, $SD = 6.505$) tended to believe there were fewer benefits to participation in clinical practice than those without doctoral degrees ($n = 88$, $M = 47.90$, $SD = 6.664$). One possible explanation is that those individuals with a doctoral degree are more concerned with promotion and tenure requirements than those without a doctoral degree. They may perceive time spent on clinical practice to be wasted time. Therefore, the respondent with a doctoral degree must spend more time pursuing those activities required for promotion and tenure. Those without doctoral degrees may not be eligible for tenure track status at their academic institutions. This may contribute to the non-doctoral degree faculty perceiving more benefits to clinical practice than those with doctoral degrees.

In examining the relationship between faculty rank and benefits to clinical practice, respondents at the Professor rank ($M = 42.63$, $SD = 6.739$) tended to rate the benefits of clinical practice to be lower than instructors ($M = 49.57$, $SD = 5.140$) or those that had other ranks ($M = 51.83$; $SD = 3.371$). One possible explanation is that many at the rank of Instructor or Other are not in tenure-track positions. Therefore, they likely do not have to meet the same expectations for tenure as do those in higher ranks. Those at the rank of Professor have recognized the importance of contributing to their own research agendas and clinical practice may be perceived as taking time away from research pursuits.

In examining the relationship between administrative duties and benefits to clinical practice, there was a significant difference between the Program Directors ($M =$

43.39; $SD = 7.180$) and the Academic Fieldwork Coordinators (AFWC) ($M = 49.40$, $SD = 3.862$). One possible explanation is that the AFWC must work closely with students in planning the requirements for the student's placements in clinical settings (AOTA, 2004). This requires close collaboration between the academic institution (the AFWC) and the clinical site. Because of the focus on finding quality programs for student placements, the AFWC may see more need for faculty members to provide supervision for students in both traditional and non-traditional clinical sites (Braveman et al., 2001; Cohn et al., 2001; Fleming et al., 1996; Hammel et al., 2001; Shordike & Howell, 2001; and Rydeen et al., 1994), thus accounting for their higher ratings of the benefits of clinical practice.

While the Program Director may support the AFWC in establishing these important programs for student education, the Program Director must also ensure that other faculty members and the department as a whole are meeting institutional requirements for promotion and tenure. The Program Director also has a heavier administrative load and may be focused more on developing their faculty member's lines of research versus supporting clinical practice.

The next highest mean value for the benefits of participation for those that had administrative duties was with the Department Chair ($M = 48.31$, $SD = 5.747$). While the Department Chair's mean responses were not significantly different from the Program Chair, it is interesting to see these differences. Perhaps the department chair also realizes the importance of establishing and supporting ties to clinical facilities because of the benefits to the students and to the faculty members.

Barriers to Clinical Practice and Demographic Variables

There were no statistically significant relationships between the barriers of clinical practice and availability of tenure at the institution, the respondent's tenure status, the respondent's faculty rank, the respondent's administrative duties or the respondent's gender. There was a statistically significant relationship between the barriers and if the respondent had a doctoral degree. No other studies could be identified that examined the barriers of clinical practice to if the institution had tenure, or the respondent's tenure status, faculty rank, administrative duties, or gender.

There were statistically significant mean differences of barriers due to doctoral degree. The means of the barriers to clinical practice of those that indicated they had a doctoral degree were higher ($n = 93$; $M = 33.16$, $SD = 7.246$) than those that did not have a doctoral degree ($n = 88$; $M = 30.35$, $SD = 5.571$). This may indicate that those with doctoral degrees are in tenure track positions. Clinical practice may present more barriers to those with doctoral degrees as they pursue promotion and tenure requirements within their institution. Therefore, clinical practice barriers tend to be rated higher for those with doctoral degrees.

