Walden University
A higher degree. A higher purpose.

Walden University
ScholarWorks

Walden Dissertations and Doctoral Studies

Walden Dissertations and Doctoral Studies Collection

2016

Supervisor Perceptions of Entry-Level Doctorate and Master's of Occupational Therapy Degrees

Sherry Lynne Muir
Walden University

Follow this and additional works at: https://scholarworks.waldenu.edu/dissertations

Part of the Education Commons, and the Occupational Therapy Commons

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Sherry Muir

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Janet Pershing, Committee Chairperson,
Public Policy and Administration Faculty

Dr. Elizabeth Hagens, Committee Member,
Public Policy and Administration Faculty

Dr. Gema Hernandez, University Reviewer,
Public Policy and Administration Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2016

Abstract

Supervisor Perceptions of Entry-Level Doctorate and Master's of Occupational Therapy Degrees

by

Sherry L. Muir

MOT, Texas Woman's University, 1991

BA, University of Missouri-Columbia, 1987

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Policy and Administration

Walden University

May 2016

Abstract

In occupational therapy (OT), there is a push to encourage the entry-level doctorate (eOTD) over the master’s of OT (MOT), without having identified which degree develops therapists who can best meet the needs of clients, while providing the fewest negative consequences for stakeholders. This collective case study assessed whether there are differences between OTs with MOT and with eOTD. Each supervisor's experiences with the two degree groups represented a separate case, then all were collectively considered. The central research question was whether OT supervisors, who have observational knowledge of clinical performance, perceived differences between MOTs and eOTDs in factors that impact the stakeholders of OT services, as identified using Freeman's stakeholder theory. Ten supervisors who geographically represented the five eOTD programs and diverse areas of OT practice were selected for initial interviews, with four others added to achieve saturation. Fourteen semi-structured interviews were conducted to begin to identify perceived similarities and differences between OTs with the different degrees. These data were inductively coded and then analyzed using a thematic analysis procedure. The results of this small, exploratory study indicate that eOTDs do not have higher skills and abilities; desire higher compensation, but do not receive it; sometimes bring attitudes of superiority; are not more respected because of their degree; and are negatively affected by higher debt load. Positive social change implications stemming from this study suggest that stakeholder theory can be used to guide policy discussions in professional healthcare associations and that policy makers in the profession of OT should exercise caution in adopting the eOTD as the required entry-level degree until further evidence on the efficacy of the eOTD degree is clear.

Supervisor Perceptions of Entry-Level Doctorate and Master's of Occupational Therapy Degrees

by

Sherry Muir

MOT, Texas Woman's University, 1991

BA, University of Missouri-Columbia, 1987

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Policy and Administration

Walden University

May 2016

Dedication

To my family: my husband, Eric and my daughters, Margaret & Amelia, who have suffered, sacrificed, encouraged, and cheered. It is FINALLY finished and now you can have all of my attention. I love you.

Acknowledgments

First, to Dr. Janet Pershing, who has patiently and persistently "noodged" me through this process. Your suggestions, so kindly given, have taught me so much and made this study into something I can be proud of. And to Dr. Bethe Hagens, who can review a huge document in less than 24 hours and provide the simplest, yet most challenging suggestions that honestly took this study to another level. I feel very blessed to have had the opportunity to learn from two great women. Thank you from the bottom of my heart.

Table of Contents

List of Tables vii

Chapter 1: Introduction to the Study 1

Introduction 1

Background 2

Standards/Accreditation for Occupational Therapy 2

Problem Statement 15

Purpose of the Study 17

Research Questions 18

Conceptual Framework for the Study 19

Nature of the Study 21

Operational Definitions 23

Assumptions 27

Scope and Delimitation 28

Limitations 31

Significance of the Study 31

Summary 33

Chapter 2: Literature Review 34

Introduction 34

Literature Search Strategy 36

Conceptual Foundations 37

Stakeholder Theory 37
Stakeholder Theory and Entry-Level Occupational Therapy Doctorate Policy 40
Change Within a Professional Associations 42
Applying Stakeholder Theory and Change Theory to Occupational Therapy 47
Controversy 49
Mandating the Clinical Doctorate in Occupational Therapy 51
Implications of Mandating the Entry-Level Occupational Therapy Doctorate 53
Effects on New Practitioners 53
Effects on Clients 57
Effects on Academia 63
Effects on the Profession 70
Effects on Employers 82
Summary 87
Chapter 3: Research Method 91
Introduction 91
Research Methodology, Design, and Rationale 92
Research Methodology 92
Research Design 94
Research Interviews 97
Data Collection: Conducting the Interviews 101
Role of the Researcher 104

Methodology 108

Population 108

Sampling Strategy 109

Number of Participants 113

Recruitment of Participants..114

Developing the Interview Guide 114

Developing the Interview Questions...115

Pilot Interviews 118

Lessons Learned from the Pilot 120

Conclusions from the Pilot Project 127

Procedures for Recruitment, Participation, and Data Collection 128

Data Analysis 130

Interview Data Analysis Plan...131

Managing Data Discrepancies 137

Issues of Trustworthiness..138

Ethical Procedures 144

Ethical Protection of Participants...145

Ethical Concerns: Recruitment 146

Ethical Concerns: Data Storage 147

Summary 148

Chapter 4: Data Analysis 149

Introduction 149
Pilot Study 150
Setting 150
Demographics 151
Data Collection 154
Data Analysis 156
    Literature Based Codes 156
    First Interview Codes 156
    Experienced Reviewer Codes 157
    Initial Code Review, Revision, and Consolidation 157
    Final Code Revision 158
Evidence of Trustworthiness 163
    Credibility (Internal Validity) 163
    Transferability (External Validity) 164
    Dependability (Reliability) 165
    Confirmability 168
    Intracoder Reliability 169
Results 170
    Skills and Abilities 171
    Desired Compensation 178
    Respect 183

Additional Themes 188

Summary 197

Chapter 5: Interpretation and Recommendations 201

Introduction 201

Summary of the Research Findings 202

Interpretation of the Findings 203

Skills and Abilities 204

Costs and Compensation 206

Stature, Recognition, and Respect 209

Summary of Interpretation 210

Limitations of the Study 211

Recommendations 212

Effects on Clients 212

Effects on New Practitioners 212

Effects on Employers 214

Implications 215

Implications for Positive Social Change 215

Methodological, Theoretical, and/or Empirical Implications 217

Conclusions 218

References 220

Appendix A: Interview Guide 231

Appendix B: Recruitment E-mails..235

Appendix C: Informed Consent...238

Appendix D: Final Code List with Quotations 241

List of Tables

Table 1. Literature Based Concept..125

Table 2. Real-life Based Initial Codes Used in Pilot Study..126

Table 3. Pilot Project Generated Codes 127

Table 4. Initial Codes for the Dissertation Analysis 133

Table 5. Demographic Codes..153

Table 6. Interview Question Summary by Participant Number.......................................161

Table 7. Intracoder Reliability Check 170

Chapter 1: Introduction to the Study

Introduction

Many of the allied health professions such as audiology, pharmacy, physical therapy, and occupational therapy require or are considering the requirement of an entry-level clinical doctorate to practice. According to Royeen and Lavin (2007), a topic of conversation at the 2005 Association of Schools of Allied Health Professionals "was the controversy surrounding clinical doctorates" (p. 101). However, the literature review of several allied health fields conducted for this study revealed that the long-term effects of increasing the degree required to practice have not been identified and the arguments that supporters make for raising the entry-level degree requirements have not been supported with research. Occupational therapists (OTs) are debating whether to require an entry-level clinical doctorate to practice. At the time this study was completed, OTs had not reached a conclusion about whether to require an entry-level clinical doctorate instead of a master's degree to practice. The purpose of this study was to gather information to assist the profession of OT to determine the entry-level practice degree that develops therapists who are sufficiently trained to meet the needs of clients, while providing the fewest negative consequences for stakeholders. The factors that impact the stakeholders of OT services are: skills and abilities (Royeen & Lavin, 2007; Royeen & Stohs, 1999; Runyon, Aitken, & Stohs, 1994), desired compensation and cost of services (Siler & Randolph, 2006), and recognition (Fisher & Crabtree, 2009; Royeen & Lavin, 2007;

Royeen & Stohs, 1999). The identified stakeholders of OT for this study are OT practitioners, clients, academia, the profession itself, employers, and payers. Stakeholders are discussed more in Chapter 2.

This chapter provides an overview of the study, beginning with background information on OT and entry-level doctorates, including the controversy that has surrounded this debate, primarily for OT. It then describes the problem statement, the purpose of the study, and the research questions. The next section provides an overview of the conceptual foundations of this study, followed by the nature of the study; the operational definitions of terms that may be unfamiliar; and the scope, delimitation, and limitations of the proposed study. The final section describes the significance of the study.

Background

This section reviews the progression of educational standards for OT over time, and describes the current movement to mandate the clinical doctorate to enter practice, and the controversy that is surrounding this push.

Standards/Accreditation for Occupational Therapy

Occupational therapy is one of the less familiar allied health professions. Occupational therapists take "a holistic approach to health care, believing that to achieve good health, a patient ha[s] to engage body, mind and spirit in the process of healing. Healing…[comes] about when patients [are] 'occupied'" (Quiroga, 1995, p. 13). The

profession of OT was officially formed in 1917 with the establishment of its professional organization, which is now known as the American Occupational Therapy Association (AOTA). Accreditation of educational programs became an official function of the AOTA in 1923, and educational standards were developed at that time (History of AOTA Accreditation, n.d., para 5.). Occupational therapy was the first allied health field to establish a relationship with the American Medical Association (AMA) in 1933 to create additional standards for the education of occupational therapists (n.d., para 7). Beginning in the 1940s, a baccalaureate degree was required to enter the OT profession. Since 1956, an entry level master's degree has also been offered.

Postbaccalaureate level. Historically, OTs could enter practice with a baccalaureate degree. Beginning in 1956/57, when the first entry level master's program was offered, there were two points of entry into the profession for the occupational therapist—the baccalaureate and the master's degree level (Coppard et al., 2009). Then in 1999, the Representative Assembly of the AOTA passed Resolution J, which mandated that beginning in January 2007, "all entry-level …programs in the United States should be at the post-baccalaureate level" (Griffiths & Padilla, 2006, p. 540) and the master's degree became the lowest degree level to allow graduates to enter the field as OTs. This extended time frame, from 1999 to 2007, was provided to allow existing programs to gradually redesign and implement the curriculum to meet the new master's standards (History of AOTA Accreditation, n.d.). The History of AOTA Accreditation (n.d.) stated,

"In August 2006, ACOTE [Accreditation Council for Occupational Therapy Education] formally adopted new Accreditation Standards for Master's-Degree-Level Educational Programs for the Occupational Therapist. An effective date of January 1, 2007, was established for all sets of 2006 ACOTE Standards" (n.d., para. 22).

There are several routes to allow students to obtain an entry-level master's degree. The first route is the traditional approach of obtaining a bachelor's degree in a related field, then entering a postbaccalaureate program to earn the Master's in Occupational Therapy (MOT). Alternatively, there are programs that do not require a bachelor's degree. Instead, students enter as first-year students, take a broad range of coursework, including OT courses, and earn the MOT. These programs usually take 5 years to complete but the students do not earn a bachelor's degree (Coppard & Dickerson, 2007). Third, there are some programs with "combined baccalaureate/master's degrees where the student completes three years of undergraduate work, is accepted into the master's degree program, and then completes two years of graduate degree work" (Dickerson & Trujillo, 2009, p. 347). These students usually earn a bachelor's degree, and then automatically progress into the professional or graduate part of the program, which includes the dedicated OT courses. Following this route allows students to earn the MOT in a total of 5 to 5 1/2 years. Finally, there are programs that combine some of these options, taking first-year and undergraduate transfer students and combining these undergraduates with postbaccalaureate students in the professional program. No matter

which route is taken, all students graduate with the MOT degree and there is no differentiation based on the degree route they took. Once the MOT is earned, graduates must pass a national board exam to practice. Passing this exam earns them the designation *registered* occupational therapist (OTR), which qualifies them to apply for state licensure and use the acronym *OTR*.

Entry-level doctorate. In addition to various routes available to obtain an entry-level master's degree, an alternate educational route was developed to meet the postbaccalaureate standard: the entry-level clinical doctorate degree. After the passage of Resolution J in 1999, Creighton University developed a master's degree, but also "initiated the first entry-level OTD [Occupational Therapy Doctorate] program in the United States" (Griffiths & Padilla, 2006, p. 542). These entry-level doctorates are also called professional, practice, or clinical doctorates. According to Griffiths and Padilla (2006), "The clinical doctorate deemphasizes research and is directed to the training of health care providers" (p.541) such as physicians and dentists, as opposed to the Doctor of Philosophy (PhD), which is a research doctorate (p. 541). At the time of this study, there were five institutions that offered the eOTD (entry-level OTD; one school has a satellite site for a total of six programs): Belmont University, Nashville, TN; Creighton University in Omaha, NE with a satellite program at the University of Alaska, Anchorage; University of the Sciences, Philadelphia, PA; University of Toledo, Toledo, OH; and Washington University, St. Louis, MO (American Occupational Therapy

Association [AOTA], 2013). According to Griffiths and Padilla (2006), these five institutions developed an entry-level OTD degree either instead of, or in addition to, the master's degree and these programs were accredited by ACOTE. However, there were no accreditation standards for the entry-level OTD degree. As long as the standards for the master's degree were met, the graduates of these programs were qualified to sit for the board exams, and the institution could call the degree anything they chose. This ACOTE accreditation of entry-level OTD degrees without separate standards resulted in controversy with AOTA, including a motion to the AOTA Representative Assembly submitted by faculty from several academic institutions, requesting ACOTE place a moratorium on the accreditation of additional eOTD programs and that the RA identify the master's degree as the required degree to become an occupational therapist (AOTA, 2007). Bollag (2007) explained that after approving only five programs, ACOTE suspended approval of any additional eOTD programs until separate and distinct standards were developed for the entry-level doctoral degree.

This type of entry-level OT doctorate includes the same acronym as the post professional clinical doctorate: OTD. There is no distinction between the entry-level and the post professional degree designations, which is a part of the controversy surrounding these degrees. Those who have returned to school after years of practicing OT to earn the post professional OTD believe they have a different, more advanced, skill set than someone who earns an entry-level doctorate with only the minimum required months of

supervised clinical internship, called *Level 2 Fieldwork*. Additionally, employers can be confused by the identical designations, especially when they want to hire someone with clinical experience. It is unclear how the institutions which offer these entry-level doctorates view their degrees. When asked directly if the degree is equivalent to the post professional degree, most programs acknowledge that it is not. However, many of their graduates claim that their degree is equivalent and should qualify them for management or academic positions. There is no published literature regarding these concerns; rather, they are discussed at professional conferences, faculty meetings at academic institutions, and in clinics which employ therapists.

Entry-level doctorates and the academy. The entry-level clinical doctorate programs are inconsistent with traditional models of education in these allied health fields and, therefore, there is uncertainty about how they fit into the university systems. Benoit, Mohr, and Shabbach (2004) summarized the issues facing institutions offering clinical doctoral degrees:

- Does the clinical doctorate best fit into the graduate school or the professional school and which school should govern these programs?
- Which institutions should be offering these degrees, as many of the allied health programs are not in doctoral universities?
- What are the required qualifications of the faculty teaching in these programs? Institutions offering graduate degrees require faculty to have

terminal degrees (PhD or EdD), but the allied health programs desire faculty with extensive clinical experience and few of these clinicians have terminal degrees.

- If the required degree to teach in the clinical doctorate programs is a terminal degree, are there enough qualified faculty, especially if these allied health professions rapidly require the clinical doctorate to practice?
- Are these clinical faculty adequately prepared to facilitate scholarship, as is often required by the graduate schools and university policy?

These issues are germane to the debate because they influence opinions about how entry-level clinical doctoral programs should fit within the academic systems, who should be responsible for oversight, what the expectations of clinical faculty (non-PhD) should be, and what benefits, like tenure, they will receive (Bollag, 2007; Lambrecht, 2005; Royeen & Lavin, 2007).

Degree/credential creep. Another point of controversy is over the content and necessity of these newer clinical doctorate degrees.

The momentum for increasing the entry-level degree requirements in OT appears to change as evidenced by the dates of the publications on this topic. In the late 1990s and 2000s, it was a hot topic. Then in the next decade, informal conversations continued, but formal discussion slowed down and there are no newer publications specifically discussing this increase in entry-level degree requirements to the eOTD. However, the

mandated eOTD resurfaced again as the primary topic at the Program Directors' Meeting at the 2013 AOTA Annual Conference (K. Barney, personal communication, May, 22, 2013). Additionally, the current president of AOTA stated in a private conversation that it is one of the current focuses of the AOTA Executive Board (G. Stoffel, personal communication, October, 27, 2013).

Some who have concerns about mandating entry-level doctorates in a variety of fields have suggested that the degrees are being developed to increase enrollment and tuition instead of to meet the demands of the professions. Some scholars have labeled the mandating of the eOTD as *degree creep* by those suspicious of the validity of these degrees (Benoit et al., 2004; Siler & Randolph, 2006). Other researchers (Coppard et al., 2009; Griffiths & Padilla, 2006; Lambrecht, 2005) and Siler and Randolph (2006) have question whether increased entry-level degree requirements will decrease the diversity of the profession, limiting the number of underserved and minority students who can attend these expanded programs. Coppard et al. (2009) argued that such an increase would eliminate any foreign-trained, entry-level therapists from practicing in the United States because there are no eOTD programs in the allied health fields outside of the United States. Bollag (2007) and Dembicki (2008) questioned whether the increased educational requirements would decrease the total number of graduates, further exacerbating the shortage of health care professionals. Both Fisher and Keehn (2007) and Siler and Randolph (2006) reported that many employers do not support these eOTDs because the

graduates expect higher salaries and often do not want to do entry-level clinical work. Siler and Randolph claimed that the increased time and cost of the advanced degrees will limit the number of minorities who can pursue these more expensive degrees, and it is often these people who return to their communities to work. Siler and Randolph argued that this potential decrease in minority therapists would increase health disparities. Lambrecht (2005) claimed that the mandate for advanced entry-level degrees would reduce the number and diversity of the workforce and adversely affect the most vulnerable and underserved populations.

In 2007, the Representative Assembly of the AOTA established an adhoc committee composed of OTs representing practice, education, ethics, and accreditation to address eOTDs. The committee was charged to "summarize and analyze the impact of two points of entry (master's and doctorate degrees) for occupational therapists on the future of the profession and the clients we serve" (Coppard et al., 2009, p. 10). The committee supported maintaining the master's degree level of entry, and also supported the continued offering of the optional eOTD degree. Despite these recommendations, there continues to be pressure, mostly verbal discussions at conferences and professional meetings (K. Barney, Personal communication, May, 22, 2013; Fisher & Crabtree, 2009), to reevaluate this recommendation and to eliminate the master's degree as an acceptable credential for becoming an occupational therapist. Some (Brown-Benedict, 2008; Royeen & Stohs, 1999) who wish to eliminate the master's degree level argue that those with

higher degrees are better prepared for practice and advocacy, are more respected, and will be more able to influence health care policy. Given the ongoing competition for health care dollars, pressure based on these concerns is likely to continue.

Some who have argued to eliminate the master's degree level requirement to become an OT express fears of professional boundary encroachment from those disciplines that do require the entry-level clinical doctorate (Fisher & Crabtree, 2009; Royeen & Stohs, 1999). In particular, encroachment by the field of physical therapy (PT). The PT professional association's Vision 2020 states they will be "the practitioners of choice to whom consumers have direct access for the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health" (American Physical Therapy Association [APTA]2014 Strategic Plan, 2013, para 3). Occupational Therapists are concerned that if PT does achieve *direct access*, meaning that patients no longer have to be referred by a physician to receive therapy services, they will take over the therapy market. This concern has been reinforced by the PT profession's choice to include *functional limitations* into their professional statements because this has traditionally been the specialty of OT (Dickerson & Trujillo, 2009).

Content. When the first clinical doctorate programs were developed in some professions, there were no accreditation standards written for them. If the profession only mandates a postbaccalaureate degree, then as long as the minimum master's standards are

met, the educational institution is free to call that degree whatever it chooses, and some chose the term clinical doctorate. Bollag (2007) explained that each institution can decide what constitutes a "doctorate; in several institutions, the amount of time it previously took to earn a master's degree is now the same amount of time it takes to earn a clinical doctorate" (p. A10). As a result of concerns that the clinical doctorate programs were not different than the master's programs, the Higher Learning Commission for North Central Association of Colleges and Schools (2006) convened a task force to "Study the current trends and growth in creation of professional doctorates" (p. 1). After completing their study, the Higher Learning Commission for North Central Association of Colleges and School further clarified some of the concerns expressed about these degrees, stating that they often do not "follow the model of the '1st Professional Degrees' as defined by the National Center for Educational Statistics (NCES)" (p. 1), and that there is no consistency between institutions regarding "length of study, rigor, substance, or content of program; or the ultimate utility of the degree to the person who earns it" (p. 1). Many of these programs do not fall under the supervising oversight of the graduate school because they are designated as professional programs, not graduate programs and some are being offered by institutions that offer no other advanced degrees.

The accreditors from the North Central Association did not believe they had sufficient guidelines to make determinations about the adequacy of these professional doctorate programs (Higher Learning Commission, 2006, p. 2). The findings of this task

force align with the concerns of those who question the content, validity, and rigor of the optional clinical doctorates. Additionally, the accreditors' inability to make determinations about the adequacy of these degrees left them without oversight because most are not in the graduate schools, and they often fall outside of the specialty accreditation standards. There was no mechanism to determine the quality of these degree programs, supporting the claims of degree creep.

The Higher Learning Commission for North Central Association of Colleges and Schools (2006) stated that to allow effective accreditation of the clinical doctorates, quality assurance standards needed to be developed for each profession, including a minimum core curriculum and best practices, which would explicate the level of skills that a graduate with each degree should have. The specialty accreditation standards were developed only for the minimum degree required, so there were often no standards for the clinical doctorates. The Higher Learning Commission for North Central Association of Colleges and Schools also identified the need to evaluate those practitioners who have received these degrees to determine if they are different from those with lower degrees, and if they are fulfilling the roles/expectations that the programs, professions, and employers hoped or have claimed that they do. Researchers have not evaluated the impacts of the mandated entry-level doctorates on affected stakeholders, or if there are differences in the skills and abilities of professionals with the different degrees. This question regarding differences was the primary impetus for this dissertation study.

Following the formation of the task force from the federal Higher Learning Commission to investigate the clinical doctorates, most professions have developed or are developing standards for accrediting the clinical doctorate programs separate from the master's programs. Many programs have extended the length of their academic requirements beyond that required for the lower degrees.

There is no evidence that any of these recommendations for additional research have been implemented in the field of OT. Those who support requiring increased degree requirements to enter clinical practice claim they are necessary because of the increased complexity of medicine (Pierce & Peyton, 1999; Royeen & Stohs, 1999), to increase respect from other health care professionals (Royeen & Stohs, 1999), and to remain competitive (Griffiths & Padilla, 2007; Royeen & Stohs, 1999). To date, there has been no research to support these statements in the field of OT.

Necessity. As health professions moved to increase entry-level degree requirements, many questioned the necessity of these increases and the motives behind these changes. Lang (2008) explained that increasing entry-level requirements based on "legitimate performance-based need" is an appropriate action (para. 9). However, "in the absence of established performance-based workplace need…for no other reason than to respond to similar moves by other professions or to promote practitioner eligibility for federal reimbursement" (Lang, 2008, para 9) is an example of degree creep. Bollag (2007), Benoit et al. (2004), and Siler and Randolph (2006) suggested that degrees were

being developed to increase prestige, enrollment, and tuition, instead of meeting the demands of the professions. Lambrecht (2005) explained that it is the professional societies or associations, not academic institutions, that determine entry-level degree requirements, and when these are increased for “the primary objective…to elevate the profession by increasing eligibility requirements for certification, might more accurately be described as ‘credential creep’” (p. 3).

Implications for allied health. Depending on where the allied health fields come out on their debates about increasing entry-level degree requirements, as well as potential actions by the Higher Learning Commission, there may be conflicts that ensue. Therefore, it would be beneficial to the other professions considering increasing the entry-level degree requirements, as well as policy-makers and stakeholders, to understand the impacts of requiring doctoral level training to enter practice. However, scholars have not discussed how these increases in educational requirements have impacted the professions, the professionals, patient care, or employers. This dearth of information points to a need for researchers to determine the consequences of mandating doctoral level education to the stakeholders of each profession.

Problem Statement

There is a problem in the profession of OT because policymakers are trying to determine which degree best prepares therapists to most effectively meet the needs of society without having solid information on which to base their decision. In the field of

OT, some are advocating for requiring new OTs to have an eOTD, but have not presented data to support such a move. Increasing the degree requirement might benefit the profession and its stakeholders by raising the level of professional expertise and quality of care, but could negatively impact the profession and its stakeholders if the move raises costs without appreciably improving outcomes for patients. Because the long-term consequences of increasing entry-level education requirements have not been identified and the justifications for these increases have not been tested, the field of OT does not have firm data on which to base a decision. Mandating the eOTD was the primary topic at the Program Directors' Meeting at the AOTA Annual Conference in 2013 (K. Barney, personal communication, May, 22, 2013) and 2014 (D. Rybski, personal communication, April 5, 2014). There is no evidence that the 2006 call issued by a taskforce for the Higher Learning Commission for research to evaluate whether clinical doctorate "students acquire professional competencies they would not otherwise gain in existing degree programs" (Higher Learning Commission, 2006, p. 8) has been heeded. It was the purpose of this research project to lay the foundation for answering this question for the profession of OT.

This study contributes to the body of knowledge in higher education public policy and administration to begin to determine if there are clinically-relevant differences in new therapists educated with different degree levels for the profession of OT. Occupational Therapy professionals can use the results of this study to determine the entry-level degree

that best meets the needs of the profession itself and provides therapists who are sufficiently trained to meet the needs of clients while having the least negative consequences on the stakeholders of OT. Possible differences in new therapists were identified by gathering the perceptions of direct supervisors who supervise both new occupational therapists with the eOTD and new occupational therapists with the MOT as they relate to the factors that impact the stakeholders of OT services: skills and abilities, desired compensation, and recognition. Based on what difference, if any, were found between new practitioners with different levels of degrees, future researchers can explore the impacts of these differences on the various stakeholders.

Purpose of the Study

The purpose of this study was to gather information to assist the profession of OT to determine the entry-level practice degree that develops therapists who are sufficiently trained to meet the needs of clients, while providing the fewest negative consequences for stakeholders. The study focused on key factors that impact the stakeholders of OT services: skills and abilities, desired compensation, and recognition. This collective case study begins to lay the foundation for additional research as called for by the Higher Learning Commission for the North Central Association of Colleges and School Task Force (2006) to investigate if there are differences between graduates with the eOTD and graduates with lower degrees. The Higher Learning Commission for the North Central Association of Colleges and School Task Force identified the need to evaluate those

practitioners who have received these entry-level doctorates to determine if they are different from those with the lower degrees and if they are meeting the expectations of their stakeholders (2006). The goal of this study was to provide data to support an evidence-based discussion of whether the OT profession should require the eOTD to enter practice as a therapist and to stimulate further research on this topic. This exploratory research provides one piece of the foundational knowledge needed to inform future decisions regarding the necessary entry-level degree requirement for OTs.

Research Questions

The overarching research question in this study was the following: What are the perceptions of direct supervisors regarding the performance of new OTs with the eOTD versus those with the MOT as they relate to the factors that impact the stakeholders of OT services: skills and abilities, desired compensation, and recognition?

The OT literature does not contain any studies on the factors that should be considered when determining whether the field should move to increase the required degree to become an occupational therapist to a clinical doctorate. Additionally, there are no studies that investigated the potential consequences of this increased requirement. Instead, although the articles were peer reviewed, they appear to be concept or theoretical works. Leaders in the field have expressed opinions about the eOTD versus the MOT (DeAngelis, 2006; Royeen & Lavin, 2007), and scholars have postulated on the reasons to increase the degree requirement, such as the complexity of the field, generating respect

for the profession, and enhancing competitiveness (Fisher & Crabtree, 2009; Royeen & Lavin, 2007; Royeen & Stohs, 1999; Runyon et al., 1994), but there has been no evidence provided to support these opinions.

Conceptual Framework for the Study

In general, discussions regarding policies primarily include a focus on costs and benefits of the policy itself, but there is little discussion regarding the consequences of changes in policy for the various stakeholders and the *passively involved*, or those who may not be affected by the changes until some distant time in the future (Derry, 2012; Freeman, 1994; Jensen & Sandström, 2013). The societal and global impacts of policies are difficult to anticipate and are not included in the decision-making process (Derry, 2012). According to Dunham, Freeman, and Liedka (2006), advances in technology and travel have resulted in changes in whom and what can be affected by decisions that once had only local consequences. Freeman (1994), Derry (2012), and Jensen and Sandström (2013) have explained that the ethics of business decisions are often treated as separate issues from the conducting of daily business, and they may not be included in the policy decision-making process. However, moral and ethical issues should be incorporated into any decision-making process.

Freeman (1984) proposed an alternative to stockholder theory called the stakeholder theory of the modern corporation. Freeman explained that firms are often run with a view that the stockholders have special rights and privileges. “Management

vigorously pursues the interest of the stockholders…in an unconstrained manner" (1984, p. 39). This approach provides little consideration for other entities, like customers and the environment. Freeman proposed that the term *stockholders* be replaced with *stakeholders*, which is defined as "groups who have a stake in or claim on the firm…suppliers, customers, employees, stockholders, and the local community, as well as management in its role *as agent* for these groups" (1984, p. 39). Freeman explained that stakeholders are "any group or individual who can affect or is affected by an organization" (p. 42). The following are included as stakeholders, with the corporation at the center: owners, management, local community, customers, employees, and suppliers (1984). Freeman further explained that it is the job of management to balance the demands of all of the stakeholders, while still protecting the interests of the corporation. Subsequent researchers have supported this focus on stakeholders and provided additional guidance on how stakeholders can be identified and engaged in decision-making processes (Derry, 2012; Jensen & Sandström, 2013).

Stakeholder theory can be used by the profession of OT as a method to identify those who will be impacted by increasing the entry-level degree requirement to become an occupational therapist. Relevant stakeholders in this context would include, at minimum: clients, students, OT practitioners, employers, academic institutions, and payers. Payers are identified as: self-payers, private insurance, and public funding like Medicaid and Medicare. When applying this theory in the context of a professional,

nonprofit association, there is no defined corporation. Instead, the profession as a whole is the equivalent of the corporation in the business setting and the professional association, AOTA, whose elected leaders make the decisions which guide the profession, is the equivalent of the board of directors.

Stakeholder theory was used to guide this study to evaluate claims made in the literature, both for and against mandating the eOTD. The stakeholder framework was used as the basis for developing and categorizing questions about new OTs based on the stakeholders most affected. This lens was also used to analyze the results of the interviews and to draw conclusions to understand how changes to entry-level degree requirements will affect the many stakeholders of OT.

A more thorough discussion of the literature providing the conceptual framework for this study is provided in Chapter 2.

Nature of the Study

This exploratory study sought to determine whether direct supervisors perceived that there are differences in the factors that impact the stakeholders of OT services: skills and abilities, desired compensation, and recognition between new OTs with the eOTD and those with the MOT, and also to provide a general outline of what those differences are, if any. These perceptions were gathered through collective case studies, using in-depth, semi structured interviews with criterion-based, purposeful sampling and viewed through a constructionist lens. McNabb (2008) stated, “meaning is ‘constructed’ out of a

subjective interpretation of phenomena….meaning is constructed in communication, discourse, and share narratives [sic]” (p. 41). A constructionist believes that people construct their views of reality based on their own social contexts, such as the society they grew up in and live in now. These views are more social in nature, and must be examined together to understand the implications for the topic of interest. The views may be compared and contrasted, but the researcher “would not pronounce which set of perceptions was ‘right’ or more ‘true’” (Patton, 2002, p. 98).

Constructionism should not be confused with constructivism. Constructionists gather the perceptions of others and interpret them to build an understanding of a topic; constructivists gather the perceptions of others and analyze each one as an individual reality (Andrews, 2012). Therefore, constructionism was used in this research project to build an understanding of the perceptions of direct supervisors of new therapists with the eOTD and those with the MOT. These interviews were transcribed and then coded using concept codes. Those concept codes were used to organize and separate the data into thematic groups, and each of those groups was analyzed. These perceptions were then used to construct an understanding of what differences there are, if any, and whether those differences are relevant to answer the over-arching research question of whether there are differences in therapists with the MOT and eOTD degrees.

My goal was to have each of the six educational program sites that offer the eOTD represented, with at least one supervisor from physical medicine and another area

of OT practice represented, resulting in a minimum of 12 participants. However, additional participants were interviewed to ensure that "the point of redundancy" (Patton, 2002, p. 246) was met, when little new information is obtained.

In preparation for conducting this exploratory study, an Institutional Review Board-approved (IRB) pilot project was completed to develop and test the interview guide which was used to gather data for the dissertation. The pilot study is discussed in detail in the *Developing the Interview Guide* section of Chapter 2.

Operational Definitions

In this section, terms used in this document that may be unclear to the reader are defined for clarity:

Autonomous practice: Having direct access to clients and not needing a physician's referral order (Griffiths & Padilla, 2006, p. 542).

Clinical doctorate: (also known as *professional doctorate* and *entry-level doctorate)*: The first professional degree; a person would enter a clinical doctorate program after earning at least a bachelor degree in another field (Griffiths & Padilla, 2006). Completion of this degree program qualifies the recipient to sit for the national board exams (Griffiths & Padilla, 2006).

*Compensation***:** Commonly understood to be salary plus benefits such as sign-on bonuses and student loan repayment. This understanding is supported by Fisher and

Keehn (2007) when they discussed how all of the categories are impacted by shortages of therapists.

Constructionism: an approach to studying society where the researcher gathers the perceptions of others and interprets them to build an understanding of a topic (Andrews, 2012).

Cost of services: The fee that is charged for an OT services (Fisher & Keehn, 2007).

Degree creep: Increasing degree requirements for a profession for reasons other than "Established performance-based workplace need" (Lang, 2008, para 9), such as for prestige or to compete with another profession.

Delivery model: The organization of the provision of therapy services; for example, a therapist may be assigned to work with a single population such as orthopedics or neurological injuries, in a particular setting (acute care, rehabilitation unit, or outpatient) or some combination of the settings and diagnoses (Fisher & Keehn, 2007).

eOTD: Entry-level occupational therapy doctorate—an acronym used in this study to differentiate the entry-level doctorate from the post professional doctorate, which carries the same acronym (OTD).

Floats: A type of therapy employment assignment where the therapist moves around a facility to work with a variety of patient populations and diagnoses, sometimes in different environments (such as outpatient or inpatient; Floater, 2003).

Direct supervisors: "the supervisor has control over and professional knowledge of the work being done" (Direct Supervision, 2014) of Level 2 Fieldwork students and new therapists; people who have personal, observational knowledge of these students and new therapists, as opposed to people who are likely to have perceptions based more on hearsay.

Job responsibilities: Those tasks that are assigned to a particular position that include the "required tasks, knowledge, skills, abilities, and reporting structure required for [that] job." (Job Description, 2014).

Level 2 Fieldwork students: A student who is participating in a 24-week supervised clinic experience that is completed towards the end or after completion of the classroom portion of the OT education. This experience allows students to apply what they have learned in the classroom and to demonstrate they have achieved the skills of an entry-level practitioners (Commission on Education [COE], 2013, p. 1); The goal of Level 2 Fieldwork is "to develop competent, entry-level, generalist occupational therapists" (p. 1). Once Level 2 Fieldwork is complete and the national boards are passed, these therapists are commonly considered new OTs.

Master's of occupational therapy (MOT) degree: The required degree to become an OT since 2007 (Griffiths & Padilla, 2006).

New occupational therapist: An occupational therapist within the first year of practice. After 1 year of practice, therapists are considered sufficiently competent to supervise Level 2 Fieldwork students (Amini & Gupta, 2012).

Occupational Therapy services: Those therapeutic interventions used to improve the functional abilities of OT clients. These interventions will vary depending on the setting and client population (Fisher & Keehn, 2007).

Occupational therapist, registered (*OTR)*: The designation that is used by an occupational therapist once the national board exam has been passed. This national exam must be passed after the educational program is completed for a person to work as an occupational therapist in the United States (National Board Certification Occupational Therapy [NBCOT], n.d.).

*Profession: "A*n occupation whose core element is work based upon the mastery of a complex body of knowledge and skills….used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain" (Cruess, S., Johnston, S. Cruess, R., 2004, p. 74).

Recognition: Acknowledgement or respect from clients and other professionals (Royeen & Stohs, 1999).

