AGENDA ITEM 11

DISCUSSION OF ACADEMIC REQUIREMENTS OF AN EDUCATIONAL PROGRAM REQUIRED FOR LICENSURE.

Several articles are attached for review.

COMMENTARY

A Contextual and Logical Analysis of the Clinical Doctorate for Health Practitioners:

Dilemma, Delusion, or De facto?

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Growth of the number of practice or clinical doctorates in allied health and nursing is examined from several different points of view. These perspectives are first discussed contextually and then organized according to the dilemmas we face, the delusions we need to address, and the de facto reality we need to acknowledge. The article concludes with an overview of internal and external review practices and interprofessional considerations. J Allied Health 2007; 36:101–106.

NOTABLE AT THE October 2005 annual conference of the Association of Schools of Allied Health in Houston, Texas, was the controversy surrounding clinical doctorates. Some of the arguments against the clinical doctorates were as follows: they were too expensive for students, required too many faculty, were confusing for accreditation agencies, were self-serving to the profession and not patients, too elitist, reduced diversity in the student body, and reflected degree "creep." Pro arguments consisted of practitioner competence, expanse of knowledge and skills needed, and parity across professions. Numerous papers were presented on the topic. It was a point of discussion at the annual deans' meeting and the subject of informal conversations. Given this background, the purpose of this paper is to address some of the common misunderstandings of the clinical doctorate, place the doctorate in context of larger educational change and innovation, and share summary judgments about the nature and course of the newer doctoral degrees.

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An earlier version of this paper was presented by Dr. Royeen at the Association of Schools of Allied Health Professions annual conference, Houston, TX, October 2005.

Received February 8, 2006; revision accepted August 14, 2006.

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The Doctoral Context

Language and history constitute two elements that define the context surrounding any discussion of the clinical doctorate. In this section, the term "doctor" is examined and the history of clinical doctoral education is presented briefly. This section concludes with a presentation on academic terminology as it relates to the professional doctoral degree and the doctor of philosophy (PhD).

The Term "Doctor"

For the purposes of this paper, the terms "clinical doctorate" and "professional doctorate" are used synonymously. Examples of clinical doctorates include doctor of medicine (MD) and doctor of veterinary medicine (DVM). Other types of clinical or professional doctorates include doctor of dental surgery (DDS) and doctor of jurisprudence (JD). Nonuniversity doctoral degrees include the doctor of chiropractic (DC), doctor of podiatric medicine (DPM), and doctor of optometry (OD). These practice-oriented doctorates are typically the entry-level degree for practice in the field.[1] (It is beyond the scope of this paper to address entry-level clinical doctorates versus the postprofessional clinical doctorate first introduced by pharmacy as they phased into doctoral-level entry for the profession.) All of the above professionals are referred to as "doctor" in all settings, whether clinical or social.

These terminological observations are especially relevant in light of American Medical Association (AMA) resolution 211, "Need to Expose and Counter Nurse Doctoral Programs Misrepresentation" (e-mail communication, American Association of Colleges of Nursing, June 22, 2006). Two sections of the AMA resolution express worry regarding the use of the term "doctor."

> RESOLVED, That our AMA pursue all other appropriate legislative, regulatory and legal actions through the Scope of Practice Partnership, as well as actions within hospital

staff organizations, to counter misrepresentation by nurse doctoral programs and their students and graduates, particularly in clinical settings; and be it further

RESOLVED, That our AMA work with all appropriate entities to ensure that all persons engaged in patient contact be clearly identified either verbally, or by name badge or similar identifier with regard to their professional licensure in order that patients are aware of the professional educational background of that person.

In response to the AMA resolution, the Association of American Colleges of Nursing developed a set of talking points, two of which speak directly to the definition and use of the term "doctor."[2] They read as follows:

No nursing schools offering the DNP are advertising these programs as a course of study to prepare physicians. For a current listing of the DNP programs, see http://www.aacn.nche.edu/DNP/DNPProgramList.htm.

The title of Doctor is common to many disciplines and is not the domain of any one group of health professionals. Many advanced practice nurses (APNs) currently hold doctoral degrees and are addressed as "Doctor," which is similar to how other expert practitioners in clinical areas are addressed, including clinical psychologists, dentists, and podiatrists. In all likelihood, APNS will retain their specialist titles after completing a doctoral program. For example, Nurse Practitioners will continue to be called Nurse Practitioners.

Obviously, terminological issues are a relevant aspect of the context within which the clinical doctorate is discussed, proposed, and implemented.

In common usage within the United States, the term "doctor" refers to physicians. The term "doctors" was entered into a Google search conducted on January 30, 2006. Eight of the top ten results referred to physicians, with the ninth referred to gadget doctors and the tenth to a veterinary practice. A second search using the term "doctor" showed that seven of the top ten results referred to physicians. This represents an unobtrusive measure of the current use of the term "doctor" in our society. It does not mean that others may not be referred to as "doctor" when holding a professional degree. It does mean that the nature of the degree needs to be clearly communicated to the public for whom they care and that professionals identify themselves as physicians, nurse practitioners, physical therapists, occupational therapists, and so on instead of using the term "doctor" as if it were synonymous with one professional group.

Current Thrust and History of Professional Doctoral Degrees

Although there is a history of earlier attempts at practice doctorates within nursing, the more recent move to the clinical doctorate began with the doctor of physical therapy (DPT) in the early 1990s at Creighton University. We now see increased clinical doctorates in various fields, including doctor of audiology (AudD), doctor of clinical nutrition (DCN), occupational therapy doctorate (OTD), and doctor of nursing practice (DNP).

Other professions may pursue professional doctorates. The American Society for Clinical Laboratory Science supports the development of a doctorate of clinical laboratory science degree.[3] Physician assistants are discussing the role of the clinical doctorate within their own profession. In response to workforce need and the need to elevate faculty, one leader in the physician assistant field recommends the doctor of education degree (EdD, a clinical degree in education) as a means of preparing faculty for academic roles.[4] As nuclear medicine technology moves toward a baccalaureate degree requirement for entry-level positions,[5] it too will need to address postbaccalaureate and graduate education issues as well.

In light of all of these clinical doctorates, one might well ask about its academic origins. E-mail communication with Jack Eckert (Reference Librarian, Countway Library of Medicine of Harvard Medical School, January 27, 2006) was informative. The oldest medical school in the United States was founded by the University of Pennsylvania. Its first medical degrees, awarded in 1768, were bachelor of medicine (MB) degrees. Progression to the professional MD degree took only 24 years. By 1792, the University of Pennsylvania was awarding MD degrees. A similar process took place at Harvard. John Fleet and George Holmes Hall were the first students to graduate with MB degrees from Harvard Medical School in 1788. Only those who practiced for seven years, submitted a dissertation, and passed an examination were eligible to receive an MD degree. Samuel Adams from the Harvard class of 1894 was the first to receive an MD degree in 1802. Another student, Benjamin Shurtleff, graduated with an MB in 1802 and received an MD in 1810. By 1811, all medical students received an MD degree. It took another 17 years for the transition from an entry-level requirement of an MB to an MD degree. Two centuries seems sufficient time for other professions to decide to make an analogous commitment to their own professional development. The reader is referred to Pierce and Peyton for more in-depth study of the history of the clinical doctorate.[6]

Academic Terminology

The professional degree is by no means the only degree within academia. The most prestigious academic degree is the PhD. The PhD refers to a research degree by virtue of which the recipient is deemed competent to conduct original research within his or her academic discipline. Emphasis is placed on the development of new and the application of advanced knowledge.[7] On the other hand, the clinical doctorate refers to knowledge and skill needed to deliver complex and advanced service/care within the scope of practice of a health care professional.[8]

TABLE 1. Tuition Costs of Doctoral-Level Education

Degree	Doctor of Pharmacy	Doctor of Medicine	Doctor of Physical Therapy	Occupational Therapy Doctorate
Length (yr)	4	4	4	4
Estimated tuition ($)	17,000	38,000	20,000	20,000
Total ($)	68,000	152,000	80,000	80,000

Note. These figures assume a prior undergraduate degree. The doctor of nursing practice was not included because it is not an entry-level degree.

These distinctions are in accord with the U.S. Council of Graduate Education and the Association of Graduate Schools, and the clinical or professional doctorate and the research doctorate may be differentiated accordingly: "The professional Doctor's degree should be the highest university award given in a particular field in recognition of preparation for professional practice whereas the doctorate of philosophy should be given in recognition of preparation for research whether the particular field of learning is pure or applied."[9]

Despite this authoritative statement, Ellis notes, there continues to be lack of clarity regarding clinical doctorates.[10] It may be that for some professions, the professional doctoral degree will be the entry-level degree; for others (e.g., nursing and occupational therapy), the doctoral degree may be the terminal practice degree or the entry-level degree for advanced practice.[11] Given this brief historical and linguistic analysis, we continue the discussion by looking at the clinical or practice doctorate in terms of dilemma, delusion, and de facto status.

Clinical Doctorate as Dilemma

A dilemma exists when a decision leads to two possible outcomes, neither of which provides a satisfactory solution to a problem. In terms of clinical doctorates, many dilemmas arise for both institutions and students. These dilemmas pose challenges for educational institutions. From the institutional perspective, typical questions are as follows.

- What is a clinical doctorate? How does it differ from a research doctorate? How does it differ from a clinical master's degree?
- Is the curriculum subject to review by the graduate school? If yes, then we are placing professional education under the purview of nonprofessionals. If no, then there are no graduate level, academic checks, balances, or oversight?
- What is the typical length, rigor, or depth of knowledge reflected in the curriculum? Is the quality of local practice sites adequate? If the required length is excessive, it places undue burden on the students. If too brief, it faces challenges regarding the adequacy of professional preparation. If local clinical practice sites are adequate, then are they being used by faculty? If sites are not available, then will the university develop them?
- Who accredits the clinical doctorate? Regional academic accreditors may not be familiar with the educational and regulatory demands of clinical doctoral programs. Professional accrediting agencies, especially those within fields only recently developing doctoral programs, of study may or may not have the knowledge and experience to understand the demands of the academic world.

These questions pose real-life dilemmas. They need to be recognized and discussed by the stakeholder groups.

There is a subtler dilemma, however. The clinical doctorate is driven by innovation in service and advancement in the related practice field.[11] The major dilemma resulting from this is that our academic institutions are based on traditional custom and culture. They do not readily change or welcome change.[12] When no solution can be reached from within, solutions may be imposed from without.

Another dilemma created by the emergence of newer clinical doctorates is the increased cost of education. Using reasonable tuition costs, total tuition over a four-year period was calculated and is presented in Table 1. Although we realize length of study varies, we chose four years as the typical postbaccalaureate length of study.

These figures are sometimes used to talk about the additional economic burden that might be placed on students desiring a clinical degree. Sometimes the additional cost is accompanied by the fear that the supply of students will decline. Other times the argument is made that it will limit minority enrollment. The evidence for such fear is not available. In fact, minority enrollment and limitations thereof is a complex, multifaceted issue that has more to do with health, lifestyle, family, and school factors in adolescence.[13] In medicine, minority enrollment has risen even as the cost of medical education has been increasing.[14,15] Despite increasing costs, enrollment has not declined either. Furthermore, its demand is masked by enrollment caps. (However, for the fall of 2007, most medical schools have increased first-year enrollment in response to AMA requests.) The public appears to accept or expect the additional costs of a clinical doctorate in medicine. What makes the figures in Table 1 significant is that most postbaccalaureate professional education is "self pay." There is relatively little scholarship/fellowship money available from federal, state, or organizational sources to subsidize postbaccalaureate professional education. Thus, students primarily pay for this type of education via federal loans or self pay. These figures as presented do not begin to cover costs of books, educational technology, travel, relocation,

or living expenses. At this point, little is known about the effects of clinical doctorates in newer fields in terms of their effect on the earning potential of graduates.

Clinical Doctorate as Delusion

What is delusional about clinical doctorates? Assuming that a delusion represents an erroneous or false belief, there may be several false beliefs related to the clinical doctorate. One may be that this doctorate prepares one not only for clinical practice but also for the academic roles of teaching and research. The clinical doctorate is intended to prepare one for direct practice in the field, for leadership in the field, and to influence health care policy.[16] The clinical doctorate is certainly not designed to prepare a faculty member for an academic career in a research-extensive or -intensive institution. It is a delusion to think that a clinical doctorate alone does so.

Given the faculty shortages in allied health and nursing, however, those with clinical doctorates are likely to be hired for a faculty position. In master's-level or comprehensive universities, which have lesser expectations in terms of research, this may be a good match. In research-extensive and -intensive institutions, the clinical doctorate in an allied health field typically does not adequately prepare a faculty member for the roles of academic teaching or research. If hired within research institutions, the institution needs to make clear the scholarship demands of an academic track and the differences between academic and clinical tracks within the same institution. Of course, the age-old exception to this rule is that of the physician hired as tenure-tract faculty within research institutions. At the better research institutions, however, these types of individuals have been mentored during research fellowship years and continue to be mentored by experts within the field. In other health care professions, postdoctoral research fellowships for those possessing clinical doctorates may be one way of bridging the clinical-academic gap.

The De facto Clinical Doctorate

Regardless of the dilemmas or delusions involved with a clinical doctorate in allied health or nursing, one fact is obvious. Pandora's box has been opened and will not be closed; the clinical doctorate is here to stay! Despite what industry, accreditation agencies (professional and academic), or skeptics might want, there is no turning back. We propose that many factors appear to be important variables in explaining this. With several professions, the corresponding associations are solidly behind development and implementation of the degree, as is the case with the American Physical Therapy Association and the American Association of Colleges of Nursing and the National Organization of Nurse Practitioner Faculties.

A second factor is the classic economic model of the supply and demand. More and more institutions of higher learning will offer degrees at the clinical doctoral level, based on student demand. Thus, innovator schools have started the trend and others will follow. The rapid increase in the number of institutions offering the DPT is illustrative of this.

A third factor is old-fashioned gender politics. The established clinical doctorates (MD, DDS) have mostly been peopled by the male gender.[17,18] It is our observation that the professional communities have been comfortable with those clinical doctorates long associated with men. Is it a surprise that female-gendered fields (occupational therapy, physical therapy, and nursing) garner controversy when moving toward degree parity? Is the controversy and resistance to clinical doctorates in fields in which women still dominate a form of sexism, cloaked in the guise of academic standards? We hope that old-fashioned gender politics is giving way to equity in professional and societal circles.

A fourth and final factor is societal need. The current demographics of the population in the United States are very different from those of 30 years ago. In the past, patients of the majority ethnicity typically presented with single health issues. Current and future trends indicate that as longevity increases, so does health care complexity. Patients present with multiple health conditions, most of which are chronic.[19] We believe that there is a need to better educate all health care professionals in terms of the complexities patients present. This education involves sophisticated cross-cultural sensitivity and expanded geriatric knowledge base, interprofessional skills, and more than a basic introduction to health care informatics. These curricular essentials should be core in all clinical doctorates, regardless of the discipline or profession.

Discussion

Cartwright and Reed identified important external and internal policy issues for consideration when creating a clinical doctorate in nursing.[20] One of their questions related to clinical doctoral education within the United States. We added this and other questions to create Table 2, developed originally as a refinement of prior questions posed by Threlkeld et al.[21] These questions are designed to facilitate discussion within institutions considering the establishment of the clinical doctorate.

Some institutions are considering the development of more than one clinical doctoral degree program. For example, at the Saint Louis University Doisy College of Health Sciences, physical therapy is currently offering entry-level DPT education. Occupational therapy is moving toward a postprofessional OTD. The School of Nursing is similarly considering a postprofessional DNP. Complementing the move toward clinical doctorates, the Doisy College has identified interprofessional research, education, and practice strategic initiatives. Core interprofessional competencies inform curricular objectives and expected outcomes. Interprofessional classroom and clinical teaching/learning

TABLE 2. Questions to Ponder When Considering Implementation of a Clinical Doctorate

1. How does the clinical doctoral degree serve the greater good?
2. How does this new clinical doctoral degree compare with more traditional doctorate degrees such as the doctor of medicine or doctor of dental surgery?
3. What funding sources might be available for students in this program?
4. Is there a match between institutional mission and standards of research, service, and teaching and the educational level of clinical doctorate?
5. Is there interprofessional activity and opportunities to interact with other professions within the host institution?
6. Is there a sound business plan underpinning implementation of the clinical doctorate?
7. Does the governance pattern of the university match socialization within the field of the clinical doctorate?
8. How is doctoral education viewed in your state or commonwealth?
9. How do relevant stakeholders view the clinical doctorate?
10. What is the university environment and how does one maneuver the system?