In examining the relationship between the barriers to clinical practice and administrative duties, there was a trend for those that were not involved in administrative duties ($n = 87$, $M = 32.67$, $SD = 6.490$) to rate barriers higher than those with administrative duties ($n = 90$, $M = 31.13$, $SD = 6.872$). However, these differences were not statistically significant. The possible reasons for this vary. Those without administrative duties are typically working toward tenure and promotion. Therefore,

clinical practice may be perceived as barriers due to time constraints. Those with administrative duties may also perceive themselves as supporting clinical practice. However, the reality as faced by the faculty member is that there is no release time nor is there any reward in the academic institution to participate in clinical practice. Therefore, those without administrative duties rated barriers higher than those with administrative duties.

Gender and barriers to clinical practice also approached significance: $F(1,176) = 3.123, p = .079$. Women ($n = 166, M = 31.396, SD = 6.510$) rated clinical practice barriers higher than men ($n = 12, M = 28.50, SD = 7.217$). The reasons for this are not known. Perhaps women have more time constraints due to traditional values such as family commitments than do men. Consequently, women may rate the barrier statements higher than men.

Research Question 5

What was the incidence of clinical practice in occupational therapy faculty members and are there any significant differences based on the academic institution's Carnegie Classification? The data used in analyzing this question were collected from the Carnegie Classification and questions 23, 24, and 31 on Section II of the survey. These questions required the respondent to answer yes or no. Four levels of yes were available on question 24. Descriptive statistics were used to calculate the occurrence of clinical practice. No other research could be located that examined these characteristics.

Most academic institutions ($n = 164$, 91.6%) did not require their occupational therapy faculty members to participate in clinical practice. About 33% of the respondents indicated that they participated in faculty clinical practice that was part of their faculty role. This number was similar to that reported by Scoggin et al. (2000) (32%). One respondent worked in an academic health center. More than half of the individuals in Scoggin et al.'s study worked in an academic health center. Fourteen respondents in this study worked in a clinic in the OT department or at an outpatient clinic operated by the OT department. Most of the respondents that participated in FCP ($n = 45$, 75%) did so in other facilities via a contract or arrangement between that facility and the academic department. Several respondents indicated that they were allowed to participate in faculty clinical practice up to 8 hours per week per their contract or per their institution's faculty handbook.

Over 50% of the respondents in this study indicated that they participated in moonlighting. This is higher than that reported by Scoggin et al. (2000) (37%).

A Chi Square Test of Association was used to examine the relationship between the academic institution requiring clinical practice, participation in FCP (yes or no), or participation in moonlighting (yes or no) and the institution's Carnegie Classification. The first analysis examined the relationship between the academic institution requiring participation in clinical practice, and the three Carnegie Classifications. The results were not statistically significant. This means that the proportion of respondents indicating they had to participate in clinical practice was equal across the Carnegie Classifications. More

respondents representing the different Carnegie Classifications would increase the likelihood of achieving statistical and practical significance.

The second analysis examined the relationship between participation in FCP (yes/no) and the three Carnegie Classifications. These results were also not statistically significant. This means that the proportion of individuals participating in FCP occurs equally across all Carnegie levels. Perhaps a more representative sample of respondents representing both the different Carnegie Classifications and the different levels of participation in clinical practice would increase the likelihood of achieving statistical and practical significance.

The third analysis examined the relationship between participation in moonlighting and the five levels of Carnegie Classifications. These results were also not significant. This means that moonlighting occurred in similar proportions across all Carnegie Classifications. Perhaps a more representative sample of respondents representing the different Carnegie Classifications would increase the likelihood of achieving statistical and practical significance.

Research Question 6

What were the characteristics (tenure status, doctoral degree, rank, administrative duties, and gender) of faculty members that participate in clinical practice either within or outside the faculty role? The data used in analyzing this question were collected from Question 24 and Question 31 in Section II of the survey and Questions 39-43 in Section III (see Appendix A). Descriptive statistics were used for data analysis.

One third of the respondents indicated that they had participated in faculty clinical practice during the last year. Those participating in FCP were usually not tenured, had a doctoral degree (45%), were at the Assistant or Associate Professor rank, and did not have other administrative duties. The largest number of respondents that participated in FCP reported that they were in Doctoral-Extensive I universities. Scoggin et al. (2000) reported that most of their respondents had master's degrees (81%). This is a higher percentage than found in this study. Scoggin et al. did not report the respondent's Carnegie Classification, rank, tenure status, administrative duties, or gender.