Stakeholders: Those who are "any group or individual who can affect or is affected by an organization's achievements" (Freeman, 1984, p. 46).

Assumptions

Several assumptions were made about the ways in which the respondents might behave that would affect the outcomes of the study, but cannot be demonstrated:

- Participants were honest when they stated they meet the inclusion criteria of personally having contact or specific knowledge of Level 2 Fieldwork students and/or new therapists with the eOTD and MOT degrees.
- Participants answered the interview questions honestly.
- Frontline supervisors who have had direct contact with Level 2 Fieldwork students and/or new OTs in clinical practice are able to base their interview responses on direct observation and interaction. This ensures that the responses are based on what is actually occurring in the field rather than on hearsay or projection.

The first two assumptions were necessary because there would be no reasonable way to verify if the participants are telling the truth without jeopardizing the cooperative relationship between the participant and me. To encourage honest interview answers, a collegial tone was set, confidentiality promised, and questions asked in different ways if any inconsistencies in the responses were heard. The final assumption was necessary because it would be beyond the scope of this research study to compare the knowledge of a frontline supervisor to that of someone who has not worked directly with the Level 2 Fieldwork students and new graduates.

Several assumptions were made about myself and my ability to conduct the study:

- I would conduct the research interviews in a professional and unbiased manner, establishing rapport with the participants to make them comfortable discussing their thoughts with me. This would increase the depth and accuracy of the information they were willing to share.
- I would use the Interview Guide (Appendix A) to ask the questions that had been determined to be relevant, based on the literature, but would also be able to identify when additional probing questions were needed to completely understand the participants' responses.
- A neutral stance would be taken as data were gathered, analyzed, interpreted, and reported by considering the data from both the proponent and opponent perspectives.

Scope and Delimitation

This study was not designed to be comprehensive, but rather to begin to lay the foundation for additional research. The overarching goal was to gain perspectives from supervisors who work with new therapists with the MOT and also those with the eOTD, to determine if there are any differences between them in areas that are important to stakeholders. This criterion confined the participants to supervisors who had worked with graduates of the six eOTD program sites. Additionally, it was a goal to have representation from nonmedical facilities. According to AOTA (2010), 61% of the OT

workforce works in some type of physical medicine facility, which leaves 39% working in other areas such as public schools, community psychiatry, and so on, which may not be represented by the arguments focusing on the *complexity of medicine*. Therefore, it was important to also include other areas of practice in the data collection phase. To allow in-depth interviews, and due to time and financial limitations, the sample size was kept small. To have each of the six educational program sites that offer the eOTD represented, with at least one supervisor from physical medicine and another area of OT practice (school system, private practice, or psychiatry) represented, a minimum of 12 participants would be interviewed. However, additional participants would be included as needed until “the point of redundancy” (Patton, 2002, p. 246), when little new information was obtained or a maximum of 18, whichever was reached first.

Because there were only five eOTD programs (six locations) in the United States at the time of this study, all other OTs educated in the United States since 2007 have earned a master’s degree, it is a reasonable assumption that nearly every supervisor in facilities in the United States has supervised students or hired new graduates with the MOT degree. The challenge was to identify those who have also had direct experience supervising those with the eOTD, a much rarer degree.

Supervisors who have directly worked with or supervised new OTs with the eOTD and also those with the MOT should be able to identify what, if any, differences there are between these two groups. This approach would allow future researchers to

build on documented perceptions of people with a basis for comparison, rather than on the kinds of speculations that have been the basis for much of the literature published on this topic to date.

I did not intend to select study participants with whom I have had any previous relationship. However, because I have been teaching and presenting in the field for approximately 12 years, there was a chance that I would have come into prior contact with a supervisor if he or she is an occupational therapist. This contact should not impact the results of this study as I have never presented on the topic of the eOTD or anything to do with educational requirements. In 2008, I was part of an adhoc committee for the AOTA, charged to "summarize and analyze the impact of two points of entry (master's and doctorate degrees) for occupational therapists on the future of the profession and the clients we serve" (Coppard et al., 2009, p. 10). The committee supported maintaining the master's degree level of entry, supported the continued offering of the optional eOTD degree, and called for more research to determine the consequences of any increase in degree requirements. Those conclusions and that project should not have influenced the participants' answers to interview questions because no conclusions were drawn about the differences between therapists educated with the different degrees, only that more research needed to be done.

Limitations

It was necessary for this initial study to be small to conduct the in-depth, exploratory interviews. Therefore, the findings may not be applicable to all those who have the eOTD and MOT degrees. Additionally, the results may not be generalizable throughout the field of OT nor to other allied health fields. Future studies may benefit from objective measures, rather than perceptions, of the differences between those with the eOTD and the MOT degrees. Objective measures will be important, but the exploratory work was needed first as the foundation for developing those studies.

Significance of the Study

The goal was to determine what, if any, differences there are in new OTs with the eOTD compared to those with the MOT. This is one piece of the foundational data needed to inform the discussion of requiring an eOTD to practice as an occupational therapist. If differences are found, then inferences can be made about how the differences could impact stakeholders, but additional research inquires will be needed to determine if and how these differences impact stakeholders. Some scholars (Dembicki, 2008; Fisher & Keehn,2007; Lambrecht, 2005; Lang, 2008; Siler & Randolph, 2006) have claimed that increasing the entry-level requirements for health professions increases the debt-load of the new graduates, decreases the number of workers in nonprofit and rural areas, decreases the number of professionals entering practice, and decreases the diversity of the work force. Others (Fisher & Crabtree, 2009; Royeen & Lavin, 2007; Royeen & Stohs,

1999; Runyon et al., 1994) claimed that the eOTDs better prepare new therapists for practice, make them more independent practitioners, enable them to work in emerging areas of practice, and improve their ability to use and produce clinical research. This study explored the perceptions of those supervising new therapists with the eOTDs to determine if there was a perceived difference from those with the MOT degree. As additional studies are completed and data begin to accumulate, OT professionals and Accreditation Council for Occupational Therapy Education (ACOTE), which is responsible for setting minimum degree standards, will be able to draw on research data to support any decision regarding entry-level practice educational requirements.

The United States has been experiencing rising health care costs for several decades (KaiserEDU, n.d.), including costs for OT services. Adding degree requirements increases the cost of education, and subsequently the salaries expected by graduates (Fisher & Keehn, 2007) and therefore, overall cost for employers. Stakeholders may not want increased costs for OT services due to added educational requirements unless there is evidence that the increased education provides better outcomes. This study provides a foundation for future researchers to assess the costs and benefits of each of the entry-level degree requirements the OT profession is considering, providing the data needed for informed public policy making.

Summary

Increasing the degree requirement to enter a profession can have long-term and unanticipated consequences. Therefore, a decision needs to be based on comprehensive data. At this point, the policy makers considering the possibility of raising the entry-level degree requirements for OTs are basing their discussions on theoretical perspectives, and lack data to support their deliberations. This proposed study begins to build that foundational data in an effort to stimulate further research to inform the decision-making process and to determine if a change in educational requirements appears to add value over a no-change strategy. In Chapter 2, the published literature relevant to this research question is reviewed. In Chapter 3, the research method that was used to answer the research question is discussed.

Chapter 2: Literature Review

Introduction

Change usually results in some type of controversy between those initiating the change and those resisting it (Cunningham & Kempling, 2009). Any change can have unintended consequences (Derry, 2012; Freeman, 1984; Jensen & Sandström, 2013). In the United States, public discussion of health care often results in emotional reactions from both sides of the issue. There have been efforts in several health care fields to increase the degree required to begin practicing as a therapist, which has resulted in different reactions from various stakeholders (American Medical Association [AMA] Approves 2 ASA-Sponsored Resolutions, 2006; Aronson, 1987; Brown-Benedict, 2008; Cohen, 2005; Dembicki, 2008; Lang, 2008; Royeen & Lavin, 2007; Runyon et al., 1994; Siler & Randoph, 2006). These increases in degree requirements put pressure, either actual or interpreted, on other fields to follow suit (Cohen, 2005; Dembicki, 2008; Lang, 2008; Royeen & Lavin, 2007; Royeen & Stohs, 1999; Runyon et al., 1994; Siler & Randolph, 2006). The field of OT is considering increasing the entry-level degree requirement to practice as a therapist from an MOT to an eOTD. Because there are only five eOTD programs in the United States, the first step to inform the discussion of which degree is needed to begin practicing as an occupational therapist is to determine if there are differences between therapists educated at these two degree levels. This study attempted to determine what differences, if any, supervisors perceive between new

therapists with the MOT and those with the eOTD degrees with regard to the factors identified in the literature as affecting the stakeholders of OT services: skills and abilities, desired compensation, and recognition.

This chapter begins with an overview of the conceptual foundation for this inquiry, stakeholder theory, with a discussion about how this theory can be applied by the profession of OT as the profession considers increasing entry-level degree requirements. This is followed by a history of health care education and regulation in the United States, which provides context for understanding how degree requirements are established in the United States. The next section discusses the controversy surrounding increasing the degree requirements in various health care professions, followed by an examination of these arguments as they relate to the stakeholders for the profession of OT. Finally, the appropriateness of using criterion-based sampling and semi structured interviews to obtain the perceptions of direct supervisors about what differences, if any, exist between new therapists with the MOT and the eOTD degrees is discussed.

A pilot project was completed to assess the usefulness of the interview guide that was developed for use in this proposed study (please see Background section in Chapter 1 for details). In preparation for that pilot project, a literature review was completed and various qualitative research techniques were analyzed (Muir, 2012).

Literature Search Strategy

Several on-line databases were searched to find sources for the literature review: Academic Search Complete, CINHAL Plus Full Text, EBSCO Host, Google Scholar, and Dissertation & Thesis-Full Text. The following terms were used in the databases: *clinical doctorate, entry-level doctorate, professional doctorate, occupational therapy, OT, implications, effects,* c*onsequences*, *OTD, occupational therapy doctorate*, and *regulation of health care providers*. For the conceptual foundation pieces, databases Academic Search Complete, Business Source Premier, and Google Scholar were searched with the terms *stakeholder theory*, *professional associations*, and *change* paired with *professional associations*.

The electronic databases at Saint Louis University were used for the majority of the literature search; the Walden University electronic library was used when searching for dissertations. A similar search pattern was conducted for each major topic area of this literature review. Each search began with a broad topic, such as *clinical doctorate*, which was then paired with *impacts*, then *effects, implications, consequences*, and *occupational therapy, physical therapy, social work, pharmacy, and audiology*. As each list was obtained, the abstracts were reviewed and those items that were appropriate were requested. The same modifiers were also applied to *professional doctorate* and *entry-level doctorate* to ensure that articles including these synonyms were not overlooked. The reference list of each article was reviewed for additional appropriate publications and also

to identify other key search words and topics. Finally, the professional literature and national conference offerings were reviewed, searching for anything related to the entry-level doctorate in OT. Those in leadership positions in state and national professional associations were also contacted, searching for additional publications or presentations on this topic. Because there have been fluctuations in focus on this topic, older articles were cited as seminal work.

Interest in mandating the eOTD appears to ebb and flow and there were few recent publications about the eOTD. While most of the published articles about the eOTD are decades old, mandating the eOTD was a topic at the 2013 AOTA Annual Conference (K. Barney, personal communication, May 22, 2013) and was a focus of the AOTA Executive Board (G. Stoffel, personal communication, October 27, 2013).

Conceptual Foundations

Stakeholder Theory

Stakeholder theory, the conceptual foundation for this study, was developed for the business sector. However, over time it has been applied to the nonprofit and governmental sectors. This discussion begins with a review of stakeholder theory as it was developed for business. It then applies the theory to other areas of society, such as nonprofits and professions.

In business, the typical focus has been on being as profitable as possible (Laplume, Sonpar, & Litz, 2008, p. 1153). However, when this focus on profits is the

only concern, decisions are sometimes made without regard for the harm they may cause to others or the environment (Freeman, 1994). Freeman proposed a different way to view business, one that included the *stakeholders,* those who are “vital to the survival and success of the corporation” and also “any group or individual who can affect or is affected by the corporation” (p. 42). In this new stakeholder theory, Freeman claimed that each of the following stakeholders should be recognized, with the corporation as the central or primary stakeholder: owners, management, local community, customers, employees, and suppliers. He argued that if organizations try to identify and consider all stakeholders in their decisions, then the organization can still be profitable, but could also have a positive impact on many of the stakeholders, and the environment, and also have the potential to remain viable over the long-term.

Additional researchers have further developed stakeholder theory (Derry, 2012; Jensen & Sandström, 2013). In these broader applications, the goal can move away from a sole focus on profits, and instead focus on organizations benefiting society (Derry, 2012). With the focus on benefiting society, then bringing stakeholders together provides opportunities to understand each other perspectives, strengths and challenges, and then to develop shared values and goals, leading to an entirely different decision making model. In this shared model, the corporation may not be at the center; rather, depending on the moral or pragmatic approach taken, any of the stakeholders may be the central focus of the decision model, and that central stakeholder would likely to change over time. It is

the decision making *process*, the dialog and negotiations between and among the various stakeholders that leads to decisions which benefit the most stakeholders.

Wellens and Jegers (2014) came to many of the same conclusions regarding stakeholder dialog and the need to consider the perspectives of a wide variety of stakeholders. These authors used an extensive literature review of 110 studies to support expanding stakeholder theory to nonprofit organizations (NPOs). They argued that NPOs will be perceived as being more effective if they can align their governance to meet the expectations of the greatest number of their various stakeholders. Additionally, if the stakeholders have a positive view of the NPOs, then this could lead to improved "stakeholder relationships and overall well-functioning of the organization" (p. 224). Based on their analysis, these authors concluded "We expect that the more NPOs try to be accountable to numerous stakeholder groups at the same time, the more effective NPOs will be perceived" (p. 234).

Garvare and Johansson (2010) proposed that the stakeholder theory should be greatly expanded and applied to the concept of management for global sustainability. "Global sustainability has been defined by the World Commission on Environment and Development (WCED, 1987, p. 54) as 'development that meets the needs of the present without compromising the ability of future generations to meet their needs.'" (p. 741). Garvare and Johansson advocated for a much broader outlook from organizations, with the goal of achieving global sustainability, not just organizational sustainability, which

would require the inclusion of stakeholders who may not have any power to influence the organization, and may not be immediately affected by the actions of the organization, but will be in the future.

Drawing from these applications of stakeholder theory, an NPO such as AOTA would be considered most effective if it would identify all of the stakeholders who could be impacted by the decision to increase the degree requirement to practice as a therapist, understand their perspectives about this decision, and make the decision which considers the greatest number of stakeholders (Wellens & Jegers, 2014). Additionally, if the central goal of AOTA and ACOTE is to make the decision that benefits society, instead of only the profession (Derry, 2012), then this goal can guide the decision process. Finally, following Garvare and Johansson's (2010) recommendation of a global sustainability viewpoint, additional stakeholders, such as foreign-trained therapists, may be included in the decision process. These applications of stakeholder theory can be applied to help guide the decisions of a variety of health care sectors, including the profession of OT and the decision regarding the degree required to practice.

Stakeholder Theory and Entry-Level Occupational Therapy Doctorate Policy

Stakeholder theory has been used to inform professional associations’ efforts to determine the consequences of proposed policy change. Driscoll, Fottler, Liberman, Pitts, and Wan (2011) used stakeholder theory as the foundation of an inquiry to determine the impacts of offering an additional educational degree for dental hygienists. Driscoll et al.

explained that researchers have indicated that changes in health care have impacts and that "supervisors and administrators must take into consideration their effects on the many different groups of individuals affected by these changes" (p. 162). Driscoll et al. advocated for the use of effective strategic planning that involved various stakeholders because those stakeholders can aid or hinder the change process, and can also be impacted by any proposed changes. In determining who the stakeholders would be for this new, optional dental degree, Driscoll et al. determined students to be the primary stakeholder with "dentists as the potential employers of graduating dental hygiene students, [as] secondary stakeholders" (2011, p. 165). Driscoll et al. identified the other secondary stakeholders as community colleges and universities with their respective boards of directors, accrediting associations, professional boards (both local and national), faculty, community and clients served, employers, clients, and third party payers.

By viewing health care as big business and following the Driscoll et al. (2011) example, stakeholder theory can be used to identify those who may be impacted, and in what ways, if the degree requirement to become an OT professional is increased to an eOTD. When stakeholder theory is applied in the context of a nonprofit professional association, there is no defined corporation. Instead, the profession as a whole is the equivalent of the corporation in the business setting and the professional association (AOTA), whose elected leaders make the decisions that guide the profession, is the

equivalent of the board of directors. Following this line of reasoning, relevant stakeholders in this context would include students, OT practitioners, employers, academic institutions, and payers (self-payers, private insurance, and public funding such as Medicaid and Medicare). The community would be the United States because therapists and clients can move around the country. As suggested by Garvare and Johansson (2010), the entire world could be the community because therapists could potentially be trained in the United States as well as other countries and travel the globe to provide treatment to clients in need. The definition of community is important because it affects the discussions of the diversity of the profession and who should be identified as clients and even employers. Once the stakeholders are identified, Freeman's (1984) Doctrine of Fair Contracts states that "any agent must serve the interests of all stakeholders…[and that] the corporation shall be managed as if it can continue to serve the interests of stakeholders through time" (p. 47).

Stakeholder theory can be used to help OT professionals to determine who will be impacted, and in what ways, of increasing the entry-level degree requirement to an eOTD or alternately of making no change. This information will assist the professionals in making a data-driven decision and reduce the potential for unintended consequences.

Change Within a Professional Associations

Professional associations (PAs) are public-sector, membership organizations that exist to oversee, protect, and promote their respective professions (Greenwood, Suddaby,

& Hinings, 2002). Changes to degree requirements to become an occupational therapist are determined by its nonprofit, professional association, AOTA, which has elected volunteer leadership. This section describes the change process in public organizations such as AOTA.

Public sector organizations. Cunningham and Kempling (2009) argued that change in public sector organizations is different than in the private sector because there are usually a large number of competing interests. Cunningham and Kempling pointed out that negotiations between these competing interests are often done publically, but the most powerful attitudes, expectations, and cultural norms are often hidden. Moreover, change in the public sector often requires additional effort, imposes increased work load, and makes people nervous. Cunningham and Kempling suggested that within this public sector context, establishing a need for change is key to helping a range of stakeholders understand and support the change. Establishing the need for change often requires articulation of a threat or crisis that must be addressed, with a connection to why change is critical to the people who are being asked to do the work of the change. During a change process, it is important to articulate the envisioned outcomes of the proposed change. This vision statement must be a guiding force for the organization, and "appeal to the core values of customers, stockholders, and employees" (Cunningham & Kempling, 2009, p. 334), be related to where the organization is at this moment, and provide a path to a better place where it can be in the future.

Membership organizations. The profession of OT is governed by its nonprofit membership organization, AOTA and several authors have argued that change in membership organizations is difficult to achieve. Cunningham and Kempling (2009) explained that there are many forces that work to prevent change, both intentionally and unintentionally. People intentionally resist change because change is scary and continuing with the known is much more comfortable than the unknown. Change can be prevented inadvertently because systems are not set up to allow the time, or reward the activities, needed for the change to occur. To decrease the resistance to change, several actions can be undertaken to prepare the stakeholders: identifying the problem and establishing the need for change (including as many members of the profession as possible), educating those professionals about the problem, and articulating how the proposed change will impact the profession and address the need.

The problem or *precipitating jolt* (Greenwood et al., 2002, p. 59) should be identified and supported with evidence-based data (Wells, Feinberg, Alexander, & Ward 2009, p. 342). The issue must be articulated in a way that makes it clear that it is enough of a threat to warrant the effort it would take to make a change (Greenwood et al., 2002). This approach parallels the principals articulated by Cunningham and Kempling (2009) for the public sector, focusing on describing the threat, clarifying why a change must be made, and explaining how this change is critical.

As the information about the problem is gathered and shared, it is important to include as many members of the profession as possible, even those who are not members of the PA (Scott, 2008). These efforts at inclusion are important for a variety of reasons. First, Greenwood et al. (2002) found that within PAs, there are many different subgroups that may be impacted by various jolts and this can apply to the profession as a whole. Secondly, as Scott (2008) pointed out, membership in general PAs has declined and using only the membership would likely present a narrow view of the situation and generate support from a limited group. Third, change must begin by educating the professionals regarding the problem. Greenwood et al. stressed that once the problem has been articulated, a case must be made to show how the current mechanisms are not working. It is important to include professionals who are not currently members of the PA. Because changes in rules and regulations impact all members of a profession, including nonmembers could strengthen their support for the change, or at least decrease their opposition based on a lack of knowledge. According to Fuller et al. (2006), if professionals believe that their voices are being heard, they will have an improved view of the PA.

This improved view and feelings of involvement may encourage them to join or rejoin the PA. As both Greenwood et al. (2002) and Scott (2008) indicated, it is the PAs that have regulatory and negotiative power to influence the professions themselves, the rules that govern them, and the policy-makers who impact them. As the numbers in the

PAs increase, so does their power. Wells et al. (2009) stated that it is important to keep members involved and active because this will "ensure coalition [association] sustainability" (p. 328) and their perceptions affect their "decisions about continuing investment" (p. 328) and involvement. Greenwood et al. (2002) stated that change will only spread if it seems that the proposed solution is better than what is currently being done and that it is only the PAs that have the strength and ability to spread changes throughout the profession and to negotiate changes in boundaries with other professions.

As the PAs are educating all of their corresponding professionals, it is important to clarify the functions and responsibilities of each level of the organization and articulate the goals of any legislative programs and how this legislative issue may impact the profession as a whole. Scott (2008) explained that there has been a change in professions to focus more on private gain or market forces, instead of solely on public good. However, Greenwood et al. (2002) found that it is not possible to justify change based only on market forces; rather, the change needs to be shown to be consistent with the traditional values of the profession and in the best interests of the clientele. Occupational therapy professionals need to clearly identify the threats supported by data, articulate a vision for the outcomes they want to achieve by mandating the eOTD, and demonstrate how this degree will address the threats and achieve the desired outcomes in a better way than the current MOT degree with the eOTD as an optional degree.

Applying Stakeholder Theory and Change Theory to Occupational Therapy

Applying stakeholder theory to the profession of OT would imply that the profession will be more effective over the long-term if it is managed in the interest of all stakeholders. There should be a focus on global sustainability “that meets the needs of the present without compromising the ability of future generations to meet their needs” (Garvare & Johansson, 2010, p. 741). According to stakeholder theory, there is a responsibility to consider all stakeholders, and to attempt to determine the most efficient use of resources. For OT, these resources would include students, money, time, and practitioners. Efficient use of recourses will help ensure that the best possible services will be available to the greatest number of people, in the greatest number of places, for the indefinite future.

Change theory suggests that to gain the support of stakeholders, those advocating for a change to doctoral level education will be more effective if they provide an articulated vision of how requiring this degree promotes the core values of the profession, how it will impact the profession, and what outcomes they expect to be achieved by mandating the eOTD. This implies that the PA needs to identify the problem impacting the profession, identify a threat, and establish the need for change.

Several proponents of mandating the eOTD have referenced a *threat*, which could be considered the precipitating jolt (Greenwood et al., 2002) from the field of physical therapy because that field now requires an entry-level doctorate (Griffiths & Padilla,

2006; Miller, 1998; Royeen & Stohs, 1999) which could make OTs appear to have less rigorous qualifications. In this context, requiring the eOTD would help the profession remain competitive and viable (Fisher & Crabtree, 2009; Royeen & Stohs, 1999). However, those who have made these arguments have based their arguments on speculation and have not provided any data to support these claims. To implement successful change, the PA must articulate the envisioned outcomes so that they can be used to guide the association throughout the change process (Cunningham & Kempling, 2009).

Within the OT profession, it does not appear that this clear vision has been articulated. Researchers (Fisher & Keehn, 2007; Griffiths & Padilla, 2006) have raised questions about how academic institutions could provide doctoral education because many institutions cannot or do not provide this advanced degree level. Additionally, there are not adequate numbers of faculty with doctoral degrees to teach in these programs (Gale, 2005). Those advocating for the increased degree requirements have to provide solutions to these concerns. Some advocates (Fisher & Crabtree, 2009; Royeen & Stohs, 1999) have pushed for an increase in education standards, but without providing evidence that the current MOT approach is inadequate. It is beneficial for the PA to educate as many members of the profession as possible, including those who are not members of the PA, about the problem, and articulate how the proposed change will impact the profession and address the need.

As OTs consider increasing the entry-level degree requirement to an eOTD, the stakeholders must be identified and every attempt made to determine what consequences, if any, the increase in degree requirements will have on them. Research is needed to establish or identify a threat. A demonstration of how mandating the eOTD will help the profession would bolster the arguments of the advocates. On the other hand, if a pressing need for change is not identified, arguments for increasing entry-level education to an eOTD may not be well-grounded. These steps have not been taken with regard to the increasing of entry-level degree requirements.

One of the foundational pieces to begin evaluating the consequences of mandating an eOTD is to determine if there are actually differences between new occupational therapists with the eOTD and those with the MOT, especially in those areas that are important to the various stakeholders. The only people who have direct comparative perspective on these potential differences are the direct supervisors. Therefore, this exploratory study begins to gather some of the foundational data needed for the OT profession to make an evidence-based decision about the degree needed to become an occupational therapist. This foundational information will serve as a platform upon which further researcher regarding other stakeholders can build.

Controversy

In each allied health profession, decisions about augmenting requirements for practicing within the field to require a clinical doctorate have faced tradeoffs. Brown-

Benedict (2008) aided the nursing profession in its deliberation over the appropriate terminal degree for practice by completing a retrospective look at several health professions that have moved to offer or require entry-level clinical doctorates. Brown-Benedict also included a look into those that were considering this move. According to Brown-Benedict, with the expansion of information in healthcare, many professions became more specialized. In response to "this expansion of knowledge and concentrated expertise has come the desire for autonomy, distinction, and public recognition" (p. 452). Those advocating for the requirement of a clinical doctorate in pharmacy claimed that "increased management responsibilities, standardization of professional training, an expanding realm of knowledge, the demand for highly trained clinicians, and the desire for greater responsibility in providing direct patient care" (p. 450) were justifications for this change. Those arguing against the increase in pharmacy claimed that increasing degree requirements to entry-level clinical doctorate leads to:

> [I]ncreasing educational costs, increasing consumer costs, underuse of the increased preparation, a reduction in overall quality compared to post-baccalaureate [education], and inadequate faculty to train PharmD students (McLeod, [as cited in Brown-Benedict, 2008]). The relative return to the student was also challenged, given that pay did not seem commensurate with the proposed educational preparation (Tse, [as cited in Brown-Benedict]). (p. 450)

An additional concern that was expressed was that requiring the entry-level clinical doctorate might decrease the number of professionals willing to go on to get the research based PhD (Brown-Benedict, 2008). There has been controversy within each allied health profession, with very similar concerns as expressed here from pharmacy, as its members debated what degree was needed to prepare graduates to enter practice (Bollag, 2007; Pierce & Peyton, 1999).

Mandating the Clinical Doctorate in Occupational Therapy

The OT profession is now divided over whether to require an entry-level doctorate, with some arguing for a transition to doctoral-level credentials for OTs (Fisher & Crabtree, 2009; Royeen & Lavin, 2007; Royeen & Stohs, 1999; Runyon et al., 1994), and others arguing that there is insufficient evidence to support such a change (Dembicki, 2008; Higher Learning Commission, 2006; Lambrecht, 2005; Lang, 2008; Siler & Randolph, 2006). Some in the field of OT had been advocating for doctorate level entry for many years (Miller, 1998; Royeen & Stohs, 1999). However, after the American Physical Therapy Association began mandating the doctor of physical therapy (DPT) for all entry-level programs starting in 2000, with the "vision statement that all physical therapy services will be provided by doctors of physical therapy by the year 2020….envision[ing] greater respect from health care professionals, autonomous practice with increased skills, and preparation for clinical scholarship" (Griffiths & Padilla, 2006, p. 542), there were some in the field of OT who made a push for OT to follow suit

(Fisher & Crabtree, 2009; Pierce & Peyton, 1999; Royeen & Lavin, 2007). This push resulted in resistive reactions from practicing OTs and some academics, demanding that any proposed change be discussed by the profession and data be gathered and analyzed to determine the consequences of such a change (AOTA, 2007; Clark, 2007).

In OT, much of the published literature regarding the appropriate entry-level degree includes authors' ideas about what effects, both positive and negative, the mandated eOTD will have, but provides no research data to support these claims (Fisher & Keehn, 2007, Royeen & Lavin, 2007, Royeen & Stohs, 1999, Runyon et al., 1994, Siler & Randolph, 2006). Other researchers have investigated people’s attitudes or perceptions (DeAngelis, 2006, Dickerson & Trujillo, 2009), but provide no information on what these attitudes were based on. Therefore, stakeholder theory can be used to identify relevant stakeholders and every attempt can be made to determine what consequences, if any, the increase in degree requirements will have on those stakeholders. Change in public organizations will be more successful if the recommended change is based on an evidence-based, articulated plan (Ayal, 1986; Cunningham & Kempling, 2009). Moving to require an eOTD to enter practice may result in division within the profession. Therefore, evidence is needed to inform this decision.

Implications of Mandating the Entry-Level Occupational Therapy Doctorate

Increasing the entry-level degree requirement to a doctorate would be a change for the profession of OT. Mandating the eOTD could have wide-ranging implications for a variety of stakeholder groups.

Effects on New Practitioners

The practitioners are the ones who will be most directly affected by a change in degree requirements. For this research project, OT students are included under the term practitioners as they will be practitioners once they pass the board exam. Researchers who have examined the effects of a shift to a clinical doctorate have identified the skills and knowledge gained, the cost of the education, differences in job responsibilities and satisfaction, and perceptions of current OT practitioners as the outcomes likely to be felt by this stakeholder group.

Skill/knowledge. The first area of controversy concerning the effects of an eOTD on practitioners involves the skills and knowledge necessary to practice effectively. One group argues that the ever-increasing complexity of medicine demands higher levels of education, and the other group argues that there has been no documented evidence of such a change or that the current level of preparation is inadequate. Proponents for mandating the eOTD claim that medicine is changing, with the required depth of knowledge so broad, that a doctorate degree is required to adequately educate entry-level practitioners. Pierce and Peyton (1999), reviewing the historical development of entry-

level clinical doctorates in other health professions, claimed that “the need for advanced practitioner preparation is a response to an increasingly complex health care environment” (p. 69) and concluded that “The professional doctorate is an effective degree structure for the development of advance clinical knowledge and competencies” (p. 68). Royeen and Stohs (1999) claimed “clinical doctorate education results in practitioners who have a greater depth of knowledge and a greater ability to apply knowledge in diverse and nontraditional settings” (p. 174). Griffiths and Padilla (2006) surveyed directors of OT educational programs to identify what factors they were considering in deciding whether an eOTD was possible at their institutions and found “All 29 respondents related the eOTD to enhanced preparation of students” (p. 545).

Many researchers have claimed that the increase in complexity of medicine means that there needs to be an increase in entry-level degree requirements. However, as Lang (2008) pointed out, there are usually no data provided to support that the level of knowledge gained at the current degree level is somehow inadequate. Coppard et al. (2009) explained that to become an occupational therapist, all graduates (with a master’s or doctorate) take the same registration exam and there have been no studies done to determine if there are deficiencies in education or area of practice at the master’s level. Although arguments for mandating the entry-level doctorate are founded on the notion that it prepares professionals more adequately, this has not been demonstrated with either quantitative or qualitative data. Additionally, no scholars have demonstrated that those

therapists prepared at the master's level are somehow inadequate or insufficiently prepared.

Cost of education. This area of controversy is over the increased cost to obtain the doctorate. Proponents of mandating the eOTD claim that the increased costs will be recovered over time through higher salaries and the opponents express that the increased costs will limit the numbers and types of people who can afford to enter the profession. Royeen and Stohs (1999) acknowledged that the clinical doctorate will take more time to complete and, therefore, the cost of the education will be higher. However, Royeen and Lavin claimed that the higher costs, which would be paid for mostly by "self-pay" and federal loan money, may be offset by higher salaries; although the earning potential from these new decreases is unknown (2007). Coppard et al. (2009) postulated that the costs of mandating a doctorate would limit who could pursue this degree and suggested that by allowing both master's and doctorate level entry, the profession of OT may "attract students who are not willing or able to absorb the additional time and financial obligation of an entry-level doctorate, but who are interested in entering the profession" (p. 13). Dembicki (2008) explained that community college students might not enter fields that required higher degrees because they could not tolerate the increased costs. The cost of doctoral education, both in dollars and time, will be higher than that of the master's degree. However, there is no information available as to what impact this might have on student numbers or types of students who can tolerate these increased costs.

Job responsibilities/satisfaction. This area of controversy centers around job satisfaction and responsibilities, with those supporting mandating the eOTD claiming that there will be more job and advancement opportunities for those with a doctorate degree and opponents claiming that there are few opportunities for advancement in the current health care environment and job satisfaction is declining. Royeen and Stohs (1999) stated "The clinical doctorate in occupational therapy provides greater employment and advance opportunities and, therefore, greater reimbursement opportunities" (p. 175). Siler and Randolph (2006) provided an alternate view, claiming that the doctorate in pharmacy has led to "growing job dissatisfaction" as new graduates realize they will not be paid more for their higher degree, but that "insurance companies pay for the kind of service provided, rather than the educational level of the provider" (para. 4). Job satisfaction is also declining because those with the doctorates have been designated as supervisors over the technicians or aides that actually get to interact with clients and, therefore, have less opportunity to use their clinical expertise (para. 12). Looking at PTs in rural communities, King, Freburger, and Slifkin (2010) found the same phenomenon: "a few [respondents] reported that they were relying more on assistants and aides because of the therapist staff vacancies; some rural employers suspected this may become more widespread if DPT salary expectations become unaffordable" (p. 31). Proponents of mandating the eOTD claim that it will increase employment and promotion opportunities, with resultant increases in pay. Those against mandating the eOTD explain that

reimbursement is based on the service provided, not the degree of the provider, so that salaries will not likely increase and job satisfaction may decline. No scholars have assessed the relationship between degree level and job responsibilities or satisfaction, marking this as an area of needed research.

Research needed concerning effects on new practitioners. Requiring the eOTD will lead to increased educational costs (Coppard et al., 2009; Royeen & Lavin, 2007; Royeen & Stohs, 1999; Siler & Randolph, 2006), may decrease job satisfaction (S. Muir, personal communication, 2013; Siler & Randolph, 2006), and may not lead to improved clinical skills (Dickerson & Trujillo, 2009; Smith, 2007). However, whether the eOTD provides advanced knowledge valuable to the profession, increased advancement and salary opportunities, or the ability to practice in nontraditional settings (Royeen & Lavin, 2007; Royeen & Stohs, 1999) has not been investigated. Therefore, making decisions based on those arguments risks leading the profession to action that is not justified by the actual needs of the field, while adding to the cost of education. Additional research is needed before action is taken.

Effects on Clients

The second stakeholder group which might be impacted by mandating the eOTD is that of the recipients of OT interventions: the clients. This section reviews the literature addressing the issues of service quality, cost, and availability.

Quality of care. Although it may seem counterintuitive, no evidence has been provided to suggest that an entry-level clinical doctorate would have any positive effect on quality of care. Several authors have claimed that doctoral level education will improve the quality of care, but do so without providing any evidence to support their claims. For example, Royeen and Stohs (1999) claimed that practitioners educated at the clinical doctorate level "are prepared to more rapidly understand and apply innovation. The net result is that clients and systems will receive a higher and more efficient level of care" (p. 174). Royeen and Lavin (2007) also stated that "the clinical doctorate refers to knowledge and skill needed to deliver complex and advanced service/care" (p. 102) and "that there is a need to better educate all health care professionals in terms of the complexities patients present" (p. 104). However, neither researcher provided any data to support these claims. Moreover, Dickerson and Trujillo (2009) surveyed OTs from states representing each region of the country These grass roots therapists believed new therapists with the eOTD "lag behind in day-to-day work demands of full-time clinicians" (p. e51). King et al. (2010) found "study participants did not perceive significant differences in the overall quality of care delivered by DPT graduates compared with other therapists" (p. 31). Without research evidence, quality of care cannot be considered a rationale for requiring a clinical doctorate.

Cost of health care. Authors on both sides of the argument—those who have claimed that the doctorate will increase efficient provision of care, as well as those who

argue that the higher degree will result in increased healthcare costs, fail to cite any research work to support their claims. For example, Royeen and Stohs (1999) claimed that doctoral-prepared practitioners "are prepared to more rapidly understand and apply innovation. The net result is that clients and systems will receive a higher and more efficient level of care" (p. 174), but they cited no evidence to support increased efficiency. Lambrecht (2005) indicated that "the creep of entry-level credentials has been called into question…because of the appearance that it is self-serving, controlling of labor market workforces, and contributing to greater health care costs" (p. 3) but provides no evidence as to whether those opinions have been substantiated. Lang (2008) claimed that the increased degree requirements "can raise the already spiraling costs of health care" (para. 10) but provided no data to explain how or why costs would rise or examples of where this has already occurred in those professions that had previously moved to doctoral education. Although it is a fundamental first step to take in gathering data to inform a discussion of increasing entry-level degree requirements, research data is not readily available to determine the effects of increased degree requirements on the cost of healthcare.