Note. These questions are formatted generically and should be adapted for use with any particular degree under consideration.

The first seven questions are adapted from Threlkeld et al.[21] The latter three questions are adapted from Cartwright and Reed.[20]

methodologies and experiences will be integrated across the curriculum of all professions.

According to Manathunga et al.[22] and Morely and Priest,[23] key scholarly attributes apply to all professional doctorates:

- Advanced knowledge and analytical skills
- Proficient applications of research and literature
- Exacting and deliberate judgment and decision making
- Self-reflection and self-knowledge fluency.

In addition, we suggest the following:

- Competent planning and delivery of interprofessional care
- Sophisticated cross-cultural sensitivity
- Effective advocacy
- Insightful policy analysis and adept policy development
- Tailored health promotion and prevention strategies
- Beyond basic health care informatics applications
- Knowledge and theory development
- Dedication to the art of practice
- Evaluation research
- Local, national, and global leadership.

This discussion of attributes assumes travel beyond the dilemma and delusion stages and welcomes the clinical doctorate as de facto reality.

Closing Comments

We predict that within less than a generation, the majority of health care practitioners in allied health and advanced practice nurses will be degreed at the level of the clinical doctorate. It is likely that reimbursement will require services provided by a signature authority of someone educated at that level. In the United States, a multiplicity of research and clinical doctoral programs exist. According to Forni,[24] this is consistent with the pluralistic nature of our society and educational structure. So be it. We predict that in the future, the boundaries between research and clinical doctorates will, as evidenced now in academic medicine, become less distinct. This is especially true because of the call for the "engaged university," the societal demand for institutions of higher education to be more responsive to community and society.[121]

The authors thank Dr. Doris Pierce for the "d" alliteration in the title.

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▲ Perceptions by Practicing Occupational Therapists of the Clinical Doctorate in Occupational Therapy

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Despite recent discussions regarding the implementation of the clinical doctorate in occupational therapy (OTD) as the entry-level degree for occupational therapy, there is a dearth of published literature that addresses the issue of the OTD. In this study, recent alumni of an occupational therapy program from an urban midwestern university were surveyed to determine their perceptions of the OTD. Most respondents agreed or strongly agreed that the OTD curriculum should include courses about managed care and/or insurance regulations, business management/ administration, effective professional communication, research, and specialization in a specific area of occupational therapy. Respondents believed that an OTD would assist in career advancement, obtaining a higher salary, and professional competence. However, the majority of respondents did not believe that an OTD would result in enhancement of interprofessional relationships, improved reimbursement from third-party payers, and enhanced public recognition of the profession or enhanced ability to practice without a referral. There was not a strong opinion whether there is an advantage to a clinical doctorate degree, and only 22% agreed or strongly agreed that they would be interested in pursuing a postprofessional OTD. J Allied Health 2007; 36:137–140.

THE PROFESSION of occupational therapy (OT) is currently considering a move to the clinical doctorate (OTD) as the entry-level degree. As of March 2004, there were four entry-level clinical doctorate programs and eight postprofessional clinical doctorate programs for OT.[1] Ongoing discussions continue, and standards for the OTD are being developed.[2] These discussions are occurring even as current programs are reestablishing themselves to offer the now-required professional master's degree as the entry-level degree. The purpose of this report is to review literature on the OTD and present results from a survey taken of recent alumni from a large, urban, midwestern university. It is believed that results would provide information to assist the profession in creating a future that reflects the opinions and concerns of practicing therapists.

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Received May 5, 2006; revision accepted October 13, 2006.

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Review of the Literature

Despite these recent discussions regarding the implementation of the OTD as the entry-level degree for OT, there is a dearth of published literature that addresses the issue of the OTD. One article promoting the OTD outlined the history of OT education, mentioning issues such as the excessive number of hours to attain a professional master's degree and the shortage of doctorally prepared faculty.[3] In that article, justification for the OTD included the need for a doctoral degree to compete for tenure, revealing that it should not be necessary to attain a PhD for tenure consideration.[3] The need for a clinical doctorate was argued for both faculty members and clinicians who desire to possess advanced clinical skills, an advanced ability to apply theory to clinical practice, and advanced supervisory and leadership training. This same article stated that many occupational therapists desire an advanced degree but do not wish to pursue a PhD. The clinical doctorate was suggested as a viable option.

Clinical doctorates in areas such as medicine, pharmacy, dentistry, social work, psychology, and education were presented as justification for the OTD.[3] The background literature mentioned in the article concluded that individuals with an OTD would provide a higher level of skilled practice service to patients and bring advanced clinical skills to the classroom.

Another article paralleled the emergence of clinical doctorates in OT and physical therapy with other professions with regard to the pressure of preparing practitioners for entry into a profession with only 2.5 yrs of professional preparation.[4] This literature presented a clear fit of the clinical doctorate curriculum with the professions' commitment to match practitioner preparation with adequate depth in professional knowledge.

In the article, the American Occupational Therapy Association provided the following reasons for the emerging clinical doctorate.[4]

1. The OTD will create a pool of more sophisticated clinicians with an advanced degree focused on clinical skills or applied practice.
2. The OTD is consistent with other health care professions in terms of clinical doctoral education.
3. The need for confident leaders familiar with health care policy, practice innovation, and positively changing and influencing practice is increasing.
4. The need for, visibility of, and stature among other health professions with advanced degrees in health care is increasing.

TABLE 1. Perceptions of Appropriate Curriculum Content for a Clinical Doctorate in Occupational Therapy Degree

	Strongly Agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly Disagree (%)
Should include courses about managed care and/or insurance regulations	42	47	10	1	0
Should include courses on business management/ administration	53	39	6	2	0
Should include courses on effective professional communication	45	36	14	6	0
Should include a strong research component	39	40	17	4	0
Should provide education and training in all specialty areas of OT	22	41	21	14	3
Should provide an opportunity to specialize in specific specialty areas of OT	54	32	9	5	0
Should prepare its graduates for teaching in OT educational programs	32	39	22	6	1

OT, occupational therapy.

5. The perceived competition in the rehabilitation arena with the movement of physical therapy toward the doctor of physical therapy as an entry-level degree is evident.

Other professions closely aligned with OT have also recently explored the issue of the clinical doctorate. A review of literature revealed that physical therapy and the nursing professions are moving toward the clinical doctorate, with the potential of this degree being an entry-level standard. The majority of the literature in physical therapy is opinion pieces, with one article surveying practitioners regarding opinions of the clinical doctorate. The profession has made recommendations for the doctor of physical therapy to be the entry-level degree in 2020.[5–8]

Nursing also has several articles that address the clinical or professional doctorate.[9–12] However, many of these articles are also opinion pieces, especially with regard to the nurse practitioner. Presently, there are many clinical doctorate degrees with various titles, with movement toward acceptance of the doctor of nursing practice. There are no plans for the doctor of nursing practice to be the entry-level degree.

Methods

A total of 353 recent alumni of an OT program from an urban midwestern university were surveyed to determine their perceptions of the OTD. Alumni surveyed included those who had graduated from the program since its inception in 1992. Therefore, alumni included students who had graduated from 1995 to 2005. Graduates in 2005 were the first students to graduate with a postprofessional master's degree in OT. Therefore, the majority of students had graduated with a bachelor of science in OT. The survey was an adaptation of the one developed by Detweiller et al.[5] Questions were modified to reflect issues more pertinent to OT. The survey contains demographic questions, questions concerning curriculum content, professional expectations of the OTD, and personal views of the OTD. Names of alumni were retrieved from the administration office of the Department of Occupational Therapy. Alumni were contacted regarding participation in the survey and, if agreeable, were questioned as to whether they would prefer to receive a survey by mail or e-mail. Of the 353 alumni, approximately 35% preferred postal mail and 65% preferred e-mail. All surveys were sent with a recruitment statement informing them of the purpose of the study and confidentiality procedures. For those choosing to complete the survey by postal mail, names and addresses were removed by office staff and destroyed. For those choosing to complete the survey by e-mail, a separate secure Web site was created to receive and compute results. The investigator had no ability to access personal identification from either source. Consent was assumed by participation in the study. A 62% participation rate resulted from 220 returned surveys out of the initial 353 distributed.

Results

Demographic data show that the majority of respondents reported that they have a bachelor of science degree (91%). The most common work settings were schools (30%), hospitals (28%), outpatient clinics (18%), and long-term care (10%). The majority of respondents worked as staff occupational therapists (91%). Sixty-one percent of respondents have practiced less than 5 yrs, and 39% have practiced 6–10 yrs. Regarding exposure to OTD students/ graduates or education, most respondents had no exposure (53%), followed by those with a working relationship (25%) and those who found information in the literature (22%). Results of the survey are as follows.

Table 1 shows the results of perceptions of appropriate curriculum content for an OTD degree. The majority of respondents (89%) agreed or strongly agreed that the OTD curriculum should include courses about managed care and/or insurance regulations, business management/ administration, effective professional communication, research, and specialization in a specific area of OT. Fewer respondents (63%) desired education and training in all specialty areas of OT. Approximately 71% believed that an OTD should prepare graduates to teach in OT educational programs.

Table 2 shows that most respondents (82%) agreed or strongly agreed that prior clinical experience should be

TABLE 2. Perceptions about Program Implementation for a Clinical Doctorate in Occupational Therapy Degree

	Strongly Agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly Disagree (%)
Prior clinical experience should be considered in meeting the graduation requirements of an OTD program	38	44	15	3	0
While obtaining an OTD, OTs should be able to maintain their current job	61	31	6	1	0
Obtaining an OTD should allow OTs to acquire continuing education credits	52	43	5	1	0

OTD, clinical doctorate in occupational therapy.

considered in meeting requirements for the OTD, that they should be able to maintain their current job while enrolled in the OTD program (92%), and that OTD coursework should be counted toward continuing education requirements for licensure (95%).

In Table 3, the results show that respondents believed an OTD would assist in career advancement (57%), obtaining a higher salary (52%), and professional competence (65%). However, the majority of respondents did not believe that an OTD would result in enhancement of interprofessional relationships (34%), improved reimbursement from third-party payers (18%), and enhanced public recognition of the profession or enhanced ability to practice without a referral (28%).

In Table 4, the results show that the majority of respondents (83%) believed entry-level programs should not move to a clinical doctorate. There was not a strong opinion whether there is an advantage to a clinical doctorate degree, and only 22% agreed or strongly agreed that they would be interested in pursuing a postprofessional OTD.

Discussion

Given the demographics, this survey is best interpreted as an assessment of current impressions of the OTD by new occupational therapists within a midwestern region. Across all respondents, there was strong agreement about the content of prospective OTD programs. However, respondents had significant concerns about the value of such a degree and their own interest in pursuing one. Results from the survey support the assertion regarding the need for training in policy, business, and management areas.[4] However, the results do not support the assertion that the OTD will result in enhanced interprofessional relationships, improved reimbursement, enhanced recognition of the profession, or ability to practice without a referral.[4] The results do support the findings of Runyon et al.[3] of the clinical doctorate as an alternative route to teaching.

The strengths of this study are the high return rate, indicating that this is an important issue for new graduates and practicing occupational therapists. Responses to survey questions showed clear and strong opinions. However, it should be noted that the convenience sample is generalizable only for new graduates or entry-level occupational therapists (10 yrs or less) in the midwestern region. Weaknesses of the study were that the sample was a convenience sample and therefore not as generalizable as a random sample to the total population of practicing occupational therapists.

Conclusions

This survey suggests that recent OT graduates do not currently perceive the OTD to be financially valuable, and most are currently not interested. One caveat is whether

TABLE 3. Expectations of the Professional Effects of Receiving a Clinical Doctorate in Occupational Therapy

	Strongly Agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly Disagree (%)
Will assist an OT in career advancement	22	35	25	16	2
Will assist OT in gaining a higher salary	17	35	25	17	6
Will enhance an OT's ability to interact with other health care professionals	8	26	36	22	7
Will enhance the professional competence of an OT	19	46	18	14	3
Will help obtain reimbursement by third-party payers for patients with direct access	1	17	41	35	5
Will enhance the public's recognition of the profession's knowledge base and integrity	7	37	33	18	5
Will enhance an OT's ability to practice independently without referral	7	21	45	24	4

TABLE 4. Personal Views of Respondents about the Clinical Doctorate in Occupational Therapy

	Strongly Agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly Disagree (%)
All entry-level programs should move to a clinical doctorate	2	4	12	46	37
At this time there are no advantages to obtaining a postprofessional OTD for practicing OTs	17	27	29	25	2
I would be interested in obtaining a postprofessional OTD	5	18	28	39	11

OTD, clinical doctorate in occupational therapy.

recent alumni are really the market segment that would be most interested in an OTD or whether a different set of students who are not currently served are a better fit for an OTD program. Although the respondents believed that an OTD might be helpful for getting a job in teaching, they did not feel as strongly about its use in a professional or clinical setting. The responses that the curriculum be based on business and professional courses versus clinically related courses suggests that perhaps advanced continuing education would be perceived as just as valuable as an OTD. Similarly, the results suggest a potential need for increased education and influence of existing occupational therapists on the value of an OTD as well as potentially needing to proactively influence other stakeholders (e.g., payers, employers) to provide additional evidence about the career and financial benefits of an OTD.

Future research is needed that would include a random survey of practicing occupational therapists who represent broader demographic and geographic areas. Before the profession makes future decisions regarding the entry-level degree and/or how postprofessional clinical doctorates are designed, a collaboration with practicing therapists appears to be warranted.

The author thanks Anvea Powermeasure and Dr. Matt Barney for assistance in collecting and graphing electronic data and for assisting in the early analysis of the surveys; Dr. Karen Barney, Chairperson, Department of Occupational Science & Occupational Therapy at Saint Louis University, for assistance in contacting Anvea Powermeasure and consultation regarding the survey; and Margaret Shelton, Administrative Assistant, Department of Occupational Science & Occupational Therapy at Saint Louis University, for her assistance in contacting alumni.

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The Clinical Doctorate: A Framework for Analysis in Physical Therapist Education

This article explores major considerations for analysis and discussion of the role of the clinical doctorate as the first professional degree in physical therapist education (DPT). A process for this analysis is posed based on a conceptual framework developed by Stark, Lowther, Hagerty, and Orczyk through grounded theory research on professional education. External influences from society and the profession, institutional and programmatic influences, and articulation of critical dimensions of professional competence and professional attitudes as major categories are discussed in relation to the DPT. A series of questions generated from the application of the model are put forth for continued discussion and deliberation concerning the DPT. We conclude that the DPT provides the best pathway to serve society, the patient, and the profession. [Threlkeld AJ, Jensen GM, Royeen CB. The clinical doctorate: a framework for analysis in physical therapist education. *Phys Ther.* 1999;79:567–581.]

Key Words: *Physical therapy profession, Professional doctorates, Professional education.*

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This article presents a conceptual model that can be used to analyze current or contemplated clinical doctoral degree programs in physical therapy (DPT). Our working assumption is that the DPT is a professional clinical degree representing initial preparation for practice. Through our model, we will discuss physical therapist education programs in a broad context in an effort to describe the choices, actions, educational policies, and practices that should be discussed among administration, faculty, students, the profession, and public agencies. We hope that this model will provide a contextual framework within which individuals bring their moral beliefs and values into a discussion that leads to *action*, a process described as "deliberative reflection."[1] The deliberative reflective process requires consideration of the trends and forces shaping professional practice and education through problem identification and problem solving.[2] By building upon a conceptual foundation proposed by Stark et al,[3] we will delineate categories of issues to be considered and present a series of questions that we believe will facilitate the deliberative process regarding implementation of a DPT program within a given site or setting. By providing this framework for consideration and evaluation of DPT programs, we hope to facilitate, focus, and advance the discussion and deliberative reflection concerning this degree.

The purposes of this article are to articulate and categorize the broad spectrum of influences and needs of physical therapist education within the context of a theoretical framework and to discuss the fit of a DPT model within that framework. In an effort to assist the practical application of this framework, we have posed a series of questions within each dimension of the model. We hope these questions will facilitate discussion and assist physical therapist education programs in the process of self-assessment when considering the DPT degree. These questions are provided as a comprehensive list in the Appendix.