The findings on these respondents have doctoral degrees and working in Doctoral-Extensive I universities are somewhat surprising, especially since most were not tenured in their position. Individuals with doctoral degrees are typically working toward promotion and/or tenure in their academic institution. This usually precludes participation in FCP. However, some of the respondents indicated that they were actively using their FCP site to gather data for research interests. Perhaps these respondents have recognized the benefits of collaboration with others to help meet their own research goals or they are pursuing the scholarship of practice as advocated by Boyer (1990).

The findings related to moonlighting were similar. Just over half of the respondents reported that they had participated in moonlighting in the past year. Most were not tenured. Less than 35% of the respondents indicated that they had a Doctoral degree. The most common faculty rank was the same as for FCP - Assistant or Associate Professor. Most were not participating in administrative duties other than those typically required of faculty members, including serving as student advisors and on committees.

Scoggin et al. (2000) reported that 76% of the respondents in their study that participated in moonlighting had master's degrees. In this study, approximately 65% had master's degrees. Scoggin et al.'s results indicated that FCP occurred more in individuals with master's degree than in this study. Scoggin et al. did not report Carnegie Classification, rank, tenure status, administrative duties, or gender.

Again, there were unexpected findings. Most Assistant or Associate Professors have not received tenure, which was confirmed in this study. Many faculty members are working to establish their lines of research with the goal of being promoted or achieving tenure. Again, perhaps these respondents have focused on developing the scholarship of practice, with a goal of developing and participating in research in the clinical setting. Further research may help identify the reasons for their participation in moonlighting.

Research Question 7

What were the characteristics of clinical practice as described by faculty members and how do these differ if the clinical practice is conducted as part of the faculty role or outside the faculty role? The data used in evaluating Research Question 7 were collected from questions 24 - 37 on Section II of the survey (See Appendix A). Descriptive statistics were used to analyze the data.

All of the individuals ($n = 99$) that moonlight reported working at facilities that were not associated with the academic institution. Sixty people reported participating in FCP. Most (75%) reported working in other facilities that were not owned by the academic institution. This is not surprising because many OT programs are located in

smaller universities. Less than 20% of the OT programs are affiliated with an academic health center (AOTA, 2004). Some programs are located in smaller communities or in colleges that focus on Liberal Arts, not on health care professions.

Most of those in FCP or in moonlighting work in their area of clinical expertise. This is not surprising because it confirms the findings from Research Question 1 on the benefits of clinical practice. The number one benefit was that clinical practice allows the faculty member to maintain clinical skills. By working in their area of clinical expertise, faculty members are maintaining their clinical skills.

Most faculty members that participate in FCP or in moonlighting do not have this participation explicitly defined in the faculty contract, nor do they receive release time. This is similar to Scoggin et al.'s study (2000) that found that most faculty members managed their own clinical practice. In this study, most respondents commented that their contract allows up to eight hours per week in clinical practice, provided that the practice did not interfere with the faculty member's responsibilities to the institution. In addition, moonlighting was usually not done during faculty work hours, so it was not included in the contract. Scoggin et al. also found this to be true.

Most respondents also reported working less than 8 hours per week in clinical practice, whether within or outside the faculty role. However, those respondents that work on a 9 or 10 month contract reported that they spent more time in clinical practice during the summer months when the academic institution is not in session. Respondents on 12 month contracts also reported spending more time in clinical practice during the summer because the course schedule is much lighter in the summer. Scoggin et al. (2000)

also identified that individuals working on a 9 or 10 month contract were more apt to participate in moonlighting.

Recommendations for Further Study

This study provided an overview of the benefits, barriers, and characteristics of clinical practice for full-time occupational therapy faculty members. The survey used items that had been identified as benefits, barriers, or characteristics of clinical practice from the literature review. However, little research on this area has been done with occupational therapy faculty. Replication would help validate and extend the results of this study. This study could also be replicated with other health professions to determine if the same benefits and barriers are identified for those professionals.