Distribution of therapists/vulnerable and underserved population. Some who oppose mandating the eOTD express concern that increasing the degree requirements will disproportionately affect those who are already underserved. Those who support doctoral preparation claim that it better prepares clinicians to practice with less supervision, in

diverse areas of practice. Regarding access to therapy services, Siler and Randolph (2006) stated that "the increased time and cost involved may also exacerbate health-care disparities in our society" (para. 13) because there are already few minority health care professionals and "given that students from underserved areas are more likely to return to practice in those areas, decreasing the number of minority students [which requiring the eOTD would do because of the increased cost of education] could make health care even less available there" (para. 13).

Lambrecht (2005) suggested that the mandate for advanced entry-level degrees, with resulting increased educational costs and decreased numbers of new graduates, will adversely affect the most vulnerable and underserved populations. Lambrecht explained that the programs which serve these vulnerable and underserved populations are often small, with limited budgets, are in rural areas, or are nonprofit and grant funded, and cannot afford to pay the same salaries as the larger and for-profit companies. Lambrecht postulated that if clinical doctorate degrees are required, education costs will consequently rise, and it is likely that graduates will need to take those jobs with higher salaries to meet their student loan obligations, further decreasing professionals available to work in nonprofit and rural areas. King et al. (2010) found that there were shortages of PTs in rural communities, which most attributed to shortages of PTs in general, but not necessarily related to the increase in degree requirements to the DPT. When asked about possible future supplies of PTs, "approximately half" felt the DPT would have a negative

impact, but “three” thought it might improve the supply (King et al., 2010, p. 30). Fisher and Keehn (2007) also found that therapist shortages were “more severe in rural areas” (p. 17) and that their “study participants proposed many impacts of the shortage including poorer health and function for those who do not receive therapy and limited achievement of desired outcomes for those that do receive therapy but at a reduced intensity” (p. 4).

Royeen and Stohs (1999) claimed, “clinical doctorate education results in practitioners who have…a greater ability to apply knowledge in diverse and nontraditional settings” (p. 174). Royeen and Lavin (2007) acknowledged the concerns that increased educational costs would decrease the number of students, especially minority students, entering educational programs. However, Royeen and Lavin claimed that there is no evidence to support these concerns, citing increases in minority enrollment in medical schools as evidence to the contrary, stating “The pubic appears to accept or expect the additional costs of a clinical doctorate in medicine” (p. 103). However, once medical students enter the residency phase of their training, approximately the second year of postbaccalaureate education, they begin to get paid for their clinical training (Santiago, n.d.). Allied health professionals do not get paid during clinicals, and physicians have higher annual salaries than OTs.

The increased costs of mandated doctoral education may limit the number of minority and underserved students who enter the health professions and because these students tend to return to their own underserved areas, fewer minority therapists means

less services for the underserved. Additionally, the increased costs of doctoral education may mean that fewer therapists can afford to work in rural and nonprofit areas, although none of these claims have been supported by research data. On the other side of the discussion, those with entry-level clinical doctorates may be better able to practice in nontraditional settings, but there has been no evidence cited to support this claim or what impact, if any, increases in degree requirements have had on minority student enrollment, and through them, local access for minority clients in allied health programs.

Research needed concerning effects on clients. Those supporting requiring an eOTD to practice claim that it will result in improved quality and efficiency of care and development of innovative areas of practice (Royeen & Stohs, 1999; Royeen & Lavin, 2007). However, no data has been provided to support these claims. Those opposed to this mandate argue that increasing the degree requirement does not necessarily improve patient care and may actually produce therapists who cannot meet the daily demands of the clinic (Dickerson & Trujillo, 2009) and will lead to increased health care costs (Lambrecht, 2005; Lang, 2008), reduced services to underserved areas and populations, and fewer practitioners overall (Fisher & Keehn, 2007; Lambrecht, 2005; Siler & Randolph, 2006). There is a shortage of therapists in underserved areas, but Fisher and Keehn (2007) did not link this shortage to degree requirements. There is a need to further evaluate how mandating doctoral education will impact the quality and cost of patient care and the number and distribution of therapists available to provide that care.

Effects on Academia

The academic programs that educate OTs will also be impacted by a mandated eOTD. This section reviews how the requirement of doctoral education may affect the organization and administration of the academic institutions which educate OTs; what may impact the number of therapists who can be educated; how this degree may affect, or be affected, by the faculty of these institutions; and how student recruitment might be impacted.

Institutional support/ability/quality. Determining the effects of increasing degree requirements to the doctoral level is a complex issue and can be affected by a broad variety of factors. In their survey to determine what factors academic OT programs were considering as they evaluated the viability of offering an eOTD at their institutions, Griffiths and Padilla (2006) found that several survey respondents indicated that a lack of institutional support would impede their ability to offer the clinical doctorate, because “costs associated with launching [an entry-level OTD] program are prohibitive” (p. 546). Several other respondents indicated that the attitudes of their administrations did not support this type of degree, with observations such as “our administration prefers a more traditional view of higher education" (p. 546). Respondents also identified challenges with how this type of degree would fit into the structure of their institution: “our college charter does not permit granting the doctorate …The OTD would not fit in well with the graduate school…because of our classification, our university would not consider an

OTD – it was ‘PhD or nothing” (p. 546). Another respondent indicated that his or her program would have to close if the doctoral-level degree was required because the institution primarily provided bachelor’s degrees (p. 546). This concern was supported by Bollag (2007) who stated:

> Doctoral programs require more resources than do master’s programs: faculty members at a higher academic level, more extensive libraries, and better laboratories. Because of this, doctoral programs are more expensive to run, and some educators are concerned that eliminating master’s or bachelor’s programs will ultimately aggravate the shortage of health-care professionals. (para. 29)

Fisher and Keehn (2007) found that “the lack of direct funding for educational program expansion” (p. 4) would impede the development of doctoral programs. Royeen and Lavin (2007) offered a very different explanation for the lack of institutional support, claiming that these clinical doctorate degrees are too innovative and will be resisted by institutions based on “traditional custom and culture. They do not readily change or welcome change” (p. 103).

Moving to require the eOTD could affect academic programs because it will require faculty to have higher degrees and requires more resources such as library holdings and clinical space. Additionally, some academic institutions will not or cannot support this nontraditional type of doctorate, which could lead to programs closing,

thereby reducing the number of new therapists. Those supporting the mandate have not provided solutions or alternatives to these concerns.

Faculty pool. The number of faculty qualified to teach in a doctoral program may be the single most important factor affecting the ability of the profession to educate professionals at the doctoral level. Gale (2005) stated, "Personnel shortages have affected many allied health professions in recent years…if additional numbers [of students] wish to enroll, there are not enough faculty members to accommodate such expansion" (p. 2). Fisher and Keehn (2007) found that a "barrier to increasing supply to meet demand [for new therapists] included the shortage of faculty for new or expanding educational programs" (p. 4).

Most universities require faculty to "hold a terminal agree in order to be eligible for promotion and tenure" (Benoit et al., 2004, p.43). Benoit et al. explained that it is unclear if the entry-level clinical doctorates will or should be considered terminal degrees. The accrediting body for physical therapy programs, Commission on Accreditation of Physical Therapy Education (CAPTE), does not consider the DPT:

> sufficient qualification for faculty members….Nursing has taken a similar approach…and audiology recognized the Ph.D., not the Au.D., as the terminal degree. Contrast this with pharmacy…approximately half of the pharmacy faculty nationwide hold the Pharm.D. including 26 pharmacy school deans. (p. 43)

Griffith and Padilla (2006) found that acceptance of the clinical doctorate degree depends on the institution, as does the decision whether those holding these entry-level clinical doctorates qualify for tenure. Nearly half of their survey respondents cited the lack of doctoral prepared faculty as the "most salient impediment to implementing entry-level OTD programs" (p. 546).

Those advocating for the eOTD argue that this degree should qualify more clinicians to become faculty members, but there are no data provided to identify how institutions are or will actually view this degree in the hiring and rank and tenure processes. Royeen and Stohs (1999) claimed that:

> In the American system of economics, demand influences supply, and supply influences demand...Movement toward clinical doctorate education would increase the need for faculty members trained at varied doctoral levels, and the need could effectively be used to lobby Congress and other organizations to better fund and attend to the critical shortage of well-qualified faculty members in occupational therapy. (p. 175)

However, Royeen and Stohs did not explain how this effective lobbying could be accomplished, or provide any evidence that this has occurred in other professions that have mandated the doctorate. Royeen and Lavin (2007) stated that "The clinical doctorate is certainly not designated to prepare a faculty member for an academic career in a research extensive or intensive institution" but argued that with the severe OT faculty

shortage, those with the eOTD could be hired into faculty positions, "In master's level or comprehensive universities, which have lesser expectations in terms of research, this may be a good match" (p. 104). However, if the eOTD is mandated, there will no longer be any master's level programs.

Producing more OTs with a doctorate by mandating the eOTD will not necessarily increase the numbers available to fill faculty positions because the institutions may not accept these eOTDs as qualified for faculty positions. There is a need for additional research to determine how many of the institutions offering MOTs would accept the eOTD degree as a qualification for a faculty appointment. If even a small number of the institutions would not accept this degree, then their programs may have to close due to a lack of doctoral-prepared faculty, decreasing the number of practitioners produced. Understanding how many programs may have to close, or how many additional PhD prepared faculty will be needed, before a decision to mandate the eOTD is made would allow OT professionals to better prepare for or prevent a sudden drop in the number of new OTs graduating.

Student recruitment and profit. Student recruitment and retention and the tuition the students provide are the financial backbone of every academic institution, and the education of practitioners is the backbone of the profession. Understanding what effects increasing degree requirements will have on the student pool is necessary to the decision process. Providing an entry-level doctoral degree may attract those students who

desire an advanced degree (Pierce & Peyton, 1999) and institutions are fearful of losing those students to other institutions that offer these higher degrees (Bollag, 2007). A small number of Griffiths and Padilla's (2006) survey respondents indicated that moving to an eOTD would improve student recruitment. One respondent wrote "as the public image of OT is enhanced by this move, so will our ability to recruit students who are looking for challenging degrees" (p. 546). Another respondent noted, "A profession with a higher status degree attracts more students" (p. 546). However, in that same survey, some of the respondents questioned if there would be a demand for this type of degree, indicating that it would instead make it harder to recruit students:

> 'The move to the OTD is not consumer driven ([by] consumers of health care services, reimbursers, and students), but is solely motivated by a small group of educators'….'We have problems with recruitment now with too many programs in our areas; adding more time to complete a clinical doctorate does not seem to be viable for a marketing standpoint'…Most of the concern was related to overall student applicant numbers due to increased tuition costs and length of program. (p. 547)

As this was a survey, it was not possible to determine what factors these comments were based on.

Fisher and Crabtree (2009) used generational cohort theory to argue that based on "the sheer number of Gen Ys and their apparent valuing of education raise questions

about the argument that the entry-level doctorate will reduce enrollments" (p. 657). Fisher and Crabtree concluded that because there are so many in this generation, and proportionately more of them are going to college and value education, they will have a greater desire to enter professions which require higher degrees. However, Fisher and Crabtree provided statistics on the increases in admission to postsecondary education, but did not offer information regarding increased applications for advanced degrees. In their conclusions, Fisher and Crabtree stated, "To ensure the profession's continued viability…We cannot afford to lose the best candidates to other professions because ours is not keeping pace with the market" (p. 659), but again provided no data to demonstrate that this has occurred. Siler and Randolph (2006) claimed that although many institutions complain about the clinical doctorates, they also "rely on the revenues clinical programs bring them – especially given that many students in those programs pay tuition over a longer period than do students earning bachelor's or master's degrees in the same fields" (para. 1).

Those advocating for mandating the eOTD claim that some students desire advanced degrees (Pierce & Peyton, 1999). Additionally, there are so many students who value education that there are sufficient numbers to fill programs and, of those students, the best students will be more attracted to doctoral education (Fisher & Crabtree, 2009). Those against the mandate state there is no evidence to support these claims; rather, the

institutions are concerned about student recruitment and retention (Bollag, 2007; Griffiths & Padilla, 2006) and profit (Siler & Randolph, 2006).

Research needed concerning effects on the academia. Educational programs are the cornerstone of the profession, and they affect the number of practitioners available to practice and the quality of those same practitioners. There is a need for researchers to determine how mandating an eOTD would affect these institutions, including what support, if any, the institutions themselves would provide for this degree requirement, the number of faculty available to teach in these programs, if the institutions would accept the eOTD as a qualification for faculty positions, and how this mandate would affect student recruitment and enrollment. Understanding the effects of mandating an eOTD on the institutions which provide the therapist for practice is important to the decision-making process because unexpected negative impacts, such as programs closing, could negatively impact the profession and patient care that would take years to remediate.

Effects on the Profession

Change in entry-level degree requirements will impact many areas of practice and possibly the profession as a whole. This section identifies how mandating an eOTD may benefit the profession. Then it investigates whether a need for the degree has been established, the effects the eOTD might have on competition with other health professions, and the claims that this push is being made to inflate the degree and not based on actual need for advanced knowledge to improve patient care.

Establishing the need. Cunningham and Kempling (2009) and Greenwood et al. (2007) found that for change to be successful in a professional association, one of the most important factors is establishing the need for that change and demonstrating that the proposed change does actually meet that need. Royeen and Stohs (1999) explained that a "clinical doctorate educates the student in the application and synthesis of theory and practice-based knowledge" (p. 172). Royeen and Stohs claimed that the clinical doctorate "fulfills both societal and professional needs…[by producing practitioners who are] skilled in communication, interdisciplinary teamwork, clinical reasoning, and cultural sensitivity" (p. 173). Additionally, the following attributes are "probably best achieved and socialized" at the clinical doctoral level: "professional identity, professional ethics, career marketability, scholarly concern for improvement, and motivation for continued learning" (1999, p. 174). Royeen and Lavin (2007) claimed that as society ages, their health problems become more complex, which requires education at a higher degree level (p. 104).

Fisher and Keehn (2007) found that "practice supervisors and national employers expressed some concerns about either the commitment or the depth and breadth of knowledge of students and graduates. Employers discussed the need to provide additional specialized training for new employees" (p. 19). Graduates may not be as prepared as employers would desire, but it is not possible to relate the deficits to preparation by

degree and, therefore, does not provide guidance with respect to what additional content or skills are needed.

Alternately, Griffiths and Padilla (2006) reported that there were many philosophical objections expressed by their academic survey respondents to the eOTD, based on the lack of evidence to support the need for change. “The recurrent opinion [was] that the degree was driven by financial incentives rather than a documented need of the profession …One person commented that ‘the decision for the OTD is market driven without examination of the consequences beyond individual program survival’” (p. 547). There are many claims and assumptions from those who support the move to mandate the eOTD, but as yet no data have been provided to support their statements and a need for the degree change has not been established. This lack of established need will make successful change more difficult (Cunningham & Kempling, 2009; Greenwood et al., 2007).

Competition. Competition can be a motivating force in any environment (Fuchs, 1988), especially one that involves large amounts of money (KaiserEDU, n.d.) as does the U.S. health care system. This section reviews the claims that mandating the eOTD will ensure that OT remains competitive with other health professions. Although competition is not usually actually defined in these writings, the term is frequently used regarding competition for clients, and health care dollars with reference to PT, and to a lesser degree social work and speech and language pathology, because there can appear

to be overlap or similarities in care provided by OT and these disciplines in physical medicine settings, and with social work and psychology in psychiatric and mental health settings. Focusing on the need to remain competitive, Royeen and Stohs (1999) stated, “occupational therapy education must change to meet the evolving health care delivery systems and to remain competitive in the health care and human services marketplace” (p. 176). Royeen with Lavin (2007) implied that there will be a financial consequence if OT is not equivalent to those other professions which require a doctorate: “it is likely that reimbursement will require services provided by a signature authority of someone educated at that [clinical doctorate] level” (p. 105). Neither researcher provided data to support these assertions.

Griffiths and Padilla (2006) quoted survey respondents whose comments supported implementing an eOTD to remain competitive, and these are representative of those found throughout the debate on mandating the eOTD: “Our PT program converted to the [entry-level clinical doctorate] and we need equity among allied health professions….OT also needs to remain competitive with other doctoral entry professions (audiology, [physical therapy], etc.)" (p. 545). Conversely, another respondent used this same comment as a reason not to support the eOTD: “this is nothing more than a move to keep up with PT; we are inflating our education” (Griffiths & Padilla, 2006, p. 547). Harvison claimed that “since physical therapy has mostly moved to the doctorate level,

we’re feeling a lot of pressure from the market to do the same” (as cited in Bollag, 2007, para. 28). Similarly, DeAngelis (2006) interviewed eight “elite” OTs and found:

> For the majority of the research participants, the issue of achieving degree parity comparable to other healthcare professions is of eminent concern, but not without trepidation. Many of the research participants believed that in order for occupational therapy to remain on-par with its colleagues, the profession must go forward with the entry-level clinical OTD, all while keeping its proper intentions/core values of the profession in mind. (p. 161)

Fisher and Crabtree (2009) claimed that the eOTD can “ensure the profession’s continued viability” (p. 659), but did not explain how this would occur. Several authors have referenced the need to remain competitive as a driving force for increasing degree requirements. However, none of them provide any data to demonstrate that the current degree is putting the profession, or OT professionals, at a competitive disadvantage. Additional research is needed in this area to gather data to support or refute these claims.

Stature and respect. There is concern among some of the health professions that as some disciplines have mandated entry-level clinical doctorates, those which do not will somehow be at a disadvantage because they will be less respected if they do not follow suit. Opponents disagree, claiming that entry-level clinical doctorates have had little impact on stature and respect for the professions that have mandated them. Pierce and Peyton (1999) claimed that “the move to the professional doctorate has enhanced the

voice and power of the practitioners in medicine, dentistry and pharmacy" (p. 66), although they provide no data to support this assertion. Royeen and Stohs (1999) predicted that if the profession does not require the eOTD, "the stature of occupational therapy can be expected to diminish" (p. 176). Siler and Randolph (2006) provided an alternate view, stating that these claims about stature and power "suggest that it is the degree, rather than the profession, that commands respect and recognition. In fact, entry-level clinical doctorates have so far had little effect on status, compensation, or reimbursement" (para. 4) in those professions that have already mandated doctoral level entry. None of these authors provided any data to support their statements or explained how they had come to these conclusions, so additional research is need regarding stature and respect of professions related to the degree that is required.

Degree inflation. Many authors have pushed for mandating the eOTD without providing any evidence about why it is needed (Royeen & Lavin, 1999; Royeen & Stohs, 1999). Due to this lack of evidence to support increasing the degree requirement to doctoral level entry, many are suspicious of the motives behind this push. For example, Siler and Randolph (2006) stated, "Universities complain about clinical doctorates, arguing that degrees like the doctor of pharmacy represent little more than degree creep" (para. 1). Dembicki (2008) iterated the possible consequences of "inflating degree requirements" (para. 4), referenced a committee studying the increasing degree requirements, stating "several of the committee members acknowledged that their

opinions were often based on speculation and assumption, and that there's little data available to make informed decisions on increasing credential requirements" (para. 18). Lang (2008) stated that elevating the degree requirements to enter a profession is degree creep when changes are made "in the absence of any established performance–based workplace need…for no other reason than to respond to similar moves by other professions or to promote practitioner eligibility for federal reimbursement" (para. 9).

Many of the survey respondents in Griffiths and Padilla's study (2006) expressed these same opinions:

> The recurrent opinion [was] that the degree was driven by financial incentives rather than a documented need of the profession… one respondent who stated that 'at this point the entry-level OTD strikes me as a degree inflation in a competitive market more than a move supported by the actual need of our clients or the knowledge base of the profession'…. One person noted that 'this is nothing more than a move to keep up with PT; we are inflating our education.' (p. 547)

Bollag (2007) stated that for most professions, there were not yet separate standards for the entry level doctorates, "There is a tendency to use the term 'doctorate"' very loosely" (para. 7). He went on to explain that most of the professional doctorates only take six or seven total years to complete, versus the average 12 for a Ph.D. and do not typically require any type of research project (para. 7).

There is an appearance that degree creep has occurred in some fields. Bollag used the American Physical Therapy Association as an example: “the group has not set separate requirements for doctoral programs. To be accredited, they need only meet the same requirements as master’s programs” (2007, para. 23). Bollag explained that OT also initially used this approach for a short time, then after approving only five programs, suspended approval of any additional programs until separate and distinct standards were developed for the entry-level doctoral degree.

Researchers have questioned the actual validity, utility, and necessity of entry-level doctorates, especially because those advocating for the eOTD have not provided evidence to demonstrate why it is needed, what benefits it might actually provide, or evaluated those already practicing with the degree to determine if they are indeed different from those with a master’s degree. Additional research is needed in all of these areas.

Knowledge base of the profession. Because the eOTD is a clinical degree focusing on practice, versus the PhD which is terminal research degree (Griffiths & Padilla, 2006), there are some who have hypothesized that mandating the eOTD will decrease the number of people willing to pursue the PhD, which could then decrease the number of people performing research to build the knowledge base of the profession and completing outcomes studies on current interventions. Several of Griffiths and Padilla’s (2006) respondents suggested that the eOTD, with its clinical focus, would not increase

the scientific knowledge base of the profession, stating "we see the need for an advanced degree as providing leadership in research and education" (p. 547), indicating that there is more need for PhDs. Siler and Randolph (2006) claimed that the increasing number of entry-level doctorate programs would threaten much needed research because these programs have few research requirements. Siler and Randolph also claimed that to make time for the faculty to teach in these programs, their research activities are curtailed, further decreasing research output for the profession. Additional research is need to determine the effects eOTDs are having on the number of people conducting research in OT, both by the graduates with these degrees, and the faculty teaching in these programs.

Diversity. According to Coppard et al. (2009), "The US occupational therapy profession is overwhelmingly white (non-Hispanic): 88.3% of AOTA members and 81.4% of non-members…where in 2006 only 66.4% of the population was white" (p. 12). Those opposed to increasing the degree requirements to enter the profession express concern that this mandate will further exacerbate the current disparity.

Low-income and minority students. The requirement of a clinical doctorate will likely decrease the diversity of the profession, limiting the number of low-income and minority students who can attend these expanded programs. Siler and Randolph (2006) stated that there are few minority health care professionals, with most minorities in the fields at the technical or aide level, and requiring a longer, more expensive professional degree will exacerbate this discrepancy because "they may be less able to afford the

longer educational programs" (para. 13). Lambrecht (2005) explained, "When access is limited through increased credentialing, it has its greatest impact on first-generation, underrepresented and disadvantaged students" (p. 3). One of Griffiths and Padilla (2006) survey respondents stated that the "OTD will make the entry-level OT area less feasible for underrepresented minorities and socioeconomic disadvantaged people" (p. 457). These concerns are supported by Coppard et al. (2009) who advocated maintaining both the master's and doctoral levels of entry into the profession:

> Current data on ethnic differences in educational attainment within the US shows that nonwhites are less likely to have master's and/or doctoral degrees than other ethnic groups….The data for doctoral degree attainment shows an even greater divide. (p. 11)

Coppard et al. concluded that allowing both the master's and doctorate degrees would "attract a more diverse student population" (2009, p. 12).

Royeen and Lavin (2007) disagreed with the claims that increased degree requirements will exacerbate the current shortages of health care workers and further limit minorities. Royeen and Lavin contended that "the evidence for such fear is not available…In medicine, minority enrollment has risen even as the cost of medical education has been increasing. Despite increasing costs, enrollment has not declined either" (p. 103). However, they did not incorporate one difference between clinical doctoral training for physicians and allied health professions: Once medical students

enter the residency phase of their training, approximately the second year of postbaccalaureate education, they begin to get paid *$40,000 to $50,000 per year* for their clinical training (Santiago, n.d.) and allied health professionals do not. In addition, physicians have higher life-time annual salaries than OTs. Additional research is needed to determine the effect that increasing degree requirements would have on low-income and minority students.

Foreign-trained therapists. Recalling Dunham et al.'s (2006) proposed definition of the stakeholder concept of community as the whole world, and Garvare and Johansson's (2010) proposal that stakeholder theory should be applied to the concept of management for global sustainability, OT professionals should consider how mandating an eOTD would impact people around the world. Currently, those trained as OTs abroad can be licensed to practice in the United States if they meet certain criteria and pass the national board exam. These therapists increase the diversity of the profession and bring different life experiences to enrich the OT profession as a whole. They may serve as role models to immigrants in this country, and to people back in their counties of origin, and may return home to provide OT services that might not be otherwise available. Fisher and Keehn (2007) stated that "restrictions on the entrance of foreign trained therapists due to limited availability of visas as well as the differences in education required in the United States compared to other countries" (p. 22) would be a negative factor for the future of OT. Coppard et al. (2009) stated that mandating an eOTD will eliminate any foreign-

trained therapists from practicing in the United States, as there are no entry-level doctoral programs internationally in OT and the profession may then have difficulty meeting the needs of society. Coppard et al. explained that based on demographic and birth rate data, there will be fewer prospective students, even as the population of the country ages. Coppard et al. concluded that “having two points of entry is expected to better prepare occupational therapists who have skills sets to meet such challenges” (p. 12), referring to the fact that foreign-therapists trained at the master’s level could still work in the United States.

Research needed concerning effects on the profession. Increasing the degree requirements to enter the profession of OT could have short- and long-term consequences. Stead and Stead (2008) postulated that consequences are often “non-linear,” explaining that harm may not be immediately identifiable until it is “irreversible” (p. 75). Ayal (1986) and Cunningham and Kempling (2009) stated that for change to be effective, a need for the change must be established and communicated to the organization, or in this case, the profession, and identify the expected outcomes of this change. The impact of either maintaining the MOT, or moving to the eOTD, on competition, stature and respect, contribution to the knowledge base of the profession, and diversity needs to be evaluated and analyzed.

Effects on Employers

Employers are stakeholders (Driscoll et al., 2011; Lang, 2008) in the discussion about increasing the degree requirements to become an OTR. This section discusses how mandating the eOTD may affect the number of OTs available for employment, OT salaries, and reimbursement for OT services.

Number of practitioners. Siler and Randolph (2006) claimed that increasing the degree requirements for entry into the profession to the doctoral level would decrease the total number of graduates, further exacerbating the shortage of health care professionals “because clinical doctorates require more time and thus tuition than a bachelor’s or master’s degree, doctorate programs may reduce the number of new graduates at a time when health-care workers are in increasingly short supply” (para. 12). The respondents in the King et al. (2010) study also expressed this concern about the numbers of future PTs for rural areas for three reasons:

> DPT students will incur higher levels of debt and will seek urban jobs with higher pay; the number of DPT applicants will decrease because of high educational costs; and DPTs will be more attracted to metropolitan practice setting with diverse clinical and professional development opportunities. (p. 30)

Fisher and Keehn (2007) completed a workforce study and did find that this had occurred. Fisher and Keehn explained that when they conducted their study, OT had moved to require a master’s degree to practice and PT had moved first to require a

master's, and now requires a clinical doctorate. These changes resulted in some programs not admitting or graduating any students for 1 to 2 years as they added on additional courses to meet the new requirements, and some programs were forced to close as they did not have the resources or faculty qualified to meet the new standards. Additionally, Fisher and Keehn found that the cost of the expanded education was contributing to the shortages of therapists because there is a "lack of direct funding for education program expansion and loan forgiveness or scholarship programs for therapy students" (p. 4).

Dembicki (2008) encouraged community colleges to get involved with the professional associations responsible for making these decisions to increase the entry-level degree requirements because "elevated degree requirement can also impede the career path [of community college students] because it could make it more difficult for two-year and four-year institutions to craft articulation agreements" (para. 5). This is important because "some 44 percent of all accredited health education programs are located at community colleges. About 64 percent of workers in allied health graduated from a two-year college" (Dembicki, 2008, para. 6). If there is no career path for the community college graduates, there will be a reduction in the number of health care workers available. There is concern that increasing the degree requirements to the eOTD will decrease the number of new therapists available to enter practice and there is some evidence that this has occurred when the degree requirements were raised in the past (Fisher & Keehn, 2007).

Salary and therapist shortages. There are two salary-related cost issues to consider: costs related to the degree the therapist holds and costs related to therapist shortages. Although several authors have expressed concern that increased degree requirements will increase the costs to hire therapists (King et al., 2010; Lang, 2008; Siler & Randolph, 2006), this fear has not been substantiated by linking the higher degrees themselves to higher salaries. Rather, it appears that it is shortages of therapists that have had the most consequences on employers because, as shortages increase, employers must pay more to entice the therapists to their facility, resulting in greater expense with no corresponding increase in reimbursement for their services (Fisher & Keehn, 2007; King et al., 2010; Siler & Randolph).

Employers do not support increasing degree requirements because there is concern that increasing entry-level degree requirements will increase their costs. Griffiths and Padilla's (2006) academic survey respondents indicated that they did not believe there was employer support for the eOTD degree, with one respondent stating "Job opportunities and pay scale do not seem to support doctorate level entry" and another stating "Our employer advisory board does not support entry-level OTD" (p. 548). Fisher and Keehn (2007) also found "Employers also expressed concern that hiring…therapists with doctoral level degrees would become increasingly expensive" (p. 20). Siler and Randolph's (2006) related increased costs to therapist shortages:

> Employers also argue that if new holders of entry-level clinical doctorates do make more money than graduates of a few years ago with lower degrees, that is not because of their increased education, but because of the growing shortage of clinicians – which is being exacerbated by the increased length of time it takes to earn a clinical degree. (para. 8)

Dembicki (2008) also found "there's little evidence to show that a higher degree for entry-level jobs increases professionalism or salaries…any increase in income among entry-level positions is likely a result of shortages of qualified workers, which drives up salaries" (para. 11). The higher degrees themselves are not driving up expenses, in the form of salaries, for employers. Instead, the extended time to complete these degrees, and the potential decreases in new graduates, may contribute to the shortages of therapists, which does drive up salaries.

Limited reimbursement and salary expectations. Intertwined with the previous section on numbers of practitioners, salary expectations will impact employers of therapists because the monies they have available to pay the salaries will be directly related to the reimbursement they receive for those therapy services. Fisher and Keehn (2007) identified changes that impacted demand and reimbursement for therapy services. One legislative change that had an impact was the Balanced Budget Act (BBA; cited in Fisher and Keehn), which moved payment of Medicare services to a prospective payment model. The prospective payment model means that facilities are paid based on what they

project they will do, instead of what they retrospectively actually did, with no additional payment for rehabilitation services over a certain number of minutes per week. This limited how much therapy will be provided to each patient, as therapy over this maximal reimbursable limit would not result in additional reimbursement. Additionally, the BBA put a cap on the total annual payment for Part B services, which primarily covers outpatient therapy services, again limiting the amount of therapy that can be provided, or at least paid for, by Medicare. Although there have been many adjustments to the BBA (1997) since its implementation, the amount of therapy that will be paid for by Medicare, and therefore private insurance, has a definite limit. This limitation on reimbursement results in a limit to the amount of income a department will receive for each patient, no matter how much therapy they provide. If a department can generate only a certain amount of money, this will limit the amount of therapy provided and the salaries it can pay to its therapists.

Siler and Randolph (2006) claimed that “Employers who hire new practitioners often oppose clinical doctorates…[as they] point out that they are reimbursed for clinical services, not according to the degrees held by their clinicians” (para 11). This concept was also supported by Coppard et al. (2009), who indicated that “Payers reimburse for services, not for credentials” (p. 12). Many employers do not support these entry-level clinical doctorates because the graduates expect higher salaries and often do not want to

do entry-level clinical work, even though they are entry-level therapists entering their first professional jobs.

Increased degree requirements may result in increased costs to employers, not directly related to the degree that the OT holds, but rather because the increased degree requirements result in shortages of qualified therapists and it is the shortages that result in increased costs. Additionally, there is concern that new eOTD therapists may expect or need higher salaries because of their increased educational costs (Siler & Randolph, 2006), but these expectations may not be met because the employer's ability to generate income is often limited by insurance regulations.

Research needs concerning the effects on employers. As with every other stakeholder, questions about the impacts of mandating the eOTD on employers remain unanswered. The profession needs a better understanding of how increasing the degree requirements will affect the number of practitioners available for hire, the salaries that are expected, and what salaries can actually be paid based on the reimbursement that is received by the employers, especially those in nonprofit or underserved areas (see Distribution of Therapists section above).

Summary

This literature review identified many possible consequences of mandating an eOTD to become an occupational therapist. The public has need of those who have skills and knowledge that they themselves do not have. These skilled people are usually labeled

as *professionals* and the public has the expectation that these professionals will have a certain level of knowledge, competency, and trustworthiness (Lester, 2009; Noordegraaf, 2007). These levels of competency in the health care fields are assured by guidelines established by each profession's professional association. These national professional associations have a responsibility to ensure adequate training and competency of their professionals, while maximizing the best interests of their stakeholders. In the field of OT, there are generally two schools of thought regarding mandating an eOTD to become an occupational therapist, those opposed and those in favor of the change, and neither side has published research data to support their theoretical postulates.

Increasing the degree requirements to enter the field of OT can affect a variety of stakeholders. Mandating the eOTD will increase educational costs and time to degree completion which may influence graduates' employment decisions and may lead to decreased job satisfaction. It may exacerbate therapist shortages, increase health care costs, decrease OT services provided in underserved areas and to underserved populations, reduce the number of minority and foreign-trained therapist available to provide care, and decrease the number of people willing to pursue the PhD which may reduce the production of research knowledge in the profession.

Alternately, increased degree requirements may result in improved knowledge, skills, and abilities of OTs, increased ability of therapists to practice with less supervision and in diverse areas of practice, greater employment and advancement opportunities, and

higher salaries. An eOTD might improve quality and innovation of care and help the profession remain competitive with other, similar health professionals, both in terms of competing for patients and in terms of stature, respect, and power. Doctoral level education may increase the number of practitioners willing and able to conduct research to add to the knowledge base of the profession.

Given all of these uncertainties, it is important for OT professionals to understand the possible effects on stakeholders before deciding whether to change OT degree requirements. Stead and Stead (2008) encouraged caution in decision-making because the consequences of some decisions are “non-linear” and “irreversible” (p. 75), meaning that the consequences may not be apparent until it is too late to halt them or repair the damage that has been done.

There are almost no data published to support the move to require the eOTD for the profession of OT. Similarly, there is little evidence to support the predictions of the negative consequences from those against mandating the eOTD. It will be important to study the consequences of this proposed degree change on all of the stakeholders identified here. However, it is important to first know if there are actually differences in new therapists with the different degrees. Then it will be possible to investigate how these differences, if any, may impact the various stakeholders. This study will lay the foundation for answering the fundamental question of whether there are differences between new therapists with the eOTD and those with the MOT by gathering the

perceptions of supervisors who have directly worked with new therapists with these degrees. The information gained in this study can be used by the OT profession as it debates the policy decision of which degree to mandate to become an occupational therapist.

Chapter 3 describes how some of the needs identified through the literature were addressed. The research design is presented, the method used to answer the research question is described, and how the data were analyzed is discussed.

Chapter 3: Research Method

Introduction

This chapter begins with a definition of the chosen research design, qualitative methodology, followed by a discussion of why the research method of a collective case study using semi structured interviews was chosen for this investigation, the strengths and weaknesses of this approach, what steps were taken to facilitate data collection, and the roles I took during this study. The chapter goes on to explain how the interview guide questions were developed, including what elements were necessary to develop interview questions and why the demographic questions were included. The following section discusses the pilot study that was conducted in preparation for this study, along with the lessons learned and how these lessons resulted in improvements to the interview guide. The chapter then describes the data collection effort: recruitment of participants based on criterion based, purposeful sampling; how those participants were protected through the institutional review board (IRB) process, use of informed consent, and storage of collected data. Additional information about how the interviews were conducted, including the interview structure, is presented next. How the interview data were analyzed, including coding, analysis, and how discrepancies in the data were handled is discussed. Finally, the chapter concludes with a discussion of the ethical procedures to protect the participants and the data.

Research Methodology, Design, and Rationale

The purpose of this study was to gather information to assist the profession of OT to determine the entry-level practice degree that develops therapists who are sufficiently trained to meet the needs of clients, while providing the fewest negative consequences for stakeholders. It accomplishes this by exploring the perceptions of direct supervisors regarding the performance of new OTs with the eOTD versus those with the MOT as they relate to the factors that impact the stakeholders of OT services: skills and abilities, desired compensation, and recognition. This section discusses the rationale for choosing a qualitative methodology, describes the research design, and the approach that was used for collecting the data needed to answer the research question.