The professional doctorate is the appropriate degree for preparation of practitioners who are competent to meet the broad societal need for physical therapy services now and in the future.

Conceptual Framework

The model proposed is adapted from the work of Stark et al[3] and their grounded theory study of 11 professions (architecture, dentistry, education, engineering, journalism, law, library science, medicine, nursing, pharmacy, and social work). Key components in the model were built upon work in professional education compiled through a review of the literature, through the incorporation of social and economic factors, and through expanded and defined levels of professional competence. The use of such a framework provides organizing principles that can allow for ongoing critical analysis as new data are discovered and incorporated.

We will focus on the application of 2 core dimensions of the framework: (1) professional education and (2) professional outcomes, which result from professional education (Figure). Like Stark et al,[3] we assert that professional education is influenced by external forces, intraorganizational forces, and internal forces. The external forces include society at large and the relevant professional community, intraorganizational forces center on institutional forces, and internal forces include issues specific to the program. These 3 forces shape the professional education of physical therapists for professional (entry-level) practice. Furthermore, the efficacy of professional education is demonstrated by the performance of graduates, as measured by professional outcomes. In this model, professional outcomes are divided into the categories of professional competence and professional attitudes. The extent to

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Concept, research design, writing, data collection and analysis, and consultation (including review of manuscript prior to submission) were provided by Threlkeld, Jensen, and Royeen.

This article was submitted October 5, 1997, and was accepted March 1, 1999.

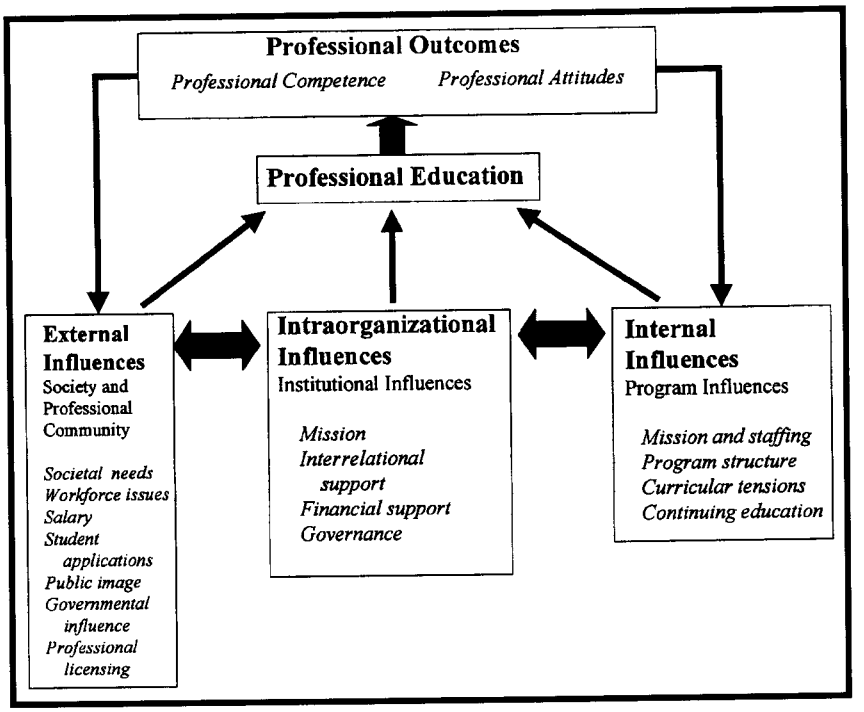

Figure.
Conceptual framework representing the major factors affecting professional education.[3]

which the professional outcomes are achieved determines whether and how graduates, in turn, will influence, refine, and perhaps redefine the external, intraorganizational, and internal forces.

Professional Education

External Influences From Society and the Professional Community

External influences are those "factors from outside the immediate program which influence the professional preparation environment."[3(p253)] According to Stark et al,[3] there are 2 primary categories of influence: society and the professional community. We will address more specific key issues that arise from these 2 powerful external influences (Figure). Critical questions include: Does the DPT degree serve the greater good of society within the marketplace? Will the DPT degree influence the current and anticipated number and type of employment prospects available to physical therapists? Will the pressures of the marketplace influence the applicant pool to DPT programs, the market niches that DPT program graduates will fill, or the salaries they earn? How is the DPT degree viewed at national, state, and local levels? What are the cultural and socioeconomic considerations in the media portrayal of the DPT degree? In the public eye, how does the DPT degree relate to other doctoral professional degrees such as Doctor of Medicine (MD) or Doctor of Pharmacy (PharmD)? What is the relationship of the DPT degree to federal, state, and local funding policies and regulations that influence the practice of physical therapy? What federal, state, and local funding sources are available for physical therapist education, and will those sources be influenced by the DPT degree? Would the DPT degree have an effect on physical therapy licensure or the scope of practice?

Societal needs. The needs of society are essential in determining the demand or need for physical therapy services as well as the social status of physical therapy as a profession, reflected in the reward system for practitioners.

Demographics in the United States suggest a dramatic and ongoing shift in our population characteristics. There are more elderly people and more immigrants from non-European countries, who have produced a change in the status of health.[4–6] Larger portions of the population, both young and old, have a chronic disease, such as acquired immunodeficiency syndrome, tuberculosis, diabetes, cancer, or asthma, and many have the accompanying disability.[7,8] A larger proportion of our children are living at or below the poverty level and are subject to the "societal diseases" of malnutrition, neglect, and abuse from which spring the medical manifestations of such living conditions.[7] Thus, the coming wave of health care consumers may look and act differently and have health care needs that are different from consumers in the recent past.

Faculty are challenged to educate physical therapists to provide services in a culturally sensitive model wherein time, space, families, and habit patterns may be markedly different from the physical therapist's own culture. Only 7.1% of physical therapist members of the American Physical Therapy Association (APTA) currently categorize themselves as nonwhite. The number of minority physical therapists is increasing, as 13.5% of physical therapist students attending programs accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE) in 1997 categorized themselves as nonwhite.[9] Yet, physical therapists are likely to be working with ever-increasing numbers of clients who are considered to be from minority backgrounds.[10–12] Moreover, the challenge is not simply to provide services to the individual, but to fulfill the professional's obligations to the communities from which these patients originate.[8,13] These obligations include using demographic and epidemiologic data to develop, implement, and monitor

physical therapy practice models. These models must include health and wellness practices and address the changing health care environments in both rural and urban areas.[8,12]

With the advent of the human genome project of the National Institute of Health (NIH), an explosion of knowledge about genetics and health is occurring. Increasing concern about health status, with the inevitable medical and ethical questions related to genetic status, will be a challenge.[13,14] Yet, what scientific foundations are our current and future physical therapists receiving in the areas of genetics, molecular biology, histology, bioethics, and health policy? In response to this explosion of knowledge, we believe that physical therapist education should prepare practitioners to meet the needs of individuals and families by reading, understanding, and incorporating into clinical practice the knowledge from both the foundational and applied sciences that is essential for the profession's expanding obligation to society. The grounding of professional education through the intensive study of the biological sciences, with the accompanying complex linkages to societal and ethical dimensions, in our view, is clearly best addressed through doctoral education. Health care consumers anticipate and expect this type of knowledge and level of integration from a practitioner bearing the doctoral title. Thus, the DPT degree provides the visible and appropriate signal to society that such services are available.

A final key issue influencing the societal role of physical therapist education and practice is the increasing concern about quality-of-life issues, including mental health, wellness, and prevention. Improving the quality of life in the presence of chronic disease or disability will be the goal of health care.[15] As physical therapy is a profession grounded in science, physical therapists, in our opinion, should recognize and use the power of human belief and health behaviors in providing their services. We contend that physical therapists must be broadly educated and understand the role of the importance of health beliefs, health behaviors, and health status.[15,16] Building the DPT degree on a firm foundation of liberal arts and the humanities, with explicit integration of social sciences into the professional curriculum, can provide graduates the broad base of knowledge necessary for understanding the larger social context of health care.

Workforce issues. Given the limited pool of DPT program graduates from the few existing professional programs, there are limited data to answer questions about the interaction of the degree with the marketplace. The traditional marketplace for physical therapists is appears to be shrinking due to changes in the health care system. Just as the workplace became oversupplied with people with MBA degrees in the 1970s and 1980s and just as physicians are currently coming into oversupply, it is likely that physical therapists will be in oversupply by the year 2005.[17] Although the current changes in health care are confusing and seen by many people as a potential threaten to the development of the profession, they also provide opportunities. Physical therapist education shares a responsibility to prepare graduates who can and will take risks through identifying new practice opportunities, assessing them, and demonstrating the ability to meet these new challenges. Education at the DPT level should be consistent with the expectations and responsibilities that graduates face in the current health care system.

Data from graduates of a DPT program surveyed less than 2 years after graduation indicated that the majority worked in clinical staff positions.[18] Six of the graduates, however, reported working in nonstandard market niches, including a research institute and a postdoctoral fellowship, and several graduates reported working in academic faculty positions.[18] In the absence of comparative data, we cannot contend that this diversity was a function of the degree over other factors. Other recent DPT program graduates who are employed in more standard settings have reported rapid advancement into management positions, assignments in the marketing arena, and assuming primary responsibilities for the development of new clinical service programs. The numbers from which these reports were drawn are small (51 graduates responding from a sample of 98), and the data must be classified as isolated comments that may not be reflective of a larger pool of DPT program graduates.

Salary. The Division of Practice and Research at APTA reported the following salary breakdown for physical therapists by professional education degree: mean salary of $52,321 for a baccalaureate-educated physical therapist (n=1,175, SD=$33,133), $45,224 for a physical therapist educated at the master's level (n=530, SD=$23,379), and $55,000 for a physical therapist educated at the doctoral level (n=4, SD=$8,831).[9] These data reflect only degree level, not years of practice. A Creighton University survey of DPT program graduates provides a slightly more complete salary picture, with a reported a salary range of $30,000 to $100,000. Approximately 66% of the DPT sample (34 of 51 respondents) reported salaries between $40,000 and $60,000, whereas 19% of the DPT sample (10 of 51 respondents) reported salaries between $60,000 and $100,000.[18] In both data sets, the sample population of therapists with DPT degrees is small and derived from a limited geographic base; thus, the influence of the professional degree on salary cannot be stated with certainty.

Student applications. With so few physical therapist education programs offering the DPT degree, the effect of the degree alone on applications cannot be specifically determined. In a retrospective survey of applicants involved in the 1998 Creighton University physical therapy admissions interview process (76 responses from 96 surveys), the majority of applicants (66%) were offered admission to multiple programs and cited the availability of the DPT degree as a decisive factor in choosing to attend Creighton University.[19] The numbers of applications to the Creighton University program have remained relatively stable (approximately 420 to 450) from 1994 through the 1998 admissions years. On a national basis, the numbers of students applying to physical therapist education programs decreased by approximately 19% when comparing the 1995 and 1997 admissions years.[12] There has been no discernable decrease in the grade point average of students entering physical therapist education programs,[12] but there have been sporadic reports of education programs that have chosen to leave student slots unfilled due to an unwillingness to admit applicants with lesser qualifications (personal communication from CAPTE).

Public image. Media portrayal or the public image of the profession of physical therapy and of the DPT degree, in our view, is important for understanding how society views the profession. Our judgment is that media portrayals of physical therapists have increased in frequency over the last 5 years. Physical therapists' practices have expanded beyond the confines of the traditional hospital and clinical outpatient settings into community-based areas such as on-site occupational health, women's health, wellness, and fitness.[17,20,21] The national organization, APTA, is critical to helping the public understand the role of the physical therapist in the health care delivery system and the unique and complex services that physical therapists provide. The recent publication and dissemination of the *Guide to Physical Therapist Practice*[22] is evidence of the Association's desire to publicly define physical therapy. What do we expect of the public image of a physical therapist? Should this image be any different for the DPT? For us, the answer is clearly "no." The emphasis of the image should be on the profession of physical therapy. We argue that the physical therapist's image should be one that the public associates with their expectations of a professional: competence, trust, and autonomy of decision making. The doctoral designation should recognize and enhance that image. The public view of physical therapists at the national, state, and local levels will evolve based on our professional contributions, the behavior of our graduates, and the public's opportunity to associate those contributions and behaviors with recognizable, established images of a professional. Socializing students in a DPT program to the obligations, responsibilities, and image associated with a professional doctoral degree is one part of how we feel that we can enhance the public's image of physical therapists.

Creighton University graduates have reported their beliefs that their doctoral credential facilitated the rapid establishment of a peer-to-peer working relationship with other doctorally educated colleagues, including physicians, dentists, podiatrists, and chiropractors.[18] The following are examples of comments taken from a recent alumni survey of the first 2 graduating classes:

> I was offered a job in a company that does not hire new graduates.
>
> I have increased respect from physicians.
>
> The degree has enhanced my career development greatly. It has opened doors for me that would not have ever opened otherwise.
>
> Opened doors to teach and direct.
>
> Opened doors because people were interested in seeing what we were about...and to meet expectations has driven me to set goals toward what I see now as a PhD.
>
> Greater initiative for advancement of self and physical therapy.
>
> My employers wished to make use of my "doctor" degree.
>
> Earlier entrance into academia...expected to contribute at management and administrative level...when other physical therapists were not asked.

These reports of early acceptance of the DPT credential into the community of doctorally prepared health care practitioners are encouraging. Establishing a clear image for the lay public of the physical therapist with a doctoral degree may be more challenging because the term "doctor" is commonly used by the general public and the media to indicate a physician. Other professions have gained wide recognition as doctorally prepared practitioners (eg, dentists, podiatrists, veterinarians, chiropractors, psychologists) but are often referred to in social or media discussions by their professional designation rather than by the term "doctor." Promoting a recognizable public image of physical therapists that is consistent with existing clinical doctoral models while making the transition in professional physical therapy education to the DPT will powerfully link the title "physical therapist" with an evoked public perception of an autonomous, doctorally prepared professional.

Governmental influence. Governmental policies and funding patterns also have an influence on the operation of an education program for the DPT. Currently, we

believe there is a "mismatch" between health care services and governmental attention to and funding for health care education. That is, most of the regulations and funding pertain to physician education even though over 60% of the health care in the United States is provided by other health care professionals, such as physical therapists, occupational therapists, and pharmacists.[10] Current and future opportunities in health care will incorporate the areas of primary care, cost awareness, community-based practice, prevention focus, population perspectives, and team provider concepts.[8,13] Evolving roles for physical therapists to serve on primary care teams is an example of these new opportunities.[21] Physical therapists will need to actively seek opportunities and demonstrate the value and worth of the physical therapist in fulfilling these roles.

There are currently no federal funding initiatives or student loan programs specific to professional physical therapist education. We cannot predict the effect of widespread adoption of the DPT degree on federal funding. We can, however, point to the availability of targeted student loan programs for doctoral students in medicine and dentistry. Although now greatly diminished, both medical and dental schools have historically been the recipients of significant federal funding to assist in educating doctorally prepared practitioners.[23] We believe that physical therapists could potentially make a stronger case for federal funding, either of educational institutions or for student loan programs, when we can point to equivalent provision of professional doctoral education programs and to the societal need for those practitioners.

Physical therapist education also reaches beyond entry level to include specialist certification and is expanding into the area of organized clinical residency programs. The physical therapist specialist certification process is well-established, and APTA has generated guidelines for recognizing clinical residency programs in physical therapy.[24] Much like professional programs, no federal funds exist to support these physical therapy–specific graduate programs or the enrolled students. The established federal models of funding for residencies are for those that enroll students who already possess a professional doctorate.[25] We propose that it is more congruent with established models to lobby for federal funds to support specialist training, fellowships, and residencies for professionals who possess a terminal doctoral degree. We contend that the widespread adoption of the DPT degree may impart an advantage in the quest for external funding for students and education programs.