A larger return rate may improve the reliability and improve external validity of the results of this study. A larger sample size may influence the results to show practical and/or significant relationships between different variables. Further study in this area is indicated.

This study used a relatively new data collection method: a web-based survey. Faculty may not respond to surveys offered in this format. In addition, it is possible that some of the e-mails never reached their intended target because of filters in place at their academic institution. Replication through other methods such as mail or telephone surveys may help support and extend these results.

Many academic institution's websites were difficult to navigate. Many others had not been updated. Therefore, individuals that were new to the institution may not have

received an e-mail. Those that no longer worked at that institution received an e-mail. Most of these e-mails were returned as undeliverable. A few made it to the correct person. However, that person was no longer working full-time at that academic institution. Finding e-mail addresses and a current list of full-time faculty members was difficult. A telephone call to every program asking for an updated list of faculty names and e-mails would help ensure accuracy of the master listing.

Technological difficulties may have hindered some responses. Having an on-site computer programmer is highly recommended so that if problems develop, they can be addressed immediately.

Other research questions should also be included. Questions that examine the use of clinical faculty versus tenure track faculty to provide clinical services are needed. Several respondents indicated that contract length at the academic institution may be a factor. Those that have 9 or 10 month contracts may be more apt to be able to participate in clinical practice during the other two to three months of the year.

Additional analyses could also be completed. For example, these analyses could examine the interaction between the doctoral degree and faculty rank on the perceived benefits and barriers to clinical practice. A factor analysis could also be completed with the benefits and barriers to examine the underlying constructs.

Conclusions

Professional schools such as health sciences, education, criminal justice, public affairs, etc. are challenged in the university environment to operate like Colleges of Arts

and Sciences. Faculty members seeking promotion and tenure are evaluated like mathematics, English, history, etc. professors, or worse, like engineer and computer scientists. There are usually two variables that are valued in the traditional academic institution: (a) refereed publications (and other research, preferably experimental) and (b) external funding or grants. Service is not valued, nor is clinical practice. To facilitate more participation in clinical practice, the academic institution must recognize its value.

For clinical practice to flourish in academic institutions, active support from administration, including the department chairperson, dean, and higher administration officials are critical. This support could be in the form of release time or in supporting faculty to develop clinical practice as their scholarship of practice with a goal of evaluating the scholarship of practice in the awarding of promotion and tenure.

Promoting the scholarship of practice has long term benefits for the faculty member, the occupational therapy department, the academic institution, and the community. However, institutional commitment to clinical practice and an appropriate reward system are critical to develop before faculty members will want to participate fully in clinical practice.

APPENDIX A
SURVEY INSTRUMENT

Occupational Therapy Faculty Member's

Perceptions of Clinical Practice

Bonnie Decker, MHS, OTR/L, BCP

bonniedeckerotr@bellsouth.net

Please carefully read the following information on the questionnaire sample, informed consent, and the definitions of terms used in this study.

QUESTIONNAIRE SAMPLE

This questionnaire is limited to occupational therapists that are full-time faculty members in accredited occupational therapy education programs. If you are NOT a full-time faculty member (i.e., you are part-time, adjunct, or clinical faculty) or if you are NOT an occupational therapist, please place a check on the appropriate line and return the questionnaire via e-mail.

_____ **I am not an occupational therapist.**

_____ **I am not a full-time faculty member in the occupational therapy education program.**

INFORMED CONSENT

Please read the following statements and place a check mark on each line for informed consent.

_____ I have read the procedures described in the e-mail.

_____ I voluntarily agree to participate in this research study. To maintain confidentiality, I understand that I do not have to sign my name. My check mark indicates my willingness to participate.

DEFINITIONS OF TERMS

Clinical practice is defined as the provision of occupational therapy services to clients or organizations, including consultation, evaluation, intervention, or education. In many cases, clinical practice results in billing the client or organization for services rendered. Clinical practice may result in advancing the research agenda of the faculty member and may result in reimbursement to the faculty member for the services.

Faculty clinical practice is provision of clinical practice that is defined as part of the faculty role. This generally takes place during normal working hours. Services are generally billed through the academic institution or the occupational therapy program.