Research Methodology

Creswell (2009) explained that qualitative research is appropriate if a problem or issue is new, or has not yet been studied extensively so that the factors that influence or impact it have not yet been identified (p. 18). McNabb (2008) explained that qualitative research is used when the researcher desires to understand the participants' experiences with a specific issue, which is studied "in context" (p. 99) and then analyzed to be explained by the researcher. Marshall and Rossman (2011) explained that qualitative researchers are interested in "complexity of social interactions expressed in daily life and by the meanings that the participants themselves attribute to these interactions" (p.2). The controversy surrounding mandating the eOTD has not been studied extensively and there

are no data available regarding possible differences in those educated at the two degree levels. Additionally, the people most likely to have direct experience with graduates with both degrees are their direct clinical supervisors. It is their experiences and personal perceptions that can provide information to determine if there are differences between these two groups. Based on these explanations, a qualitative approach is most appropriate.

In contrast, the quantitative tradition is not appropriate for achieving the goals of this study. Quantitative research has traditionally been considered *scientific* research and is a way to test hypotheses or theories about relationships between and among variables. These variables are measured, usually using validated tools, and the resulting numeric data are statistically analyzed to determine if and what type of relationships exist (Creswell, 2009, p. 4). There are two research methods typically used to gather quantitative research data: surveys and experimental research. Survey research includes questions to identify subjects' opinions or beliefs about a topic using some form of a scale which can be converted into numeric data. The subject group is chosen as a subsection of a larger population so that the results can reasonably be generalized and applied to that larger population. McNabb (2008) used the term *causal* instead of experimental and explained that these types of studies can be used to determine how variable are related to one another, or if one thing might cause another. A quantitative approach would not be appropriate for gathering perceptions from direct supervisors of

new therapists. At this time, there are no validated tools to measure differences among the two groups (MOTs vs. eOTDs). Additionally, neither group, nor part of either group, received any experimental treatment. There may be a place for the development of a tool to measure differences in these two groups in the future, but there is not yet sufficient foundational data to develop that tool.

Research Design

A constructionist lens was used to build an understanding of the data gathered with this collective case study. The constructionist lens is based on the notion that "meaning…is a process by which people's experiences, abilities, common sense, and knowledge are both forged in, and reproduced throughout, their societies and/or communities….[and that] meaning is constructed in communication, discourse, and share [sic] narratives" (McNabb, 2008, p. 41). Patton (2002) explained that someone using a constructionist lens "would expect that different stakeholders…would have different experiences and perceptions" (pp. 97-98) and that all of these different perceptions are equally valuable. This lens fits this research project, which explored how direct supervisors perceive the skills and abilities of the two groups of new therapists and used these perceptions to begin to construct an understanding of how these groups are the same and different. To gain a complete understanding of how the differences, if any, between therapists with the different degrees are perceived by other stakeholders, those groups will need to be consulted (Patton, 2002). However, basic "insights and ideas about

the research problems" (McNabb, 2008, p. 96) need to be developed first, to guide additional research. This study focused on developing basic insights about differences between new OTs with the MOT and eOTD to serve as the foundation for subsequent studies investigating the experiences and perceptions of various stakeholder groups.

A case study has five main uses: "(1) to create theories, (2) to test previously established theories, (3) for identifying preceding or contributing conditions, (4) for testing the importance of the antecedent conditions, and (5) for explaining cases of fundamental or intrinsic importance" (McNabb, 2008, pp. 10-11). For this study, it was the latter use that applied; there is a fundamental need to understand what differences, if any, exist between those with the MOT and those with the eOTD. Once any differences are identified, then additional studies can be undertaken to determine if and how these differences impact stakeholders.

McNabb (2008) explained that there are different types of case studies, from using only a single person as a case up to a collective case study which is "a multiple-case design. A group of individual cases are studied together because they contribute to greater understanding of a phenomenon" (p. 289). Baxter and Jack (2008) used the term multiple-case design, explaining this is used to "understand the similarities and differences between the cases" (p. 550). Swanborn (2010) explained that the case "is carried out within the boundaries of one social system (the case), or within the boundaries of a few social systems (the cases), such as people, organizations, groups, individuals,

local communities or nation-states, in which the phenomenon to be studied exists" (p. 13).

The boundaries of the social system in which the differences in this dissertation study are observed would be the contexts and interactions of the clinic or work environment of the individual supervisors. Each individual supervisor's experiences with the two degree groups represented a separate case. When viewed together, the collective cases of the individual supervisors interviewed helped to build an understanding of the two degree groups. This information provides a preliminary understanding of the impact, or non-impact, of these different degrees.

Other qualitative approaches were considered for this investigation. McNabb (2008) explained that ethnography "identifies patterns in human activity…focuses on the way that people interact and cooperate" (p. 10); ethnography does not meet the needs of this research project because an understanding of patterns of human activity did not help answer the research questions. Phenomenology is "used to establish 'meanings' social actors apply to events, works, symbols…concept of interest in the *life history* of individual persons" (p. 280). Phenomenology would have delved too deeply into the experiences of the supervisors and would not have provided the information needed to understand the factors that drive the effectiveness of entry-level occupational therapists. Grounded theory's "primary objective [is] to develop theory out of the information gathered…by gathering all possible facts pertaining to the problem through personal

interviews, analysis of participant's diaries, and participant observation" (p. 383); theory development was not the goal of this research project.

Research Interviews

The interviews would provide information about the views of supervisors regarding new OTs with the MOT degree and those with the eOTD and how these two groups seem the same or different. To gather these perceptions, in-depth interviews were conducted using a semi structured interview guide.

Strengths of the research interviews. Kvale and Brinkmann (2006) explained that "interviews are particularly well suited for studying people's understanding of the meaning in their lived world, describing their experiences and self-understanding, and clarifying and elaborating their own perspective on their lived world" (p. 116). However, interviews require the investigator to be knowledgeable enough about the topic to be able to identify subtle nuances and innuendos in the participants' statements, but not have a preconceived idea or list of what the interview will find (2006). This is often accomplished with a semi structured interview style, which means that there is a general guideline that "focuses on certain themes and that may include suggested questions" (p. 27), but is still general enough to allow the participant to move down any number of paths to provide a comprehensive understanding of the facts and meaning the participant attributes to the research topic. To gain this depth of understanding, the researcher

encourages the participant to be descriptive, providing sufficient detail so that this participant's perspectives are understood.

Well-constructed and executed interview research provides information that would be difficult, if not impossible, to obtain using quantitative methods. Kvale and Brinkmann (2006) stated, "In a postmodern epistemology… Knowledge is neither inside a person nor outside in the world, but exists in the relationship between persons and world" (p. 53). These relationships, how and why they have been constructed and are maintained or broken, and how they influence the behavior of people cannot be understood only by studying the subjects in labs with standardized measurement tools. Interview research allows a researcher to establish a relationship with the subject, and gain rich, complex knowledge about the research topic, sometimes uncovering unknown connections or producing new knowledge from which new theories or courses of action can be developed.

Through interviews, researchers are granted flexibility to pursue new courses of action and theory without invalidating the research process, and allows them to confirm their understanding or interpretation of the subjects' words during the interview itself (Kvale & Brinkmann, 2006). Interviewing allows the researcher to gather data in a short amount of time and provides the benefit of allowing the researcher to follow-up and clarify anything that is new or may not be clear during the data analysis (Marshall & Rossman, 2011).

Kvale and Brinkmann (2006) claimed to take a “pragmatic approach” (p. 15) to interviewing, explaining that it is what the researcher wishes to learn that should guide the type of questions to ask and how to analyze the data obtained. These authors did not advocate for a spontaneous method of questioning as this often leads to disjointed, and generally unusable data, nor did they advocate for a structured, rigid interview approach as this often leaves large gaps in the recording of the subjects’ thoughts and perceptions. To conduct a research interview and discover these additional levels of information, researchers often use “active interviews” (p. 37), where the researcher challenges the subjects to explain their answers, clarify any inconsistencies in their statements, articulate reasons for their conclusions/beliefs, and sometimes even reflect on abstract issues. These questions help the researcher gain an understanding of the subjects, their particular contexts, and how their opinions and beliefs were formed.

One way to gain the information needed, and keep the focus narrow enough to be helpful is by using an “interview guide or topical approach” (Marshall & Rossman, 2011, p. 144). This approach is somewhat structured, with the interview being scheduled with subjects and conducted with a list of topics or questions to be discussed. For this research project, an interview guide was developed based on the literature review for a general topic guide, but in the questions, I encouraged the participants to answer those questions in an open manner with the statement “tell me about that.” Understanding each

participants' experiences and perceptions was what was needed to answer the research questions of this study.

Weaknesses of interview research. There are several challenges when gathering data using interview research, including the risk of gathering opinions and prejudices, difficulty establishing the rapport necessary for the subjects to share their true perspectives, and that the interviewer may lack the skills necessary to actually get the subjects to discuss the desired topics and to ask clarifying questions to understand the subjects' meaning. One of the challenges of interview research is that, because it reassembles everyday conversation, it appears simple and many novice researchers "grab a sound recorder, go out and find some subjects, and start questioning them"; this approach leads to little actual data, but instead often "reproduces common opinions and prejudices" (Kvale & Brinkmann, 2006, p. 15). An additional difficulty or limitation can be the challenge of establishing the intimacy and honesty required to gain an understanding of the subject's perspectives on the research topic (Marshall & Rossman, 2011, p. 145). Additionally, based on the skills of the interviewer, the questions asked may not lead to substantive narratives, or the researcher may not identify the subtleties or meaning behind the subject's words, leading to gaps or misinterpretations of the data.

Steps to facilitate good data collection. For this research inquiry, several steps were taken to address the challenges and facilitate the benefits of interview research. I have training and experience in conducting in-depth interviews and do so regularly in my

clinical and academic work. The interview guide (Appendix A) was constructed with open-ended and nonleading questions, developed based on a literature review, evaluated for face-validity, and trialed in a pilot project (see Development of the Interview Guide in one of the following sections of this chapter). These steps were used to minimize the risk that the information gathered was simply "opinion and prejudices" (Kvale & Brinkmann, 2006, p. 15). A preliminary analysis of the pilot results produced a draft of a coding system and did appear likely to provide useful information to answer the research questions.

Data Collection: Conducting the Interviews

Types of interviews. Three modalities were considered for conducting the research interviews: face-to-face, telephone, and videoconferencing through the Internet. Recorded face-to-face or videoconference conversations was the planned preferred methods for conducting the interviews, with the recorded telephone interview being used as a last resort. Based on the limited literature on these interview methods, face-to-face and videoconferencing would have netted similar results, but these methods also have the same challenge of ensuring privacy. Face-to-face and videoconferencing were offered to several of the first research participants. However, they all declined, due to challenges with scheduling a time that a computer would be available. Therefore, all of the interviews were conducted over the telephone.

According to Kvale and Brinkmann (2006), there are two advantages to telephone interviews: "increased opportunity to talk to people who are geographically distant from the researcher or who are located in dangerous places," but these do not allow the researcher "access to nonlinguistic information expressed in gestures and facial expressions" (p. 149). For this research project, the preference was to conduct interviews which allowed visual contact with the participants, in-person or on-line through a video format. However, this did not occur, and is discussed in Chapter 4. I had planned to only have an audio recording, to prevent the participant from being identified by his or her appearance and this was done.

Interview structure. Gathering data through interviews can be difficult. Therefore, the interview process should be planned and executed. Kvale and Brinkmann (2006) explained that the setting in which the interviews are to be conducted is important and should make the interviewees comfortable and at ease with sharing their thoughts and feelings about the research topic. These positive feelings are established within the first minutes by the interviewer, who should appear confident and relaxed, be an attentive listener, and focus on the interviewee, by "showing interest, understanding, and respect for what the subject says" (Kvale & Brinkmann, 2006, p. 128). The interviews began with a briefing that set the context for the interview by defining the purpose of the interview, essentially repeating the explanation from the informed consent, explaining how the interview would proceed, and asking questions from the interview guide, and

explaining that an audio recording device would be used, and that the interview was expected to last approximately 20 minutes, and finally asking if the subject has any questions before the interview began.

Qualifying questions. Although the qualifying criteria were iterated in the informed consent during the pilot project, which is described fully below, one participant did not actually meet the inclusion criteria, even though she had read and signed the informed consent form. Therefore, in each dissertation interview, the first two questions, which are the inclusion criteria, were asked to ensure that the participant was a qualified participant. It was planned that if he or she was not, this would be explained, the participant would be thanked for his or her generosity and willingness to participate, and the interview would then be ended.

Using the interview guide. Kvale and Brinkmann (2006) suggested using an interview guide to provide some structure and consistency to the interviews. An interview guide was developed, as discussed above, and a copy can be found in Appendix A. The interviews began with me introducing myself and providing a summary of my work history in the field of OT, and how this research project developed out of my interest in public policy. The first questions on the guide, which are the qualifying questions and those that are demographic in nature, were used to set a positive tone for the interview and help establish rapport.

The questions on the interview guide were constructed to be neutral, and not lead the participant toward any particular answer. The questions were also open-ended to allow the participant to expand on his or her answers (Creswell, 2009). Prompts were used as needed and several had previously been identified in the guide to ensure that relevant data are gathered from all participants. It was expected that the flow of conversation may not exactly follow the guide, and I was prepared to allow the participant to discuss his or her ideas in a manner that was natural to him or her. When there was a lull in the conversation, or it began to veer too far off of the research topic, then I asked other questions from the guide. Each section ended with an open-ended question, inviting the participant to add anything else they would like, and the interview itself ended with two open-ended questions to provide the participant with multiple opportunities to include anything about the research topic that was important to him or her.

Role of the Researcher

Creswell (2009) explained that the characteristics of the researcher will have an influence on the study results. Therefore, it is necessary for the researcher to "explicitly identify reflexively their biases, values, and personal background" (p. 177) and how the researcher gained access to the research subjects/site. For example, the researcher should provide information about his or her personal past experiences, which led to the interest in the research topic, and background information on the topic to help the reader

understand the researcher's interpretation and history of the problem. Additionally, the researcher should explain how he or she came into contact with the research subjects, his or her work setting and/or organizational affiliations, which may have some impact/influence on the study. The researcher should explain the IRB process completed to protect the research subjects, and discuss any sensitive or ethical issues that may arise and how these will be addressed.

I became an OTR after earning an MOT degree in 1991. I have worked in two different states. in a variety of settings, with a variety of patient populations and diagnosis beginning with an acute care psychiatric hospital and then moving to work with adults in physical medicine hospitals, out-patient clinics, and home health. I began teaching in a MOT program in 2003 and continue to teach full time today, while continuing to practice in a variety of physical medicine hospitals and clinics. This experience has provided me with many different experiences and exposure to many different stakeholders' perspectives on issues related to OT. Therefore, interest in what degree should be required to become an occupational therapist grew from both my work in academia and also from talking with many therapists and supervisors in the hospitals and clinics. My current academic program offers an MOT and a post professional OTD. My institution could transition to offering an eOTD if it becomes mandated, and the degree requirement would not impact my employment in any way. Additionally, I have served as a school board member in the past for eight years and, during that time, there were many

discussions at that public school about the costs of providing mandated therapy services in the public schools, where therapists' salary may be influenced by negotiations with the unions (at least in the state of Illinois) and primarily based on degree (requiring the eOTD would likely increase costs of providing OT services, at least in some states). Finally, my coursework in the PhD in Public Policy and Administration program has increased my awareness of the impacts of policy decisions, especially relating to stakeholder theory, leading to concerns about how degree requirements could impact the stakeholders of OT services and the profession as a whole.

I recruited subjects for the research, conducted the interviews, analyzed the data, and wrote the report of the research findings. I have experience with conducting interviews in my regular clinic and academic work and am skilled at identifying discrepancies in responses and asking additional questions to clarify the respondent's actually meaning. A transcriptionist was used to transcribe the audio recordings of the interviews. It was planned that at least two of the initial transcripts would be fully reviewed and compared to the audio recordings, which was done and is discussed in Chapter 4. Since those were found to be accurate, then random sections of other transcripts were regularly reviewed and compared to the audio recordings to ensure accuracy. I analyzed and coded the transcripts, analyzed and summarized the data, and formulated it for reporting and dissemination.

Managing research biases. I did not have any personal or professional relationships with the participants. However, if the supervisors are OTs, they may be familiar with me based on presentations at state and national conferences and professional publications. None of the presentations has been related to degree requirements and so should not influence the participants to respond to the interview questions in any particular way. However, in 2008, I was part of an ad hoc committee for the AOTA, charged to "summarize and analyze the impact of two points of entry (master's and doctorate degrees) for occupational therapists on the future of the profession and the clients we serve" (Coppard et al., 2009, p. 10). The committee supported maintaining the current master's degree level of entry, supported the continued offering of the optional eOTD degree, and called for more research to determine the consequences of any increase in degree requirements. I was the fourth author listed on this publication, and because no presentations were done at conferences, it is unlikely the supervisors would connect authorship of that article with this research project. Even if that connection was made, the article did not include discussion of differences between therapists with the two degrees, but rather called for more research, as was being done with this research project. I did not have an opinion about the eOTD controversy itself, but did have an opinion about the need to base this decision on actual data, especially relating to the consequences on stakeholders of OT. No other ethical issues were identified.

Methodology

In this section, the plan for answering the research question is described, beginning with the inclusion criteria, the sampling strategy that was used to select the participants, the minimum number of participants that was planned to be interviewed, and how this number was determined for the sample size. Then, how the interview guide was developed and tested is explained, the lessons that were learned from the pilot project are discussed, and the changes that were made to improve the data collection for the dissertation study are described. The recruiting method for potential participants, how they were contacted, and how informed consent was obtained are explained. Next, the chosen data collection method is discussed, including the types of interviews and possible differences in those types, the planned structure of the interviews themselves, the use of an interview guide and audio recordings, and how the interview data is being stored.

Population

According to Creswell (2013), "criterion sampling works well when all individuals studied represent people who have experience with the phenomenon" (p. 155). The goal of this dissertation research was to interview supervisors who have directly worked with or supervised new OTs who have the eOTD and also those with the MOT. By having contact with new therapists from both of these the groups, the supervisors should be able to identify what, if any, differences there are between the two groups. This approach will allow future researchers to build on documented perceptions,

rather than on postulations of leaders in the field or academics who have not had direct experience with the new therapists in actual practice settings.

Other than the five eOTD programs (six locations), all other OT educational programs in the Unites States have offered a master's degree, at least since 2007, if not before. It is a reasonable assumption that nearly every supervisor in facilities in the United States has supervised students or hired new graduates with the MOT degree. The challenge was to identify those who have also had direct experience supervising those with the eOTD, a much rarer degree.

Sampling Strategy

Due to education confidentiality laws, it was not possible to obtain lists of OT graduates and where they are working or who their clinical supervisors were when they were students. Therefore, a more creative route was taken to identify research participants who met the inclusion criteria. It was initially planned that the six educational program locations which offer the eOTD would be asked to share lists of fieldwork sites that have supervised student therapists and employers that have hired their new graduates (but not the names of any students or therapists specifically). The facilities from these lists would then be categorized into two lists by type of practice (physical medicine and all others) and then sites would be randomly selected from each of these two lists. The plan was to that the chosen facilities would be called and the name, phone number, and e-mail address of the rehabilitation/therapy manager would be requested.

If the universities did not agree to share their lists, or if the lists did not yield sufficient potential participants, I had planned to contact OT supervisors at several facilities which are geographically near the six locations that offer the eOTD degree by phone to request information about individuals who have supervised students or hired new OT graduates, and this was actually how the research participants were recruited, which is discussed in the Data Collection section of Chapter 4. Facilities that are close to the schools usually have relationships with them, and are likely to accept students and employ new graduates from the schools.

An additional goal of this project was to interview supervisors from medical facilities and an equal number from any other distinct or different areas of OT practice to better represent the wide practice areas of OT. Approximately 61% of OTRs work in physical medicine or long-term care (26.2% hospital, 19.9% skilled nursing, 9.3% out-patient, 5.8% home health; AOTA, 2010), and this is the area most referenced in the literature (i.e., medicine is so complex). However, that leaves 39% of the OT work force working in other areas such as public schools, community psychiatry, and so on, which may not be represented by the arguments focusing on the complexity of medicine. Therefore, it was important to also include other areas of practice in the data collection phase. To address this concern, the goal was that approximately half of the interview participants would be supervisors who work in adult physical medicine or long-term care,

and half would be those who work in other practice settings. This goal was achieved and discussed more fully in Chapter 4.

Criterion based sampling. The primary selection criteria for this study was that the participants have directly supervised or worked with new OTs (defined as those with less than 1 year of experience) with the eOTD and also those with the MOT degrees. The purpose of this criterion was to gather information from those supervisors who have direct experience and knowledge of these students and new therapists. This strategy helped to ensure that the interview responses were based on the individual's own experiences, rather than on hearsay or assumptions.

At the time this study was conducted, there were only five universities (one had two separate campuses) that offered the eOTD. Although there is no publically available data regarding the exact number of students in each program, from the web-pages of each university, it appears that maximum class sizes are from 10-42 students, so probably no more than 100 to 150 eOTDs likely graduate each year in the United States. Consequently, there are likely few people who have worked directly with these graduates and it was a challenge to identify a sufficient number of people to meet the inclusion criteria.

Therefore, supervision of Level 2 Fieldwork students was accepted as appropriate supervisory experience in this research study because there are so few people with the eOTD. It was anticipated that it would likely be difficult to find sufficient numbers of

supervisors who have worked directly with actual licensed therapists with this degree. This is what happened in the pilot study; some participants had never worked with therapists with the eOTD, only with eOTD students on Level 2 Fieldwork experiences. To clarify, the only research participants are direct supervisors, but to qualify for participation, these participants must have supervised Level 2 Fieldwork students and/or new therapists with the MOT and also those with the eOTD. Participants were determined to meet the inclusion criteria based on their positive responses to three separate mechanisms asking the qualifying questions: the recruitment email, the Informed Consent, and the first questions on the Interview Guide.

All students completing a degree in OT (MOT and eOTD) must complete at least 24 weeks of supervised clinic experience towards the end or after completion of the classroom portion of the OT education before they can sit for the national board exam. This experience allows students to apply what they have learned in the classroom and to demonstrate they have achieved the skills of entry-level practitioners (COE, 2013, p. 2). However, eOTD students must complete an additional 16 weeks (640 hours) of an experiential fieldwork that “shall include an in-depth experience in one or more of the following: clinical practice skills, research skills, administration, leadership, program and policy development, advocacy, education, or theory development” (AOTA, 2012, p. 37). Therefore, if the eOTD education is different than that of the MOT education, then Level 2 Fieldwork students should be different, and different in ways that matter to their

stakeholders: the clients, the employers, and the profession and there is no reason to exclude supervision of them from the inclusion criteria.

Number of Participants

Patton (2002) explained that in qualitative research, sample sizes are:

> Relatively small…and selected *purposefully* to permit inquiry into and understand of a phenomenon *in depth*….This leads to selecting *information-rich cases* for study in depth….Those from which one can learn a great deal about issues of central importance to the purpose of the research. (p. 46)

Kvale and Brinkman (2006) identified that the sample size of a typical interview study is 15 +/- 10. The overarching goal for this research project was to gain perspectives from supervisors who work with new therapists (which include Level 2 Fieldwork students) with the MOT and those with the eOTD to determine if there are any differences between them in areas that are important to stakeholders. Additional interviews would have been conducted for this study if (a) it did not appear that saturation has been reached and (b) additional appropriate interview participants were identified who may have divergent experiences from those already interviewed. The minimum goal of the dissertation research was to have each of the six educational program sites which offer the eOTD represented, with at least one supervisor from physical medicine and another area of OT practice represented, resulting in a minimum of 12 participants. However, I continued to recruit and interview additional participants until “the point of redundancy” (Patton,

2002, p. 246), when little new information was obtained, up to a maximum of 18 participants.

Recruitment of Participants

Once possible participants were identified, an e-mail (if an e-mail address could be identified) was sent (Appendix B), introducing myself, explaining the purpose of the research project, and requesting the participant's participation. If the participant was willing to participate, she or he was asked to "Reply" indicating that willingness. If e-mail was not available or the person did not respond to the emails, I called the supervisor and read the appropriate components of the recruitment e-mail, allowing the supervisor to verbally decline or agree to participate.

Once willing participants were identified and agreed to participate, I forwarded the Informed Consent (Appendix C) via email. Each participant signed the form and emailed it back to me. This allowed them to retain a copy and for me to have a copy

Developing the Interview Guide

In this section, the process of selecting topics for the interview questions based on the published literature advocating for and against mandating the eOTD is discussed, as are the steps that were taken to develop interview questions around these topics, and how the interview questions were tested during a pilot study.

Developing the Interview Questions

The literature review described in Chapter 2 included a search to determine if any published tool could be used or adapted to assist in answering the research questions, but none were identified. Each published article advocating both for and against mandating the eOTD was then reviewed in an effort to identify the data upon which the authors based their assertions, but little actual data could be identified. Therefore, the claims made in these articles were used as the basis for designing the interview questions.

Selecting interview topics. Kvale and Brinkmann (2006) stated, "A good interview question should contribute thematically to knowledge production and dynamically to promoting a good interview interaction" (p. 131). The interview guide for this research was structured thematically to ensure that the interviews would systematically cover the ideas raised in the literature. In particular, the published literature on mandating the eOTD was considered through the conceptual lens of stakeholder theory to identify and group the topic areas and then to identify more details under each topic area. The researchers' claims fell into three broad areas: skills and abilities (Pierce & Peyton, 1999; Royeen & Stohs, 1999; Runyon et al., 1994), compensation (Fisher & Keehn, 2007; Griffiths & Padilla, 2006; Royeen & Lavin, 2007; Siler & Randolph, 2006), and recognition (Fisher & Crabtree, 2009; Royeen & Lavin, 2007; Royeen & Stohs, 1999). Under the category of skills and abilities, the subquestions related to (a) knowledge required to provide treatment, (b) providing entry-level

treatment to patients, (c) supervisory/management responsibilities, (d) advocacy for patients, and (e) clinical research. Under the general category of compensation, the subquestions related to (a) differences in starting salaries, (b) salary expectations, (c) correlation between the cost of education for the degree and salaries, and (d) correlation between higher degrees and higher patient costs. Finally, under the category of recognition, the subquestions related to (a) people choosing a profession because it requires a higher degree, (b) higher degrees being more respected by other professionals, and (c) higher degrees being more respected by patients.

Developing strong interview questions. In order to ensure a dynamic and positive interview interaction as advised by Kvale and Brinkmann (2006), the lead questions in each thematic section were designed to be unstructured. This approach was selected to help elicit the interviewees' thoughts and feelings about the subtopic, allowing for both responses that might have been predicted by the literature and surprises that might arise spontaneously from the participants. Additionally, the interview questions were structured in such a way as to be neutral, or not influence the participants to answer in a specific way, without "inflammatory" or "loaded" words, slang terms or colloquialisms, technical terms or abbreviations, or "all-inclusive terms, such as 'never' or 'always'" (Frey & Oishi, 1995, p. 71-72). Additionally, the "funneling technique" (Frey & Oishi, 1995), where a general, open-ended question is asked, and then each additional question is more specific or narrowly focused, was used when developing the

interview questions. This allows the researcher to introduce a topic or provide context so that he or she is sure the subject is thinking in the same framework, and can then lead the subject through a complex topic. Questions under each topic area begin more general, and then depending on the participant's response, clarifying questions can be asked, or the questions become more narrowly focused.

As advised by Kvale and Brinkmann (2006), draft probes were crafted in advance with attention to the ways in which they would elicit further detail and explanation in a comfortable, nonconfrontational way. The tone sought was one of collegial exploration to encourage spontaneous and descriptive responses. In the pilot project, I found that those who work in physical medicine and rehabilitation are at least somewhat familiar with the controversy surrounding mandating the eOTD, but that those in the other practice settings, such as primary schools, may not be as familiar. Therefore, to ensure that all participants understand the questions, every effort was made to avoid jargon in the writing of the research questions.

Because the initial thematic areas were drawn from academic literature, the terminology, though comprehensible to the professionals to be interviewed, was formal and might have felt stilted in a conversational setting. To ensure that the questions were phrased in a way that made the participants feel comfortable interacting with the interviewer and sharing their thoughts and feelings about the topic, the questions were

reframed in technically accurate but more every-day language, as recommended by Kvale and Brinkmann (2006).

Demographic questions. Several questions were developed to gather information about the interview participants, specifically about the professional degree they hold, the highest degree they have earned, how many years they have been in practice, their current job title, how many years they have been in this position and others within this organization, how this current role related to the OTs in this facility (peer, supervisor, etc.), and the structure of delivery of OT services. This information allowed me to consider whether other issues might be influencing the perceptions of these supervisors regarding the two degree levels.

Pilot Interviews

In 2012, an exploratory study was completed to assess the quality of the semi structured interview guide and to allow me to practice using the guide and to hone my ability to administer the interviews effectively. Walden University's IRB approval was obtained (number 05-26-11-0024611, expired on May 25, 2012).

Two supervisors of local, hospital-based, physical medicine and rehabilitation departments were contacted by e-mail and phone, requesting their participation in the pilot project interviews. These participants were chosen because they manage departments large enough to have multiple OTs and are known to take Level 2 Fieldwork students. One of the original goals in conceptualizing the research plan was to represent

the 39% of the OT work force who do not work in adult physical medicine. Adult physical medicine, including long-term care, is the area most referenced in the literature, (i.e., medicine is so complex). However, this leaves out more than one third of the OT practitioners. It was important to also include as many other areas of practice as possible in the data collection phase. However, this effort to draw from different areas of practice failed in the pilot project as neither of the large public school systems contacted, nor therapists in local community psychiatry, had experience with eOTD students or graduates.

Informed consent was obtained from the two rehabilitation supervisors and face-to-face interviews were conducted in their offices at the hospitals. These interviews were audio recorded, field notes were taken, and input about the instrument and the skills of the interviewer were solicited. The audio files were sent to the transcriptionist via secure e-mail. There were initially problems with the transcriptionist opening a particular type of file format, but this process was eventually corrected and transcripts of the interviews received. I listened to the entire first interview, while reviewing the transcript to evaluate the accuracy of the transcription and it was found be to excellent. Random portions of the second transcript were compared to the audio recording and were also found to be accurate.

Suggestions about the interview questions. Both of the rehab supervisors interviewed during the pilot project using the interview guide stated that they believed the

interview questions were well written and allowed the participants to express their opinions without influencing their answers. Both also said that they thought the questions coved all topic areas they would have wanted to discuss and could not provide any other suggested questions; neither had any suggestions for additional questions or revisions of the guide.

Suggestions for the interviewer. Neither participant had any suggestions or recommendations for me as the interviewer on technique or style. Participant 2 stated that I helped to get "the conversation going," implying that this made it easy to answer the questions. She also stated that she liked that there were open-ended questions throughout, and stated that the interview should end with one, as it does.

Lessons Learned from the Pilot

This section discusses the lessons learned from conducting pilot interviews, beginning with the importance of the qualifying questions, and the need to differentiate answers about Level 2 Fieldwork students versus new therapists. Additionally, the difficulties of identifying therapists from various areas of practice and what new questions arose from the pilot interviews will be discussed.

Qualifying questions. Despite the inclusion criteria being identified in at least three separate places prior to the initiation of the interview (the recruitment e-mail, the Informed Consent, and verbally when the interview appointment was made), one of the participants did not actually meet those criteria. This reinforced the importance of

stressing the inclusion criteria and the first two qualifying questions on the interview guide. Therefore, during the dissertation, these two questions were asked before actually making arrangements to conduct the interviews and again at the beginning of the interview itself (in addition to continuing to have them on the recruitment e-mail and Informed Consent).

Fieldwork students versus new therapists. As the pilot interviews were being reviewed, it seemed apparent that for the dissertation it would be necessary to differentiate when the participants were discussing Level 2 Fieldwork students versus new therapists for two reasons. First, neither of the participants had ever supervised someone with an eOTD, so they had no direct experience actually working with OTs with this degree. Secondly, Participant 2 stated that she did not expect to see any differences between fieldwork students with the two degrees because they were all just too busy learning the basics. However, with additional academic and fieldwork requirements, it seems that the eOTD students should appear different in some way from those with less academic education. Alternately, any possible differences may not be seen until the first year of actual practice or later.

Therefore, the recruitment e-mail, the informed consent form, and the interview guide were changed to include the phrase “Level 2 Fieldwork students” in addition to “new therapists.” The first qualifying question was changed at the beginning of the

interview guide to ask the participant their experiences with Level 2 Fieldwork students and new therapists including both those with the MOT and those with the eOTD.

Additional areas of practice. The effort to interview supervisors from different areas of practice failed in the pilot project, as those in the local public school systems and OTs in local community psychiatry have had no experience with eOTD students or graduates. However, understanding the perspectives of supervisors in different areas of practice was still important for answering the research questions, so that the findings could be applied more broadly to the profession Therefore, interviewing supervisors from different areas of practice continued to be a goal for the dissertation research.

For the larger dissertation project, where participants were recruited from other geographical locations, this was not expected to be an issue. Based on conversations with colleagues who have worked in other regions, therapists with eOTDs do work in the public school systems and with psychiatric in-patient and community based programs. Therefore, for the dissertation project, every effort was made to identify participants from the other areas of practice. It was planned that, if necessary, the participant search would broaden geographically out from the regions where the academic programs are located until other practice settings (other than physical medicine) were represented. Having other areas of practice represented is important because researchers who have promoted the eOTD use examples from medicine, but OTs work in so many other settings (e.g., mental health, primary schools, work hardening, low vision) that gathering information

from only medical facilities would have omit perspectives that might be offered by participants in other practice settings. The perceptions gathered through this small work are not fully representative or generalizable, but would provide a range of perspective on which to ground future work.

Additional research questions. In the pilot project, I identified several additional research questions that needed to be answered to inform the discussion regarding the eOTD. The respondents wondered where those with eOTDs are being employed because neither of them could recall having someone with an eOTD apply for a job at their large metropolitan hospitals. Additionally, the local public schools and community psychiatric OTs have not had any fieldwork students, nor have they worked with or hired therapists with the eOTD. This lack of eOTD fieldwork students and job applicants in the three primary areas of practice (hospitals, schools, and mental health) in this region generated the question of where those graduating with the eOTD are working. This is important to the discussion of mandating an entry-level doctorate because requiring this degree to enter the profession would impact every area of practice and all employers. It is critical for OT professionals to understand if the higher degree will impact employers, especially their ability to hire therapists. Additionally, OT professionals need to determine if obtaining this degree influences where the graduates are willing and/or able to work and the salaries they require. These concerns were expressed by both of the supervisors contacted in the public school systems. They postulated that many primary schools would

not be able to pay higher salaries to therapists with doctorates, and were concerned that this will limit the number of therapists who can be hired to work in schools although the provision of therapy services is mandated by the Federal Department of Education. While these concerns are important for the profession, they go beyond the scope of the research questions that drive this study. Therefore, they are discussed as areas for further research, but were not addressed in this dissertation study.

Analysis of pilot data. Another goal of the pilot project was to ensure that I was competent in the use of any tools to be used for data analysis in the dissertation. The qualitative data analysis program, Atlas.ti, version 5.5.9 was chosen for data analysis because it is available to me through my employer and because it is a well-known and respected program. The two transcripts of the interviews were uploaded into the program and the open coding function was used to develop initial codes and tables that could be used for the dissertation itself. I concluded that this program would be adequate for the dissertation.

Coding. One of the primary goals of the pilot project was to begin developing the coding system to be used in the dissertation process. The interview guide was developed based upon a review of the literature and the questions were grouped according to topics. The initial codes were also developed based on the literature: “concept-driven coding uses codes that have been developed in advance by the researcher, either by looking at

some of the material or by consulting existing literature in the field" (Kvale & Brinkman, 2006, p. 202) and can be found in Table 1.

Table 1

Literature Based Concept Codes Used in Pilot Study

Broad Topic	Codes
Job Responsibilities (of the OT)	Knowledge for general, entry-level practice Direct patient care Supervisions/management Advocacy (for patients) Conducting clinical research Use of clinical research
Compensation	Salary Salary expectations Cost of education Patient costs (related to therapist compensation)
Recognition	Status/Recognition influencing career choice Respect from professionals Respect from patients

Additional codes were identified based on "real-life data" (Marshall & Rossman, 2011, p. 211) such as the knowledge of the profession, how OT services are delivered in different settings, and speculations that have been made about factors which might impact peoples' opinions about the different degrees (Table 2).

Table 2

Real-Life Based Initial Codes Used in Pilot Study

Broad Topic	Codes
Demographics (of the interview subject)	Professional degree Highest degree of subject Years of OT practice Current job title Years in management roles Other positions held at this facility Role (as it relates to the OTRs at this facility)
Occupational Therapy delivery model at facility	Specific/designated population Float Designated clinic setting Acute In-patient General rehab unit Out-patient Home health Pediatrics Public school system Inclusionary model Pull-out model Community based

Finally, as the transcripts were being reviewed, it became apparent that several codes needed to be added (Table 3).