Professional licensing. Licensing of the profession of physical therapy has an impact on educational format. Specifically, any proposed or anticipated changes in occupational licensure are of paramount importance to the structure of education programs. Physical therapists are granted access to practice licensure on a state-by-state basis. The nature of the respective state licensure laws, therefore, influences the scope of practice within a state. The first model practice act for physical therapy was recently released by the Federation of State Boards of Physical Therapy.[26] Currently, all US-licensed physical therapists must be a graduate of an accredited program (or prove equivalent education if a graduate of a non-US program not accredited by the CAPTE) and must pass a national licensure examination provided by the Federation of State Board of Physical Therapy. There is no differentiation among degree levels in licensure examinations or in state practice acts. Licensure represents an example of the social-political process of occupations as they seek to protect the public and establish practice boundaries through their professional practice acts.[26] In present and future state licensure debates, we argue that physical therapists would be well-served to ground their arguments in the professional obligations and responsibilities necessary to meet societal needs and provide evidence of cost-effective care. These foundational arguments in conjunction with the expectation for autonomous professional practice are most credible and effective when supported by the widespread adoption of a professional doctoral degree.

In times of turmoil, those who succeed are usually those who are willing to experiment, take risks, and adapt. Ongoing changes in government regulation require that graduates understand the complexity of health care and the influence of economic and political forces. Graduates should enter the field with the professional awareness and social responsibility to affect governmental regulation. The expectations placed on the professional doctoral student by society, practitioners, faculty, and peers are consistent with the challenges presented by clinical practice as it is predicted to evolve during the coming decades. The goals of DPT education clearly extend beyond the realm of job training or technical education and place strong emphasis on professional responsibilities and expectations. The DPT, in theory, is a degree that is well-positioned for meeting current and future challenges.

Intraorganizational Influences

Intraorganizational influences are those "influence(s) of the university, school, college, department, or division on the specific program."[3(p253)] Such intraorganizational variables are the mission, the interrelational support between programs, the financial support, and the governance patterns (Figure). The interaction of these intraorganizational influences can contribute powerfully to the professional culture. This culture will fundamentally shape the values and behaviors of practitioners

Table 1.
Carnegie Classification of Higher Education Institutions[28] Sponsoring Accredited Physical Therapist Education Programs[34]

Institutional Classification	Definition
Research universities I	Full range of baccalaureate programs Graduate education through doctorate[a] High priority on research 50 or more doctorates granted per year $40 million or more in annual federal support
Research universities II	Full range of baccalaureate programs Graduate education through doctorate[a] High priority on research 50 or more doctorates granted per year $1.5 to $40 million in annual federal support
Doctoral universities I	Full range of baccalaureate programs Graduate education through doctorate[a] At least 40 doctorates granted annually in 5 or more areas
Doctoral universities II	Full range of baccalaureate programs Graduate education through doctorate[a] Annually grants at least 10 or more doctorates in 3 or more disciplines or 20 or more doctorates in 1 or more disciplines
Master's universities and colleges I	Full range of baccalaureate programs Graduate education through master's degree 40 or more master's degrees granted annually in 3 or more disciplines
Master's universities and colleges II	Full range of baccalaureate programs Graduate education through master's degree 20 or more masters granted in 1 or more disciplines
Baccalaureate colleges I	Undergraduate education 40% or more degrees granted in liberal arts Restrictive admissions
Baccalaureate colleges II	Undergraduate education <40% of degrees granted in liberal arts Less restrictive admissions
Medical schools and medical centers	Specialized institutions awarding degrees in medicine; may include other health professional schools
Other separate health professions schools	Specialized institutions awarding most of their degrees in fields such as chiropractic, nursing, pharmacy, or podiatry

[a] The Carnegie definition of doctorate includes only Doctor of Education, Doctor of Juridical Science, Doctor of Public Health, and the PhD in any field.

trained within that environment. A rich culture will facilitate an expansive horizon for its students and faculty; a restricted culture will set limits on professional development that must be accommodated or overcome.

Thus, the types of questions to consider are: Do the intent and content of the DPT program match the institutional mission? Is the DPT program to be housed within an appropriate institutional structure? Are the scholarly, service, and teaching values associated with the host setting matched to those of a DPT education program? What is the availability of frequent and prolonged interactions of the DPT students with multiple other professional and service disciplines in training, particularly those at a doctoral level? Does the institution facilitate, monitor, and reward interactions of the DPT students and faculty across programs? Is the host institution sufficiently stable financially to implement and then support the DPT program? Is the primary institutional purpose for implementing a DPT program focused on professional doctoral education? Will the DPT program be adequately funded at start-up and remain at a steady state? Is the governance structure of the institution, school, and proposed program congruent or at least compatible with the professional competency expectations of the DPT education program? Do institutional programs or structures exist for the faculty and staff of a DPT education program to fully participate in the governance patterns?

Institutional mission. The mission statement of an institution is, in our view, of paramount importance to the professionalization of physical therapy and to the implementation of the DPT degree.[16,27] We strongly argue that the institutional mission should be congruent with and inclusive of professional doctoral degrees based on

Table 2.
Frequency Count by Carnegie Foundation Ranking[a] of Higher Education Institutions Sponsoring Accredited Physical Therapist Education Programs[b] as of August 1998

Rating	No. of Physical Therapist Programs
Research university I	33
Research university II	6
Doctoral university I	10
Doctoral university II	13
Master's college and university I	47
Master's college and university II	11
Baccalaureate liberal arts college I	2
Baccalaureate liberal arts college II	9
Medical centers	22
Not listed	12
Other health professions schools	3
Total	168

[a] Rankings drawn from the most recent (1994) Carnegie Foundation publication.[28]
[b] This list does not include programs outside of the United States or physical therapist assistant programs.

rigorous scientific and theoretical foundations, interdisciplinary interactions, and a commitment to societal service. Comprehensive implementation of this mission across multiple programs provides the physical therapist student with the opportunity to become truly immersed in an academic and professional milieu. The vast majority of physical therapist programs are located in institutions rated by the Carnegie system as master's college and university I or higher or are housed within medical centers (Tabs. 1 and 2).[28] Level I and II research institutions are historically committed to the discovery of knowledge, whereas traditional academic doctoral preparation is conducted in institutions possessing the research or doctoral designation. We contend that the clinical research milieu and culture of health care professionals exists best in institutions that sponsor multiple professional doctoral programs. Notably, the Carnegie rating system is not based on professional doctorates (eg, medicine, dentistry, pharmacy).

Thus, we propose that, at a minimum, DPT programs should be housed in institutions with a doctoral university II or higher rating, within a medical center, or at institutions that provide a spectrum of professional education at the doctoral level. We do not believe that it is consistent with societal needs, nor is it consistent with professional needs, to educate physical therapists at the DPT level in institutions that do not possess an appropriate scholarly and professional culture. The higher expectations placed on faculty for traditional and clinical scholarship and the production of new knowledge at institutions that have doctoral programming are consistent with the needs of the profession and provide powerful role models for students enrolled in those programs. The implementation of the institutional mission, coupled with an informed review of the Carnegie rating, provides clear evidence of the scholarly and clinical environment and indicates the probability of fostering a broadly educated, scientifically based, professionally socialized, autonomous physical therapist practitioner.

Interrelational support. *Program interrelationship* refers to the administrative and scholarly relationships that a DPT program would have with other programs, departments, or centers in the host institution. The long-standing custom of strong disciplinary, isolated educational structures existing among schools has been challenged by the need for educational and economic reform.[8] Thus, the positioning of a DPT program within an institution should require consideration of the presence of the existing milieu of client-directed, medically oriented programs that share an orientation toward doctoral professional education. In our view, students need frequent exposure to a spectrum of professionals in training who aspire to autonomous practice. For example, a DPT program situated within a medical center will be in a different culture and climate than one situated within a school of arts and sciences or an isolated professional school. Indeed, the culture of scholarship, dress, professional socialization, and demeanor are intimately related to positioning of the program within the organizational structure. The intraorganizational structure and orientation should ensure that these interactions will be integrative, positive, and rewarded.[29–32]

Financial support. The level of financial support necessary for any professional program is considerable. At a minimum, financial commitments are required for development and maintenance of teaching facilities, research laboratories, library holdings, technology, and student space.[33] We are tempted to speculate that the recent growth in the number of new physical therapist programs[34,35] is based primarily on an administrative perception that a program in physical therapy can enhance undergraduate enrollment and recruit competitive students for an array of programs in the host institution. Financial benefit certainly should be part of implementing any new program, but we believe that this consideration alone is insufficient to sustain and nurture viable professional education programs, least of all those at the doctoral level. These considerations emphasize the need to place DPT programs within institutions that have a history of commitment to professional education at the doctoral level.

Governance. Governance patterns of university systems are traditionally organized to facilitate the larger bureaucracy of higher education, whereas professional education programs are focused on producing competent professionals. In professional education, this has been called the "education-practice discontinuity," where the

academic culture may be seen as unresponsive to practice needs and the professional program seems indifferent to academic needs.[1]

We contend that the governance structure of a physical therapist program should provide support for a central focus on educational preparation of competent professionals. The presence of diverse health care professional educational programs within an institution can provide wider understanding and support for the need of those disciplines to ensure professional competency of the graduates, a need that might be given less recognition or value by disciplines not involved in the direct provision of patient care. Thus, the interaction of the governance patterns of the host institution and the manner in which the faculty and students are socialized into these governance patterns is extremely important to the success of the educational process.

Internal Influences

Stark et al[3] described 4 sources of internal influences: mission and staffing, structure of the professional program, curricular tensions, and continuing professional education (Figure). Questions to consider include: Is the educational philosophy of the program, in terms of both instructional methods and outcome objectives, consistent with the philosophy of the DPT program? Do the shared professional values of the faculty support the foundation of beliefs for the development and conduct of a DPT curriculum? What are the student expectations of the DPT educational process? Do the students view the DPT curriculum as preparing them to assume specific professional roles? Do DPT students display behaviors consistent with the expectations for professional practice? Are the demographic characteristics of students enrolled in DPT programs different from those of students enrolled in other degree levels? What student-to-faculty ratios are necessary to support DPT education? Does the DPT curriculum adequately reflect an integration of the basic and social sciences necessary for current practice? Does the DPT curriculum systematically prepare students for future areas of physical therapy practice? Do instructional methods foster open-mindedness, critical thinking, and self-reflection? How will a sense of community and homogeneity of practice be fostered among physical therapists with differing professional degrees through post-professional routes?

Program mission and staffing. The elements of mission and staffing address the skills and beliefs that the faculty and students bring to the program and the curricular philosophy that guides their interaction. Both faculty and students bring with them knowledge, skills, attitudes, and values that have been shaped, at least in part, by prior education and experience. For example, a physical therapy faculty member with a post-professional PhD in a traditional foundation science (eg, anatomy, physiology) might be expected to advocate controlled bench research as a primary means of advancing the knowledge base of the profession. In contrast, this faculty member's approach to the generation of knowledge and the value he or she places on descriptive clinical reports and qualitative studies might be mitigated by his or her professional physical therapist education, by his or her years and quality of clinical physical therapy experience, and by the mentorship he or she received during his or her post-professional studies. Even more important than individual faculty skills and attitudes is the aggregate influence of the faculty mix, which will determine the education, skills, and values imparted to the students.

Graduates need theoretical and technical knowledge along with reflective and practical knowledge and competencies to deal with the complexities of current practice.[1] Thus, the faculty mix should swing toward doctorally prepared faculty. The importance, however, of clinical skills should not be lost or devalued in the transition of the staffing of the academic core of DPT programs by doctorally prepared faculty.

Faculty members who primarily represent general and specialized clinical practice should always, in our view, be part of the full-time core teaching cadre. When considering the continuum of physical therapist professional education, a large percentage of the curriculum is provided by individuals who are qualified by their professional clinical credentials and by patient care experiences rather than by traditional academic degrees. Often, 50% of curricular clock hours in a physical therapist education program are devoted to clinical experiences.[12] This extensive commitment of curricular time to the clinical experience is also seen in the professional educational programs of physicians, dentists, and pharmacists, whose clinical training is more centralized. Clinical education experiences within medicine, dentistry, and pharmacy are primarily staffed by identifiable and closely aligned clinical faculty possessing a doctoral professional degree and relevant clinical experience within their own disciplines.

The lack of traditional academic linkages for physical therapist clinical teachers is bewildering and fosters an artificial, unhealthy separation between the didactic and clinical phases of physical therapist education. Part of this problem stems from the lack of recognition of the bachelor's or master's professional degree as appropriate for academic appointment. Conversely, the academic appointment of individuals with clinical doctorates is a common and widely accepted model for some other professions. Given this widespread academic precedent, the adoption of the clinical doctorate as the professional

degree for physical therapists may facilitate the incorporation of clinical educators into the academic fold and help to mend the division between clinical and academic educators. This view is consistent with the description of "core" faculty within physical therapy accreditation guidelines.[33]

The model of faculty possessing a professional doctorate as their only "credential" is firmly established across doctorally prepared professions (eg, medicine, dentistry, pharmacy, law, veterinary medicine, podiatry). The choice of placing clinically credentialed faculty in a tenure line is related far more to the institutional mission and culture than to the presence or absence of an academic degree. The same is true about the probability of a clinically credentialed faculty member obtaining tenure. These faculty are primarily reliant on productivity originating from their clinical skills and efforts in establishing a scholarly base for the award of tenure within any given set of institutional guidelines. We feel that this system fosters credible clinical research.

We have argued that the DPT degree may help bridge the gap between academic and clinical faculty. We feel that division of faculty into tenure-track and clinical compartments based solely on degrees impedes integrated professional education and does not promote adequate scholarly collaboration between foundational and clinical sciences. The inclusion of people with terminal professional doctorates as core faculty is also congruent with existing disciplines that award the professional doctorate.

Perhaps after firmly establishing their clinical competence, the graduates of DPT programs can meet some of the needs of education programs, particularly at the applied clinical level. The professional doctoral degree clearly and historically bridges the gap between traditional didactic and purely clinical educational experiences. The obvious danger is placing physical therapists with professional doctorates in academic roles for which they are not prepared. Academic administrators should recognize and employ holders of the DPT degree for what they are: well-prepared scientific practitioners. Given time and opportunities to develop mature clinical judgment, DPT practitioners can provide valuable academic services, as have doctoral practitioners in other professional disciplines.

The interaction of program philosophy with the beliefs and values of the faculty and students comprises a notable and conspicuous component of the education program. The program's ideology and mission guide the interaction between faculty and the implementation of the curriculum. The relative importance of and the emphasis placed on clinical skills, development as a teacher (clinical and academic), and utilization and conduct of research are primarily influenced by the attitudes and skills of the physical therapy faculty and the program ideology. The characteristics of students who enter DPT programs will also influence the outcome. In general, these students expect an intensive, post-baccalaureate professional experience and may anticipate that doctoral education will place them at the forefront of professional knowledge and allow them to assume leadership roles more easily after graduation. These attitudes are consistent with the development of lifelong learning behaviors, career goals, and professional identification so crucial to the long-term development of the profession.[1,27] The DPT would appear to be an appropriate professional degree for educating physical therapists as scientific, reflective practitioners.[36]

We contend that students need to make distinctions between traditional academic work at the graduate level and professional doctoral education. It is easy for students to mistakenly assume that a DPT curriculum will permit them to engage in narrow or selective educational pursuits, much like those associated with traditional academic graduate education. The professional DPT program, like other professional programs, is designed to prepare generalist practitioners and must rigorously enforce this requirement in its educational philosophy. We have found that educational efforts and targeted discussions of the roles of professional doctoral education are needed. Although some additional curricular clock hours can be gained in the transition to a DPT degree, the curricular emphasis should be squarely focused on preparing graduates for the broad scope of physical therapy practice. Students enrolled in DPT curricula, in our view, must be encouraged to exercise intellectual humility and integrity as part of their critical thinking skills.[37] Education at the professional doctoral level does not confer the efficiency, wisdom, skill, or political savvy inherent to years of experience. The DPT program graduate certainly should have the background and capacity to undertake rapid career advancement, but this advancement will be based on overt demonstrations of knowledge and skills, not on a conferred degree. The concept of intellectual humility extends to the manifestation of appropriate professional behaviors of DPT program students and graduates. Only through clear recognition and acknowledgment of their strengths and weaknesses will therapists with DPT degrees be able to become integrated into the existing diverse pool of practicing physical therapists and health care providers to effectively assist in the evolution of the profession.