Moonlighting is any practice as an occupational therapist that is not part of a faculty role. This generally takes place outside of normal working hours. It may include working evenings or on the weekends. Services are generally billed by the faculty member or through an agency that is not affiliated with the academic institution or the occupational therapy program

Please begin the questionnaire on the next page

Instructions: The following factors have been identified as benefits or barriers for occupational therapy faculty members participating in clinical practice. Please rate your agreement with each statement by checking the box by the number, even if you are not currently participating in clinical practice.					
	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
	SD	D	[A/]	A	SA
<u>Possible Benefits of Clinical Practice</u>					
1. Clinical practice allows me to maintain my clinical skills.	1	2	3	4	5
2. Clinical practice supplements my income.	1	2	3	4	5
3. Clinical practice allows me to supervise students in the clinical setting.	1	2	3	4	5
4. Clinical practice enhances collaboration for clinical research.	1	2	3	4	5
5. Clinical practice enhances my teaching.	1	2	3	4	5
6. Clinical practice provides data for my research interests.	1	2	3	4	5
7. Clinical practice fits with the mission of our OT program.	1	2	3	4	5
8. Clinical practice is a source of personal satisfaction.	1	2	3	4	5
9. Clinical practice improves my credibility with students.	1	2	3	4	5
10. Clinical practice offers opportunities to network with others.	1	2	3	4	5
11. Clinical practice helps me maintain my professional identity.	1	2	3	4	5
12. Clinical practice produces revenue for our department.	1	2	3	4	5
<u>Possible Barriers to Clinical Practice</u>					
13. Clinical practice interferes with my research production.	1	2	3	4	5
14. Clinical practice interferes with my success in the academic setting.	1	2	3	4	5
15. Clinical practice is not supported by the Department Chairperson.	1	2	3	4	5
16. Clinical practice is not supported by the Dean.	1	2	3	4	5
17. Clinical practice would be an additional responsibility.	1	2	3	4	5

18. Academicians outside the OT department do not value clinical practice.	1	2	3	4	5
19. Clinical practice is not a component of faculty promotion expectations.	1	2	3	4	5
20. Clinical practice is not a component of tenure expectations.	1	2	3	4	5
21. Clinical practice is limited because of teaching responsibilities.	1	2	3	4	5
22. My OT clinical specialty area is not needed in this locale.	1	2	3	4	5

Please indicate your answers by marking the appropriate box with an X.

23. Does your academic institution require OT faculty to participate in clinical practice?
- Yes
- No
24. In the past year, have you participated in OT faculty clinical practice sponsored by your institution *as part of your faculty role*?
- Yes, in an academic health care center.
- Yes, in a clinic located in the OT department at the academic institution.
- Yes, in an outpatient clinic owned or operated by the academic institution.
- Yes, Other (Please specify: _____).
- No, I have not participated in OT faculty clinical practice in the past year as part of my faculty role.
- ↳ **If no, skip to 31**
25. (If yes to 24) Is your position considered a joint appointment?
- Yes
- No
26. (If yes to 24) Is this clinical practice in your area of clinical expertise?
- Yes
- No
27. (If yes to 24) Is the faculty clinical practice included in your academic institution contract?
- Yes
- No

28. **(If yes to 24) On average, how many hours per week are spent in faculty clinical practice as part of your faculty role?**

- Less than 2 hours per week
- 2 - 4 hours per week
- 5 - 8 hours per week
- More than 8 hours (Please specify: _____)

29. **(If yes to 24) Do you receive release time for participation in faculty clinical practice?**

- Yes
- No

30. **(If yes to 24) Do you receive extra financial benefits (such as salary, hourly wage, or a consultation fee) from the faculty clinical practice?**

- Yes, I receive extra financial benefit (the income is above my faculty salary)
- Yes, but I must turn in a portion of the income to my department or college.
Please indicate the percent that must be turned in: _____
- Other (Please specify: _____).
- No, I do not receive financial benefit.