Table 3

Pilot Project Generated Codes

Broad Topic	Codes
Level 2 Fieldwork Student	Knowledge for general, entry-level practice
	Direct patient care
	Supervisions/management
	Advocacy (for patients)
	Conducting clinical research
	Use of clinical research
Compensation	Salary
	Salary expectations
	Cost of education
	Patient costs (related to therapist compensation)
Recognition	Status/Recognition influencing career choice
	Respect from professionals
	Respect from patients
Physical Therapy	Direct access
	Competition
eOTD	Useless degree
	Degree inflation
	Academic degree for research

Conclusions from the Pilot Project

The primary goal of this pilot project was to evaluate the quality of the draft interview guide developed in preparation for the dissertation research. The goal was to determine if the wording of the questions was clear to the interviewee, if the questions elicited the intended information, and if these experienced supervisors could identify any relevant topics that had not been addressed with the interview questions. It was

determined that the interview guide was clear, did elicite the desired information, and was comprehensive. In the pilot project, it was found to be challenging to identify qualified participants representative of the primary areas of OT practice, so there was a conscious effort to do so for the dissertation. Finally, the pilot project allowed me to practice my interview skills using the interview guide, establish the quality of the transcriptionist, begin to develop a list of codes, and to draft tables for the reporting of the dissertation data.

Procedures for Recruitment, Participation, and Data Collection

In this section, the details and procedures of data collection will be described. All personal contact with individual potential research participants and the interviews themselves were conducted by me, the researcher. A student worker was used to find the names, e-mail addresses, and phone numbers of the appropriate contact people at a portion of the potential providers of OT services and she did call some of those facilities to identify names and contact information for direct supervisors of the OTs. I completed this process to identify a sufficient number of recruits, and I made all telephone or e-mail contact with them.

Appendix C includes the recruitment e-mails which were sent to possible research participants or summarized in a phone call if e-mail was not available. Once a possible research participant was identified as meeting the inclusion criteria and had expressed a willingness to participate, the Informed Consent (Appendix C) was sent to him or her, via

e-mail and the potential participant was asked to return a signed copy. Because all possible participants were working in an organization within the United States, it was expected that they would have access to e-mail, and they did. Once the signed Informed Consent was received, the participant was contacted to arrange a time and method to complete the interview. It was planned that if the participant was within four hours of driving distance, the interview would be conducted in person, or if the participant was farther away, a video interview would be suggested (although only an audio recording would be made) to facilitate a more personal interaction and allow the participant and me to see facial expressions and body language. If neither a face-to-face or video interview was possible, a phone interview would have been conducted and audio recorded. However, all interviews were conducted through telephone interviews, and this change is discussed in the Data Analysis section in this chapter.

Each interview was expected to last approximately one hour, as it did in the pilot project, and interviews are planned to begin as quickly as possible after the proposal and IRB were approved and then be completed within 8 weeks, which did occur. Each interview began by reviewing the informed consent form, and reminding the respondent that participation was voluntary, and that they could withdraw from the study at any time, although no one did. They were also reminded of the purpose of the study, and confirmation of their permission to record the interview was obtained. Interviews were recorded on a mini audio recorder and also on the Recorder function of my desktop

computer. The Internet was used to identify organization geographically near each educational location that would likely employee OTs. These facilities were contacted to determine if anyone at that facility met the inclusion criteria. Additionally, snowball sampling was used, where each participant was asked to identify others who might be qualified and willing to participate in this research study, and those people were then contacted. This process continued until there were adequate numbers to meet the goals of this research project.

Participants would have been allowed to exit the study at any time, although no one did. Everyone who participated in the study was offered the opportunity to review the transcript of their interviews, the few who did want to review their transcript did not respond with any questions or requests for changes or clarifications. However, if they indicated on the Informed Consent that they would like a summary of the study results, this will be sent to them via the preference they indicated, after the study is approved by the dissertation committee. Because every participant has my e-mail and phone number, any one of them could contact me with questions or concerns at any time during and after the study.

Data Analysis

This section describes the plan that was developed for dealing with the data once the interviews had been completed beginning with details of the data analysis: coding, analyzing the content, and managing discrepancies. Then issues of trustworthiness are

discussed, and finally the ethical procedures are discussed. Changes to this planned analysis are discussed in the Data Analysis chapter.

Interview Data Analysis Plan

The data analysis would begin using the concept codes to code the transcriptions of the interviews. Then those concept codes would be used to organize and separate the data into thematic groups, and each of those groups would be analyzed to answer the overarching research question of whether there are differences in therapists with the MOT and eOTD degrees and what those differences might be, if any.

Coding. The primary tool used to organize the narrative data in this study for analysis was concept coding. Coding is the physical categorization and grouping of the data (Babbie, 2007), and Kvale and Brinkmann (2006) explained that “coding and condensation provide structure and give overviews” (p. 201). Concept codes are “codes that have been developed in advance by the researcher, either by looking at some of the material or by utilizing existing literature in the field” (p. 202). Table 4 presents the initial concept codes that would be used for analyzing the data. These codes were initially developed and tested during the pilot project.

The demographic codes would provide information which may identify personal factors or themes that impacted the supervisors’ perceptions of the two degree levels. For example, those therapists with only a bachelor degree may be against the eOTD because they are intimidated by those with higher degrees. The OT delivery model at the facility

likely affects the demands and expectations on the fieldwork students and new graduates. For example, a facility where the OT "floats" (moves around to work with a variety of patient populations and diagnosis), requires flexibility and broader knowledge than for an OT who works with one diagnostic group, in one location. The codes related to skills and abilities, desired compensation, and recognition were teased out of literature review and grouped into conceptual topics where there might be differences between the two degree levels. Finally, the last two areas labeled "PT" and "eOTD" were generated from analysis of the pilot interviews, as the participants spontaneously introduced the topics under these headings. These two labels were thought to allow additional sorting of the conceptual topics. As the new transcripts were reviewed, I thought that there may be concepts that did not fit into one of the preconceived codes, and so new codes would be developed for those. Therefore, it would be necessary to review previously coded transcripts in light of the new codes.

Table 4

Initial Codes for the Dissertation Analysis

Broad Topic	Codes
Occupational Therapist	Knowledge for general, entry-level practice
Job Responsibilities	Direct patient care
	Supervisions/management
	Advocacy (for patients)
	Conducting clinical research
	Use of clinical research
Compensation	Salary
	Salary expectations
	Cost of education
	Patient costs (related to therapist compensation)
Recognition	Status/Recognition influencing career choice
	Respect from professionals
	Respect from patients
Level 2 Fieldwork Student	Knowledge for general, entry-level practice
Job Responsibilities	Direct patient care
	Supervisions/management
	Advocacy (for patients)
	Conducting clinical research
	Use of clinical research
Compensation	Salary
	Salary expectations
	Cost of education
	Patient costs (related to therapist compensation)
Recognition	Status/Recognition influencing career choice
	Respect from professionals
	Respect from patients

(*table continues*)

Broad Topic	Codes
Physical Therapy	Direct access Competition
eOTD	Useless degree Degree inflation Academic degree for research
Demographics of the interview subject	Professional degree Highest degree of subject Years of OT practice Current job title Years in management roles Other positions held at this facility Role (as it relates to the OTRs at this facility)
Occupational Therapy delivery model at facility	Specific/designated population Float Designated clinic setting Acute In-patient General rehab unit Out-patient Home health Pediatrics Public school system Inclusionary model Pull-out model Community based

The qualitative data analysis program, Atlas.ti, version 5.5.9 was used for coding and data analysis. This program was selected because it is available to me through my employer. Its appropriateness for this analysis was first assessed based on its ease of use,

the coding hierarchy, and report functions, which were then tested during the pilot project and found to meet the needs of the analysis.

The transcripts of each interview were uploaded into the Atlas.ti program and planned to be coded in a three-part process. First, the transcripts would be coded using all of the preconceived concept codes developed during the pilot project, based on what the participants said. Second, a knowledgeable colleague would also code at least two of the early transcripts using these same codes, and would be encouraged to add any additional codes that may be missing. These coded transcripts would be compared to my coded transcripts to evaluate intercoder reliability (Marshall & Rossman, 2011) and any new codes would be evaluated for appropriateness and usefulness. If the intercoder reliability was deemed to be good, the preconceived codes would be deemed valid for the coding process. If new codes generated by the colleague were deemed suitable, all previously coded transcripts would be reanalyzed and recoded with the new code, as appropriate. Finally, the remainder of the transcripts would be analyzed and coded, and reanalyzed and coded until a point of “theoretical sufficiency, whereby we have categories well described by and fitting with our data” (Marshall & Rossman, 2011, p. 220) was reached.

Analyzing the content. Once the coding was completed, then the Atlas.ti program would be used to separate the transcripts by thematic codes for analysis. These thematic codes would be “crossed with one another to generate new insights or typologies for further exploration of the data” (Marshall & Rossman, 2011, p. 215). For

this research project, the overarching goal was to determine the perceptions of direct supervisors regarding Level 2 Fieldwork students and new OTs with the eOTD versus those with the MOT degrees as they relate to the factors that impact the stakeholders of OT services in the general areas of skills and abilities, desired compensation, and recognition. The data would be analyzed to determine if there are perceptions of differences between those with the two degrees and if any patterns of what those differences are can be found.

In this part of the analysis, "the occurrence or nonoccurrence" (Kvale & Brinkmann, 2006, p. 203) of each factor (is there a difference, yes or no?) would be identified, and if there was a difference, what that difference was perceived to be. It would also assist with determining the "strength of an opinion" (p. 203), allowing the determination of how many of the respondents expressed this opinion, for example, eight of 10, or 80% of participants. The extent to which concepts identified from the literature resonated with participants could be used for those parts of the interview questions which can be answered with a "yes or no." This analysis could then be compared to the claims in the literature to determine if there is evidence to support or refute these claims and then further analyzed to evaluate whether a theory can be generated about the difference, or lack thereof, and how these findings could contribute to the decision of which degree should be mandated for the profession.

The concept codes would be crossed with each of the demographic factors, and also with the treatment delivery model codes, to determine if there were additional patterns or insights to be gained. As new patterns or insights were gained, it might have been necessary to review all of the transcripts again through the new perspective lens that had been developed.

Managing Data Discrepancies

The open-ended nature of the interview questions may have resulted in broad and divergent answers. Therefore, in the interviews, it was planned that responses would be explored in sufficient depth so that when divergent views emerged, the basis for those views could be articulated and available for the analysis, which was done. It was important to understand if the subject's explanations were grounded in beliefs that are not true. For example, a participant might believe that instruction in the clinical application of research is not included in the MOT curricula when it is, in fact, an accreditation requirement for all MOT programs. It was planned that when these inaccurate beliefs were identified during the interviews themselves, accurate information would be provided and additional questions would be asked to determine if this new information changed the subject's views. However, it was important not to alienate the participants or inhibit their willingness to answer the remaining questions by repeatedly correcting them. Therefore, it was planned that if it became apparent that the subject's answers were based on inaccurate information, then this would be noted in the field notes, although this did

not actually occur. During the data analysis, these answers, or possibly the entire interviews would be excluded from the analysis, and this exclusion would be noted in the reporting of the data to ensure transparency. Although answers based on inaccurate information did not occur during the dissertation interviews, one participant, who had very recently completed a *post professional* OTD, repeatedly state "we" when answering about the eOTD, despite several prompts from me. This discrepancy is discussed in the Data Analysis chapter below.

Issues of Trustworthiness

According to Marshall and Rossman (2011), trustworthiness is a way to "conceptualize the soundness" (p. 39) of qualitative research and can be supported by several concepts.

Credibility (internal validity). Kvale and Brinkmann (2006) explained, "Validity refers…to the truth, the correctness, and the strength of a statement….in the social sciences pertained to whether a method investigates what it purports to investigate" (p. 246). To establish the validity of the Interview Guide as it was being developed, several experts, including three OTs, two with PhDs and one working in clinical practice, and one medical anthropologist with a PhD reviewed and commented on the interview guide. The reviewers provided editing suggestions to enhance clarity. All agreed that the interview guide was appropriate for eliciting the information needed to answer the research question and that the tone of the questions was neutral and non-leading. None of

the reviewers suggested thematic changes, and all agreed that the themes covered will provide data that is needed in the profession but has not yet been published. The Interview Guide was then used in the pilot project and the nature of the responses further confirmed that the questions were eliciting the desired information.

Creswell (2009) discussed different aspects of validity, explaining that "validity,…is one of the strengths of qualitative research, and is based on determining whether the findings are accurate from the standpoint of the researcher, the participant, or the readers of an account" (p. 191) and described "eight primary strategies" (p. 191) that can be used. It was planned that for this research study, member checking, the use of rich, thick descriptions to convey the findings, presentation of negative or discrepant information, and peer debriefing would be used. Member checking is a method the researcher can use to check the accuracy of the information he or she has gathered by asking the research participants to review it and assess whether it is an accurate representation of what they provided or intended to provide (Creswell, 2009, Marshall & Rossman, 2011). This could be done in three separate ways. During the interviews, as was done in the pilot project, responses were summarized and rephrased back to the subject to ensure that the responses had been accurately understood. Second, each participant was offered the opportunity to review the transcription of his or her audio recording to improve accuracy, although few did. Of those who did state they wanted to review their transcripts, none responded with any questions or suggestions. Finally, it was

planned that during the analysis phase, if there was discrepant information or it appeared that the answer(s) were somehow incongruent with the question(s) that were asked, the responses would have been rephrased and the subject would be asked to verify the accuracy of that summary. This did occur in the dissertation and is discussed in the Data Analysis chapter.

It was expected that research participant perceptions of differences between Level 2 Fieldwork students and therapists with eOTD and MOT degrees would vary on a number of dimensions. Identifying and reporting on those differences would be essential to give the reader confidence that a full and fair picture has been painted of the input that had been received (Creswell, 2009; Patton, 2002). Additionally, considering any discrepant data would force the re-evaluation of the patterns that had been identified or the conclusions that had begun to be drawn during data analysis (Patton, 2002), and may increase accuracy or applicability of the study findings. In addition, reporting on discrepant information would be of importance for this study because part of the goal was to capture nuances that will help inform future scholars.

It was planned that peer debriefing would be used. Peer debriefing is when a knowledgeable peer is asked to review the study and its finding and ask questions. This is a method to determine if the study and its findings make sense to others (Creswell, 2009; Marshall & Rossman, 2011). Several colleagues had been identified as experienced qualitative researchers and had expressed an interest in reviewing this research progress

as it developed. The final choice of who was chosen to complete the review depended on the time it was ready for review (compared to their other commitments), and also which ones had the expertise to provide the most constructive feedback to improve the study.

Transferability (external validity). It was not the goal of this research project to be broadly transferable or generalizable. Creswell (2009) explained that qualitative research is appropriate if a problem or issue is new, or has not yet been studied extensively so that the factors that influence or impact it have not yet been identified. Because there is little data available about those with the eOTD, this project was meant to construct the groundwork to determine if there is any difference between those with the eOTD and with the MOT. Once this is established, then additional studies can be built upon this foundational information and those will likely be more transferable. However, to make these foundational data more transferable and representative of the distribution of OT practice, the plan was to have half of the participants be from physical medicine facilities and half from any other area of OT practice.

In-depth interviews allow researchers to gather sufficient details or “rich data” (Maxwell, 2005, p. 110) so that they can get a clear picture of the research topic. Providing “rich, thick descriptions” is my natural writing style and usually needs to be reduced for scholarly writing. Therefore, this suggestion occurred spontaneously during the discussions of the data analysis and discussion.

Dependability (reliability). Because qualitative research is more subjective in nature, researchers need to take steps to demonstrate that their methods are consistent and trustworthy (Kvale & Brinkmann, 2006). According to Creswell (2009), "qualitative reliability indicates that the researcher's approach is consistent across different researchers and different projects" and recommended the following "reliability procedures" and each was done for this dissertation study:

- Check transcripts to make sure that they do not contain obvious mistakes made during transcription.
- Make sure that there is not a drift in the definition of codes, a shift in the meaning of the codes during the process of coding.
- Cross-check codes developed by different researchers by comparing results that are independently derived. (p. 190)

The first two transcripts would be reviewed in their entirety, while listening to the audio recordings of the corresponding interviews. If no discrepancies were found, as was the case in the pilot project, then only random sections of additional interviews would be evaluated. Additionally, if during the interview processes itself I noticed background noise or possible poor quality recording, then that transcript would be reviewed for accuracy. The consistency of code definitions would be regularly reviewed throughout the coding process, and especially as transcripts were reanalyzed for additional condensation and categorization and when new codes were identified and previous

transcripts were reanalyzed for the new code. Finally, any new codes developed by the colleague during his or her analysis of transcripts would be evaluated. If these new codes were deemed accurate and useful, previously coded transcripts would be reanalyzed, adding the new codes as appropriate.

Confirmability. The interview guide was developed based on the claims both for and against mandating the eOTD to become an occupational therapist and this literature was also used to develop the initial set of concept codes for the data analysis. However, because it was important to encourage the participants to fully discuss their experiences with the new therapists, the interview questions were designed to be open-ended and there were multiple opportunities throughout the interview for the participants to add other topics or insights that were not asked about. There would likely need to be new concept codes added as each interview is added. It would then be necessary to return to the previously coded interviews to determine if the new code could or should have been applied to those transcripts as well, and this was done during the final analysis.

I planned to keep a reflexive journal throughout the research process, which I did. Every researcher comes to each research project with certain biases and preconceived ideas. These biases and preconceived ideas do not invalidate the research. Rather, it is important for the researcher to honestly reflect on what those are, and strive to understand how they may impact the research. One way to do this is to write about them in a journal, which the researcher can then reflect on over time (Kvale & Brinkmann, 2006).

The "concept of reflexivity in which the writer is conscious of the biases, values, and experiences that he or she brings to a qualitative research study" (Creswell, 2013, p. 216) requires the researcher to honestly consider how his or her previous experiences and beliefs impact the study and to also understand how these experiences impact "the researcher's interpretation of the phenomenon" (p. 216). The journal would be used to document my observations and thoughts during the interviews themselves as well as thoughts and decisions made during the coding and analysis of the data.

Intracoder reliability. I would be the only one coding the interviews, so there was no need to establish intercoder reliability. To improve intracoder reliability, a blank copy of the first interview transcription that was coded would be re-evaluated after at least four transcripts had been coded, and that first transcript would then be recoded. These two separately coded transcripts would then be compared to assess the consistency of the coding.

Ethical Procedures

Creswell (2009) stated, "Researchers need to protect their research participants; develop a trust with them; promote the integrity of research; guard against misconduct and impropriety that might reflect on their organizations or institution; and cope with any, challenging problems" (p. 87). The federal government mandates that universities take measures to ensure that researchers understand their ethical responsibilities when conducting research and that research participants are protected by requiring researchers

to go through an IRB process. This is a comprehensive process which requires the researcher to submit a proposal that contains detailed procedures about how the research will be conducted and about the research participants. Additionally, the researcher is required to develop and submit an informed consent form which the participants will sign to indicate their consent to participate in the study (Creswell, 2013, p. 89).

Ethical Protection of Participants

Walden University's IRB process was followed, which requires that the proposal be approved before an application can be submitted to the IRB. Once the dissertation proposal was approved, all required information was submitted to the Walden IRB and approval was received prior to proceeding with the research. Please see Appendices A, B, and C for the final versions of the Interview Guide, recruitment e-mails, and Informed Consent form. These documents were originally developed and approved for the pilot project and then modified slightly for the dissertation IRB application. The Informed Consent (Appendix C) included an introduction to the researcher and the purpose of this research and what was expected of the participants. In the Informed Consent, the benefits and risks of the study were reiterated, as is that participation was voluntary, and it explained how participant confidentiality is protected. Additionally, the contact information for a Walden representative who the participant could call with questions or concerns was provided. Each participant was asked to sign an informed consent form, which was returned to me by email, which also allowed the participant to keep a copy.

The signed consent forms are being kept in a password protected file on a password protected university server.

Unless the researcher has clear consent from the research participants to reveal their identities, every effort should be made to maintain their confidentiality (Creswell, 2007; Kvale & Brinkmann, 2006). For this research, confidentiality was ensured by assigning each participant a number such as Participant 1, Participant 2, and so on. Additionally, the real names of the participants were not used during the interview itself, so that within the body of the interviews, no names appear in the transcripts.

Ethical Concerns: Recruitment

All participants for this project were working professionals and recruited via phone call and e-mail from me. The names of those contacted are being kept on a master list, which includes those who were initially contacted, but then declined to participate, to prevent them from being contacted again. This list is being kept in a separate, password-protected document in a password-protected computer and saved on a flash drive, which is being kept in a locked drawer in a locked office.

Participant contact and informed consent. Those participants who agreed to participate were emailed an informed consent form, which contained the explanation of the project and the inclusion criteria. Once the signed informed consent was returned to me, I contacted the participant to determine how and when the interview would be conducted. The participant information from this research project is confidential. There is

a master list with all of the potential participants' contact information and whether they had declined or agreed to participate in the study. When someone agreed to participate, he or she was assigned an identification name, such as Participant 1, and this identification name was added to a separate list with the date and time of the interview. However, this identification name was not connected to any other identifying information from the master list so that the date and time of an interview could not be connected back to the master list with identifying information. The audio recording of the interview was only labeled with the date and time of the interview to protect confidentiality during the transcription process.

Ethical Concerns: Data Storage

A database of each participant's full name, their employer's name and type (public school, physical medicine hospital, etc.) was developed. The assigned participant number, and contact information will be maintained and kept in a separate, password-protected document in a password-protected computer in my locked office. Creswell (2009) recommended making duplicate copies of all documents; all documents for this research study are electronic, and no paper copies were made. All electronic data would be backed up onto two flash drives, one which would be stored in a locked drawer in my locked office and the second at my home in a locked file cabinet. I am the only one who has access to the data with identifiers. The data will be kept for at least 5 years. The document with the link between the study code numbers and the direct identifiers of the

informants will be kept only until the analysis is finished and the dissertation approved, then the identifiers will be destroyed.

As explained in the informed consent form, those who were recruited to participate in the study were free to refuse or withdraw from the study at any time. If a potential participant was contacted and declined to participate or did not qualify, that name was being kept on a master list with a notation so that he or she was not contacted again. If, during the interview, a participant had decided they no longer want to participate, I planned to ask questions to try to discover the reason for his or her wish to withdraw, and the interview would have ended. However, this did not occur.

Summary

In this chapter, the chosen research method was discussed, as was how the interview questions were developed and tested with a pilot project, and what changes were made based upon that project. The planned approach to data collection was described in detail, as was how the collected data would be coded, analyzed, and stored. Finally, the ethical protections which are being taken to protect the research participants in the recruitment of those participants and in the storage of data were described.

Chapter 4: Data Analysis

Introduction

This exploratory study sought to identify whether direct supervisors perceive that there are differences between new OTs with the eOTD and those with the MOT with regard to skills and abilities, desired compensation, and recognition, and if so, what those differences might be. These perceptions were gathered through a collective case study, using in-depth, semi structured interviews with criterion-based, purposeful sampling, and viewed through a constructionist lens.

The goal of this study was to provide data to support an evidence-based discussion of whether the OT profession should require the eOTD to enter practice as a therapist and also to stimulate further research on this topic. This exploratory research will provide one piece of the foundational knowledge needed to inform future decisions regarding the necessary entry-level degree requirement for OTs.

This chapter begins with a discussion of the pilot study, then moves on to discuss this current study, beginning with the setting where the research was conducted. It then discusses the demographics of the study population, describes how the data were collected, and moves on to describe how that data were analyzed and what actions were taken to improve the trustworthiness of the research findings. Finally, it presents the findings of data analysis, and ends with a summary of those findings.

Pilot Study

Prior to the development of the dissertation proposal, an exploratory study was completed in 2012 to assess the quality of the semi structured interview guide and to allow me to practice using the guide and to hone my ability to administer the interviews effectively. Walden University IRB approval was obtained (number 05-26-11-0024611, expired on May 25, 2012). Please see Chapter 3, under Development of the Interview Guide, for a detailed discussion of the pilot project and how its results informed the final interview guide and protocol.

Setting

This study was conducted through telephone interviews of OT supervisors at locations of their choosing. The only setting factor that could be identified as influencing the participants was time, or lack of it. The original research plan was to conduct video interviews through the computer, or in-person interviews, but several of the first participants requested phone interviews instead, because they were easier to schedule and allowed the participant more freedom to use their cell phone in a location of their choice. During scheduling, every participant made some comment about how busy she was, and how it was difficult to find even 20 minutes of free time during the day. One willing participant was not included in the study because she said she could not find 20 minutes for the interview, even in the evening or on weekends, for at least two months. Although time was a factor in scheduling the interviews, none of the participants brought up the

need to finish the interview quickly. Therefore, I believe the participants had sufficient time to express their full thoughts about the interview topics. This is important from the constructionist standpoint; constructionists gather the perceptions of others and interpret them to build an understanding of a topic (Andrews, 2012). Allowing the research participants to fully express their thoughts provided me with more information on which to build my understanding of their perceptions about those with the eOTD and those with the MOT.

Demographics

I completed a total of 14 interviews between February 9th and March 19, 2015. Table 5 presents data about participants with regard to five characteristics. The first characteristic, treatment population, indicates the age of the population the participants and new therapists work with. The second characteristic, treatment setting, refers to the type of organization through which the treatments are provided. Treatment structure indicates whether the OTs work with a variety of diagnoses, which likely requires more breadth of knowledge, or with a specific population, which likely requires more depth of knowledge. Location is the state where the participants and new therapists provided treatment. Because facilities geographically close to educational programs usually take fieldwork students, and hire graduates from the local area, I wanted to make sure that the participants were not highly skewed toward one area or school, and was successful. I did

not want the results of this study to be misinterpreted as an assessment of any educational program.

The research participants held a variety of professional degrees themselves, and three of the participants had additional degrees in other areas: a master's in rehabilitation sciences, a master's in special education, and a doctorate in rehabilitation sciences. Participants had been practicing from two to 37 years, with the mean of 14 years. Job titles ranged from staff occupational therapist to supervisors of rehabilitation to owners of private practices. Participants had been in their current job roles for three days to 18 years, with the mean of six years.

This demographic information was used for two purposes. First, this information allowed me to determine if the participants represented a wide array and variety of OT practices. The data showed good variety, with participants equally divided between those working with adult populations and those working with pediatric populations, and representing a wide variety of treatment settings, some representing more than one area. The second purpose was to determine if certain perceptions were more prevalent based on these characteristics; no demographics-based patterns were identified during the data analysis.

Table 5

Demographic Codes

Characteristics	Number of participants
Treatment Population	
Adult	7
Pediatric	7
Treatment setting (may work in more than 1 setting)	
Small rural hospital	1
Community residential mental health	2
Acute care	4
Inpatient	3
Outpatient	10
Early intervention	4
School	3
Trauma Center	1
Treatment Structure	
Variety	11
Specific	3
Location	
Arizona	1
Florida	1
Illinois	3
Missouri	3
Nebraska	4
Ohio	1
Tennessee	1

(table continues)

Characteristics	Number of participants
Participant Professional Degree	
OT Degrees	
Bachelor's	4
Master's	5
eOTD	3
ppOTD	1
PT Degree	
Master's	1
Years in Practice	
Less than 5 years	1
5-10 years	4
11-16 years	2
17-23 years	4
35 or more year	3
Current Job Title	
Owner & Therapist	3
Manager/Supervisor	5
Senior/Lead OT	4
Staff OT	2
Years in Current Job	
Less than 1 year	2
1-5 years	4
6-10 years	3
11+ years	5
Unknown	3

Data Collection

This section discusses the number of participants involved in this study, where and how the data were collected and recorded, variations that occurred from the research plan, and finally any unusual circumstances that occurred during the data collection. All

14 participants were identified via Internet searches for facilities likely to employ OTs, listed OT providers in the geographic regions close to those schools that offer the eOTD, and through snowball sampling. When qualified participants were identified and agreed to participate, the Informed Consent was emailed to them. Once the signed informed consent was returned via email, the participant was contacted to arrange a time to complete the phone interview. I conducted all of the interviews from my home office, with the door closed, using my cell phone. The participant chose where to receive their phone call, and that location was not discussed with me. Each interview lasted 15-25 minutes and began by reviewing the informed consent form, and reminding the respondent that participation was voluntary, and that they could withdraw from the study at any time. They were also reminded of the purpose of the study, and confirmation of their permission to record the interview was again verbally obtained. Interviews were recorded on a mini audio recorder and also on the audio recorder of my desktop computer, as a backup. The participants were only verbally identified by the date and time of the interview, with no other identifying information recorded.

Originally, I planned to offer video conference interviews, or in person interviews if the participants were within four hours driving distance. However, the first two participants chose to have phone interviews and these went very well. Therefore, I decided to conduct all interviews in the same way because they were easier to schedule, allowed the participants to be at any location of their choosing, instead of tied to a

computer with a camera, and still provided a good quality recording. There were no other variations in data collection or unusual circumstances.

Data Analysis

This section describes the processes used to analyze the data obtained in the research interviews, beginning with the development of codes and the coding process itself. The section then explains how those codes were analyzed, revised, and combined to develop categories and themes.

Literature Based Codes

Prior to reviewing any of the transcripts, an initial code list was developed based on the pilot project and literature review. Broad main categories were developed to match the categories of the interview questions: DEMO= Demographic Info, JR= Job Responsibilities, COMP= Compensation/costs, and RECG= Recognition. Then sub-codes were created for each of the specific interview questions, such as *RECG: Resp of Professionals* and *COMP: eOTD: Cost of education.* See Appendix D for the complete final list of codes.

First Interview Codes

I coded the first two transcripts using these predetermined codes, but additional codes were also needed. Because the interview questions were open ended, the research participants expanded their answers in ways that required me to add additional concepts or perceptions that I believed to be important for understanding the research topic or to

capture more detailed information. For example, for the quote "The facility that I work at is notorious for being on the lower end of pay scale" the code, *COMP: pay lower salaries,* was developed to capture this more detailed response of how this facility dealt with compensation, which could impact employment of OTs with the different degrees. In the second transcript, the quote "I don't know at this time that it [the eOTD] is being recognized as different. I'm not sure that our docs here recognize that there's a difference in the degrees between our therapists", was coded as *eOTD not recognized* to capture this important perception.

Experienced Reviewer Codes

As an initial check of the appropriateness of the codes, and the coding process so far, an experienced qualitative researcher was asked to code the first two transcripts. She suggested seven additional codes, which are discussed in the Dependability section below. I agreed with her logic and believed that the codes identified additional, detailed concepts that could be important to fully answer the interview questions. Therefore, I added these codes to the code list and used them during coding, as appropriate.

Initial Code Review, Revision, and Consolidation

I then coded the next two interviews using this expanded code list, plus added additional new codes as needed, resulting in four fully coded transcripts. To determine intracoder reliability, I then re-coded the first interview to check for a drift in the definition of codes (Creswell, 2009) and to evaluate the thoroughness of the coding for

that initially-coded interview; please see the Dependability (reliability) section found later in this chapter. At this time, I re-evaluated the current codes list. Some codes were renamed for precision and others were integrated to improve the structure and utility of the code list. For example, the code *eOTD not recognized,* discussed above*,* was integrated into a newer code, *eOTD not understood* because this code seemed more broadly applicable, but still captured the essence of the confusion regarding the eOTD. Then the remaining ten transcripts were coded with this revised code list.

Final Code Revision

The final code revision began with the careful evaluation of the quotations under the codes for each interview question, for fit and utility under that code. First, I checked each interview question code to make sure that there was a response from each participant. If one was missing, I went back to the transcript to determine if I had missed coding a quotation, or if I had not actually asked the question. I found I had not asked one participant about whether eOTDs could introduce themselves as doctor. I also found that I had, at times throughout the interview process, inadvertently combined two interview questions, those about the use of clinical research and the conducting of clinical research. After reviewing the quotations under these two separate codes, I decided that the answers were so similar that they could be combined without any loss of data. There were also a few errors in one demographic code; I found that I had not asked about amount of time in current job for three of the participants.

The next step in the code revision was to review all of the additional codes that were developed throughout the coding process, beginning with those codes with only one or two quotations listed under them. For most of these codes, the few quotations were already included in other codes, so those codes were deleted. For example, there were three quotations under the code *Physical Therapy.* Two were actually in the transcript of the interview with the physical therapist, when she identified her own degrees, and did not identify any meaningful information. The third referenced the need for OT to remain competitive with physical therapy, so this quote was moved to the code *Support for eOTD*. Codes that could not appropriately be merged were left for analysis.

There were several codes with a large number of quotations. A review of *DEMO: Subj: Job Title* revealed 23 quotations coded, which seemed excessive based on 14 participants. As I reviewed these quotations, I realized that under this code, in addition to current job title, I had also included the job title the participant had held in relation to the new OTs we were discussing. To improve precision, I created a new code, *DEMO: Subj: Role related to OTs*. I then went back and coded or re-coded the job titles and roles in each interview. The codes *Comp: eOTD: Cost of education,* and *JR: Direct Pt Care,* also had large numbers of quotations coded, and each quotation was reviewed and found to be appropriately coded under these codes.

The most challenging quotations were those that came from the open ended question, "Is there anything else you would like to add?" at the end of each major

category. These, along with other unsolicited opinions that were offered throughout the interviews, and did not fit under the existing interview question codes, were coded as *Anecdotal Evidence.* Upon review, many of these quotes had already been more precisely included in other codes and these were removed from this code. Those remaining were appropriately placed under this code.

Finally, the codes *No difference* and *eOTD over* MOT were re-evaluated. For both of these codes, I determined that all of the quotations had also been more precisely included in the codes for specific interview questions, and no new information was housed here, so those codes were deleted.

The final stage of the data analysis was to analyze the quotations under each code to answer the interview questions and understand the additional themes that were identified. Table 6 demonstrates the approach used to organize the codes and link them to the interview questions.

Table 6

Interview Question Summary by Participant Number

Interview question	eOTD advanced over MOT	No difference	MOT advanced over eOTD	Unsure
Knowledge required for general, entry-level practice in your treatment area?	7 specialized training in their area, 11 Lit. reviews	1, 2, 3, 4, 5, 6, 9, 10, 12, 13, 14	8	
Skills for direct patient care?	7, 9 specialized training	1, 2, 3, 4, 5, 6, 10, 11, 12	8, 13, 14	
Handling required supervisor responsibilities?	4	1, 3, 5 ,6, 8, 10, 11, 12	13, 14	2, no opportunity 9 Individual, not education 10 Neither
Advocacy for patients?	7 specialized training	1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14		
Use of, conducting of, clinical research?	2, 4, 8, 9	1, 3, 5, 6, 10, 11 (but better than bachelor's), 12, 13, 14		7 no opportunity
Difference in starting salary?	4, 9	1, 2, 3, 5, 6, 7, 8, 10, 11, 12, 13, 14		1
Differences in salary expectations?	2, 4, 5, 7, 9, 10, 12, 13, 14	1, 3, 8, 11		6 (unsure what to expect)

(*table continues*)

Interview question	Worth it	Not worth it	No discussion	Unsure
Cost of their education vs. salary?	6	5, 7, 8, 9, 10, 12, 13, 14	2, 3, 11	1, 4

Interview question	Yes	No	No discussion	Unsure
Status/Recognition influence career choice	2, 5, 14	6, 7, 8, 9	1, 4	Within OT profession: 3, 10, 11, 12, 13
Higher degrees results in increased patient costs?	5, 6	1, 2, 3, 7, 8, 9, 10, 11, 12, 14		4, 13
Higher respect for those with the eOTDs by other professionals?	4, 7	1, 2, 3, 5, 6, 8, 9, 10, 11,12, 13, 14		
Degree of the professional on their name badges?	3, 4, 5, 7, 10	2, 6, 8, 9, 11, 12, 13, 14		1
"Doctor" reserved for physicians?	3, 4, 10, 11, 12, 13	1, 5, 9, 14	8 Not asked	6 First names only 2, 7

Note. The numbers in this table represent the research participants, assigned in the order they were interviewed, so the number 1 is the first person interviewed.

I carefully evaluated all of the quotations under each of the codes and compiled the results, using selected quotations to illustrate the perceptions of the participants. Finally, I reviewed the quotations under the codes developed to identify additional themes in the data and described them as well.

Evidence of Trustworthiness

This section begins with a discussion the actions taken to improve credibility, then discusses the transferability of the findings, and also the steps to improve dependability and confirmability.

Credibility (Internal Validity)

The credibility of the Interview Guide was established in the pilot project (see Chapter 3 for details). For this research study, I used member checking; rich, thick descriptions to convey the findings; presentation of negative or discrepant information; and finally, peer debriefing.