Program structure. The structure of the DPT professional program encompasses admissions requirements

and chronologic, demographic, and evaluative elements of the program. These elements are clearly articulated in *A Normative Model of Physical Therapist Professional Education*[16] and in *Evaluative Criteria for Accreditation of Education Programs for the Preparation of Physical Therapists.*[33] These elements are very consistent with the needs of post-baccalaureate education of physical therapists, including the use of the DPT degree. Conversely, these are minimal standards, and they may not encompass some of the elements desirable for a DPT program. We suggest that a lack of anticipation of the future needs of practice is inherent in the current accreditation standards, as they permit the formation and continuation of physical therapist education programs at institutions that do not offer and are not chartered for the award of professional doctoral degrees. The issue of providing an appropriate scholarly environment to facilitate professional education and advancement of the knowledge base of the profession is often a point of noisy contention among academic administrators but is at the core of the debate on professional doctoral education.

It is conceivable that the nature of a DPT program could influence the types of students who apply and the numbers of faculty necessary to support the program. Programs offering the DPT degree have not been in existence long enough to determine whether the demographic mix of students (gender, ethnic background) will be affected by the degree offered. Currently existing DPT programs are similar in length, requiring approximately 8 academic semesters to complete.[34] The average faculty/student ratio is currently 1:13 across post-baccalaureate physical therapist programs.[12] The ratio of faculty to students in a DPT program should increase if there is, as we suggest, an expanded need for faculty scholarship, curricular expectations, and lengthened academic time span. Additionally, in the first years of DPT education, there is a greater need for student and curriculum evaluation in order to document student experiences and performances related to the degree and the educational process.

Curricular tensions. Curricular tensions are the internal influences produced by the struggle to merge the range of faculty values and beliefs concerning curricular content and to reconcile divergent faculty teaching philosophies. Typical elements that produce tension include the content and sequencing of knowledge, the integration of theory and practice, and differing faculty choices among available teaching methodologies. The curriculum resulting from these choices should facilitate efficient development of professional knowledge, foster lifelong learning behaviors, encourage critical thinking, and promote diagnostic, prognostic, evaluative, and moral reasoning.[1,16,38]

One of the basic premises of *A Normative Model of Physical Therapist Professional Education*[16] as well as the existing DPT curricula is that strong foundational science courses should be a part of the professional curriculum. The foundational science courses may include courses such as histology, embryology, and pharmacology, along with the traditional focus on anatomy and physiology. In addition, the basics of diagnostic imaging, as they relate to understanding interventions and patient management, are increasingly important in selected areas of physical therapy practice.

Changes in the culture of medicine and health care delivery will increase the demand for professional competence in understanding patient belief systems, performing community-based assessment and intervention, and assuming a professional role of advocacy for patients. These expanded professional roles demand more background in the behavioral and social sciences, including health education, health policy, health services research, and ethics.[1,8,16,38]

Because excellence in clinical practice is a desired outcome in professional education, clinical practice components must be included in the curricular sequence at the earliest feasible time and should be given equal emphasis with the foundational sciences. Considering the finite period of curricular time, emphasis should be placed on physical therapy practice of the future. The future of clinical practice is always a dangerous thing to predict. We suggest, however, that physical therapists will be performing more evaluation, diagnosis, and patient management; delegation and supervision of treatment; writing of clinical case reports; documentation using outcome data; education of patients, families, students, peers, and outside agencies; and confrontation with the ethical and financial dilemmas imposed by shrinking health care financing.

Continuing education. The final element stemming from internal influences is the need for ongoing professional development, which takes many forms, including specialization, clinical residencies, and traditional continuing education. One way to improve practice homogeneity and sense of community among physical therapists is by offering a clear route for existing practitioners to renew and build on their skills through transitional DPT programs. These programs would allow physical therapists with bachelor's or master's credentials to obtain the DPT credential. Helping bachelor's or master's educated practitioners make the transition to the doctoral level has been a key element in the conversion of other professions, such as pharmacy, to the doctoral entry level by eliminating much of the rancor caused by a dichotomy between level of academic degree and level of clinical experience. This route also provides a means

Table 3.
Dimensions of Professional Competence[3]

Competence	Definition
Conceptual	Understands the theoretical foundations of the profession and the application of professional science
Technical	Ability to perform tasks or fundamental skills of the profession
Integrative	Ability to integrate theory and practice, as evidenced by professional judgment
Contextual	Understands the societal context of practice, including the broader social, economic, and cultural issues of practice
Adaptive	Ability to anticipate and adapt to changes that affect practice and the profession
Interpersonal communication	Ability to effectively use written and oral communication

Table 4.
Key Professional Attitudes[3]

Attitude	Definition/Application
Professional identity	Graduates accept norms of the profession; value the roles; become members of the professional community
Professional ethics	Graduates internalize the moral responsibilities and ethics of the profession; are willing to assume social responsibility
Career marketability	Graduates are competent candidates for professional practice
Scholarly concern for improvement	Graduates are dynamic learners; can interpret results of research in context of practice
Continued learning	Graduates are committed to lifelong learning

of updating the knowledge and skills of existing practitioners in areas that may not have been included during or may have fundamentally changed since their professional education and are not easily available via traditional post-professional offerings. Thus, the profession and the practice of physical therapy become more homogeneous, and physical therapists become more easily identifiable as the primary providers of a consistent level of evaluation and treatment for movement dysfunction.

Professional Outcomes

The professional education environment is directed by external, intraorganizational, and internal influences that, in turn, lead to graduate professional outcomes. Stark et al[3] proposed that professional outcomes be viewed as 2 core areas: professional competence and professional attitudes (Figure).

Professional Competence

Professional competence is the primary outcome of professional educational programs. Professionals are assumed to have acquired "special competence" as a result of prolonged education and training.[36] The model suggests 6 areas of professional competence: conceptual, technical, integrative, contextual, adaptive, and interpersonal communication (Tab. 3). For these areas of professional competence, the following questions focus on the assumed relationship between what happens in the education program and graduate performance: Does the DPT graduate possess the core foundation knowledge in physical therapy? Is the DPT graduate knowledgeable of the key theories in the profession? Does the DPT graduate possess the technical skills of the profession, and are the skills linked to the knowledge base? Does the DPT graduate possess the fundamental skills for professional practice? Does the DPT graduate's professional practice behavior demonstrate the integration of theory with practice? Does the DPT graduate demonstrate professional judgment in practice? Is the DPT graduate's mastery of knowledge and skills in physical therapy comparable to other doctorally educated professionals' mastery in their respective areas? Does the DPT graduate demonstrate professional practice behaviors that recognize and respond to the broad social, economic, and cultural context? Does the DPT graduate demonstrate evidence of problem identification and problem solving during practice?

The competencies and the questions related to the competencies can be viewed as applicable across professional education. We believe that DPT programs have the responsibility to emphasize certain competencies. The areas of *conceptual* and *integrative* competence both focus on the central importance of theory in understanding knowledge and guiding practice. Graduates of DPT programs should demonstrate the ability to integrate theory and practice as part of their clinical judgments. If the DPT curricular emphasis is on scientific and theoretical foundations coupled with a faculty committed to the scholarly generation, application, and integration of knowledge, this focus should foster these competencies in the students. Furthermore, as health care professionals, graduates must demonstrate the *contextual* and *adaptive* competence necessary to take risks and promote necessary change in society. These competencies are central to the role of an autonomous professional and must be nurtured during the student's education.

Professional Attitudes

A final component of professional outcome is professional attitudes. These attitudes span a wide range, including professional identity, professional ethics, career marketability, scholarly concern for improve-

ment, and continued (lifelong) learning (Tab. 4). Questions that are applicable in this area include: Does the DPT graduate demonstrate evidence of clear communication, including evidence of clinical scholarship? Does the DPT graduate view himself or herself as a professional? Does the DPT graduate participate in the professional community? Does the DPT graduate demonstrate moral, ethical, and social responsibility? Can the DPT graduate adapt his or her talents and skills to a changing environment? Does the DPT graduate understand and apply evidence-based practice? Does the DPT graduate seek continued professional development?

The DPT degree provides a very clear indication of professional identity that is consistent with other health care professionals and would assist with the public recognition of physical therapists as professionals. Professional preparation that emphasizes the social, moral, and scholarly responsibilities expected of doctoral graduates is consistent with the DPT degree. Finally, an educational environment where inquiry and scholarship are fundamental values of the work environment, role modeled by faculty, and cultivated within students provides an essential foundation for the preparation of the next generation of professionals. We argue that DPT programs are well-positioned to provide this kind of academic environment.

Conclusion

We believe that there is broad societal need for physical therapy services now and in the future. The professional doctoral degree is the appropriate degree for preparation of practitioners who are competent to meet these needs. Support within the profession for doctoral professional education is emerging, as reflected by a recent editorial by Rothstein:

> We need to prepare physical therapists to exemplify the highest standards of health care, to use evidence, to skillfully apply techniques, to be thoughtful and effective—and to do so within the confines of a health care system that can promise us nothing but chaos for the foreseeable future. The DPT can offer the freedom we need, but only if we first have an open dialogue about what form the DPT should take.[39(p360)]

The conceptual framework discussed and analyzed in this article provides a useful tool for this open dialogue about the role of the professional doctoral degree in physical therapy.

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Appendix.
Questions for Consideration

External Influences

1) Does the DPT degree serve the greater good of society within the marketplace?
2) Will the DPT degree influence the current and anticipated number and type of employment prospects available to physical therapists?
3) Will the pressures of the marketplace influence the applicant pool to DPT programs, the market niches that DPT program graduates will fill, or the salaries they earn?
4) How is the DPT degree viewed at national, state, and local levels?
5) What are cultural and socioeconomic considerations in the media portrayal of the DPT degree?
6) In the public eye, how does the DPT degree relate to other doctoral professional degrees such as Doctor of Medicine (MD) or Doctor of Pharmacy (PharmD)?
7) What is the relationship of the DPT degree to federal, state, and local funding policies and regulations that influence the practice of physical therapy?
8) What federal, state, and local funding sources are available for physical therapist education, and will those sources be influenced by the DPT degree?
9) Would the DPT degree have an effect on physical therapy licensure or the scope of practice?

Intraorganizational Influences

10) Do the intent and content of the DPT program match the institutional mission?
11) Is the DPT program to be housed within an appropriate institutional structure?
12) Are the scholarly, service, and teaching values associated with the host setting matched to those of a DPT education program?
13) What is the availability of frequent and prolonged interactions of the DPT students with multiple other professional and service disciplines in training, particularly those at a doctoral level?
14) Does the institution facilitate, monitor, and reward interactions of the DPT students and faculty across programs?
15) Is the host institution sufficiently stable financially to implement and then support the DPT program?
16) Is the primary institutional purpose for implementing a DPT program focused on professional doctoral education?
17) Will the DPT program be adequately funded at start-up and remain at steady state?
18) Is the governance structure of the institution, school, and proposed program congruent or at least compatible with the professional competency expectations of the DPT education program?
19) Do institutional programs or structures exist for the faculty and staff of a DPT education program to fully participate in the governance patterns?

Internal Influences

20) Is the educational philosophy of the program, in terms of both instructional methods and outcome objectives, consistent with the philosophy of the DPT program?
21) Do the shared professional values of the faculty support the foundation of beliefs for the development of a DPT curriculum?
22) What are the student expectations of the DPT educational process?
23) Do the students view the DPT curriculum as preparing them to assume specific professional roles?
24) Do DPT students display behaviors consistent with the expectations for professional practice?
25) Are the demographic characteristics of students enrolled in DPT programs different from those of students enrolled in other degree levels?
26) What student-to-faculty ratios are necessary to support DPT education?
27) Does the DPT curriculum adequately reflect an integration of the basic and social sciences necessary for current practice?
28) Does the DPT curriculum systematically prepare students for future areas of physical therapy practice?
29) Do instructional methods foster open-mindedness, critical thinking, and self-reflection?
30) How will a sense of community and homogeneity of practice be fostered among physical therapists with differing professional (entry-level) degrees through post-professional routes?

Professional Outcomes

31) Does the DPT graduate possess the core foundation knowledge in physical therapy?
32) Is the DPT graduate knowledgeable of the key theories in the profession?
33) Does the DPT graduate possess the technical skills of the profession, and are the skills linked to the knowledge base?
34) Does the DPT graduate possess the fundamental skills for professional (entry-level) practice?
35) Does the DPT graduate's professional practice behavior demonstrate the integration of theory with practice?
36) Does the DPT graduate demonstrate professional judgment in practice?
37) Is the DPT graduate's mastery of knowledge and skills in physical therapy comparable to other doctorally educated professionals' mastery in their respective areas?
38) Does the DPT graduate demonstrate professional practice behaviors that recognize and respond to the broad social, economic, and cultural context?
39) Does the DPT graduate demonstrate evidence of problem identification and problem solving during practice?
40) Does the DPT graduate demonstrate evidence of clear communication, including evidence of clinical scholarship?
41) Does the DPT graduate view himself or herself as a professional?
42) Does the DPT graduate participate in the professional community?
43) Does the DPT graduate demonstrate moral, ethical, and social responsibility?
44) Can the DPT graduate adapt his or her talents and skills to a changing environment?
45) Does the DPT graduate understand and apply evidence-based practice?
46) Does the DPT graduate seek continued professional development?

Invited Commentary

Expecting to see a commentary at the end of this Perspective on what is an especially timely and controversial topic in physical therapy? It's up to you! The Journal invites readers to respond to this article. Responses that meet criteria for thoughtful dialogue supported by literature will be published as Letters to the Editor and posted on the Journal's Web site. Forward your response to Editor, *Physical Therapy*, APTA, 1111 North Fairfax Street, Alexandria, VA 22314-1488; ptjourn@apta.org

Issues Impacting Entry-level Occupational Therapy Education

Neil Harvison PhD, OTR, FAOTA

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- other issues impacting education.

Growth

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Program growth

	OT Doctoral	OT Master's	OTA
Accredited	5	146	175
Candidate	6	10	19
Applicant	8	10	32
Total	19	166	226

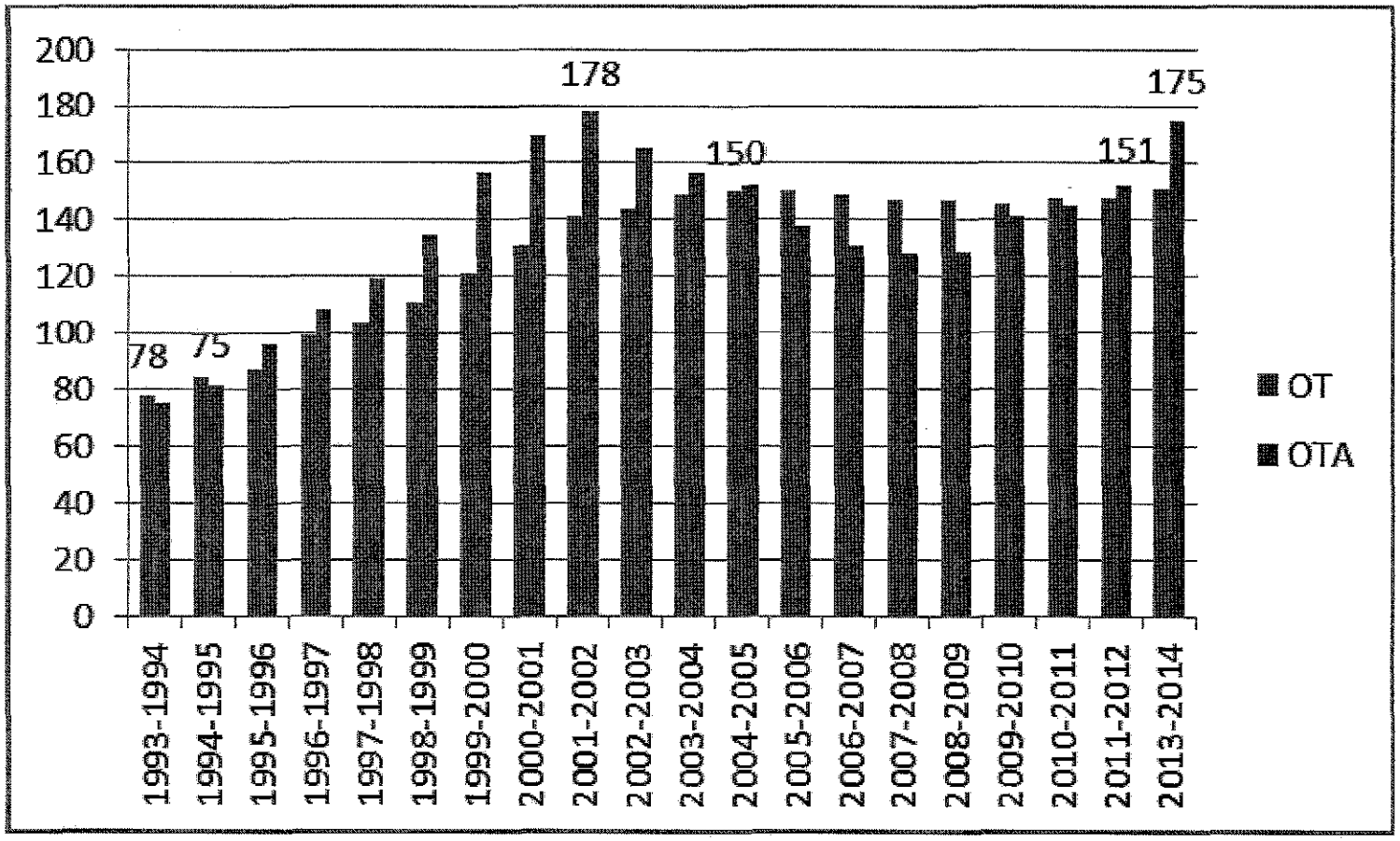
Note: Numbers reflect April 15, 2014

Accredited: The academic program is accredited by ACOTE.