31. **In the past year, have you participated in OT clinical practice that has NOT been an official part of your faculty role (i.e., working on weekends or evenings or moonlighting)?**

- Yes
- No, I have not participated in this type of OT clinical practice in the past year.
↳ **If no, skip to 38**

32. **(If yes to 31) Is this clinical practice in your area of clinical expertise?**

- Yes
- No

33. **(If yes to 31) Please briefly describe the setting (types of clients) in this box.**

34. **(If yes to 31) Is clinical practice included in your faculty contract?**

- Yes
- No

35. **(If yes to 31) On average, how many hours per week are spent working in clinical practice outside the faculty role (moonlighting)?**
- Less than 2 hours per week
 - 2 - 4 hours per week
 - 5 - 8 hours per week
 - More than 8 hours (Please specify: _____)
36. **(If yes to 31) Do you receive release time for participation in clinical practice that is outside the faculty role (moonlighting)?**
- Yes
 - No
37. **(If yes to 31) Do you receive extra financial benefits (such as salary, hourly wage, or a consultation fee) from clinical practice that is outside the faculty role (moonlighting)?**
- Yes, I receive full financial benefit.
 - Yes, but I must turn in a portion of the income.
Please indicate the percent that must be turned in: _____
 - Other (Please specify: _____).
 - No, I do not receive financial benefit.
38. **Does your academic institution have tenure?**
- Yes
 - No
39. **Are you tenured in your current position?**
- Yes
 - No
40. **Do you have a doctoral degree?**
- Yes (Please specify degree: _____)
 - No
41. **What is your current faculty rank?**
- Lecturer
 - Instructor
 - Assistant Professor
 - Associate Professor
 - Professor
 - Other (Please specify: _____)

42. **Do you have administrative duties associated with your faculty position?**

- Yes, I am a Program Director
- Yes, I am a Department Chairperson
- Yes, I am an Academic Fieldwork Coordinator
- Other (Please specify: _____)
- No

43. **What is your gender?**

- Male
- Female

YOUR ACADEMIC INSTITUTION

I am interested in differences between the academic institution's Carnegie Classification and clinical practice factors. Please place the name of your institution here. This information is for coding purposes only. Once the information is coded, this sheet will be deleted and the data will not be attached to your name or your institution.

Name of your academic institution: _____

If you have any additional comments, please do so in the box below.

Thank you for your participation.

Please click this button to submit your answers.

Bonnie Decker, MHS, OTR/L, BCP
708 Bahia Drive
St. Augustine, FL 32086
800 241-1027x232 bonniedeckerotr@bellsouth.net

APPENDIX B

E-MAIL TO RELIABILITY STUDY SAMPLE

Dear Occupational Therapy Faculty Member:

Please help me complete a reliability study of my survey for my dissertation! I obtained your name and e-mail from your University's website.

I am a doctoral student in Education Leadership at the University of Central Florida under the supervision of faculty member Dr. William Bozeman. I am writing to ask for your help in a study of occupational therapists that are employed full-time as occupational therapy faculty members. This study is an effort to explore faculty member's opinions on barriers and benefits of participation in clinical practice, either as part of the faculty role or in working privately on the side (moonlighting). Operational definitions for key terms, including the questionnaire sample, informed consent, clinical practice, and moonlighting are on the first page of the survey.

Your answers will be completely confidential and will be released only as summaries in which no individual answers can be identified. The survey will take about 10 minutes to complete and a quick reply would be appreciated. Please click on this link to complete the survey:

<http://www.techhut.com/decker>

If the link does not work, please cut and paste it into the address line on your browser. Once finished with the survey, please click on the "submit this questionnaire" button at the end of the survey. Results are compiled into a database that keeps all information confidential. Neither your name nor e-mail address are included in the database.

Participation in this study is voluntary. You do not have to answer any question you do not wish to answer. If for some reason you prefer not to respond, please return the blank questionnaire in the enclosed envelope. This research has been approved by the Institutional Review Board at the University of Central Florida. Questions or concerns about research participants' rights may be directed to the UCFIRB office, University of Central Florida Office of Research, Orlando Tech Center, 12443 Research Parkway, Suite 207, Orlando, FL 32826. The phone number is (407) 823-2901.