I used member checking during the interviews themselves, as responses were summarized and/or rephrased back to the subject to ensure that the responses had been accurately understood. Additionally, each participant was offered the opportunity to review the transcript of her audio recording to improve accuracy. The first three people interviewed stated that they would like to review their transcripts. None of them provided any comment on the transcripts they received by email. The remaining participants declined to review their transcripts. Finally, during the analysis phase, it was planned that, if there was discrepant information or it appeared that the answer(s) were somehow incongruent with the question(s) that were asked, the response in question would be rephrased and the participant would be asked to verify the accuracy of that summary, but

this was not necessary because clarifications were made during the interviews themselves.

Peer debriefing was also used to improve credibility. Two colleagues agreed to review the research project and data analysis to identify areas that needed clarification and to determine if the findings made sense. Both are OTs, teaching in OT programs, one with a Ph.D. in Curriculum and Instruction, the other with a Master's of Rehabilitation Administration and Services who continues to actively treat patients in a variety of settings. Both reviewers made editing suggestions for grammar, punctuation, and the need for section organization sentences. Additionally, both believed that the Results section was clearly written and answered the research questions, providing data that is needed by the OT profession. Neither reviewer identified any additional questions they had, or points that needed clarification, indicating that the credibility of these findings is high.

Transferability (External Validity)

It was not the goal of this research project that its results be transferable or generalizable. Because there is little data available about those with the eOTD, this project was meant to construct the groundwork to begin to determine if there are any differences between those with the eOTD and with the MOT. Once this is established, then additional studies can be built upon this foundational information and the results of those studies will likely be more transferable. However, to make these foundational data

more applicable and representative of the distribution of OT practice, I was able to achieve broad representation of the profession as the participants represented a wide variety of practice areas (see Demographic section above).

Maxwell (2005) explained that in-depth interviews allowed researchers to gather sufficient details or “rich data” so that they could get a “full and revealing picture of what is going on” (p. 110). The richness of the data is also important for using the constructionist lens to gain a full understanding of the participants’ perceptions. Using an open-ended questioning format allowed the research participants to expand on their answers, giving them the opportunity to provide as much detail as they believed necessary to present their ideas. This thorough picture, along with the broad representation of practice settings, makes the results of this research transferable as foundational data for other research to build upon. Providing “rich, thick descriptions” is my natural writing style and usually needs to be reduced for scholarly writing. Therefore, this suggestion occurred spontaneously during the interviews and discussions of the data analysis.

Dependability (Reliability)

To enhance dependability, the study analysis procedures included three key "reliability procedures," following Creswell (2009). The first reliability procedure was to "check transcripts to make sure that they did not contain obvious mistakes made during transcription” (Creswell, 2009, p. 190). I reviewed the first three transcripts in their

entirety, while listening to the audio recordings of the corresponding interviews and no discrepancies were found. Random sections of additional interviews were evaluated and no discrepancies were found. However, two audio recordings were labeled as “difficult” to transcribe, and had some “inaudible” spots. I listened to these sections of the recordings and in most cases, I could understand what was said. In those spots that I could not, I had asked the participant to repeat their answer during the interviews, so no information was lost.

The second reliability procedure was to “make sure that there is not a drift in the definition of codes, a shift in the meaning of the codes during the process of coding” (Creswell, 2009, p. 190). The consistency of code definitions was regularly reviewed throughout the coding process. Initially, after the first four transcripts were coded, the first transcript was re-coded to check for code drift, thoroughness and accuracy. There was an 89% agreement with 25 codes in recoding and 28 in initial coding. Analysis of the discrepancies revealed that the code *eOTD over MOT* was coded in the recoding, but not the first transcript, when it should have been. This was corrected. The codes *Interview questions: Additional: NO*, and *Interview Question: Improve: NO*, were coded in the first transcript, and in the second, third, and fourth, but upon consideration, this was not providing any valuable information, and these codes were deleted. I decided that the responses to these interview questions would only be coded if participants had suggestions for improvement. The final code discrepancy was *JR: Direct Pt Care*, which

was coded once more in the first transcript. After review, I determined that this code from initial coding was inappropriately attached to a quotation that did not meet the criteria, so it was removed. This process of re-evaluating code definition and utility continued throughout the data analysis, and especially as transcripts were re-reviewed for additional condensation and categorization of codes, and when new codes were identified and previous transcripts were reviewed for the new code.

The third reliability procedure I used was to cross-check the codes (Creswell, 2009). Although I was the only one coding the data for analysis, at the beginning of the coding process, as an additional check of dependability, an experienced qualitative researcher was asked to code the first two transcripts. She added the codes: *No Difference, Unsure of Difference, Some Difference, Very Small Community Hospital, Historical Background for Perspective, Frustrated by Attitude,* and *Anecdotal Evidence.* These seven new codes were evaluated and deemed to be appropriate and useful during the initial coding. She stated that the other codes were appropriate, with clear meaning, and easy to apply to the interviews. Previously coded transcripts were then reanalyzed, adding the new codes as appropriate. Some of these were later merged or deleted during later analysis. For example, I determined that all of the quotations under the code "No difference" had been properly included in other sections, and no new information was housed under this code, so it was deleted.

Confirmability

Schwandt (2007) explained that confirmability is clearly explaining how the "assertions, findings, [and] interpretations" (p. 299) are linked to the data, and the logic or thought processes that led to them. The interview guide questions were developed based on the claims in the literature both for, and against, mandating the eOTD, because these claims are central to the controversy. However, using the constructivist lens to gain a full understanding of this topic, it was important to encourage the participants to fully discuss their perceptions of new therapists through open-ended questions, with multiple opportunities for the participants to add other topics or insights that were not asked about. Therefore, during the data analysis, as new concepts and themes were identified, it was necessary to return to the previously coded interviews to determine if the new concepts and themes could be identified there as well. This process ensured that all of the transcripts were fully evaluated for emerging or discrepant themes, and that I had a full understanding of the data.

A reflexive journal was kept throughout the research process and was used to document my observations and thoughts during the interviews themselves, as well as thoughts and decisions made during the coding and analysis of the data. This process improved the accuracy of iterating the data analysis process and allowed me to explain why coding and interpretation decisions were made. When reviewing this journal, I realized that each of those participants who had the eOTD themselves had spontaneously

made comments about the cost of their own education. Although not an original research question, I believe this information is important to the debate about mandating the eOTD, so it was added as a theme in the data analysis. Another common theme that was identified from the journal was that several participants had expressed frustration with the attitudes of those with the eOTD, so this was further evaluated and added to the discussion of findings. Finally, I noted in the journal that one of the participants had used many personal pronouns, such as we and us, and was the only participant to do so. Therefore, this transcript and the codes that were used were carefully evaluated in the data analysis (please see the discussion of the discrepant case in the Discrepant Data section of this chapter).

Intracoder Reliability

I was the only one coding the interviews, so there was no need to establish intercoder reliability. To improve intracoder reliability, a blank copy of the first interview transcription that was coded was re-evaluated and re-coded after four transcripts had been coded. These two separately coded transcripts were compared to assess the consistency of the coding and the accuracy was found to be acceptable at 89% agreement (25 codes in re-coding, 28 in initial coding). Please see Table 7 for the analysis of the discrepancies and actions taken.

Table 7

Intracoder Reliability Check

Discrepancy	Assessment of Reason	Action
eOTD over MOT was coded in the re-coding, but not the initial.	Oversight	Quotation properly coded in primary document one.
The codes *Interview questions: Additional: NO,* and *Interview Question: Improve: NO*, were coded initially (and in primary documents two, three, and four).	These codes were not providing any valuable information, since no one had any suggestions for additions or changes. Therefore, I decided that the responses to these interview questions would only be coded if participants had suggestions for improvement.	Codes were deleted in all four documents and removed from the code list.
JR: Direct Pt Care, which was coded once more in the initial coding than in the re-coding	In the initial coding, this code was inappropriately attached to a random piece of text in the transcript for unclear reasons.	This code was removed.

Results

This sections begins with a discussion of the findings for each interview question and then the additional themes that were identified during the analysis, with supporting quotations. The section ends with a discussion of the single discrepant case. The interviews were labeled in chronological order, as they were conducted. For example, the

designation *P1* after a quotation represents a statement made by the first person interviewed.

Skills and Abilities

Those who support requiring increased degree requirements to enter clinical practice have claimed the entry-level doctorate is necessary because of the increased complexity of medicine. They argue that the ever-increasing complexity of medicine demands higher levels of education (Pierce & Peyton, 1999; Royeen & Stohs, 1999) and that the doctorate prepares graduates to deliver more complex and advanced care (Royeen and Lavin, 2007). Those who oppose requiring increased degree requirements argue that there has been no documented evidence that the current level of preparation is inadequate or that those with the eOTD possess advanced knowledge or skills over the MOTs (Coppard et al., 2009; Dickerson & Trujillo, 2009; Smith, 2007). To address these claims, these research interviews included questions about knowledge required for entry-level practice in the participant's area of practice, the provision of direct patient care, handling of management or supervisory responsibilities, advocacy for patients, and the use of, or conducting of clinical research.

Knowledge for entry-level practice. Those advocating for requiring the eOTD claim that medicine is increasingly complex and this complexity requires additional education for mastery of the needed knowledge (Pierce & Peyton, 1999; Royeen & Stohs, 1999). Eleven of the participants stated that they did not see any difference in the mastery

of knowledge required for general, entry-level practice; "I feel the knowledge is about the same, just basic understanding of clinical skills, population, delivery of services, evaluations, that I feel is about the same" (P13). One of the participant, P8, believed that, contrary to expectation, those with the MOT have basic knowledge that is actually above those with the eOTD. Two participants believed that the eOTDs had knowledge above the MOTs. One participant (P7) explained that the one eOTD person she had experience with had knowledge above those with the MOT because she had completed her specialized training and projects in areas directly related to that practice setting. Another participant (P11) stated that the eOTDs were better at doing literature reviews.

Providing direct patient care. Proponents of the eOTD have claimed that doctoral level education will better prepare therapists to deliver more complex and advanced care (Royeen and Lavin, 2007), but do so without providing any evidence to support their claims. Nine participants did not perceive any differences in the preparation of new occupational therapists with MOT and eOTD degrees for providing direct patient care. "We take students from all over the country, from a variety of programs. I see no difference in terms of their clinical skills, in terms of what they come out of school with" (P14), and "I'm not sure that [the eOTD] necessarily makes a better treating therapist because it does a lot of research, et cetera, which isn't getting paid for" (P10). P12 stated, "I haven't noticed any differences in patient treatment." In fact, three believed that those with the MOT have basic skills that are above those with the eOTD. P8 noted, "I feel like

the MOT students have done a lot more as far as preparing for interventions." P13, from a pediatric facility, reported,

> I feel like there's a huge difference in terms of professionalism and how things are delivered that way, and it's kind of a negative difference that I see between the two degrees….the MOTs have a little bit more professionalism or they're willing to take direction in terms of…dealing with the parents, because we have to work a lot with the parents. And I feel like the MOTs have a better way of interacting with the parents than those with the eOTD do.

Finally, probably the strongest statement of all, "We take students from all over the country, from a variety of programs. I see no difference in terms of their clinical skills in terms of what they come out of school with" (P14).

Although most of the participants saw little difference or stronger skills from MOTs, two participants reported that the eOTDs have clinical skills above those of the MOTs, specifically referring to the additional training specific to their particular treatment area. P7 stated, "There was more flexibility, and we had an established learning contract for the eOTD students, where it was less about direct client interaction and treating the child, than about some of the other more emerging areas of OT practice." In reflecting on the reasons that eOTDs seem to demonstrate stronger skills, P9 speculated that "just that level of experience in having those different projects or different experiences [improves the skills of the eOTDs]."

Experience over education. Although the interview asked participants to focus on the differences in the outcomes achieved by the two degrees, two of the participants volunteered that they believed that it is experience on the job that makes the difference in performance, not the degree or education of the therapists. P10 clearly articulated this view when she said "…my OTDs are good, but it's because of the experience that they've had now, *just* because of the experience that they've had and the people that they are, you know, the skills they've developed after they got licensed." P9 stated, "But I also feel that those are things that you might – that you could learn as you – when you get out of school and you start practicing."

Supervisory and management skills. Those supporting mandating the eOTD claim that these graduates are better prepared to take supervisory roles and that there will be more advancement opportunities for those with a doctorate degree (Royeen & Stohs, 1999). Opponents claim that there are few opportunities for advancement in the current health care environment and that it is experience that prepares people for supervisory roles (Siler & Randolph, 2006).

Regarding the handling of supervisory and management responsibilities, two said they did not have an opportunity to observe these skills, since the eOTDs were either students or new graduates. Of those who did observe these skills, eight stated that they saw no differences between those with the two degrees. P10 did not believe that either degree level was prepared for management, but rather that it is experience which

develops management skills, stating, “we have a [large] staff working…in hundreds of schools, we have a leadership team, too, and every single person on my leadership team is an entry-level Bachelor’s person.” P9 stated that leadership ability is more based on the individual, than the degree, explaining, “I think it can still be an individual thing. I had two [with the eOTD] and…I would respond, maybe differently, to each of them.” One participant, P4, believed that the eOTDs had slightly superior supervisory and management skills stating,

> I think there's a little bit higher caliber with the eOTDs, just from the fact that the life experiences they've had, and they've been out in the working force a little bit longer than our Master's level students or therapists had. And so that experience with communication and scholarly ability, the scholarly research, and support that they're doing there.

Finally, two participants stated that the MOTs had better supervisory and management skills than the eOTDs, P13 stating,

> The MOTs,…I guess,…do have a better role with taking on some of those [management] roles too. I feel like the eOTDs kind of are—how do I say it? Maybe like stuck in their ways like, "I have a doctor's degree so this is what – I don't really need to take as much direction," or, "I should be able to manage because of my degree," if that kind of makes sense?

P14 stated, “I would tell you that every master student that I have had has been better

than any entry-level [doctorate] student I have had.”.

In response to the open ended question, “Do you have anything you would like to add regarding job responsibilities?” one of the participants, P4, indicated that the eOTD degree would provide additional opportunities,

> Well, I think there's more leadership opportunities with an entry-level doctorate program than there is with a Master's level. Leadership opportunities such as being involved in a higher capacity within a department, looking at the financial aspects of the department, the business aspect of the department, or just the clinical and providing care aspect.

Advocacy for patients. Some who support the eOTD argue that those with higher degrees are better prepared for advocacy (Brown-Benedict, 2008; Royeen & Stohs, 1999) but did not provide evidence to support this claim. Only one participant (P7) in this research study believed that the eOTD resulted in better ability to advocate for the patients, and related this back to the additional fieldwork and training in the pediatric setting. She explained that the eOTD student was more able to consult with teachers about activities for the classroom, and “advocating for what the child needed in the classroom or with the parents and in daycare class settings.” The 13 other participants saw no difference between the MOTs and eOTDs in advocacy for patients.

Research. Those advocating for the eOTD claim that the higher degree prepares graduates to apply existing research and to conduct clinical research (Royeen & Stohs,

1999). Those opposed again claim there is no evidence to support that those with the eOTD are more prepared (Siler & Randolph, 2006). The majority of participants, nine, saw no difference between the eOTDs and the MOTs in the use of, or conducting of, clinical research, but one pointed out that both degree levels were better than the therapists with the bachelor degree. One stated that there was no opportunity to observe this at her facility. However, because there is such a demand for evidence-based practice in healthcare, it is important to note that four participants stated that the eOTDs are better at using the research. One (P8) explained,

> I find that the OTDs are much more up to date on the latest techniques…especially if they're going to work in a field that they – a certain section that they love, [like] in mental health. They're really, really up to date on the latest studies and evidence-based practice.

Skills and abilities section summary. The majority of these research participants, eleven, did not perceive any difference between new therapists with the MOT and those with the eOTD in terms of knowledge for entry-level practice, and two actually believed that those with the MOT have more knowledge. One participant believed the eOTD has more knowledge because of the special projects that particular eOTD therapist had done specific to that practice setting. For providing direct patient care, nine of the participants did not perceive a difference in skills, three believed that MOTs have better treatment skills, and two believed that the eOTDs have stronger skills,

both again relating this to the additional experience in special projects. Unsolicited, three of the participants indicated that it is actual experience on the job that improves treatment skills, and has very little to do with the degree of the therapist.

Of those participants who had observed supervisory or management activities, more than half saw no difference between the two degree levels, two thought the eOTDs have better skills, one believed the MOTs have higher skills, and one believed that these skills have little to do with education, and are more about the individuals themselves. Thirteen of the participants saw no difference in the ability to advocate for patients, and one believed that specific treatment setting special projects gives the eOTDs better advocacy skills. For the use of, or conducting of, clinical research, four of the participants believed the eOTDs have higher level skills, which is actually the most responses in favor of the eOTD in these results. Nine saw no difference in research related skills and abilities.

Therefore, the results of this study indicate that overall, with regard to skills and abilities required for entry-level practice, there is little difference between new therapists with the MOT degree and those with the eOTD. The one area where the eOTDs may be somewhat stronger is in the use and conducting clinical research.

Desired Compensation

Proponents of mandating the eOTD claim that the increased costs to graduates will be recovered over time through higher salaries (Royeen & Lavin, 2007; Royeen &

Stohs, 1999) and the opponents express concern that increased degree requirements will limit the places graduates can afford to work, and will increase the costs to hire therapists (Coppard et al., 2009; Royeen & Lavin, 2007; Royeen & Stohs, 1999; Siler & Randolph, 2006). Interview questions asked about starting salaries, salary expectations, cost of education, and potential to increase cost of services to patients.

Therapists' salaries. Proponents of the eOTD predict that the advanced degrees will increase salaries (Royeen & Stohs, 1999), but opponents claim this is not likely because the employer's ability to generate income, and therefore money for salaries, is often limited by insurance reimbursement (Coppard et al., 2009; Fisher & Keehn, 2007; Siler & Randolph, 2006). Regarding starting salaries for therapists with either degree, one participant did not have knowledge of the pay scale at her facility, so was unable to answer the question regarding salaries of new graduates. Eleven of the participants, which was a majority, stated there was no difference in the pay scale of occupational therapists based on the degree of the applicant. One participant spontaneously included those with the Doctor of Physical Therapy (DPT) in her answer because that profession now requires an entry-level doctorate, "the DPTs are paid the same as any entry-level OT or speech therapist" (P14). Some of the research participants who worked in pediatrics identified that their practice area has a low pay scale in general, "Obviously, a pediatric clinic is not paid as high as a hospital or skilled nursing facility" (P13). Alternately, there

was a higher pay scale for the eOTDs at two of the facilities, between $1,500 and $3,000 per year.

Salary expectations. There is concern that new eOTD therapists may expect or need higher salaries because of their increased educational costs, but these expectations may not be met (Siler & Randolph, 2006). Nine of the participants identified that the eOTDs did initially expect a higher salary because of their degree, four did not see a difference in salary expectations, and one stated that graduates were unsure of what to expect. One of the participants who stated the eOTDs expected more, explained,

> The OTDs have said to me that they believe that they're worth more than the starting salary I'm offering. And so we've had to have that conversation that, you know,…that it's about your experience and your years licensed and I'm sorry you feel that way. I'm sorry you were told you could expect that, but that's not the case here. (P10)

Cost of education. Scholars on both sides of this debate agree that the entry-level doctorate will result in higher education costs (Coppard et al., 2009; Fisher & Keehn, 2007; Royeen & Stohs, 1999). Although graduates from both degree levels typically graduate with loan debt, those with the eOTD have higher debt load resulting from the longer educational program. When asked about discussions with therapists about the cost of their education as compared to the amount of salary they can make, five participants had not had this discussion or were unsure. One had a positive impression, "The OTD

student that I had, I think she felt like the [added] six months or whatever part of the program for the doctorate over the master's was worth that extra tuition." (P6) A total of eight had a negative impression of the cost of the education. One stated,

> Oh, absolutely! I have therapists come in just so upset because they're sitting on $100,000.00 worth of school loans, from their graduate program primarily, and they can't make enough to pay those loans or it certainly gouges what they can possibly have for a mortgage. (P10)

Another participant added additional details about how the debt load impacted a new graduate's life,

> She got her doctorate and was a student here, and told me the cost of paying for her student loans has very much impacted her life, in terms of when she could get married and have children, the neighborhood she was able to afford to live in, and thus the school systems for her children. That high, high student loan impacted her life greatly. (P5)

Finally, three of the participants added additional information about pay scale, indicating that working for nonprofits, either in pediatrics or community mental health, results in a lower pay scale in general. One explained,

> Many eOTD therapists I know have struggled with finding a job they love, like in pediatrics, because the pay is lower, versus taking a job in rehab, which pays more, so that they can pay back their student loans. Many of them have taken

> second, even third jobs, to pay down their loans, so they can move on with their lives. (P13)

Increased patient costs. Some scholars have questioned whether higher degrees will result in increased patient costs (Siler & Randolph, 2006). When asked to consider this idea, two of the research participants believed this might be true, “I guess I could see the indirect effects of that. If a company…is paying out higher salary amounts for their therapists, those costs have to come through somewhere. I guess I could indirectly see how that’s right” (P6). Two participants were unsure. The other 10 disagreed. They did not believe that patient costs would increase, either citing the fact that the salaries are not actually higher or that payors pay for treatment, not the degree of the provider, “the insurance and Medicare/Medicaid aren’t changing their pay structures for the therapists providing the care” (P1).

Desired compensation section summary. In general, those with the eOTD do not have higher starting salaries according to twelve of the research participants, although, nine of them indicated that the eOTDs initially expect higher salaries. Only one participant has spoken with an eOTD who believed the degree was worth the additional cost. Eight indicate that through their discussion with eOTDs, and three through personal experience, the benefits of the eOTD did not offset the additional costs. The majority, ten, of the participants did not believe that mandating the higher eOTD degree will increase patient costs.

Therefore, the results of this study indicate that overall, those with the eOTD expect to make a higher starting salary, but they usually have the same starting salaries as those with the MOT. Additionally, the additional costs to obtain the eOTD do not result in tangible benefits in the work place. Participants did not believe that mandating the higher degree will result in increased patient costs.

Respect

There is concern among some of the health professions that as some disciplines have mandated entry-level clinical doctorates, those which do not will somehow be at a disadvantage because they will be less respected if they do not follow suit (Bollage, 2007, Fisher & Crabtree, 2009; Griffiths & Padilla, 2006; Pierce & Peyton, 1999; Royeen & Stohs, 1999). Opponents disagree, claiming that entry-level clinical doctorates have had little impact on stature and respect for the professions that have mandated them (Siler & Randolph, 2006). These discussions led to interview questions about students choosing their degree program based on desired status, and those with the eOTD being more respected by other professionals and patients.

Status. Some advocating for mandating the eOTD claim that some students desire the status of an advanced degrees and some of those students will choose their profession because a doctorate is required (Fisher & Crabtree, 2009; Griffiths & Padilla, 2006; Pierce & Peyton, 1999). Opponents disagree, claiming that students choose their profession based on the type of work that will be done (Siler & Randolph, 2006). Two of

the participants had not ever had this discussion and four did not believe potential status had an impact. Only one of the participants suggested that the status of the advanced degree could be the deciding factor in choosing the *profession,* stating, “I definitely think that a lot of our therapists were seeking an advanced degree. I don't know that they would have gone into this profession if it was not an advanced degree” (P2). However, six did believe that it was status that influenced the decision of which degree to pursue *within the profession*, stating “There have been a couple students that, yeah, to be able to say, ‘I have a doctorate,’ was very, very important to them. That was why they got the doctorate versus the master’s” (P5). Another stated, “I think that’s the way the programs sell their program over another [MOT program]” (P10). Another stated,

> Oh, that’s funny…We were just talking about an OTD clinician that we know that requires people to call her doctor and so yes, I would say I have, and I think it’s quite frankly, ridiculous. (P14)

Two of the participants indicated that there were reasons other than status for pursuing the eOTD. One reason was practicality, “It wasn't felt as though it was a significant amount of time more to go ahead and get the higher degree, versus what it would take to go back later and get…an actual doctorate or a bridge program” (P3). Another indicated that the decision to get the eOTD was to maximize competency, “I feel like at least the ones who are in more of the pediatric setting, it's because they have that general desire to help, to improve that quality of life” (P13).

Respect from professionals. Supporters of mandating the eOTD claim that it will increase respect for OTs (Royeen & Stohs, 1999). Therefore, the interview asked about the differences in the level of respect for those with the eOTDs compared to the MOTs *by other professionals.* Two of the participants believed there was a difference. P4 noted that there was a difference in level of respect, but that this was related to the eOTDs' knowledge of the science behind the clinical care, not to the quality of the clinical care itself. The other twelve participants did not believe there was any difference in levels of respect by other professionals, many expressed thoughts similar to these quotations, "When you're on the floor treating patients and in the very many multi-disciplinary teams that includes everyone from doctors to social workers, no one even knows [what degree you have]" (P5). And another said,

> I don't think that [the degree] even comes into play a lot of the times because physical therapists have to get a doctorate in order to practice. So I often feel like people don't even know that OTs don't have one. I think they often think, "Well, PTs have one so OTs have one." So I don't really see a difference in respect. Maybe among the actual population where, OT to OT, we can say, "Well, you have the doctorate. You went through the extra work that I wasn't willing to do. I'm impressed. (P8)

One of the participants who did not believe there was a difference in respect, spontaneously expanded her answer, indicating that her master's degree is all that is

needed for respect at her facility and that the clinical doctorates are not really considered advanced degrees. Additionally, she indicated that the clinical doctorate in physical therapy (DPT) has resulted in fewer Ph.D. physical therapists, which her facility requires to manage their physical therapy department,

> We're having a lot of trouble hiring a Director of Physical Therapy right now. We've had a vacancy for so many years, it's making me crazy, because they [the employer] want a Ph.D., but their profession [physical therapy] went to the DPT….And so the people out there with the DTPs have hardly any experience, but they're claiming a doctorate. (P10).

As a possible explanation for the lack of additional respect for those with the eOTD, three participants expressed the opinion that the eOTD is not well understood or not recognized as different, especially by other professions.

Respect from patients. Changing the focus slightly, the next area of interest asked about differences in respect from patients. None of the fourteen participants believed there was any difference between those with the MOT and those with the eOTD, most stating that the patients don't have any idea about the therapist's degree:

> I think they have no clue.…In terms of clinical skills, they're looking for a good clinician. You could have somebody with a bachelor's degree that's fabulous and my patient wouldn't know the difference between a bachelor's and a doctorate

> degree….They're looking for somebody that fits their family and fits their kid and they don't know. (P14)

Credentials on name badges. During the first interview that I conducted, I became curious as to whether the credentials, such as MOT or OTD, were on the name badges, because seeing this might impact how patients and other professionals view the OTs. One of the participants did not know. At three of the facilities, no badges are worn, no credentials are on the badges at five facilities, and the credentials are on the badges at four facilities. Finally, at one facility, only those with a doctorate have credentials on their badges. One participant provided a unique explanation for not providing credentials on badges,

> Our facility decided to just do away with all of that, to do away with all the different letters. We felt like it confused patients, and it did kind of undermine people who had 50 years of experience but didn't have that Master's or Doctorate. It felt like they were being undermined, so they've completely done away with that. (P2)

Titles of therapists. Another area of interest is how the therapists are labeled or titled, because this too, may influence how patients and other professionals view the OTs. At two of the facilities, the therapists only use first names, one participant was unsure if or what titles are used, and one was mistakenly not asked the question. At five of the facilities, *doctor* is reserved only for the physicians. At one facility, "It's reserved for

Ph.D.s and physicians in my facility. I have never heard one of my OTD therapists refer to themselves as doctor" (P10). At the other four facilities, the therapists can use the term doctor, if they choose.

Respect section summary. Twelve of the research participants did not believe those with the eOTD were more respected by other professionals, and none of them believed that patients had more respect for the higher degree. The credentials are on the name badges at only five of the participants' work facilities. The title *doctor* is reserved for physicians at six of the facilities.

Therefore, the results of this study indicate that overall, those with the eOTD, because of their degree, are not more respected by other professionals or patients, frequently do not even have this credential on their name badge, and are often not allowed to use the title *doctor* at work.

Additional Themes

The open ended formatting of the interview questions allowed participants to explain their answers and several additional themes were identified during the coding and data analysis: opinions about mandating the eOTD, the attitudes of those with the eOTD, and their own opinions about the MOT versus the eOTD.

Frustrated by attitude. There is concern within the profession, and with some stakeholders that clinical doctorates facilitate a sense of superiority or entitlement in some graduates (Siler & Randolph, 2006). This concern was supported by four of the

participants. They made multiple statements about the attitudes of those with the eOTD, resulting in 10 statements being grouped under the *frustrated by attitude* code. Essentially, these participants stated that those with the eOTD had a belief that their degree placed them above those who didn't have doctorate, despite lack of skill or experience,

> My experience with entry-level doctorates has been the most frustrating, I think because they seem to come out feeling very – almost superior, and yet the least ready for the nuts and bolts hands-on clinical reasoning, what do I do with this patient in front of me? (P5)

One participant, who holds a Master's degree, described encounters with those with the eOTD:

> I have had applicants say to me, who is just a Master's level person, that their degree makes them uniquely qualified to do things that a therapist without a clinical doctorate can do. And I'll just look at them say, "Really? You're saying that to me, who's been working 35 plus years?" I said, "You really need to get a check on that ego."… I'll tell them that that's a dangerous way to approach a potential supervisor. (P10)

Another sentiment expressed was that those therapists with the eOTDs, because of that degree, did not believe that they have to be as prepared as others,

> We interview [our potential fieldwork] students,…[the eOTD students], they're not prepared. They haven't done their research…They walk in…and they think, I'm this OTD person, you should take me. Whereas, I feel like the master's students walk in and they're like, I might be a step behind because I have a master's and I'm going show up and knock your socks off, and they do! I haven't accepted an OTD student in about two years because they haven't passed the interview process. (P13)

eOTDs on cost of their education. One of the most common arguments against mandating the eOTD is that the cost of the additional schooling will put significant strain on new graduates (Siler & Randolph, 2006) and this was supported by the participants. Unsolicited, all three of the participants who had the eOTD themselves provided opinions about the cost of their education, discussing how the additional cost of the eOTD, and the loans taken to pay for it, have not resulted in significant benefits in their work environment. One explained that her sister went to OT school after her, and she discouraged her sister from pursing the eOTD, due to the cost. Another stated.

> Well, to give you a little background, my husband is a physician, and he and I graduated around the same time, and we had the same loans. So he was paying back the same amount of loans with a medical degree that I was with an [e]OTD, and obviously we are never gonna make the same pay, so you start off at such a disadvantage with that. I think that's one of the biggest drawbacks, especially as I

> was looking for my first job and realizing how upside down I would be for so long in that. (P12)

A third stated, “Looking back on it, I might have chosen something different, maybe the MOT, if I would have known where my student loans are right now and I'm only seven and a half years out of school” (P13)

Negative connotations toward the eOTD. Several participants offered comments that demonstrated negative connotations toward the eOTD. One participant verbalized the ambivalence that many in the OT profession feel, expressing both negative and positive statements about the eOTD. She stated, “I think it's that keeping up with the Joneses thing, and I don't know at what point you stop that, if it's necessary or not necessary” (P2). She then also acknowledged that the number of hours many OT students complete equals what is called a doctorate in other professions,

> I think it has always felt like overkill a little bit to me, but at the same token, I want our profession to be pushed forward, and I don't want us to be left behind…Even lawyers have a juris doctorate, and they go to the same amount of schooling that even our Master’s went to. So, to some degree, to me, it feels a little bit like semantics. And is it really more of an education, or is it just a change in what we're calling a degree? (P2)

Four participants made statements with a negative connotation toward the eOTDs, three indicated that they did not see any advantages or real differences with this degree. One stated,

> I don’t feel like there's any pull really or any salary advantage, or – I think from what I’ve heard and what I’ve seen it seems like people almost don’t know what to do with this extra degree people have – for OT at least. (P6)

Another stated,

> I guess that’s my only point. I, like I said, graduated with an OTD, but I honestly haven’t noticed any difference, from a career standpoint, in what I’ve been able to do with it or with the patient care, or salary. And like I said, my sister is also an OT and I discouraged her from doing it for all those reasons. (P12)

Another brought in the educational programs,

> I think that’s the way the programs sell their program over another. I have a lot of pre-OTs here, you know, moms and dads and people calling me and saying – because in our community, there’s an MOT program and an OTD program, eOTD, and I have a lot of people interested in entering our profession calling or emailing me and asking me the difference and I tell them the exact thing I’ve been talking to you about, there is no difference. (P10)

Finally, one just stated her strong opinion, “No, but thank God you’re doing this research because I don’t think we should go to the eOTD, personally” (P14).

Several participants made statements that provided additional information, explanation, or context for the participants' perceptions and opinions. P5 stated,

> I guess again, just pleading with our professors and our education and the political people out there, to please advocate for OT. I think that we, at this facility and everywhere I've been, are the least understood, least utilized and sometimes most disrespected.

P10 suggested that, as an alternative to mandating the eOTD, the profession should consider promoting specialty certification,

> I'm a Board Certified Pediatric Therapist,…I've been talking to the therapists in my community about the possibility that that specialty credential could begin to separate the ethical, evidence-based practitioners from those who maybe aren't as ethical or evidence based in the way they work.

P10 also suggested that the PhD would be a better option for moving the profession forward, "I see the Ph.D. as a far more rigorous, meaningful degree." Finally, P13 expressed concern that changing the educational programs, which are already producing good therapists, to eOTDs, would have a negative impact on the quality of the graduating therapists,

> I guess my only concern is that if they change things to – the programs are working the way they are and if they try to change them you're going to impact, I think – I mean some of the schools already have really good, quality programs, and

> I think by changing that it's gonna negatively impact what they're wanting to get out. (P13)

Support for the eOTD. Two participants made statements in support of the eOTD that did not fit into the other codes, one indicating that the eOTD education provides higher level of skills for the eOTDs, and the other with concern with competition. The participant who is a physical therapist referenced changes she has seen in her own profession's move to an entry-level doctorate,

> I have not read the research for occupational therapy, but we've sort of gone through some of this in physical therapy. And I do think that because they have an extra – extra time, you come out with a bigger support base underneath you, sort of technical …research looking at outcomes, development measurement tools, psychometric development, a bigger base for that. (P9)

The second participant expressed support for the eOTD because of concern about competition, "And certainly with the physical therapy world going that direction [to the entry-level doctorate], there's a concern of being left behind if we don't." (P2)

MOT over eOTD. Four participants made a total of nine statements throughout the interviews that indicated that the MOTs had skills more advanced than those with the eOTD. The most common statements were about professionalism and communication skills, explaining the MOTs are more willing to take direction and have better communication skills. Participants identified difficulties when the eOTDs were being

interviewed themselves, and also when they were the ones conducting the interviews of clients and families. Specifically in relation to being interviewed themselves, one participant said, “I feel like the masters students walk in and they’re like, I might be a step behind because I have a masters and I’m going show up and knock your socks off, and they do:! I haven’t accepted an OTD student in about two years because they haven’t passed the interview process” (P14). With regard to being able to interview clients, one participant said, “I feel like the MOTs have a better way of interacting with the parents than those with the eOTD do” (P13), and also,

> I, honestly, feel like the MOTs have a little bit more of that professionalism when they're coming in and I don't know why. But I feel like the eOTDs definitely don't have that. I mean their interview skills are really poor, they're not prepared for anything. Clinical skills, I think it's good, but those interview skills carry over to evaluations. We do a lot of parent report in our evaluations and so they struggle with that because they can't do it themselves, then so they can't sit there and talk to a parent in an appropriate way.” (P13)

Three indicated that the MOTs have clinical skills that are greater than the eOTDs. One stated, “I feel like the MOT students have done a lot more as far as preparing for interventions” (P8). Another explained, “My strongest therapist…[has] been working seven or eight years, [has an] MSOT and she’s in the front of the pack,…she’s got it going on over any of my OTDs and I’ve got six or seven OTDs” (P10). The third stated,

“I would tell you that every master student that I have had has been better than any entry-level [OTD] student I have had” (P14). This participant also offered this perspective unique perspective, as she has taught in both MOT and eOTD programs, “I taught in an OTD program for [several] years…I’m teaching in both programs now. I am telling you these master’s degrees are by far better than these entry-level [doctorate degrees]” (P14).

Additional themes section summary. Four participants expressed frustration over the sense of superiority or entitlement common among those with the eOTD. The three participants who had the eOTD themselves, strongly expressed that the additional costs of this degree were very burdensome, which was not offset with professional or work benefits. A few of the participants’ comments reflect the ambiguity about the eOTD in the broader profession, expressing concern about remaining competitive if it isn’t mandated, but also concern about the potential negative consequences on the profession if it is mandated. Four of the participants were clearly against mandating the eOTD, and two were in support.

Therefore, the results of this study indicate that overall, there is very little support for increasing the entry-level degree requirements for occupational therapists.