Candidate: The program has been granted candidate program status (step 2) by ACOTE and can admit students, but has not yet completed the initial on-site evaluation that leads to granting accreditation.

Applicant: The academic program has submitted a letter of intent to apply for developing program status (step 1).

Program Growth



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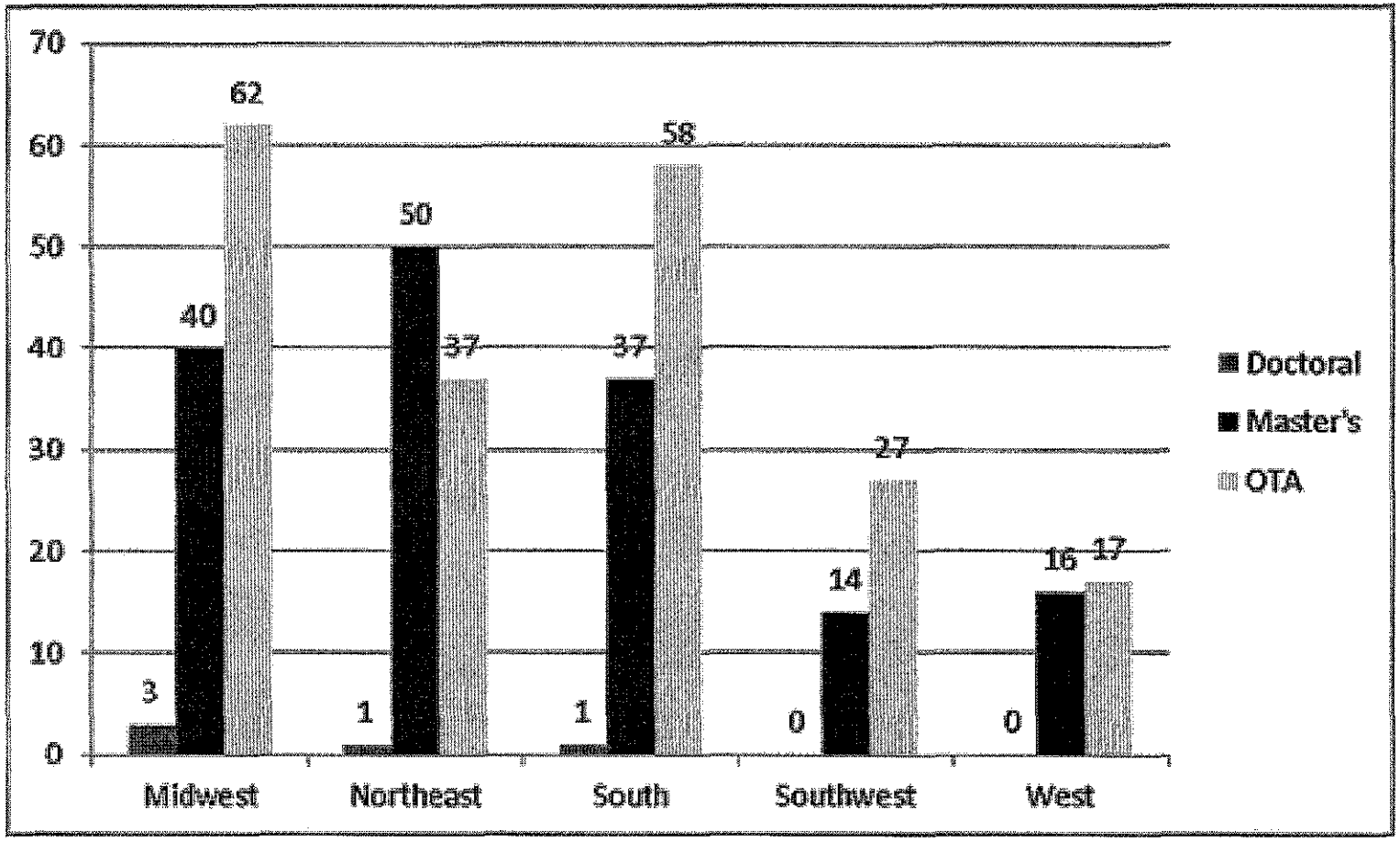
Regional Distribution of Accredited Programs



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Why?

BLS Occupational Outlook Handbook:

- Percent change in employment, projected 2012-22
  - Occupational therapists 29%
  - Health diagnosing and treating practitioners 20%
  - Total, all occupations 11%
  - Occupational therapy assistants 43%

Why?

- US News Best Healthcare Jobs: OT #9 and OTA #13.

Forbes

- Forbes Top 200 Jobs in 2014 : OT is #9 overall and #3 in Health Care

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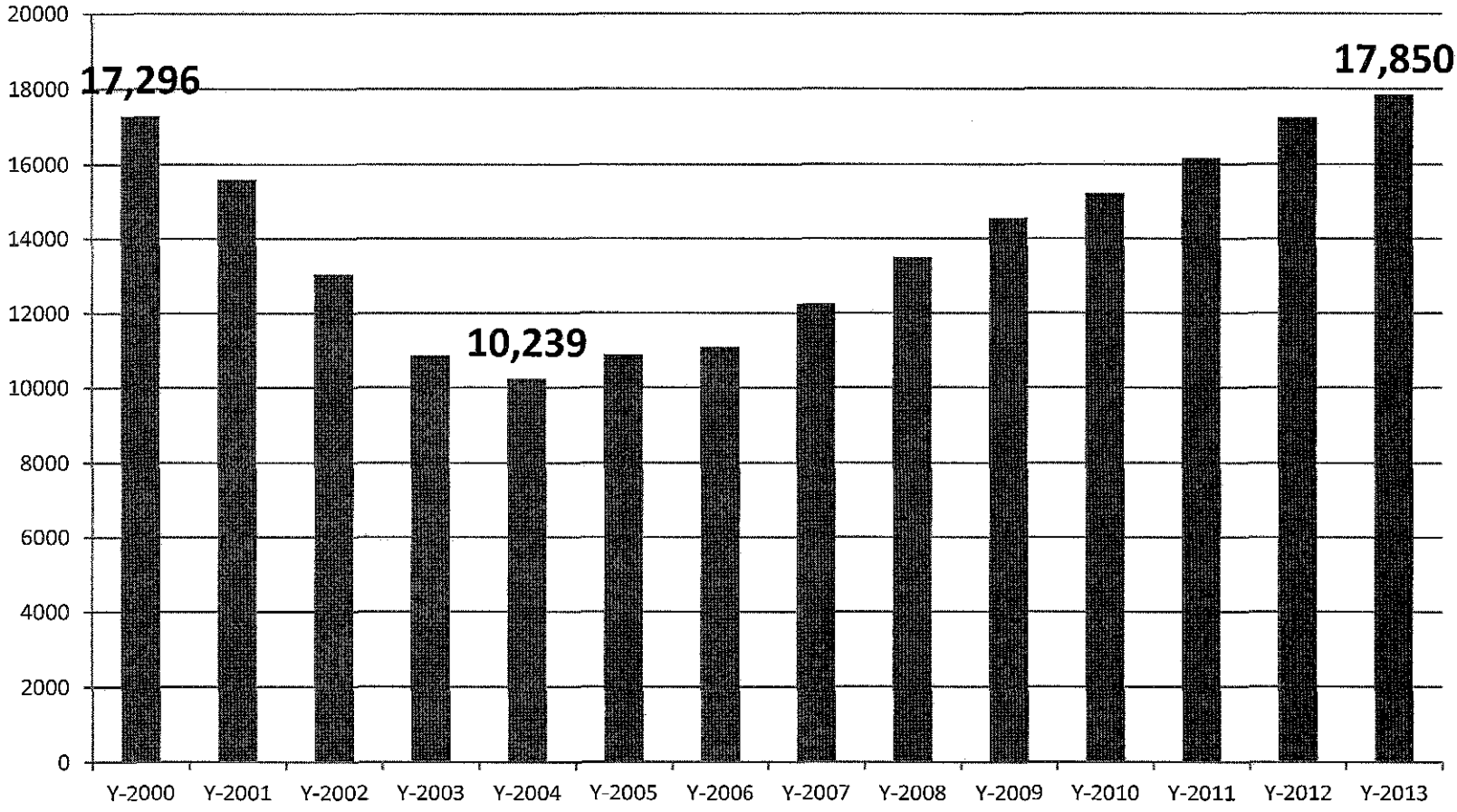
OT Student Enrollment



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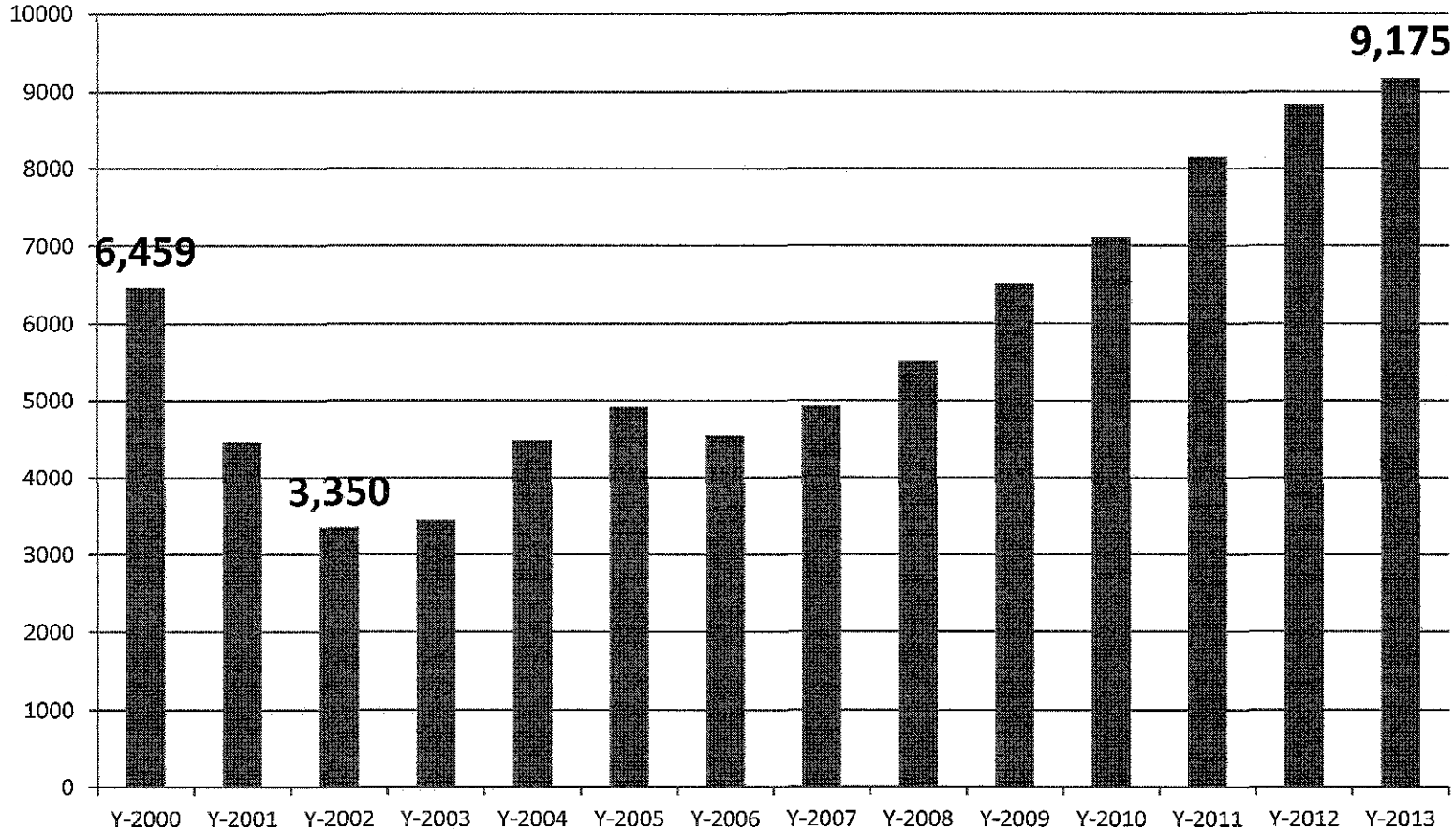
OTA Student Enrollment



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Graduate Numbers

	Doctoral- OT	Masters- OT	OTA
2009	88	3946	2354
2010	95	4398	2888
2011	97	4789	3678
2012	111	5164	4233
2013	108	5439	4313
5 yr growth	23%	38%	83%

Entry-level Degrees

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Roles & Responsibilities

- AOTA Board of Directors: establishes strategic goals and initiatives
- AOTA Representative Assembly: establishes official policies
- ACOTE: accreditation of academic programs

Current O.T. Entry-Level Degree Requirement

- 1958: Jantzen, Reilly and Fidler publish article in AJOT calling for masters as the entry-level requirement.
- 1969: First masters at USC.
- 1999: After 41 years of "dialogue" the Representative Assembly adopts a policy endorsing the post-baccalaureate entry-level requirement.

Current O.T. Entry-Level Degree Requirement

- At its August, 1999 meeting, ACOTE voted unanimously to adopt the following motion:
- "Only post-baccalaureate occupational therapy degree programs will be eligible to receive or maintain ACOTE accreditation status as of January 1, 2007.

2014: AOTA Board Of Directors

In response to the changing demands of higher education, the health care environment, and within occupational therapy, it is the position of the American Occupational Therapy Association (AOTA) Board of Directors that the profession should take action to transition toward a doctoral-level single point of entry for occupational therapists, with a target date of 2025.

Why now?

- President appointed the Future of Education Ad Hoc Committee.
- A subgroup of the Board reviewed the committee's report and collected further data that was shared with the full Board.
- Board came to consensus based on future of changing health care system.

What did the Board consider?

- Evolving changes in the health care system, higher education, and the profession.
- Potential implications of making changes in entry-level degree:
  - e.g. impact on OTA
  - e.g. diversity in the profession
  - e.g. costs/ resources/ faculty/ institutions

Considerations on Having Two Entry-Level Degrees

- Two entry-level degrees for a single certification exam.
- Many prospective students express confusion.
- Many legislators and regulators question difference in student learning outcomes with two degree levels.
- Employers ask whether they should hire doctorally prepared new graduates vs. master's prepared.
- Professions with more than one entry level are in the minority.
- The benefits of two entry-level degrees do not outweigh the inconsistencies.

Why Choose the Doctoral Degree vs. the Master's?

- Many master's programs already meet or exceed the minimum credit load for a doctoral degree.
- Schools are being asked to add more content to address the changing health care system.
- The majority of health care professions are at the doctoral level, transitioning, or debating this change.
- If we hadn't transitioned from the bachelors to the master's entry level, we may not have been included in health care reforms and initiatives.
- Profession already approved entry-level doctoral programs.