You can help me very much by taking a few minutes to share your thoughts and beliefs about clinical practice. If you have any questions or comments about this study, I would be happy to talk with you. My toll-free number is 800 241-1027 x232, or you reply to this email. Thank you very much for helping with this important study.

Sincerely,

Bonnie Decker, MHS, OTR/L, BCP
Doctoral Candidate, University of Central Florida
bonniedeckerotr@bellsouth.net

P.S. If you are not an occupational therapist or are not employed full-time as a faculty member in an occupational therapy program, please respond to this e-mail by putting NOT IN SAMPLE on the subject line and I will remove your name and address from my sample list. Thank you.

APPENDIX C

INSTITUTIONAL REVIEW BOARD PERMISSION LETTER



Office of Research

ORIGINAL

November 15, 2004

Bonnie Decker
708 Bahia Drive
St. Augustine, FL 32086

Dear Ms. Decker:

With reference to your protocol entitled, "The Participants of Occupational Therapy Faculty in Clinical Practice," I am enclosing for your records the approved, expedited document of the UCFIRB Form you had submitted to our office.

Please be advised that this approval is given for one year. Should there be any addendums or administrative changes to the already approved protocol, they must also be submitted to the Board. Changes should not be initiated until written IRB approval is received. Adverse events should be reported to the IRB as they occur. Further, should there be a need to extend this protocol, a renewal form must be submitted for approval at least one month prior to the anniversary date of the most recent approval and is the responsibility of the investigator (UCF).

Should you have any questions, please do not hesitate to call me at 407-823-2901.

Please accept our best wishes for the success of your endeavors.

Cordially,

Barbara Ward

Barbara Ward, CIM
IRB Coordinator

Copies: IRB office

APPENDIX D

INITIAL E-MAIL TO THE SAMPLE

Dear Occupational Therapy Faculty Member:

Please help me complete my dissertation! I obtained your name and e-mail from your Institution's website. A quick response would be very much appreciated.

I am a doctoral student in Education Leadership at the University of Central Florida under the supervision of faculty member Dr. William Bozeman. I am writing to ask for your help in a study of occupational therapists that are employed full-time as occupational therapy faculty members. This study is an effort to explore faculty member's opinions on barriers and benefits of participation in clinical practice, either as part of the faculty role or in working privately on the side (moonlighting). Operational definitions for key terms, including the questionnaire sample, informed consent, clinical practice, and moonlighting are on the first page of the survey.

Your answers will be completely confidential and will be released only as summaries in which no individual answers can be identified. The survey will take about 10 minutes to complete and a quick reply would be appreciated. Please place your cursor on this link and press control to obtain the survey:

<http://www.techhut.com/decker>

If the link does not work, please cut and paste it into the address line on your browser. Once finished with the survey, please click on the "submit this questionnaire" button at the end of the survey. Results are compiled into a database that keeps all information confidential. Neither your name nor e-mail address are included in the database.

Participation in this study is voluntary. You do not have to answer any question you do not wish to answer. This research has been approved by the Institutional Review Board at the University of Central Florida. Questions or concerns about research participants' rights may be directed to the UCFIRB office, University of Central Florida Office of Research, Orlando Tech Center, 12443 Research Parkway, Suite 207, Orlando, FL 32826. The phone number is (407) 823-2901.

You can help me very much by taking a few minutes to share your thoughts and beliefs about clinical practice. If you have any questions or comments about this study, I would be happy to talk with you. My toll-free number is 800 241-1027 x232, or you reply to this email. Thank you very much for helping with this important study.

Sincerely,

Bonnie Decker, MHS, OTR/L, BCP
Doctoral Candidate, University of Central Florida
bonniedeckerotr@bellsouth.net

P.S. If you are not an occupational therapist or are not employed full-time as a faculty member in an occupational therapy program, please respond to this e-mail by putting NOT IN SAMPLE on the subject line and I will remove your name and address from my sample list. Thank you.

APPENDIX E

E-MAIL TO THE SAMPLE ABOUT DATABASE PROBLEMS

Dear OT Faculty Member:

Several people have e-mailed me to indicate that they are not currently working in a clinic. I would still like to have your opinions on the benefits and barriers of clinical practice.