Discrepant data. There was one instance of discrepant information during the interview and analysis process for one of the participants who had recently completed her *post professional OTD*, versus the eOTD. At times during the interview, she used personal pronouns, such as “the doctorate level prepares *us* more for the leadership roles

that we take on in the future" and "*we're* looking for evidence to support and *we're* documenting providing the evidence to support what *we're* doing" (P4). When this occurred, I would remind her the questions are asking about the eOTD, not the post-professional doctorate, or try to clarify that the statements were actually about the eOTD, and she would respond in the affirmative. Therefore, these statements were initially coded under the codes for the corresponding interview question and other codes, as appropriate. However, during the data analysis, when the specific codes were being analyzed, I could not be confident that she was actually discussing her perceptions of those with the eOTD. I went back to the entire coded document, and reviewed it in its entirety. In two cases, I could not determine if she was actually referring to the eOTDs or those with the post professional OTD and therefore excluded two coded statements, one from the code *Support for eOTD* and one under *Anecdotal Evidence*.

Summary

There are almost no data published to support the move to require the eOTD for the profession of OT. Similarly, there is little evidence to support the predictions of the negative consequences from those against mandating the eOTD. This study provides data to lay the foundation for answering the research question, what are the perceptions of direct supervisors regarding the performance of new OTs with the eOTD versus those with the MOT as they relate to the factors that impact the stakeholders of OT services: skills and abilities, desired compensation, and recognition?

The first part of this research question focuses on the differences in skills and abilities. Overall, this study found that the majority of supervisors do not perceive a significant difference in those new therapists with the MOT and the eOTD in knowledge for entry-level practice, providing direct patient care, supervisory and management skills, advocacy for patients, nor in the use of, or conducting of clinical research. Several participants expressed the opinion that, for several of the categories, it is experience, not education that improves skills and abilities.

Regarding the second part of the research question focusing on compensation, at the vast majority of the facilities, there is no difference in starting salaries for the different degree levels. However, in general, the eOTDs do *expect* a higher salary when they first graduate. About half of the participants stated that the cost of education had a negative impact on the new eOTDs, where they could work, and even other life decisions such as when to get married and buy a house. The majority of the participants did not believe that the eOTD would increase patient costs for occupational therapy services.

The final part of the research question focuses on recognition. This research suggests that the desire for the status of a doctorate does not play a role in choosing the *profession*, but that status may influence the decision of which degree to pursue *within the profession.* Overall, the vast majority of participants did not believe that there is a difference in the level of respect for OTs with the different degrees by either other professionals or by patients. At just over half of the facilities, either no name badge is

worn, or the credentials are not on the name badges, so it is not even possible to know the degree of the OTs. At only four of the facilities are those with the eOTD allowed to use the title *doctor.*

Finally, four additional themes were identified in the analysis process. One was frustration over the challenging attitudes of superiority that some with the eOTD demonstrated. Second, unsolicited, all of the participants who had eOTDs themselves indicated that the cost of the additional education has had a negative impact on their lives and has not provided much, if any, benefit to their careers. Third, several participants expressed opinions about the eOTD, mostly negative, with only two indicating support for mandating the eOTD. Finally, a little over one third indicated that the MOTs had skills more advanced than the eOTD.

This exploratory study sought to identify whether direct supervisors perceive that there are differences between new OTs with the eOTD and those with the MOT with regard to skills and abilities, desired compensation, and recognition, and if so, what those differences might be. The findings indicate that overall, there is very little difference in clinical knowledge and skills for treatment, except that the some eOTDs may do better with regard to utilizing research. Starting salaries are usually the same, although the eOTDs initially expect higher salaries. There is no difference in level of respect from either other professionals or patients.

In the next chapter, I will discuss the interpretation of these research finding and make recommendations for further studies.

Chapter 5: Interpretation and Recommendations

Introduction

This section briefly reviews the purpose and nature of the study, describes why it was conducted and summarizes the key findings. The purpose of this study was to gather information to help the profession of OT determine the entry-level practice degree that develops therapists who are sufficiently trained to meet the needs of clients, while providing the fewest negative consequences for other stakeholders. The overarching research question was whether direct supervisors perceive that there are differences between new OTs with the eOTD and those with the MOT with regard to skills and abilities, compensation, and recognition, and if so, what those differences might be. These perceptions were gathered through collective case studies, using in-depth, semi structured interviews with criterion-based, purposeful sampling, and viewed through a constructionist lens. This research found that overall, supervisors perceive very little difference between new therapists with these degrees, despite the additional education. This finding has important implications for positive social change in the field of OT, because without the knowledge that there is little perceived difference between those with the MOT and those with the eOTD, the profession might make poor choices about future degree requirements. These results demonstrate that the field currently has insufficient evidence of the benefits of the eOTD to warrant increasing the degree requirements, potentially adding costs and burden without adding value for patients and other

stakeholders. This research has provided evidence to help decision makers in the profession of OT, and in the eOTD educational programs to make more informed choices.

Summary of the Research Findings

The first part of this study focused on the differences in skills and abilities. This research suggests that there is very little difference between new therapists with the MOT and the eOTD with regard to knowledge for entry-level practice, providing direct patient care, use of or conducting of clinical research, supervisory and management skills, or advocacy for patients.

The second part of the study focused on compensation and found that, at the vast majority of the facilities, there is no difference in starting salaries for the different degree levels, participants did not believe that the eOTD would increase patient costs for occupational therapy services, that in general the eOTDs do *expect* a higher salary when they first graduate, and that the cost of education has a negative impact on the new eOTDs.

The final part of the study focused on recognition and found that there is no difference in the level of respect for OTs with the different degrees either by other professionals or by patients. Name badges are frequently not worn, or the credentials are not on the name badges, so it is not even possible to know the degree of the OTs in daily interactions. In general, those with the eOTD are not allowed to use the title *doctor* in the

work place. Finally, the desire for the status of a doctorate does not play a role in choosing the *profession*, but that status may influence the decision of which degree to pursue *within the profession.*

Finally, additional themes were identified through this research. First, some with the eOTD present with challenging attitudes of superiority and entitlement, despite lack of skills or experience. Second, the cost of the additional education for the eOTD has long-term negative impacts on the lives of these OTs and has not provided much, if any, benefit to their careers. Finally, this research found the eOTD is not seen as an asset by occupational therapy supervisors.

Interpretation of the Findings

In OT, much of the published literature regarding the appropriate entry-level degree includes authors' ideas about what effects, both positive and negative, the mandated eOTD will have, but provides no research data to support these claims (Fisher & Keehn, 2007, Royeen & Lavin, 2007, Royeen & Stohs, 1999, Runyon et al., 1994, Siler & Randolph, 2006). Other researchers have investigated people's assessment of whether the eOTD is good or not, rather than looking at how eOTDs compare with MOTs (DeAngelis, 2006, Dickerson & Trujillo, 2009). In this section, I will provide my interpretations of what the research findings mean to the profession.

Skills and Abilities

Pierce and Payton (1999) stated the "The professional doctorate offers a successful and accepted degree structure of the preparation of advanced practitioners…[who can] sensitively interpret the human condition presented by patients" (p. 70). Royeen and Stohs (1999) claimed "clinical doctorate education results in practitioners who have a greater depth of knowledge and a greater ability to apply knowledge in diverse and nontraditional settings" (p. 174). This research study found that overall, eOTDs do not have knowledge, skills and abilities that are different from those with the MOT, sometimes are even less skilled, and sometimes exhibit behaviors that are frustrating to supervisors.

The primary argument in favor of mandating the eOTD is that the profession will accept some possible drawbacks for other stakeholders to benefit patients. However, if the eOTDs have neither more knowledge nor better skills and abilities that do benefit patients, there would be insufficient benefits to offset the drawbacks to a higher degree requirement.

This research suggests a discrepancy between the quality of OTs that the eOTD education programs intend to produce and what the supervisors perceive in the day to day work environment. Because the eOTD educational programs strive to graduate eOTDs with advanced-level knowledge and skills, this discrepancy implies that these academic institutions may not be receiving sufficient feedback from their graduates' fieldwork and

work places to pinpoint areas for continued improvement in their programs, or may not yet have identified techniques for further enhancing their students' skills and abilities.

The frustrating behaviors and poor communication skills identified by eOTD supervisors are an unanticipated consequence that has not previously been identified, and raises a serious concern. These findings suggest that some eOTD programs training on interpersonal communication skills, both to communicate with patients and with supervisors is insufficient. Additionally, there appears to be inadequate education on what roles and responsibilities the eOTD degree actually prepares the new graduates to pursue.

Those advocating for the eOTD claim that the higher degree prepares graduates to apply existing research and to conduct clinical research (Royeen & Stohs, 1999), and a small number of the research participants did perceive that the eOTDs were better able to apply existing research to their clinical work. This skill is important because the expectation for evidenced based practice has become the norm, and often a requirement for reimbursement for OT services. Therefore, the OT profession needs people who can apply clinical research. However, we must also have OTs who can actually interact well with patients and families and provide good treatment. Although these skills are not mutually exclusive, the results of this study suggest that an academic focus on enhanced research skills is correlated with lower clinical skills. This implies that the profession needs to assess whether it is best served by enhancing its eOTD programs to produce OTs

who can do clinical work to the standard of the MOTs as well as effectively applying research to their practice, or may be better served by allowing graduates to specialize in one area or the other.

Those supporting mandating the eOTD claim that these graduates are better prepared to take supervisory roles and that there will be more advancement opportunities for those with a doctorate degree (Royeen & Stohs, 1999). At the time of Royeen and Strohs' publication, the profession of OT was moving to require a post baccalaureate degree to become an OT (History of AOTA Accreditation, n.d.) but most practicing therapists had a bachelor’s degree. A doctorate would have required significantly longer education, which may have made them more qualified for supervisory roles than those with a bachelor’s degree. Now that all new OTs have a master’s degree, there is a less dramatic difference in education. This research found that many with the eOTD continue to believe or even expect that they should have positions of authority, or should not be accountable to those with lower degrees, even though all new therapists now have at least a master’s degree. This implies that the eOTD education programs may need to be more explicit in helping their students to understand the value of on the job experience, and to have more realistic expectations about their roles and skills as new graduates.

Costs and Compensation

This area of controversy is over the increased cost to obtain the doctorate and how this may impact the new therapists, and also concern that the higher degree will increase

employer and patient costs. Fisher and Keehn (2007) found "employers also expressed concern that hiring . . . therapists with doctoral level degrees would become increasingly expensive" (p. 20). This research did not find evidence to support this concern as eOTDs generally are not paid more than the MOTs. Those who pay for OT services do so based on the service, or type of intervention provided and not based on the degree of the provider. Organizations that provide OT services are limited in the amount of income they can generate, and will logically be hiring the least expensive therapists to maximize their profits. This implies that there is little incentive for employers to pay higher salaries to those with the eOTD, especially considering the overall finding of this research study that those with the eOTDs do not have stronger skills and abilities than those with the MOT.

An additional concern has been that new eOTD therapists may expect or need higher salaries because of their increased educational costs (Siler & Randolph, 2006) and this concern was supported by this research. Lambrecht (2005) postulated that because of the increased costs for doctoral education, graduates will need to take those jobs with higher salaries to meet their student loan obligations and this concern was also supported by this research. About half of the participants stated that the cost of education had a negative impact on the new eOTDs such as where they could work, and even other life decisions such as when to get married and buy a house. This implies that eOTDs with higher loan debt will have difficulty with loan repayment, which will in turn affect the

jobs they can afford to take, may cause them to leave the profession for higher paying positions, and may dissuade potential OTs from entering the profession.

Cost of health care. Lambrecht (2005) indicated that "the creep of entry-level credentials has been called into question…because of the appearance that it is self-serving, controlling of labor market workforces, and contributing to greater health care costs" (p. 3) but provides no evidence as to whether those opinions have been substantiated. Lang (2008) claimed that the increased degree requirements "can raise the already spiraling costs of health care" (para. 10). These concerns were not supported by these research findings because starting salaries are no different, payors pay for services rather than the degree of the provider, and participants did not believe that the eOTD would increase patient costs for occupational therapy services. This implies that mandating a higher degree would not increase patient costs, unless for several of the reasons discussed above, the higher degree requirement eventually resulted in decreased numbers of people entering the profession. Shortages of OTs would drive up salaries and potentially, costs.

Student recruitment. Student recruitment and retention and the tuition the students provide are the financial backbone of every academic institution, and the education of practitioners is the backbone of the profession. Providing an entry-level doctoral degree may attract those students who desire an advanced degree (Pierce & Peyton, 1999) and improve student recruitment (Griffiths & Padilla, 2006). In their

conclusions, Fisher and Crabtree (2009) stated, "To ensure the profession's continued viability…We cannot afford to lose the best candidates to other professions because ours is not keeping pace with the market" (p. 659). These claims were not supported by this research as only one participant believed that desire for an advanced degree is the deciding factor in choosing the *profession.* Those advocating for mandating the eOTD claim that some students desire advanced degrees (Fisher and Crabtree, 2009; Pierce & Peyton, 1999) and this claim was supported in this research regarding the decision of which degree to pursue *within the profession*. This implies that making an eOTD available will meet the desire some students have for an advanced degree.

Stature, Recognition, and Respect

There is concern among some of the health professions that as some disciplines have mandated entry-level clinical doctorates, disciplines that do not will be at a disadvantage because they will be less respected if they do not follow suit (Bollag, 2007, Fisher & Crabtree, 2009; Griffiths & Padilla, 2006; Pierce & Peyton, 1999; Royeen & Stohs, 1999). This study found that credentials are not usually on name badges, that eOTDs do not use the title *doctor*, and that most team members and patient do not know the degree of the OT. This implies that it is not the degree of the OT that garners respect. This finding weakens claims that the degree itself will increase recognition and respect and improve the stature of the profession, at least with patients and co-workers.

What was not addressed in this research study is the requirement of many research funding agencies that the principle investigators must have a doctorate to be eligible for research funding. The importance of this requirement cannot be overlooked as all of healthcare seeks to find evidence to support their practice. Maintaining the master's degree requirement will result in the profession having fewer practitioners with doctorates than other professions that now require the entry-level doctorate, like pharmacy and physical therapy. This could limit much needed research funding to support the OT profession.

Summary of Interpretation

The findings of this research indicate that there is a discrepancy in the quality of OTs that the eOTD programs intend to produce and what the supervisors perceive in the day to day work environment with regard to skills and abilities, attitudes, communication skills, realistic expectations about salaries, and qualifications for management positions. For potential new OT students, these findings indicate that they should carefully consider which degree to pursue because the increased debt load for the eOTD will not likely result in higher salaries or more respect from patients and co-workers, and may affect where they can afford to live and work. For the profession, if the eOTDs have neither more knowledge nor better skills and abilities that can benefit patients, this finding undermines the primary argument for raising the degree requirement. This suggests that the profession should not move to requiring the doctorate without closely examining the

actual knowledge and skill differences between graduates with the different degrees, and identifying mechanisms to ensure that those with the eOTDs do actually have skills and abilities that benefit the patient and other stakeholder of the the profession.

Limitations of the Study

This study was not designed to be comprehensive, but rather was intended to lay the foundation for additional research. The overarching goal was to gain perspectives from supervisors who work with new therapists with the MOT and also those with the eOTD, to determine if there are any differences between these new OTs in areas that are important to stakeholders. Therefore, it was necessary for this initial study to be small to conduct the in-depth, exploratory interviews. To make these foundational data more broadly applicable and representative of the distribution of OT practice, I sought broad representation of the profession, and interviewed participants representing a wide variety of practice areas and geographic locations. Despite these efforts, the findings may not be applicable to all those who have the eOTD and MOT degrees. Additionally, it should be considered that those who feel strongly about the eOTD would be more likely to take the time to participate in this study, which could have influenced the outcomes. Therefore, the results of this small study may not be generalizable throughout the field of OT, or to other allied health fields.

Recommendations

The overarching finding of this small, exploratory study is that supervisors perceive very little difference between new therapists with the MOT and those with the eOTD in skills and abilities, compensation, and recognition or respect. Recommendations from this study center around the perceived effects of the mandated eOTD on relevant stakeholders, including clients, new practitioners, and employers.

Effects on Clients

This research did not find improvements in direct patient care with the eOTD, but there was some support for the concerns that some eOTDs struggled with the daily demands of the clinic. Therefore, additional research is needed to understand if the eOTDs are actually having challenges meeting the daily demands of the clinics and what those challenges are specifically. Additional research is needed to specifically evaluate the knowledge, skills, and abilities of the eOTDs compared to the MOTs and if their additional education and training affects patient care and practice innovation. Although the results of this study indicated that supervisors have not yet seen any effect on patient costs, it will be important to understand if, over time, the presence of more eOTDs with greater salary expectations will actually increase patient costs.

Effects on New Practitioners

Those opposing mandating the eOTD have speculated that requiring the eOTD will lead to increased educational costs (Siler & Randolph, 2006). These concerns were

supported in this research and the participants indicated that this increased debt is not usually offset by higher salaries. In addition, debt load may be preventing new eOTDs from accepting employment in practice settings that traditionally offer lower salaries, like pediatrics, mental health, and nonprofits. Additional research is needed to understand how the higher debt-load from earning the eOTD is influencing employment choices, and also other life events, such as getting married and having children.

Proponents of the eOTD claim that it provides advanced knowledge valuable to the profession, increases advancement and salary opportunities, and enhances the ability to practice in nontraditional settings (Royeen & Lavin, 2007; Royeen & Stohs, 1999). This research did find some support that if the additional fieldwork for the eOTD was completed in an area directly related to the practice setting, this resulted in advanced skills and abilities. Additional research is needed to identify where those with the eOTDs are working, whether and how their additional fieldwork is being utilized in their jobs, if they are practicing in innovative settings, and if they have been able to advance into management roles more quickly. Finally, the supervisors did not perceive that new therapists of either degree level have supervisory ability. Therefore, educational programs for both degree programs should consider adding curriculum content to improve management skills. Alternately, schools should make it clear what the new graduates are actually qualified and not qualified to do, so that they do not have unrealistic expectations upon graduation.

Additionally, this research did find that some eOTDs have difficulties with communicating with supervisors and patients, have difficulty taking direction from others, and exhibit a superior attitude which is frustrating to supervisors. Therefore, additional research is needed to specifically assess communication skills, attitudes toward and interactions with those lower degrees, and abilities to effectively participate in learning relationships with those clinicians who have more experience, as all new therapists need to do.

Effects on Employers

Although several authors have postulated that increased degree requirements will increase the costs to hire therapists (King et al. 2010; Lang, 2008; Siler & Randolph, 2006), this fear was not substantiated by this research study. A larger work force study is needed to better understand salary scales for those with the eOTD compared to the MOTs. It would be important to differentiate this information by practice area and facility type, to begin to understand if salaries may influence where those with the eOTD can afford to work. Since this study did find that eOTDs often do expect higher salaries, future studies should also investigate if, as more eOTDs enter the workforce, these expectations do drive up salaries for new eOTDs. Additionally, future studies would benefit from objective measures that can substantiate with empirical evidence the differences, or lack thereof, identified in this study.

Effects on the Profession

The findings of this research indicate that the profession of OT does not yet have sufficient data to support a move to raise the entry-level degree requirements to the eOTD because the justifications given by proponents were not generally supported. There was some support for the claim that eOTDs are better at utilizing research to guide treatment. However, if, as the respondents for this study indicated, the research work is correlated with lower clinical skills, the profession may need to think about division of labor - with researchers who focus on designing studies to gather evidence, and practitioners who collaborate with them, but focus on patient care.

Implications

Implications for Positive Social Change

This study provides crucial information for the profession of OT as it tries to determine the entry-level degree that best meets the needs of the profession itself, provides therapists who are sufficiently trained to meet the needs of clients, and has the least negative consequences on the stakeholders of OT. The study's findings that supervisors do not perceive differences in skills and abilities for patient care provides vital information for the field, because once the entry-level degree requirement is increased, it cannot logically be reversed. Future researchers can use the foundational information of this research study to identify additional factors that need further

investigation. Additionally, the educational programs could use this foundational research to help them design outcome studies to understand if their graduates actually do have the clinical skills and abilities they are striving to teach.

On the broadest level, research to identify if and how those with the clinical doctorates are different from those with lower degrees was requested by the Higher Learning Commission in 2006 as it considered accreditation standards for entry-level doctorates, and this study contributes significantly to that call for information. Understanding similarities and differences between MOTs and eOTDs is necessary as the academic community reviews relevant accreditation standards and curricular content; this study is the first to provide that information for occupational therapists Additionally, the results of this study provide information to aid in the development of relevant outcomes measures to ensure that the eOTD degree will provide the stakeholders, i.e. students, employers, patients, and payors, with OTs who have some knowledge and skills that are different, and more advanced than those with a master's degree. This information could, over time, build the evidence that justifies increasing the entry-level degree requirement, which the profession does not have now. Alternatively, it could provide the basis for choosing not to proceed with a higher degree requirement.

This study provides the foundational data that will allow academic programs to identify what their stakeholders need and want from new OTs, and evaluate if their graduates are meeting those needs. The academic programs can then use this information

to improve their course offerings and to evaluate student and new graduate outcomes on specific measures important to stakeholders. This outcomes data could be used in student recruitment, in fieldwork site recruitment, and to encourage employers to hire their graduates.

Finally, this study will help individuals interested in becoming OTs to make informed decisions about which degree best meets their needs, and justifies the debt load they will incur.

Methodological, Theoretical, and/or Empirical Implications

The results of this small, qualitative, exploratory, multiple case study design research provides only very foundational knowledge about the similarities and differences between those with the MOT and the eOTD degrees. The results of this study identified that these supervisors do not perceive those with the eOTD to have higher skills and abilities in many areas important to stakeholders, but do sometimes have an attitude of superiority that is frustrating to supervisors and difficulties with communication. Larger studies could be developed based on each of the interview questions, using more objective outcomes measures, to help the profession understand if these results are truly representative of those with the eOTD.

The stakeholders identified in this study provide a beginning guide of those who will be impacted by degree requirements, and future researchers can determine if they agree with the stakeholders identified here and if others need to be added. Stakeholder

theory can help shape a comprehensive outcomes research agenda for the profession of OT to ensure that the entry-level practice degree develops therapists who are sufficiently trained to meet the needs of clients and society, while providing the fewest negative consequences for stakeholders.

Finally, the profession needs to continue to build the evidence to support practice. Future research needs to look specifically at the kinds of research that are needed to support practice and how to best train OTs to do this research, and in sufficient numbers to meet the needs of the profession. Additionally, it would be beneficial to understand if those with the eOTDs are actually doing clinical research, how much of that research is sponsored or funded, and how those numbers compare to those with the MOT, and even with OTs who have the PhD. This knowledge would provide the profession with further information on which degree actually does support the research needed to inform practice, improve patient outcomes, and facilitate payment for services.

Conclusions

The Centennial Vision for AOTA states, "We envision that occupational therapy is a powerful, widely recognized, science-driven, and evidence-based profession with a globally connected and diverse workforce meeting society's occupational needs" (AOTA, n.d.). As the profession considers increasing the entry-level degree requirement to an eOTD, it needs to base its decision on evidence and consider the perspectives of all stakeholders of OT. This study found that there are almost no differences between new

therapists with the MOT and those with the eOTD in skills and abilities for patient care, compensation, and recognition and respect. However, there are negative consequences with increased debt load that may impact OT employment choices and life decisions, such as where to live and when to have children. Additionally, those with the eOTD may sometimes bring difficult attitudes, which may decrease their acceptance at fieldwork sites and in hiring decisions.

The profession would benefit from partnering with eOTD and MOT academic programs, using stakeholder theory to design a comprehensive outcomes research agenda to ensure that the entry-level practice degree develops therapists who are sufficiently trained to meet the needs of clients and society, while providing the fewest negative consequences for stakeholders.

References

Accreditation Council for Occupational Therapy Education. (2006). Accreditation standards for a doctoral-degree-level educational program for the occupational therapist, Standard B.10.16, p. 13. Retrieved from http://www.aota.org/education-careers/accreditation/standardsreview.aspx

American Medical Association Approves 2 ASA-Sponsored Resolutions. (2006). Resolution 211: Need to expose and counter nurse doctoral programs (NDP) misrepresentation. Retrieved from http://archive.is/XeuiA

American Occupational Therapy Association. (n.d.) Centennial vision. Retrieved from http://www.aota.org/aboutaota/centennial-vision.aspx

American Occupational Therapy Association. (2007). AOTA's 2007 Representative Assembly proposed business agenda. *OT Practice*, *12*(4), 28-33.

American Occupational Therapy Association. (2010). Workforce Trends in Occupational Therapy: Resources for Students from the American Occupational Therapy Association. Retrieved October 29, 2011 from: http://www.aota.org/-/media/corporate/files/educationcareers/prospective/workforce-trends-in-ot.pdf

American Occupational Therapy Association. (2012). 2011 Accreditation Council for Occupational Therapy Education (ACOTE®) standards and interpretive guide: December 2012 interpretive guide version. Retrieved from http://www.aota.org/Educate/Accredit/Draft-Standards/50146.aspx?FT=.pdf

American Occupational Therapy Association. (2013). OT doctoral-level programs – accredited. Retrieved from http://www.aota.org/en/Education-Careers/Find-School/AccreditEntryLevel/DoctoralEntryLevel.aspx

American Physical Therapy Association 2014 Strategic Plan. (2013.). APTA vision statement for physical therapy 2020 (HOD P06-00-24-35). Retrieved from http://www.apta.org/uploadedFiles/APTAorg/About_Us/Vision_and_Strategic_Plan/Strategic_Plan/StrategicPlan_112310.pdf

Amini, D., & Gupta, J. (2012). Fieldwork Level 2 and occupational therapy students: A position paper. *American Journal of Occupational Therapy*, *66* (6), Supplement, S75-S77. doi:10.5014/ajot.2012.66S75.

Andrews, T. (2012). What is social constructionism? *The Grounded Theory Review*, *11*(1), 39-46.

Aronson, A. (1987). The clinical PhD: Implications for the survival and liberation of communicative disorder as a health care profession. *A Journal for the American Speech-Language-Hearing Association 29*, 35-35. Retrieved from http://journals.asha.org/

Ayal, I. (1986). Planning for a professional association. *Long Range Planning, 19*(3), 51-58. Retrieved from http://www.journals.elsevier.com/long-range-planning/

Babbie, E. R. (2007). The practice of social research. Belmont, CA: Thomas Wadsworth

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and

implementation for novice researchers. *The Qualitative Report, 13*(4), 544-559

Benoit, J. N., Mohr, T. M., & Shabbach, C. H. (2004). Entry-level doctoral degrees: Issues facing graduate school. *Journal for Higher Education Strategists, 2,* 39-56.

Bollag, B. (June, 22, 2007). Credential creep. *Chronicle of Higher Education,* 10. Retrieved from http://chronicle.*com*/section/Home/5

Brown-Benedict, D. (2008). The doctor of nursing practice degree: Lessons from the history of the professional doctorate in other health disciplines. *Journal of Nursing Education 47*(10), 448-457. Retrieved from http://www.healio.com/journals/jne

Clark, D. (2007).Why should we not study the OTD? *ADVANCE for Occupational Therapy Practitioners*, *23*(12), 28.

Cohen, D. (2005). Educational vision: Advanced degrees and lifelong learning are set to transform rehab professionals' lives. *Rehab Management, 8(*10), 12-13.

Coppard, B., & Dickerson, A. (2007). A descriptive review of occupational therapy education. *American Journal of Occupational Therapy, 61*(6), 672-677.

Coppard, B., Berthelette, M., Gaffney, D., Muir, S., Reitz, S. M., & Slater, D. Y. (2009). Why continue 2 points of entry education for occupational therapists? The case for both master's- and doctoral-level entry into the profession. *OT Practice, 14*(4), 10-14.

Commission on Education. (2013). COE Guidelines for an Occupational Therapy

Fieldwork Experience—Level II. Retrieved from http://www.aota.org/

Creswell, J. (2009). *Research design: Qualitative, qualitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Creswell, J. (2013). *Qualitative inquiry & research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Cruess, S., Johnston, S., & Cruess, R. (2004). "Profession": a Working definition for medical educators. *Teaching & Learning in Medicine*, *16*(1), 74-76.

Cunningham, J., & Kempling, J. (2009). Implementing change in public sector organizations. *Management Decision, 47*(2), 330-344. doi:10.1108/00251740910938948

DeAngelis, T. (2006). *Elite occupational therapists' attitudes regarding the entry-level clinical occupational therapy doctorate degree*. (Doctoral dissertation). Retrieved from ProQuest (UMI 3209078).

Dembicki, M. (2008). Colleges eye 'degree creep': Allied health fields consider raising minimum degree for entry-level jobs. *Community College Times*. Retrieved from http://www.communitycollegetimes.com/article.cfm?ArticleId=1262&PF=Y

Derry, R. (2012). Reclaiming marginalized stakeholders. *Journal of Business Ethics*, *111*, 253-264. doi:10.1007/s10551-012-1205-x

Dickerson, A., & Trujillo, L. (2009). Practitioners' perceptions of the occupational therapy clinical doctorate. *Journal of Allied Health, 38*(1), e47-e53.

Direct Supervision. (2014). In *U.S. Legal definitions*. Retrieved from http://definitions.uslegal.com/d/direct-supervision/

Driscoll, A., Fottler, M., Liberman, A., Pitts, L., & Wan, T. (2011). Demand study for advanced dental hygiene educational degrees: Part 2: Assessing educational demand. *Health Care Manager, 30*(2), 161-17. doi:10.1097/HCM.0b013e318216f9b8

Dunham, L., Freeman, R. E., & Liedtka, J. M. (2006). Enhancing stakeholder practice: A particularized exploration of community. *Business Ethics Quarterly, 16*(1), 23-42. doi:10.5840/beq20061611

Fisher, G., & Keehn, M. (October 2007). Workforce needs and issues in occupational and physical therapy. University of Illinois for the Midwest Center for Health Workforce Studies. Retrieved from http://www.westga.edu/~distance/ojdla/spring161/workforce.pdf

Fisher, T., & Crabtree, F. (2009). The issue is - generational cohort theory: Have we overlooked an important aspect of the entry-level occupational therapy doctorate debate? *American Journal of Occupational Therapy, 63*(5), 656-660.

Floater. (2003). In *Merriam-Webster's online dictionary.* Retrieved from http://www.merriam-webster.com/dictionary/floater

Freeman, R. E. (1984). *Strategic management: A stakeholder approach*. Boston, MA: Pitman.

Freeman, R. E. (1994). The politics of stakeholder theory: Some future directions. *Business Ethics Quarterly, 4*(4), 409-421. doi:10.2307/3857340

Frey, J., & Oishi, S. (1995). *How to conduct interviews by telephone and in person* (vol. 4). Thousand Oaks, CA: Sage Publications.

Fuchs, V. (1988). The "competition revolution" in health care. *Health Affairs, 7*(3), 5-24. doi:10.1377/hlthaff.7.3.5

Fuller, J. B., Hester, K., Barnett, T., Frey, L., Relyea, C., & Beu, D. (2006). Perceived external prestige and internal respect: New insights into the organizational identification process. *Human Relations, 59*(6), 815-846. doi:10.1177/0018726706067148

Gail, D. (2005, July-August). President's message. *Trends: Association of Schools of Allied Health Professions*, 2.

Garvare, R., & Johansson, P. (2010). Management for sustainability - A stakeholder theory. *Total Quality Management & Business Excellence, 21*(7), 737-744.

Greenwood, R., Suddaby, R., & Hinings, C. R. (2002). Theorizing change: The role of professional associations in the transformation of institutionalized fields. *Academy of Management Journal, 45*(1), 58-80. doi:10.2307/3069285

Griffiths, Y., & Padilla, R. (2006). National status of the entry-level doctorate in occupational therapy (OTD). *American Journal of Occupational Therapy, 60*(5), 540-550. doi:10.5014/ajot.60.5.540

Higher Learning Commission for North Central Association of Colleges and Schools Task Force. (2006). A report to the board of trustees from the task force on the professional doctorate. North Central Association of Colleges and Schools. Retrieved from http://www.ncahlc.org/download/TaskForceProfDocFinal0606.pdf

History of AOTA Accreditation. (n.d.). Retrieved from http://www.aota.org/en/Education-Careers/Accreditation/Overview/History.aspx

Jensen, T., & Sandström, J, (2013). In defense of stakeholder pragmatism. *Journal of Business Ethics*, *114*, 225-237. doi:10.1007/s10551-012-1338-y

Job Description. (2014). In *U. S. legal definitions.* Retrieved from http://definitions.uslegal.com/j/job-description/

Kaplan, R., & Porter, M. (2011). How to solve the cost crisis in health care. *Harvard Business Review*, *89*(9), 46-64.

KaiserEDU. (n.d.). Issue modules: US health care costs. Retrieved from http://www.kaiseredu.org/issue-modules/us-health-care-costs/background-brief.aspx

King, J., Freburger, J., & Slifkin, R. (2010). What does the clinical doctorate in physical therapy mean for rural communities? *Physiotherapy Research International, 15,* 24-34. doi:10.1002/pri.455

Kvale, S., & Brinkmann, S. (2006). *Interviews: Learning the craft of qualitative research*

interviewing (2nd ed.). Thousand Oaks, CA: Sage Publications.

Lambrecht, R. (2005). "Degree creep" in the health professions: A misunderstood notion. *National Accrediting Agency for Clinical Laboratory Sciences*, *90*, 3. Retrieved from http://www.naacls.org/PDFviewer.asp?mainUrl=/docs/naacls-news/vol90.pdf

Lang, J. (2008, October 23). 'Degree creep' can add to health care shortages. *Community College Times*. Retrieved from http://www.communitycollegetimes.com/article.cfm?ArticleId=1269&PF=Y

Laplume, A. O., Sonpar, K., & Litz, R. A. (2008). Stakeholder theory: Reviewing a theory that moves us. *Journal of Management, 34*(6), 1152-1189. doi:10.1177/0149206308324322

Lester, S. (2009). Routes to qualified status: Practices and trends among UK professional bodies. *Studies in Higher Education, 34*(2), 223-236. doi:10.1080/03075070802528296

Mashall, C., & Rossman, G. (2011). *Designing qualitative research* (5th ed.). Thousand Oaks, CA: Sage Publications.

Maxwell, J. (2005). *Qualitative research design: An interactive approach* (2nd ed.). Thousand Oaks, CA: Sage Publications.

McNabb, D. (2008). *Research methods in public administration and nonprofit management: Quantitative and qualitative approaches* (2nd ed.). Armonk, NY:

M.E. Sharpe.

Miller, R. (1998, March 19).Is a doctoral education relevant to a practicing OT? *OT Week*, 16.

Muir, S. *(2012). Knowledge Area Module 7: Qualitative research design: Pilot project. Front line manager's perception of eOTDs vs MOTs.* Unpublished manuscript, Department of Public Policy & Administration, Walden University, Minneapolis, MN.

National Board for the Certification in Occupational Therapy. (n.d.) Retrieved from http://www.nbcot.org/index.php?option=com_content&view=article&id=200:how-does-a-candidate-earn-nbcot-certification&catid=27:faq

Noordegraaf, M. (2007). From "pure" to "hybrid" professionalism: Present-day professionalism in ambiguous public domains. *Administration & Society, 39*(6), 761-785.

Parker, L. (2007). Boardroom strategizing in professional association: Processual and institutional perspectives. *Journal of Management Studies*, *44*(8), 1454-1480. doi:10.1111/j.1467-6486.2007.00713.x.

Patton, M. (2002). *Qualitative research & evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Pierce, D., & Peyton, C. (1999). A historical cross-disciplinary perspective on the professional doctorate in occupational therapy. *American Journal of Occupational*

Therapy, 53, 64-71. doi:10.5014/ajot.53.1.64

Quiroga, V. (1995). *Occupational therapy: The first 30 years: 1900 to 1930.* Bethesda, MD: AOTA Press.

Royeen, C., & Lavin, M. A. (2007). A contextual and logical analysis of the clinical doctorate for health practitioners: Dilemma, delusion, or de facto. *Journal of Allied Health, 36*(2), 101-106.

Royeen, C. B., & Stohs, S. J. (1999). Should the clinical doctorate degree be the standard of entry into the practice of occupational therapy? In P.A. Crist (Ed.), *Innovations in occupational therapy education,* 171-177.

Runyon, C. P., Aitken, M. J., & Stohs, S. J. (1994). Commentary: The need for a clinical doctorate in occupational therapy (OTD). *Journal of Allied Health, 23*(2), 57-63.