Impact for Education: Student Numbers

- Number of graduates has grown in existing OTD programs at the same rate as the master's programs.
- No negative impact on number of PT graduates with move to DPT; number of graduates has continued to rise at the same rate as OT.
- No negative impact on number of graduates in pharmacy with move to ParmD; number of graduates has continued to increase.
- There is no evidence that degree level impacts the number of graduates.

Impact for Education: Student Diversity

- No significant change in diversity was experienced with AOTA move to post-baccalaureate entry.
- No negative impact reported by APTA on diversity with move to the DPT. Most groups did not change, with the exception of more males.
- No significant difference noted in race/ethnicity between the doctoral-level audiology and master's-level speech pathology students.
- There is no data to support the argument that a move to a doctoral entry-level will significantly impact diversity.

Impact for Education: Institutional Capability

- Potential impact on costs to a system that is already considering a cap on credit hours for master's degrees.
- Potential increased debt load for graduates.
- Can our current schools transition to a doctorate?
- Do we have the qualified faculty o teach in the programs?.
- Will we be able to balance faculty with professional doctorates (e.g. OTD) and faculty with research doctorates (e.g., PhD)?
- Reliance on adjunct faculty could be exacerbated.

Impact on Practice:

- Increased potential for autonomy in emerging practice models.
- Better positioned to address potential roles in emerging delivery models (e.g., primary care, community practice).
- Institute of Medicine recommends interprofessional team-based care….easier to advocate for our position and leadership roles if we have the same entry-level degree.

Impact on Practice:

- Impact on involvement of OTs in private practice/entrepreneurial efforts?
- Opportunity to specialize.
- Advanced skills and knowledge in research, evidence-based practice, management, leadership, and systems navigation compared with master's-level entry.
- Role of OTA

OTA Entry-Level Ad Hoc

- Will institutions housing OTA programs being able to change to bachelors?
- Would it change the quality of the OTA educational experience?
- Will faculty shortages prevent a move?
- What is the impact on credit load?
- What is the impact on diversity in the profession?
- What are the costs incurred when adding additional time?

OTA Entry-Level

- Impact of the ACA on breadth of practice and reimbursement?
- What will be the role of associate versus bachelors prepared practitioners in the emerging practice models.
- If OT moves to the doctorate what will be the impact on OTA practice?
- Will there be supervision changes?
- What will be the impact on role delineation?

Fieldwork

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Issues impacting fieldwork:

- Growth in student numbers.
- Changing demands on practitioners.
- Costs- supervision and payment.
- Potential move to the doctorate and the added experiential component.

Other issues impacting education:

IOM Global Forum Initiatives

- Interprofessional Collaborative Education/ Practice
- Community Based Practice
- Primary Care: Addressing health and wellness of individuals and populations- especially those with chronic conditions.
- Impact of technology on service delivery.
- Access and disparities.

Questions??

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DISCUSSION OF CONSIDERATION OF LEGISLATIVE PROPOSALS.

The following are attached for review:

a) BPC Section 2570.2(k)
b) BPC Section 2570.32(f), followed by other boards' similar language
c) Proposed BPC Sections 2570.33 and 2570.35
d) 2015 Legislative Calendar

Amend Business & Professions Code Section 2570.2(k)

(k) "~~Practice of~~ oOccupational therapy" means the therapeutic use of purposeful and meaningful goal-directed activities (occupations) which engage the individual's body and mind in meaningful, organized, and self-directed actions that maximize independence, prevent or minimize disability, and promote or maintain health, well being, and quality of life. Occupational therapy services encompass research, education of students, occupational therapy assessment, treatment, education of, and consultation with~~,~~ ~~individuals who have been referred for occupational therapy services subsequent to diagnosis of disease or disorder (or who are receiving occupational therapy services as part of an Individualized Education Plan (IEP) pursuant to the federal Individuals with Disabilities Education Act (IDEA)).~~ individuals, groups, programs, organizations, or communities.

(1) Occupational therapy assessment identifies performance abilities and limitations that are necessary for self-maintenance, learning, work, and other similar meaningful activities. Occupational therapy treatment is focused on developing, improving, or restoring functional daily living skills, compensating for and preventing dysfunction, or minimizing disability. Occupational therapy techniques that are used for treatment involve teaching activities of daily living (excluding speech-language skills); designing or fabricating selective temporary orthotic devices, and applying or training in the use of assistive technology or orthotic and prosthetic devices excluding gait training). Occupational therapy consultation provides expert advice to enhance function and quality of life. Consultation or treatment may involve modification of tasks or environments to allow an individual to achieve maximum independence. Services are provided individually~~,~~ or in groups.~~, or through social groups.~~

(2) The licensed occupational therapist or occupational therapy assistant may assume a variety of roles in their profession, including but not limited to, clinician, supervisor of occupational therapy students and volunteers, researcher, scholar, consultant, administrator, faculty, clinical instructor, continuing education instructor and educator of consumers/clients. The term "client" is used to name the entity that receives occupational therapy services. Clients may be categorized as:

a) individuals, including individuals who may be involved in supporting or caring for the client (i.e. caregiver, teacher, parent, employer, spouse);

b) individuals within the context of a group (e.g., a family, a class); or

c) individuals within the context of a population (e.g., an organization, a community).

(l) "Hand therapy" is the art and science of rehabilitation of the hand, wrist, and forearm requiring comprehensive knowledge of the upper extremity and specialized skills in assessment and treatment to prevent dysfunction, restore function, or reverse the advancement of pathology. This definition is not intended to prevent an occupational therapist practicing hand therapy from providing other occupational therapy services authorized under this act in conjunction with hand therapy.

(m) "Physical agent modalities" means techniques that produce a response in soft tissue through the use of light, water, temperature, sound, or electricity. These techniques are used as adjunctive methods in conjunction with, or in immediate preparation for, occupational therapy services.

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

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DCA 2010 LEGISLATIVE PROPOSAL CONCEPT PAPER

PROGRAM
California Board of Occupational Therapy

TITLE
Mandatory Reporting

SUMMARY
This proposed legislation would require employers of Occupational Therapists (OTs) and Occupational Therapy Assistants (OTAs) to report the suspension or termination of the practitioners in their employ for specified reasons.

IDENTIFICATION OF PROBLEM
The California Board of Occupational Therapy (Board) does not have the statutory authority to request or receive notice of suspensions or terminations of practitioners and is therefore unable to identify any violations of law that impact the health, safety and welfare of its consumers. For example, the Board has identified employers that have terminated practitioners (their employees) for use of controlled substances or being under the influence of alcohol while on the job. On numerous occasions, the Board determines that this is not the first offense; the practitioner has simply jumped from job to job and avoided detection by the Board due to the employers' failure to report.

In addition, the Board often encounters resistance from employers who refuse to respond to or comply with the Board's request for this information when investigating. The Board believes that this lack of compliance is due to the Board's lack of statutory authority to request and receive this information.

PROPOSED SOLUTION
Amend Business and Professions Code to require employers of OTs and OTAs to report the suspension or termination of practitioners for cause of any practitioner in their employ.

JUSTIFICATION
The Board's Enforcement staff believes that without the authority to request and receive information on the suspension of termination of practitioners for cause, it is unable to uphold its consumer protection mandate, due to the employers' failure to cooperate.

PROGRAM BACKGROUND/LEGISLATIVE HISTORY
The California Board of Occupational Therapy, established on January 1, 2001 (SB 1046, chapter 697, Statutes of 2000) regulates the practice of occupational therapists

and occupational therapy assistants. The Board has seven members (four professional and three public) and an annual budget of $1,469,000, with 7.0 authorized PYs. The Board issues both licenses to occupational therapists and certificates to occupational therapy assistants. As of a September 2009, the Board had licensed 10,735 OTs, and certified 1,931 OTAs in California. In addition, as of July 2009, the Board approved 1,322 hand therapy, 1,497physical agent modality, and 788 swallowing assessment evaluation or intervention advanced practice certificates.

ARGUMENTS PRO AND CON

Pro:

- This proposed legislation will encourage employer compliance and cooperation as employers may be more likely to report these types of actions to the Board since they can inform the practitioner that that issue cannot be kept "in house;" they are required by law to report it.
- This proposed legislation will further enable and the support the CBOT in its effort to carry out its consumer protection mandate.

Con:

- The mandated information contained in this proposal may be confidential employment information or information protected under HIPAA.

PROBABLE SUPPORT AND OPPOSITION

Support: None known.

Opposition: The California Association of Health Facilities opposed this provision last year (SB 821).

FISCAL IMPACT

The Board reports that this proposed legislation would have an insignificant fiscal impact. The amendments will likely impose additional costs associated with increased enforcement activity. However, because of the small population of licensees, the number of enforcement would likely be low. The CBOT is optimistic that the profession will comply with mandatory reporting requirements proposed by this bill.

ECONOMIC IMPACT

The Board reports that this proposed legislation would have an insignificant fiscal impact.

COMPARISON WITH OTHER STATES: N/A

PERFORMANCE INDICATORS:

(Describe how program's outcomes will be measured.)

OTHER AFFECTED AGENCIES AND THEIR ROLES/VIEWS
(Indicate other state entities that will be impacted. Discuss their roles and views regarding the proposed legislation.)

APPOINTMENTS
This proposal will not require any changes to the Governor's and/or Legislative appointments.

PROPOSED NEW LANGUAGE

Business and Professions Code Section 2570.33
(a) Any employer of an occupational therapy practitioner shall report to the California Board of Occupational Therapy the suspension or termination for cause of any practitioner in their employ. The reporting required herein shall not act as a waiver of confidentiality of medical records. The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800, and shall not be subject to discovery in civil cases.
(b) For purposes of the section, "suspension or termination for cause" is defined to mean suspension or termination from employment for any of the following reasons:
(1) Use of controlled substances or alcohol to such an extent that it impairs the ability to safely practice occupational therapy.
(2) Unlawful sale of controlled substances or other prescription items.
(3) Patient neglect, physical harm to a patient, or sexual contact with a patient.
(4) Falsification of medical, treatment, client consultation or billing records.
(5) Incompetence or negligence.
(6) Theft from patients, other employees, or the employer.
(c) The first failure of an employer to make a report required by this section, shall result in a letter educating the employer of their reporting responsibilities. The second failure to make a report by this section shall be punishable by an administrative fine not to exceed one thousand dollars ($1,000). The third and any subsequent violations shall be punishable by an administrative fine not to exceed five thousand dollars ($5,000) per violation.

Business and Professions Code Section 2570.35
(a) In addition to the reporting required under Section 2570.33, an employer shall also report to the board the name, professional licensure type and number, and title of the person supervising the licensee who has been suspended or terminated for cause, as defined in subdivision (b) of Section 2570.33. If the supervisor is a licensee under this chapter, the board shall investigate whether due care was exercised by that supervisor in accordance with this chapter. If the supervisor is a health professional, licensed by another licensing board under this division, the employer shall report the name of that supervisor and any and all information pertaining to the suspension or termination for cause of the person licensed under this chapter to the appropriate licensing board.

(b) The failure of an employer to make a report required by this section is punishable by an administrative fine not to exceed five thousand dollars ($5,000) per violation.

Business and Professions Code Section 2570.36
(Existing language)

If a licensee has knowledge that an applicant or licensee may be in violation of, or has violated, any of the statutes or regulations administered by the board, the licensee shall report this information to the board in writing and shall cooperate with the board in providing information or assistance as may be required.

BPC Section 2570.32. (OT Board)

(a) A holder of a license that has been revoked, suspended, or placed on probation, may petition the board for reinstatement or modification of a penalty, including reduction or termination of probation, after a period not less than the applicable following minimum period has elapsed from either the effective date of the decision ordering that disciplinary action, or, if the order of the board or any portion of it was stayed, from the date the disciplinary action was actually implemented in its entirety. The minimum periods that shall elapse prior to a petition are as follows:

(1) For a license that was revoked for any reason other than mental or physical illness, at least three years.

(2) For early termination of probation scheduled for three or more years, at least two years.

(3) For modification of a penalty, reinstatement of a license revoked for mental or physical illness, or termination of probation scheduled for less than three years, at least one year.

(4) The board may, in its discretion, specify in its disciplinary order a lesser period of time, provided that the period shall not be less than one year.

(b) The petition submitted shall contain any information required by the board, which may include a current set of fingerprints accompanied by the fingerprinting fee.

(c) The board shall give notice to the Attorney General of the filing of the petition. The petitioner and the Attorney General shall be given timely notice by letter of the time and place of the hearing on the petition, and an opportunity to present both oral and documentary evidence and argument to the board. The petitioner shall at all times have the burden of proof to establish by clear and convincing evidence that he or she is entitled to the relief sought in the petition.

(d) The board itself shall hear the petition and the administrative law judge shall prepare a written decision setting forth the reasons supporting the decision.

(e) The board may grant or deny the petition, or may impose any terms and conditions that it reasonably deems appropriate as a condition of reinstatement or reduction of penalty.

(f) The board may refuse to consider a petition while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole or subject to an order of registration pursuant to Section 290 of the Penal Code.

(g) No petition shall be considered while there is an accusation or petition to revoke probation pending against the petitioner.

(Added by Stats. 2002, Ch. 1079, Sec. 11. Effective September 29, 2002.)

BPC Section 2661.7. (PT Board)

(a) A person whose license has been revoked or suspended, or who has been placed on probation, may petition the board for reinstatement or modification of penalty, including modification or termination of probation, after a period of not less than the following minimum periods has elapsed from the effective date of the decision ordering that disciplinary action:

(1) At least three years for reinstatement of a license or approval revoked for unprofessional conduct, except that the board may, for good cause shown, specify in a revocation order that a petition for reinstatement may be filed after two years.

(2) At least two years for early termination or one year for modification of a condition of probation of three years or more.

(3) At least one year for reinstatement of a license revoked for mental or physical illness, or for modification of a condition, or termination of probation of less than three years.

(b) The petition shall state any facts as may be required by the board. The petition shall be accompanied by at least two verified recommendations from physical therapists licensed by the board who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed.

(c) The petition may be heard by the board. The board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board that shall be acted upon in accordance with the Administrative Procedure Act.

(d) The board or the administrative law judge hearing the petition may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities during the time the license was in good standing, and the petitioner's rehabilitative efforts, general reputation for truth, and professional ability. The hearing may be continued, as the board or the administrative law judge designated in Section 11371 of the Government Code finds necessary.

(e) The administrative law judge designated in Section 11371 of the Government Code when hearing a petition for reinstating a license, or modifying a penalty, may recommend the imposition of any terms and conditions deemed necessary.

(f) No petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole. No petition shall be considered while there is an accusation or petition to revoke probation pending against the petitioner. The board may deny, without a hearing or argument, any petition filed pursuant to this section within a period of two years from the effective date of the prior decision following a hearing under this section.

(g) Nothing in this section shall be deemed to alter Sections 822 and 823.

(Amended by Stats. 2013, Ch. 389, Sec. 61. Effective January 1, 2014.)

BPC Section 1686. (Dental Board)

A person whose license, certificate, or permit has been revoked or suspended, who has been placed on probation, or whose license, certificate, or permit was surrendered pursuant to a stipulated settlement as a condition to avoid a disciplinary administrative hearing, may petition the board for reinstatement or modification of penalty, including modification or termination of probation, after a period of not less than the following minimum periods have elapsed from the effective date of the decision ordering disciplinary action:

(a) At least three years for reinstatement of a license revoked for unprofessional conduct or surrendered pursuant to a stipulated settlement as a condition to avoid an administrative disciplinary hearing.

(b) At least two years for early termination, or modification of a condition, of a probation of three years or more.

(c) At least one year for modification of a condition, or reinstatement of a license revoked for mental or physical illness, or termination, or modification of a condition, of a probation of less than three years.

The petition shall state any fact required by the board.

The petition may be heard by the board, or the board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code.

In considering reinstatement or modification or penalty, the board or the administrative law judge hearing the petition may consider (1) all activities of the petitioner since the disciplinary action was taken, (2) the offense for which the petitioner was disciplined, (3) the petitioner's activities during the time the license, certificate, or permit was in good standing, and (4) the petitioner's rehabilitative efforts, general reputation for truth, and professional ability. The hearing may be continued from time to time as the board or the administrative law judge as designated in Section 11371 of the Government Code finds necessary.

The board or the administrative law judge may impose necessary terms and conditions on the licentiate in reinstating a license, certificate, or permit or modifying a penalty.