Thank you for all of the responses regarding the problem of getting an error message when you hit submit. If you did not receive this message, everything is fine - thank you so much for your response! The problem we are having is getting the database to accept the information. I do not know if it is being overwhelmed with responses or what, but many get an error message when they hit submit. If you received this message, your responses were not included in the data base. I would greatly appreciate it if you would try again once the problem is fixed.

If you do get the error message, please hit the refresh button. That should submit the form and you should get a response that says thank you. In the meantime, my computer person is working hard to fix the problem (we thought we had it fixed Tuesday morning, but when I tried it, it did not work).

There are a couple of options: one person copied her answers, then pasted them into an e-mail to me. I will then hand enter the data - your name will not be on any of the forms. Others have emailed the survey as an attachment. I then save the attachment under a number system and will enter it into the system by hand. This is not necessary. I will also e-mail everyone again when I know the problem has been fixed.

Thank you so much for your willingness to participate. I am looking forward to learning the results of this survey.

Bonnie Decker
Doctoral Candidate, University of Central Florida
bonniedeckerotr@bellsouth.net

PS: Here is the link to my survey if you need it: <http://www.techhut.com/decker>

APPENDIX F

RESENDING THE E-MAIL TO THE SAMPLE

Dear Occupational Therapy Faculty Member:

A big thank you to all of you that have completed my survey that asked about your opinions and beliefs on participation in clinical practice, either as part of the faculty role or in working privately on the side (moonlighting). The comments of faculty that have already responded include a wide variety of benefits and barriers to participating in clinical practice.

I am pleased to report that the problem with the link to the database has now been fixed. Please re-submit your responses if you received an error message. I really appreciate your time in completing this survey.

If you have not responded yet, please do so today. It is only if I hear from almost everyone in the sample that I can be sure that the results are truly representative. Here is the link:

<http://www.techhut.com/decker>

A few people have written to say that they are no longer full-time faculty members. If this applies to you, please let me know by return e-mail so that I can delete your name from the mailing list.

A comment on my survey procedures. Your answers are completely confidential. This research has been approved by the Institutional Review Board at the University of Central Florida. Questions or concerns about research participants' rights may be directed to the UCFIRB office, University of Central Florida Office of Research, Orlando Tech Center, 12443 Research Parkway, Suite 207, Orlando, FL 32826. The phone number is (407) 823-2901.

I hope that you will complete the survey soon. Thank you for all of your help.

Sincerely,

Bonnie Decker, MHS, OTR/L, BCP
Doctoral Candidate, University of Central Florida

P.S. If you have any questions, please feel free to contact me by return e-mail. The toll-free number where I can be reached is 1-800-241-1027 x232.

APPENDIX G

FINAL E-MAIL TO SAMPLE

Dear Occupational Therapy Faculty Member:

During the last few weeks I have sent you several e-mails about an important research study I am conducting of full-time occupational therapy faculty. Its purpose is to explore your opinions on participation in clinical practice, either as part of the faculty role or in working privately on the side (moonlighting).

A big thank you to all of you that have completed my survey that asked about your opinions and beliefs on participation in clinical practice, either as part of the faculty role or in working privately on the side (moonlighting). The comments of faculty that have already responded include a wide variety of benefits and barriers to participating in clinical practice.

The study is drawing to a close, and this is the last contact that will be made with you. I am sending this final contact because of my concern that people that have not responded may have different experiences than those who have responded. Hearing from everyone helps assure that they survey results are as accurate as possible. Here is the link to the study:

<http://www.techhut.com/decker>

I also want to assure you that your response to this study is voluntary and confidential.

I appreciate your willingness to consider my request as I conclude this effort to better understand faculty beliefs about pursuing clinical practice. Thank you very much.

Sincerely,

Bonnie Decker, MHS, OTR/L, BCP
Doctoral Candidate, University of Central Florida

P.S. If you have any questions, please feel free to contact me at the above address or e-mail. The toll-free number where I can be reached is 1-800-241-1027 x232.

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