No petition under this section shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole. No petition shall be considered while there is an accusation or petition to revoke probation pending against the person. The board may deny without a hearing or argument any petition filed pursuant to this section within a period of two years from the effective date of the prior decision following a hearing under this section.

Nothing in this section shall be deemed to alter Sections 822 and 823.

(Amended by Stats. 1999, Ch. 655, Sec. 13. Effective January 1, 2000.)

BPC Section 2760.1. (Registered Nurse)

(a) A registered nurse whose license has been revoked or suspended or who has been placed on probation may petition the board for reinstatement or modification of penalty, including reduction or termination of probation, after a period not less than the following minimum periods has elapsed from the effective date of the decision ordering that disciplinary action, or if the order of the board or any portion of it is stayed by the board itself or by the superior court, from the date the disciplinary action is actually implemented in its entirety, or for a registered nurse whose initial license application is subject to a disciplinary decision, from the date the initial license was issued:

(1) Except as otherwise provided in this section, at least three years for reinstatement of a license that was revoked, except that the board may, in its sole discretion, specify in its order a lesser period of time provided that the period shall be not less than one year.

(2) At least two years for early termination of a probation period of three years or more.

(3) At least one year for modification of a condition, or reinstatement of a license revoked for mental or physical illness, or termination of probation of less than three years.

(b) The board shall give notice to the Attorney General of the filing of the petition. The petitioner and the Attorney General shall be given timely notice by letter of the time and place of the hearing on the petition, and an opportunity to present both oral and documentary evidence and argument to the board. The petitioner shall at all times have the burden of proof to establish by clear and convincing evidence that he or she is entitled to the relief sought in the petition.

(c) The hearing may be continued from time to time as the board deems appropriate.

(d) The board itself shall hear the petition and the administrative law judge shall prepare a written decision setting forth the reasons supporting the decision.

(e) The board may grant or deny the petition, or may impose any terms and conditions that it reasonably deems appropriate as a condition of reinstatement or reduction of penalty.

(f) The petitioner shall provide a current set of fingerprints accompanied by the necessary fingerprinting fee.

(g) No petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole, or subject to an order of registration pursuant to Section 290 of the Penal Code. No petition shall be considered while there is an accusation or petition to revoke probation pending against the petitioner.

(h) Except in those cases where the petitioner has been disciplined pursuant to Section 822, the board may in its discretion deny without hearing or argument any petition that is filed pursuant to this section within a period of two years from the effective date of a prior decision following a hearing under this section.

(Amended by Stats. 2009, Ch. 308, Sec. 33. Effective January 1, 2010.)

BPC Section 2878.7. (Vocational Nurse)

(a) A person whose license has been revoked, suspended, surrendered, or placed on probation, may petition the board for reinstatement or modification of the penalty, including modification or termination of probation, after a period not less than the following minimum periods has elapsed from the effective date of the disciplinary order or if any portion of the order is stayed by the board itself or by the superior court, from the date the disciplinary action is actually implemented in its entirety:

(1) Except as otherwise provided in this section, at least three years for the reinstatement of a license that was revoked or surrendered, except that the board may, in its sole discretion, specify in its order a lesser period of time, which shall be no less than one year, to petition for reinstatement.

(2) At least two years for the early termination of a probation period of three years or more.

(3) At least one year for the early termination of a probation period of less than three years.

(4) At least one year for the modification of a condition of probation, or for the reinstatement of a license revoked for mental or physical illness.

(b) The board shall give notice to the Attorney General of the filing of the petition. The petitioner and the Attorney General shall be given timely notice by letter of the time and place of the hearing on the petition, and an opportunity to present both oral and documentary evidence and argument to the board. The petitioner shall at all times have the burden of proof to establish by clear and convincing evidence that he or she is entitled to the relief sought in the petition.

(c) The board itself or the administrative law judge, if one is designated by the board, shall hear the petition and shall prepare a written decision setting forth the reasons supporting the decision.

(d) The board may grant or deny the petition or may impose any terms and conditions that it reasonably deems appropriate as a condition of reinstatement or reduction of penalty.

(e) No petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole or subject to an order of registration pursuant to Section 290 of the Penal Code. No petition shall be considered while there is an accusation or petition to revoke probation pending against the petitioner.

(f) Except in those cases where the petitioner has been disciplined for a violation of Section 822, the board may in its discretion deny without hearing or argument any petition that is filed pursuant to this section within a period of two years from the effective date of a prior decision following a hearing under this section.

(g) Nothing in this section shall be deemed to alter the provisions of Sections 822 and 823.

(Repealed and added by Stats. 2001, Ch. 728, Sec. 24. Effective January 1, 2002.)

BPC Section 4309. (Pharmacy)

(a) A person whose license has been revoked or suspended or who has been placed on probation may petition the board for reinstatement or modification of penalty, including modification or termination of probation, after not less than the following minimum periods have elapsed from the effective date of the decision ordering disciplinary action:

(1) At least three years for reinstatement of a revoked license.

(2) At least two years for early termination of probation of three years or more.

(3) At least one year for modification of a condition, or reinstatement of a license revoked for mental or physical illness, or termination of probation of less than three years.

(b) The petition shall state any facts required by the board, and the petition shall be accompanied by two or more verified recommendations from holders of licenses issued by the board to which the petition is addressed, and two or more recommendations from citizens, each having personal knowledge of the disciplinary penalty imposed by the board and the activities of the petitioner since the disciplinary penalty was imposed.

(c) The petition may be heard by the board sitting with an administrative law judge, or a committee of the board sitting with an administrative law judge, or the board may assign the petition to an administrative law judge. Where the petition is heard by a committee of the board sitting with an administrative law judge or by an administrative law judge sitting alone, the decision shall be subject to review by the board pursuant to Section 11517 of the Government Code.

(d) In considering reinstatement or modification of penalty, the board, committee of the board, or the administrative law judge hearing the petition may consider factors including, but not limited to, all of the following:

(1) All the activities of the petitioner since the disciplinary action was taken.

(2) The offense for which the petitioner was disciplined.

(3) The petitioner's activities during the time the license was in good standing.

(4) The petitioner's documented rehabilitative efforts.

(5) The petitioner's general reputation for truth and professional ability.

(e) The hearing may be continued from time to time as the board, committee of the board, or the administrative law judge designated in Section 11371 of the Government Code finds necessary.

(f) The board, committee of the board, or administrative law judge may impose necessary terms and conditions on the licensee in reinstating the license.

(g) No petition under this section shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole. No petition shall be considered while there is an accusation or petition to revoke probation pending against the person. The board may deny without a hearing or argument any petition filed pursuant to this section within a period of two years from the effective date of the prior decision following a hearing under this section.

(h) Nothing in this section shall be deemed to amend or otherwise change the effect or application of Sections 822 and 823.

(i) The board may investigate any and all matters pertaining to the petition and documents submitted with or in connection with the application.

(Amended by Stats. 1997, Ch. 549, Sec. 120. Effective January 1, 1998.)

4990.30. (BBS)

(a) A licensed marriage and family therapist, marriage and family therapist intern, licensed clinical social worker, associate clinical social worker, licensed professional clinical counselor, professional clinical counselor intern, or licensed educational psychologist whose license or registration has been revoked, suspended, or placed on probation, may petition the board for reinstatement or modification of the penalty, including modification or termination of probation. The petition shall be on a form provided by the board and shall state any facts and information as may be required by the board including, but not limited to, proof of compliance with the terms and conditions of the underlying disciplinary order. The petition shall be verified by the petitioner who shall file an original and sufficient copies of the petition, together with any supporting documents, for the members of the board, the administrative law judge, and the Attorney General.

(b) The licensee or registrant may file the petition on or after the expiration of the following timeframes, each of which commences on the effective date of the decision ordering the disciplinary action or, if the order of the board, or any portion of it, is stayed by the board itself or by the superior court, from the date the disciplinary action is actually implemented in its entirety:

(1) Three years for reinstatement of a license or registration that was revoked for unprofessional conduct, except that the board may, in its sole discretion, specify in its revocation order that a petition for reinstatement may be filed after two years.

(2) Two years for early termination of any probation period of three years or more.

(3) One year for modification of a condition, reinstatement of a license or registration revoked for mental or physical illness, or termination of probation of less than three years.

(c) The petition may be heard by the board itself or the board may assign the petition to an administrative law judge pursuant to Section 11512 of the Government Code.

(d) The petitioner may request that the board schedule the hearing on the petition for a board meeting at a specific city where the board regularly meets.

(e) The petitioner and the Attorney General shall be given timely notice by letter of the time and place of the hearing on the petition and an opportunity to present both oral and documentary evidence and argument to the board or the administrative law judge.

(f) The petitioner shall at all times have the burden of production and proof to establish by clear and convincing evidence that he or she is entitled to the relief sought in the petition.

(g) The board, when it is hearing the petition itself, or an administrative law judge sitting for the board, may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities during the time his or her license or registration was in good standing, and the petitioner's rehabilitative efforts, general reputation for truth, and professional ability.

(h) The hearing may be continued from time to time as the board or the administrative law judge deems appropriate but in no case may the hearing on the petition be delayed more than 180 days from its filing without the consent of the petitioner.

(i) The board itself, or the administrative law judge if one is designated by the board, shall hear the petition and shall prepare a written decision setting forth the reasons supporting the decision. In a decision granting a petition reinstating a license or modifying a penalty, the board itself, or the administrative law judge, may impose any terms and conditions that the agency deems reasonably appropriate, including those set forth in Sections 823 and 4990.40. If a petition is heard by an administrative law judge sitting alone, the administrative law judge shall prepare a proposed decision and submit it to the board. The board may take action with respect to the proposed decision and petition as it deems appropriate.

(j) The petitioner shall pay a fingerprinting fee and provide a current set of his or her fingerprints to the board. The petitioner shall execute a form authorizing release to the board or its designee, of all information concerning the petitioner's current physical and mental condition. Information provided to the board pursuant to the release shall be confidential and shall not be subject to discovery or subpoena in any other proceeding, and shall not be admissible in any action, other than before the board, to determine the petitioner's fitness to practice as required by Section 822.

(k) The board may delegate to its executive officer authority to order investigation of the contents of the petition.

(l) No petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole or the petitioner is required to register pursuant to Section 290 of the Penal Code. No petition shall be considered while there is an accusation or petition to revoke probation pending against the petitioner.

(m) Except in those cases where the petitioner has been disciplined for violation of Section 822, the board may in its discretion deny without hearing or argument any petition that is filed pursuant to this section within a period of two years from the effective date of a prior decision following a hearing under this section.

(Amended by Stats. 2010, Ch. 653, Sec. 49. Effective January 1, 2011.)

2015 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE ASSEMBLY CHIEF CLERK

Revised 10-21-14

JANUARY

	S	M	T	W	TH	F	S
					1	2	3
Wk. 1	4	5	6	7	8	9	10
Wk. 2	11	12	13	14	15	16	17
Wk. 3	18	19	20	21	22	23	24
Wk. 4	25	26	27	28	29	30	31

FEBRUARY

	S	M	T	W	TH	F	S
Wk. 1	1	2	3	4	5	6	7
Wk. 2	8	9	10	11	12	13	14
Wk. 3	15	16	17	18	19	20	21
Wk. 4	22	23	24	25	26	27	28

MARCH

	S	M	T	W	TH	F	S
Wk. 1	1	2	3	4	5	6	7
Wk. 2	8	9	10	11	12	13	14
Wk. 3	15	16	17	18	19	20	21
Wk. 4	22	23	24	25	26	27	28
Spring Recess	29	30	31				

APRIL

	S	M	T	W	TH	F	S
Spring Recess				1	2	3	4
Wk. 1	5	6	7	8	9	10	11
Wk. 2	12	13	14	15	16	17	18
Wk. 3	19	20	21	22	23	24	25
Wk. 4	26	27	28	29	30		

MAY

	S	M	T	W	TH	F	S
Wk. 4						1	2
Wk. 1	3	4	5	6	7	8	9
Wk. 2	10	11	12	13	14	15	16
Wk. 3	17	18	19	20	21	22	23
Wk. 4	24	25	26	27	28	29	30
No hrgs.	31						

DEADLINES

Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 5 Legislature reconvenes (J.R. 51(a)(1)).

Jan. 10 Budget Bill must be submitted by Governor (Art. IV, Sec. 12 (a)).

Jan. 19 Martin Luther King, Jr. Day observed.

Jan. 30 Last day to submit **bill requests** to the Office of Legislative Counsel.

Feb. 16 Presidents' Day observed.

Feb. 27 Last day for bills to be **introduced** (J.R. 61(a)(1), J.R. 54(a)).

Mar. 26 **Spring Recess** begins upon adjournment (J.R. 51(a)(2)).

Mar. 30 Cesar Chavez Day observed.

Apr. 6 Legislature reconvenes from Spring Recess (J.R. 51(a)(2)).

May 1 Last day for **policy committees** to hear and report **fiscal bills** for referral to fiscal committees (J.R. 61(a)(2)).

May 15 Last day for **policy committees** to hear and report to the Floor **nonfiscal** bills (J.R. 61(a)(3)).

May 22 Last day for **policy committees** to meet prior to June 8 (J.R. 61(a)(4)).

May 25 Memorial Day observed.

May 29 Last day for **fiscal committees** to hear and report bills to the Floor (J.R. 61(a)(5)). Last day for **fiscal committees** to meet prior to June 8 (J.R. 61(a)(6)).

*Holiday schedule subject to final approval by Rules Committee.

2015 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE ASSEMBLY CHIEF CLERK

Revised 10-21-14

JUNE

	S	M	T	W	TH	F	S
No Hrgs		1	2	3	4	5	6
Wk. 1	7	8	9	10	11	12	13
Wk. 2	14	15	16	17	18	19	20
Wk. 3	21	22	23	24	25	26	27
Wk. 4	28	29	30				

JULY

	S	M	T	W	TH	F	S
Wk. 4				1	2	3	4
Wk. 1	5	6	7	8	9	10	11
Wk. 2	12	13	14	15	16	17	18
Summer Recess	19	20	21	22	23	24	25
Summer Recess	26	27	28	29	30	31	

AUGUST

	S	M	T	W	TH	F	S
Summer Recess							1
Summer Recess	2	3	4	5	6	7	8
Summer Recess	9	10	11	12	13	14	15
Wk. 3	16	17	18	19	20	21	22
Wk. 4	23	24	25	26	27	28	29
No Hrgs.	30	31					

SEPTEMBER

	S	M	T	W	TH	F	S
No Hrgs.			1	2	3	4	5
No Hrgs.	6	7	8	9	10	11	12
Interim Recess	13	14	15	16	17	18	19
Interim Recess	20	21	22	23	24	25	26
Interim Recess	27	28	29	30			

June 1-5 **Floor Session only**. No committee may meet for any purpose (J.R. 61(a)(7)).

June 5 **Last day to pass bills** out of house of origin (J.R. 61(a)(8)).

June 8 Committee meetings may resume (J.R. 61(a)(9)).

June 15 Budget Bill must be passed by midnight (Art. IV, Sec. 12(c)(3)).

July 3 Independence Day observed.

July 17 Last day for **policy committees** to meet and report bills (J.R. 61(a)(10)). **Summer Recess** begins upon adjournment, provided Budget Bill has been passed (J.R. 51(a)(3)).

Aug. 17 Legislature reconvenes from Summer Recess (J.R. 51(a)(3)).

Aug. 28 Last day for **fiscal committees** to meet and report bills to the Floor (J.R. 61(a)(11)).

Aug. 31 – Sept. 11 **Floor Session only**. No committee may meet for any purpose except for Rules Committee and Conference Committees (J.R. 61(a)(12)).

Sept. 4 Last day to **amend** on the Floor (J.R. 61(a)(13), A.R. 69(e)).

Sept. 7 Labor Day observed.

Sept. 11 Last day for any bill to be passed (J.R. 61(a)(14)). **Interim Study Recess** begins upon adjournment (J.R. 51(a)(4)).

IMPORTANT DATES OCCURRING DURING INTERIM RECESS

2015

Oct. 11 Last day for Governor to sign or veto bills passed by the Legislature on or before Sept. 11 and in the Governor's possession after Sept. 11 (Art. IV, Sec. 10(b)(1)).

2016

Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 4 Legislature reconvenes (J.R. 51(a)(4)).

*Holiday schedule subject to final approval by Rules Committee.