Santiago, A. (n.d.). What is medical residency training? All about medical residency training. Retrieved from http://healthcareers.about.com/od/medicalschooldoctors/a/MedResidency.htm

Scott, W. R. (2008). Lords of the dance: Professionals as institutional agents. *Organizational Studies, 29*, 219-238. doi:10.1177/0170840607088151

Schwandt, T. A. (2007). *The Sage dictionary of qualitative inquiry.* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Siler, W., & Randolph, D. (July 21, 2006). A clinical look at clinical doctorates. *Chronicle of Higher Education*, B12. Retrieved from

http://ezp.slu.edu/login?url=http://search.ebscohost.com

Smith, D. (2007). Perceptions by practicing occupational therapists of the clinical doctorate in occupational therapy. *Journal of Allied Health,* 36(3), 137-140.

Stead, J. G., & Stead, W. E. (2008). Sustainable strategic management: An evolutionary perspective. *International Journal of Sustainable Strategic Management 1*(1), 62-81. doi:10.1504/IJSSM.2008.018127

Swanborn, P. (2010). *Case Study Research: What, where, and why.* London: Sage Publications.

Weithaus, B. (1993, Summer).New directions for allied health education accreditation. *Journal of Allied Health, 22*(3), 239-247.

Wellens, L., & Jegers, M. (2014). Effective governance in nonprofit organizations: A literature based multiple stakeholder approach. *European Management Journal 32*, 223-243. doi:10.1016/j.emj.2013.01.007

Wells, R., Feinberg, M., Alexander, J. A., & Ward, A. J. (2009). Factors affecting member perceptions of coalition impact. *Nonprofit Management and Leadership, 19*(3), 327-348. doi:10.1002/nml.222

Appendix A: Interview Guide

You have indicated that you are someone who has worked both with new therapists who have the entry-level occupational therapy doctorate (which I will call "eOTD") and those with the entry level master degree (MOT). I want to learn your views about new therapists with these degrees.

Qualifying & Demographic Questions:

1) Have you directly worked with or been responsible for supervising Level 2 Fieldwork students or OTRs with the MOT?
   - Which one or both?
2) Have you directly worked with or been responsible for supervising Level 2 Fieldwork students or OTRs with the eOTD? (If "no" thank participant for his/her time and ask if he/she might suggest some else who has had this type of direct contact.)
3) Please describe the TYPE of facility where you had contact with these new therapists (without saying the name, please)
   - Adults or Pediatrics
4) Tell me a bit about how you got to the position you hold here – things like your educational background and experience in occupational therapy.

- **Prompts/hints** (make sure each of these questions is addressed)
  - *What is your professional degree?*

- *Is this the highest degree you have obtained?*
- *How many years have you been in practice?*
- *What is your current job title?*
- *How many years have you held this position?*
- *Have you held other positions at this facility before this one?*
- ***Your role** as it relates to the occupational therapists in your facility? (peer/co-worker, team leader, direct supervisor, rehab manager over several disciplines)*

5) How is your facility structured as it relates to therapy delivery? For example, are your therapists hired for a specific position with a specific population, or do they float around and work with a variety of diagnosis or on different units?

Thank you, now I have a sense of your experience.

Job Responsibilities

Please answer the following questions based on your own personal experiences, or those therapists you have personal knowledge about.

1) What differences do you see (if any) in the preparation of new occupational therapists with MOT and eOTD degrees in terms of:
   - **Knowledge** required for general, entry-level practice in your treatment area?
   - Providing direct patient care?

- Handling required supervisory/management responsibilities?

2) eOTD are designed to give students additional training beyond what MOTs get. In what ways (if any) does this additional training result in differences in?

- Patient treatment
- Advocacy for patients
- Use of, or conducting of, clinical research

3) Is there anything else that you would like to add regarding therapists with eODTs and MOTs in terms of job responsibilities?

Compensation:

1) Do you have any knowledge of the compensation or pay scale for the therapists at your facility? (if yes, continue to #2)
2) Can you give me an estimate of the difference in starting salary for new eOTDs and MOT therapists (if any), with no prior OT experience?
3) In talking to eOTDs and MOTs, have you seen any differences in salary expectations?
    - Tell me more about that.
4) Have you ever talked with therapists about the cost of their education as compared to the amount of salary they can make? Tell me about that.
5) Some researchers think that hiring therapists with higher degrees results in increased patient costs. Others disagree. What are your thoughts?

6) Can you give me any concrete examples of how costs are/are not affected from your facility?

Recognition

1) Some of the published literature has stated that people choose their profession in order to enjoy the status of an advanced academic degree. Have you ever talked with a health care worker where this desire for an advanced degree was the deciding factor in choosing their profession? Can you describe that conversation for me?
2) Can you describe differences, if any, in the level of respect for those with the eOTDs (compared to the MOTs) **by other professionals**? Can you share an example?
3) Can you describe differences, if any, in the level of respect for those with the eOTDs (compared to the MOTs) **by patients**? Can you share an example?
4) Is the degree of the professional on their name badges?
5) Do those with the doctorate introduce themselves as "Dr." or is this reserved for physicians.
6) Is there anything else that you would like to add about eOTDs and or MOTs?
7) Do you have any suggestions for improving the questions asked in this interview?
8) Do you have any suggestions for me, on ways that I can improve this interview process?

Appendix B: Recruitment E-mails

Hello:

My name is Sherry Muir and I am a doctoral student at Walden University and an occupational therapist. Over the last several years, many health care professions have moved to require a “clinical” or “entry-level” doctorate to enter the profession. Occupational therapy has periodically considered this change as well, and AOTA has now recommended this change to the Accreditation Council for Occupational Therapy Education (ACOTE). This would involve all educational programs moving from the currently required master’s degree to an entry-level doctorate (identified here as the eOTD).

The purpose of this study is to gain an understanding of front line supervisors' perceptions of new occupational therapists with these degrees and how they relate to entry-level practice. The questions were developed based on the literature advocating both for and against requiring the eOTD for occupational therapy and tested in a pilot study.

For this study, I am seeking supervisors/managers who have worked with Level 2 Fieldwork students or new therapists who have the entry-level occupational therapy doctorate degree (eOTD) AND ALSO those with the master of occupational therapy degree (MOT). If you meet this criterion and might be interested in participating in this research project, please email me back or call and I will provide additional information.

If you do not meet this criterion, or do not wish to participate, please email me back, or call telling me so, and I will remove you from my list so that I don’t bother you with follow up emails or phone calls.

Thank you for your time in considering participating in this research project. If you have any questions or want more information, please email me at sherry.muir@waldenu.edu or call me at 618-530-4545.

Sherry

Follow email:

Hello:

Several days ago, you received an email from me about a study gathering information comparing new therapists with the entry-level occupational therapy doctorate versus those with the master's of occupational therapy. The complete text of that email is in *italics* below.

I am following up to ask that you email (sherry.muir@waldenu.edu) or call me (618-530-4545) to let me know if you would be willing to participate in this important study or if you would like me to remove you from the list so that you are not contacted again. If I do not hear from you by [date] I will try to reach you by phone.

Thank you,

Sherry

My name is Sherry Muir and I am a doctoral student at Walden University and an occupational therapist. Over the last several years, many health care professions have moved to require a "clinical" or "entry-level" doctorate to enter the profession. Occupational therapy has periodically considered this change as well, and AOTA has now recommended this change to the Accreditation Council for Occupational Therapy Education (ACOTE). This would involve all educational programs moving from the currently required master's degree to an entry-level doctorate (identified here as the eOTD).

The purpose of this study is to gain an understanding of front line supervisors' perceptions of new occupational therapists with these degrees and how they relate to entry-level practice. The questions were developed based on the literature advocating both for and against requiring the eOTD for occupational therapy and tested in a pilot study.

For this study, I am seeking supervisors/managers who have worked with Level 2 Fieldwork students or new therapists who have the entry-level occupational therapy doctorate degree (eOTD) AND ALSO those with the master of occupational therapy degree (MOT). If you meet this criterion and might be interested in participating in this research project, please email me back or call and I will provide additional information.

If you do not meet this criterion, or do not wish to participate, please email me back, or call telling me so, and I will remove you from my list so that I don't bother you with follow up emails or phone calls.

Thank you for your time in considering participating in this research project. If you have any questions or want more information, please email me at sherry.muir@waldenu.edu or call me at 618-530-4545.

Sherry

Appendix C: Informed Consent

CONSENT FORM

You are invited to take part in a research study of **front line supervisors' perceptions** of new therapists with entry-level occupational therapy doctorates (eOTDs) and those with the master's of occupational therapy (MOT) degree. You are invited to participate in the study because you are a supervisor or manager who has experience in working with new therapists from both degrees tracts. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Sherry Muir who is a doctoral student at **Walden University.** Ms. Muir is an occupational therapist and an assistant professor at Saint Louis University, for the Program in Occupational Science and Occupational Therapy. This study, and the request for your participation in it, is **completely separate** from Ms. Muir's role at Saint Louis University and no one else there will know if you agree or decline to participate.

Background Information:

Over the last several years, many health care professions have moved to require a "clinical" or "entry-level" doctorate to enter the profession. Occupational therapy has periodically considered this change as well. This would involve moving from the currently required master's degree to an entry-level doctorate (identified here as the eOTD).

The purpose of this study is to gain an understanding of front line supervisors' perceptions of new occupational therapists with these degrees and how they relate to entry-level practice. The questions were developed based on the literature advocating both for and against requiring the eOTD for occupational therapy and tested in a pilot study.

Procedures:

If you participate in this study, you are agreeing to:

- Participate in one audio-recorded interview with the researcher lasting approximately one hour.
- Review the typed transcript of your interview, if you wish, to check for accuracy.

Voluntary Nature of the Study:

Your participation in this study is voluntary. This means that I will respect your decision of whether or not you want to be in the study. No one at your work place will know if you decide not to be in the study. If you decide to join the study now, you can still change your mind during the study. If you feel stressed during the study, you may stop at any time. You may skip any questions that you feel are too personal.

Risks and Benefits of Being in the Study:

There are no substantial risks from participating in this research project; there may be a mild risk of emotional discomfort if the questions remind you of an unpleasant interaction with another person. Your participation will benefit the profession of occupational therapy by helping the researcher to collect the first information about possible differences between graduates with these two degrees.

Compensation:

There will be no compensation for participating in this research study.

Confidentiality:

Any information you provide will be kept confidential. The researcher will not include your name or anything else that could identify you in any reports of the study. The audio recording of your interview will not include your name, only the date and time you were interviewed. The audio recording and the transcription of it will be stored on a flash drive and also on a secure server. The flash drive will be stored in a locked drawer, in a locked office. The computer is also in a locked office and requires a password to open, and the server is password protected as well. The results of this study may be published in scientific research journals or presented at professional conferences. However, your name and identity will not be revealed and your record will remain confidential. No person or facility will be identified in any presentations or publications.

The data will be retained for a minimum of five years. Once the data’s usefulness has expired, the audio recordings will be erased from the flash drive and the password protected server and the “recycle bin” will also be “emptied”. The original interview transcripts will be shredded by a professional shredding service.

Contacts and Questions:

You may ask any questions you have now, or after the interview is completed. Or if you have questions later, you may contact the researcher via email at sherry.muir@waldenu.edu or by phone at 618-530-4545. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 1-612-312-1210, extension 3121210. Walden University's approval number for this study is 01-07-15-0289999 and it expires on January 6, 2016. If you have questions about your rights as a research participant, you can also call the Saint Louis University Institutional Review Board at 314-977-7744 and reference IRB #25274.
The researcher will give you a copy of this form to keep.

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below, I am agreeing to the terms described above.
Electronic signatures are regulated by the Uniform Electronic Transactions Act. Legally, an
"electronic signature" can be the person's typed name, their email address, or any other identifying marker. An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically.

Printed Name of Participant ____________________________________

Date of consent ____________________________________

Participant's Written or Electronic* Signature____________________________________

Researcher's Written or Electronic* Signature____________________________________

Appendix D: Final Code List with Quotations

The quotations for each of the final codes are listed below; the interviews were labeled in chronological order, as they were conducted. Therefore, the designation *P1* represents a statement made by the first person interviewed. The headings are formatted just as they were in the Atlas.ti program, which added organization to the code list and improved ease of coding. The code itself is **bolded**, followed by my definition of that code, and then all of the statements that were under that code after the final coding.

Ambivalent

Statements that contained both positive and negative connotations toward the eOTD or that indicated uncertainty about the degree.

P 2 Yes. I think it's that keeping up with the Joneses thing, and I don't know at what point you stop that, as it's necessary or not necessary. But, at the same token, there is certainly that competition, and as healthcare gets tighter and tighter, I see it. I mean, I see all the different therapy disciplines encroaching on each other's areas, trying to vie for the same dollar amounts. And so I think that's something that needs to be kept in mind. And I don't know, I don't know if a higher degree is going to be an asset or a hindrance when it comes down to payer sources. I don't know the answer to that question, but I definitely think it's something that needs to be kept in mind.

P 2 I think it has always felt like overkill, a little bit to me. But at the same token, I want our profession to be pushed forward, and I don't want us to be left behind. So it's very interesting to me. Even lawyers have a juris doctorate, and they go to the same amount of schooling that even our Master’s went to. So, to some degree to me, it feels a little bit like semantics. And is it really more of an education, or is it just a change in what we're calling a degree? I don't know because I don't know what's going on in the doctorate programs. I’m not seeing that in the entry-level right now, but that doesn't mean it's not there. I just − I'm not seeing it with the entry-level students. I see it with our people who are going back to school for sure.

Anecdotal Evidence

Statements that provided additional information, explanation, or context for the participants' perceptions and opinions. Many of these statements were made in response to the open ended question "Is there anything else you would like to add about the eOTD and or the MOT?"

P5 I guess again, just pleading with our professors and our education and the political people out there, to please advocate for OT. I think that we, at this facility and everywhere I've been, are the least understood, least utilized and sometimes most disrespected. No one knows what we do. It's a constant struggle to educate, and I'm not even sure some of the students when they ask them for a concise description of OT could come up with one. And please help them learn the very basic day-to-day skills along with all this other great research-based knowledge they have.

P10 I'm a Board Certified Pediatric Therapist, and I wanted to review it too and I have felt – well, I've been talking to the therapists in my community about the possibility that that specialty credential could begin to separate the ethical, evidence-based practitioners from those who maybe aren't as ethical or evidence based in the way they work.

P10 And so the people out there with the DTPs have hardly any experience, but they're claiming a doctorate and I don't know, I just can't call someone with a clinical doctorate "doctor", I can't do it. I will call a Ph.D. "doctor", but I won't call someone with a clinical doctorate "doctor," ever.

P10 I see the Ph.D. as a far more rigorous, meaningful degree, and I've just never had the money or the energy to go get it and I regret it, you know. I regret it, but I'm too close retirement to do it so yay you.

P10 I'm at a university medical center,… and there's a physical therapy education program at my medical center… and that program was one of the last to agree to be DPT, instead of MSPT, and I remember very clear,… the discussion and just hemming and hawing about riding the wave into the DPT business and they basically said, you know, this is where the momentum is, we're just going along to go along. We don't believe that it makes a difference and they don't, from a cultural perspective, they don't teach their students the sense that they are doctors like Ph.D.s are doctors.

P13 I guess my only concern is that if they change things to – the programs are working the way they are and if they try to change them you're going to impact, I think – I

mean some of the schools already have really good, quality programs, and I think by changing that it's gonna negatively impact what they're wanting to get out. They're gonna have to change everything that they've already established that's working really well, and I think that that could have some negative repercussions. I think they're gonna see a decline because people aren't gonna wanna pay those costs of a doctorate tuition.

COMP: eOTD: Cost of Education

Statements made about the cost of education to become an occupational therapist.

P1 I'm not sure that it necessarily makes a better treating therapist because it does a lot of research, et cetera, which isn't getting paid for.

P2 No, I have not [discussed it with the eOTDs].

P3 No [discussed it with the eOTDs].

P4 Maybe too soon for me and my exposure that I've had to really be able to fully answer that

P5 She got her doctorate and was a student here, and told me the cost of paying for her student loans has very impacted her life in terms of when she could get married and have children, the neighborhood she was able to afford to live in, and thus the school systems for her children. That high, high student loan impacted her life greatly.

P5 Other than on a – and again, my frame of reference is pretty humble, long-term staff therapist, I really can't say that I see anything that justifies the extra money and time. They are not coming out with any better skills.

P6 I don't feel like there's any pull really or any salary advantage.

P6 The OTD student that I had, I think she felt like the [added] six months or whatever part of the program for the doctorate over the masters was worth that extra tuition.

P7 We talk a lot about, you know, you understand the cost of our education for that because of our passion for what we do in pediatrics and working for a nonprofit who serve the underserved population. We recognize that they aren't able to pay us more than maybe what they do.

P8 And I've heard other OTs say that they don't think that they would pay that amount

of money based on their salary, and they're so in debt for student loans that it just doesn't seem worth it to, maybe, go for the extra degree or go to the better school.

P9 It is a discussion because particularly in the entity that I work is a not for profit, early intervention with some children older. It was clear to most of the therapists who come in that they could probably make more money somewhere else.

P10 Oh, absolutely. I have therapists come in just so upset because they're sitting on $100,000.00 worth of school loans, from their graduate program primarily, and they can't make enough to pay those loans or it certainly gouges what they can possibly have for a mortgage

P11 I don't think so

P12 I guess informally. I know from my personal experience that it is not at all—I can't even think of the right term, but what we end up making after school does not at all justify what we paid for education.

P12 So I haven't discussed it at length with anyone else, besides just maybe to discourage it. I will say—and again, this is personal—but my sister is also an OT, and I discouraged her from doing the OTD program for all the reasons we've sort of discussed for this, because you don't make more money, you spend more time at school, and you have much higher loans to pay back when you are done, and I think you end up with good training either way. So I guess that's my experience with that question.

P12 Well, to give you a little background, my husband is a physician, and he and I graduated around the same time, and we had the same love. So he was paying back the same amount of loans with a medical degree that I was with an OTD, and obviously we are never gonna make the same pay, so you start off at such a disadvantage with that. I think that's one of the biggest drawbacks, especially as I was looking for my first job and realizing how upside down I would be for so long in that.

P13 Yes, the eOTD's – a lot of the people that I know have said that if they would have known the amount of debt or loans that they would have to pay then they would have chosen a different direction. They probably would have chosen the MOT.

P13 Looking back on it, I might have chosen something different, maybe the MOT, if I would have known that where my student loans are right now and I'm only seven and a half years out of school. So I might've changed what I would have done. I felt like I got a great education, I don't feel like it necessarily prepared me anymore for

being in the management role that I have. I feel like I've done that based more on my experience, my clinical skills, just my professionalism and leadership skills and I don't think it had any impact on where my degree was. And so I don't necessarily think that that the degree should be a deciding on those types of positions because it's not about the degree you have, it's how you can present yourself when you're in that type of position. That would just be my thoughts on it too.

P13 And I worry that there might be a change and more people wanting to do OT school if it does change to a doctorate because it's a lot money-wise and it's something we hear a lot of students, they ask that question when they come for clinical, it's, "How do you manage finding a job that you have love and still being able to do your tuition?" We hear that too.

P13 Many eOTD therapists she knows have struggled with finding a job they love, like in Pediatrics, because the pay is lower, versus taking a job in rehab, which pays more, so that they can pay back their student loans. Many of them have taken second, even third jobs, to pay down their loans, so they can move on with their

P14 Yes, I have. I have a couple that are – have the ERT degree and they get out of school and they have $100,000 and they struggle some times. So yes, we have talked about that and we have talked about how it doesn't make any difference

COMP: eOTD: Increased Pt Costs

Statements about whether the higher degree, the eOTD, would lead to higher patients costs for OT treatments.

P1 So I don't see how regardless of your degree, you could necessarily justify increased – a significant increase in starting wages because the money that you will bring in would be the same.

P1 The insurance and Medicare/Medicaid aren't changing their pay structures for the therapists providing the care.

P2 I guess, since we do not pay the therapists more for a higher degree at this time, I don't really see that that's gonna increase the cost to the patient

P3 My facility, because we hire most often new grads that don't have experience, and they're paid the same, the higher degree doesn't impact their salary or what they're compensated, so it doesn't have any impact.

P4 Maybe too soon for me and my exposure that I've had to really be able to fully answer that, because I see both sides of it.

P5 I'm not really sure, but I will say if they demand and receive higher wages, somehow that has to be paid for.

P6 I guess I could see the indirect effects of that. If a company or an organization is paying out higher salary amounts for their therapists, those costs have to come through somewhere. I guess I could indirectly see how that's right.

P 7 There's not a salary difference in terms of an entry level OTD or entry-level Masters, coming to be hired so the cost for the therapies would not change. I guess so yeah, I don't have any other thoughts at that question I guess

P8 Well, I don't think so. As of right now, we're not paying the OTD therapists anymore. They really should have been pro-rated the patient cost, especially in my facility. Like I said, OT doesn't cost the clients at all

P9 No increases in patient costs.

P10 I think the insurance companies are regulating things and with the government [regulation], so much that, no, I don't think the degree of the person treating makes any difference at all. You probably saw my signature block that I'm a Board Certified Pediatric Therapist, [Inaudible], and I wanted to review it too and I have felt – well, I've been talking to the therapists in my community about the possibility that that credential could begin to separate the ethical, evidence-based practitioners from those who maybe aren't as ethical or evidence based in the way they work

P10 No, I don't see the basic degree or how you sign your name as making a difference. If you have a Ph.D.[maybe, but], I mean clinical charges are clinical charges; we don't have that much control over that.

P11 Well, if they're not being paid any different salaries, then, I don't think there's any increase in patient cost.

P12 I disagree. We see hundreds and hundreds of pediatric patients. I have never once had a parent request a therapist with a higher degree.

P13 I don't really know if it makes much of a difference.

P14 I don't think there's any difference, but I only do insurance based therapy. So I don't differentiate what I do with any kind of therapist, especially in OT. There are

different billing codes, but I don’t differentiate by their degree, at all.

COMP: eOTD: Salary

Statements about the salaries of new OTs.

P1 No knowledge.

P2 There is no difference. New grads get the same compensation.

P3 They are not compensated any differently as a new graduate with no experience.

P4 So that 75-cent difference is based on their doctorate degree.

P5 This facility is the first facility I’ve ever worked at that has a union. Currently it is based solely on seniority. Work performance and education does not – at least it does not give you any more or any less pay.

P6 I heard things like they're not getting paid more.

P7 I don’t think there’s a difference.

P8 Not in my position, no. We’re a nonprofit, so they pay the occupational therapists as much as they possibly can, but even then it’s not really as relatable as to, say, a hospital position.

P8 Didn’t see any difference in salaries

P9 Closer to 3 [thousand dollars annually].

P10 Absolutely none. It’s all about years licensed.

P11 There was no difference.

P12 We have no difference in the starting salary for either degree.

P13 Obviously, pediatric clinic is not paid as high as a hospital or skilled nursing facility,

P13 I don't think – there's not a difference, at least not at our clinic, no. But I don't know of any difference where it's based on your degree, it's based more on experience, at least in our area and, I guess, the type of studying you're in.

P14 I do not see any difference, nor would I ever pay anybody any more as an entry level clinician.

P14 We hire a lot of PT. We have PT as well, so we – they only have the DPT, but the DPTs are paid the same as any entry level OT or speech therapist.

P15 No [salary difference].

COMP: eOTD: Salary expectations

Statements about the salary expectations of new OTs.

P1 I haven’t seen any difference in expectations in salaries

P2 Now, I've seen a huge difference in their expectations of what they're going to get.

P2 I think the entry-level doctorates expect a much higher level of compensation than the MOTs. And that is not, at least in our facility, no experience, new grad is a starting salary is the same. And they expect a lot more.

P3 No.

P4 I will say that the expectation is that there's the higher salary, just sort of the applicant coming in.

P5 Oh yes, I will say my doctorate friends anticipate quite a high salary, and have been told they will make more than the other OTs.

P6 I think they just weren’t sure of what to expect.

P7 I think that people who come out OTD you would expect that they would be paid more because of the additional training on knowledge that they would bring.

P8 I have not [had that discussion].

P9 I think there was a difference in salary expectations.

P10 Yes, I have, and that goes back to the comments that I made earlier. The OTDs have said to me that they believe that they’re worth more than the starting salary I’m offering. And so we’ve had to have that conversation that, you know, I’ve already alluded to, that it’s about your experience and your years licensed and I’m sorry you

feel that way, I'm sorry you were told you could expect that, but that's not the case here.

P11 No [I have not had that conversation].

P12 I think coming out of an eOTD program, they may think that they're going to receive a higher salary, but I think they quickly learn that isn't the case in our facility and elsewhere.

P13 Yeah, I feel like the eOTDs feel that they should have – be paid higher, regardless of where their experience is, because they have that background, because they've gone to school longer, which, really, the schooling is not all that much longer, but they do have that expectation, too.

P14 Oh yes, the eOTDs think that they should get paid more.

P15 I haven't seen any difference in expectations in salaries

COMP: Pay lower salaries

Statements that indicated the type of practice setting or organization had a overall lower scale, compared to other practice settings or organizations.

P1 The facility that I work at is notorious for being on the lower end of pay scale, so I would say – and in interviewing people we – it's not all that often that someone's hired and we have a very low staff count.

P7 In pediatrics, and in especially working for a nonprofit agency, we know that our pay is considerably lower than a lot of other practice settings for routine OT, I think. We talk a lot about, you know, you understand the cost of our education for that because of our passion for what we do in pediatrics and working for a nonprofit who serve the underserved population. We recognize that they aren't able to pay us more than maybe what they do.

P13 Obviously, pediatric clinic is not paid as high as a hospital or skilled nursing facility,

DEMO: Popul: Adults

The patient population of the work setting was an adult clientele.

P3 Adults.

P4 Adults.

P5 I've supervised these students in both outpatient settings and a very small community hospital, and currently at a Level 1 trauma center in a city.

P6 Outpatient neural department at a rehabilitation hospital.

P8 Community mental health facility.

P11 Adults.

DEMO: Popul: Peds

The patient population of the work setting was an adult clientele.

P1 Pediatric outpatient orthopedic facility.

P2 Children.

P 7 Nonprofit agency, we do early intervention.

P9 It was an early intervention program and then probably I think – I guess it would've been like birth to 15. We did a lot of early intervention and then also from older kids as well.

P10 I have an additional four FTE probably that [is pediatric] medical.

P12 Outpatient pediatric clinic.

P13 Outpatient pediatric clinic.

P14 Outpatient pediatric therapy clinic

DEMO: Sub Degree: Additional

Any degree, other than the OT degree, the research participant has earned.

P9 Doctorate of Science in [pediatric] rehabilitation.

P10 I have a Master's Degree in Special Education, and I finished that in 1986.

P11 No. I have a master's of science in rehabilitation administration.

DEMO: Sub Prof Degree: Bach

Research participants with a bachelor's degree in occupational therapy.

P1 I have bachelor's in OT.

P5 Bachelor's

P10 Bachelor's in Occupational Therapy in 1978.

P11 I have a bachelors in OT.

P15 Bachelor's in OT.

DEMO: Sub Prof Degree: eOTD

Research participants with the eOTD degree in occupational therapy.

P7 My personal degree is [entry-level] OTD.

P12 I have an [entry-level] OTD.

P13 I have an [entry-level] OTD.

DEMO: Sub Prof Degree: Master PT

Research participants with a master's of physical therapy degree.

P9 A Bachelor of Science and Physical Therapy, a Master of Science and Physical Therapy

DEMO: Sub Prof Degree: MOT

Research participants with a master's degree in occupational therapy.

P2 Master's in occupational therapy

P3 Master's level degree.

P6 I have an MSOT.

P8 MOT.

P14 MS in OT

DEMO: Sub Prof Degree: ppOTD

Research participants with a post-professional degree in occupational therapy.

P4 I am a supervisor so I have attained that role through my years of clinical service in the area of physical disabilities as well as I do have a [post-professional] doctorate degree in occupational therapy

DEMO: Sub: Job Title

The job title of the research participant.

P1 Senior occupational therapist.

P2 Assistant manager of occupational therapy

P3 Lead occupational therapist.

P4 I am a supervisor so I have attained that role through my years of clinical service in the area of physical disabilities as well as I do have a doctorate degree in occupational therapy.

P5 Staff therapist.

P6 A staff OT –

P7 Manager of clinical mentorship and professional development, and occupational therapies.

P8 Lead therapist responsibilities as well as everything else.

P9 I presently have – running a private practice doing – seeing children in their homes [for] early intervention and some a little bit older [through insurance].

P10 Director of Occupational Therapy. I have 22 therapists on my staff.

P11 Program director

P12 I’m a co-owner and an occupational therapist

P13 I am the lead occupational therapist; I've been there for about five years now. And I'm also the clinical education coordinator, so I set up all the clinical experiences both level one, the level two's across all disciplines, PT, PTA, OT's as well.

P14 Owner and treating OT

DEMO: Sub: Yrs in Current Position

The number of years that the research participant has been working in his or her current job position.

P1 Eighteen

P2 Eight years

P3 Three

P4 [Not asked the question]

P5 Four

P6 Five

P7 Less than a year

P8 Two years

P9 [Not asked the question]

P10 Eight

P11 Three days

P12 Seven years

P13 Been there for about five years now

DEMO: Subj: Role related to OTs

Indicates the role the research participant held when he or she had contact with the new therapists with the eOTD and those with the MOT.

P1 Team leader

P2 50 percent clinical [and 50 percent assistant manager of OT]

P3 Lead occupational therapist

P4 Supervisor

P5 Staff therapist

P6 Peer or a coworker for the OTs

P7 Mentorship and professional development for all of the therapy teams and education teams. So for OT, PT, speech, developmental therapy and our educator and inclusion specialists.

P8 I am the only therapist so I do all the lead therapist responsibilities as well as everything else.

P9 I was the manager of the direct service therapists so all of the physical therapists, occupational therapists and speech therapists.

P10 Supervise work directly in the schools and then I have an additional four FTE probably that does medical.

P11 Was a manager of inpatient rehab for occupational and physical therapy.

P12 I'm a co-owner and an occupational therapist

P13 I am the lead occupational therapist; I've been there for about five years now. And I'm also the clinical education coordinator, so I set up all the clinical experiences both level one, the level two's across all disciplines, PT, PTA, OT's as well.

P14 Owner and treating OT

DEMO: Tx Structure: Broad

Describes the type of treatment setting where the OTs treat patients with a variety of diagnosis and impairments.

P1 We work with a variety of diagnoses within that gym?

P2 Our therapists treat a variety of diagnoses. We do tend to hire for either our outpatients clinic or our inpatient facility, although we do have a couple of therapists who float

P4 We actually look for generalists, as this is an acute care setting. So they float around

from area to area within the acute care setting and see varying diagnoses.

P5 We float. Because we're chronically understaffed, we float everywhere. I've worked in everything from outpatient Parkinson's clinic to the ICU to the inpatient rehab. I think I've been on every unit in this hospital. And my coworker has even, on a couple of occasions, floated over to the adolescent psych unit.

P6 So probably 90 percent are specified what we were hired for, 10 percent helping out on other departments.

P7 What you would call outpatient in the clinic, as well as community base homes, daycare for all age kids..

P8 Right, so all of our clients reside inside of our facility. They live there. We are a residential treatment facility. We can take up to 15 men. They have to be homeless and mentally ill with an Axis I mental illness. There's not a very large staff. There's a social worker, there's a substance abuse counselor, and myself.

P9 They generally treated a variety of diagnoses.

P10 The therapists are hire are typically hired to work in the schools

P11 In an outpatient clinic.

P13 They treat a variety of diagnoses; we're all pediatric therapists. We treat a wide range of diagnoses and a wide range of ages from birth to the highest we see right now is about 20 years old.

P14 Variety of diagnosis.

DEMO: Tx Structure: Specific

Describes the type of treatment setting where the OTs generally treat patients with a limited number of diagnosis and impairments.

P3 They are hired for a specific area. However, they are trained to float across all areas.

P6 So probably 90 percent are specified what we were hired for, 10 percent helping out on other departments.

P10 The schools, but if I hire someone with some very specific skills experience, for example, if I had someone with a lot of background in feeding, I might also use them to do some outpatient feeding,

P12 We hire for a specific population.

DEMO: Type of Facil: Community Mental Health

The type of treatment facility where the new therapists work provided community mental health services.

P8 Community mental health facility.

DEMO: Type of Facil: Early Intervention

The type of treatment facility where the new therapists work provided early intervention services. This is an industry term indicated treatment for children before they go to kindergarten.

P2 Outpatient clinic associated with a hospital.

P7 Nonprofit agency we do early intervention.

P9 It was an early intervention program and then probably I think – I guess it would've been like birth to 15. We did a lot of early intervention and then also from older kids as well.

P10 University Center for Excellence in Developmental Disabilities, and we have a large contract with the school district.

DEMO: Type of Facil: IP

The type of treatment facility where the new therapists work provided in-patient rehabilitation services.

P10 I have an additional four FTE probably that does medical.

P10 For feeding, yeah. If they've had a lot of experience of feeding and swallowing, I might pull them a little bit from the schools or reduce their school caseload and use them as a medical provider for those specific referrals or evaluations.

P11 One was a large suburban medical center, or hospital system, and then, for the eOTD, that was at a large urban [inpatient] medical center.

DEMO: Type of Facil: OP

The type of treatment facility where the new therapists work provided out-patient rehabilitative services.

P1 A pediatric outpatient orthopedic facility.

P2 Outpatient clinic associated with a hospital.

P6 Outpatient neural department at a rehabilitation hospital.

P7 Would call outpatient in the clinic, as well as community base homes, daycare for all age kids.

P11 In an outpatient clinic.

P12 Outpatient pediatric clinic.

P13 Outpatient pediatric clinic.

P14 Outpatient pediatric therapy clinic

DEMO: Type of Facil: Residential

The type of treatment facility where the new therapists work provided treatment to clients who actually live at the facility where the treatment is provided. This is contrasted to a hospital where the clients stay there temporarily due to an acute medical condition.

P8 We are a residential treatment facility.

DEMO: Type of Facil: Trauma

The type of treatment facility where the new therapists work had been designated by industry standards as a trauma center, which can provide care to patients with very complex and acute medical needs.

P5 Both outpatient settings and a very small community hospital, and currently at a Level 1 trauma center in a city.

eOTD not understood

Statements indicating the others in the work environment do not have a clear understanding of how the eOTD is different from other OT degrees.

P2 We were having this discussion the other day at work with our thoughts and if we felt like they − I don't know at this time that it is being recognized as different. I'm not sure that our docs here recognize that there's a difference in the degrees between our therapists. So I'm not sure it's making a difference. But would they? I don't know. I'm not sure if it would make a difference at the MD level; now, with other professions, maybe.

P7 I mean different from what I've heard, like pediatric settings that it's not likely recognized – get what – what that OTD actually means and a lot of times – and where I work is one example that it not OT is doing the hiring. So other profession may or may not understand what OTD even mean.

Experience, not degree

Statements indicating that it is work and or life experiences that impact an OTs skills and abilities, and not the actual degree that they had earned.

P9 But I also feel that those are things that you might – that you could learn as you – when you get out of school and you start practicing.

P10 No, when I'm hiring, I'm hiring according to the number of years that they've had [in the clinic] and the amount of pediatric experience that they've had. And the job is what the job is, and if they haven't had background in it, then they're a different animal to me than – their degree really is absolutely irrelevant.

P10 And my OTDs are good, but it's because of the experience that they've had now, just because of the experience that they've had, and the people that they are, you know, the skills they've developed after they got licensed. And they would tell you the same thing, all of them would tell you the same thing.

Frustrated by attitude

Statements indicating that the attitudes or behaviors of new therapists with the eOTD are problematic or difficult for their supervisors to deal with in the workplace.

P5 My experience with entry-level doctorates has been the most frustrating, I think because they seem to come out feeling very – almost superior, and yet the least ready for the nuts and bolts hands-on clinical reasoning, what do I do with this patient in front of me? And overall for my occupational therapy students, it's almost to the level of embarrassing, and when I compare them with the same education level, physical therapy students. Because those students know what to do with a patient, at least on a basic level. My girls don't even know how to complete a transfer, use a sock aid. They don't seem to have ever seen any of these invasive lines. Very unprepared for real live work.

P5 Doctorate students come out with the expectation to be a manger.

P10 I might add, and this is a bias coming through, but the professional programs that we get the most students from, that come in eOTDs or who are in an OTD program, there tends to be a level of arrogance that we have to manage because of the way that they've been acculturated to believe – well, to the entitlement that they believe their degree allots them, and I'll expand on that later.

P10 I've got OTDs, I have had applicants say to me, who is just a Master's level person, that their degree makes them uniquely qualified to do things that a therapist without a clinical doctorate can do. And I'll just look at them say, "Really? You're saying that to me, who's been working 35 plus years?" I said, "You really need to get a check on that ego. And she goes, but you know, they're acculturated to think that way and I'll tell them that that's a dangerous way to approach a potential supervisor.

P10 No, I think I have vented adequately. I just get really, really frustrated with just the culture that has been created by this OTD and even honestly, the advanced practice for OTD is not that meaningful to me. I won't call those people because I've seen too many go straight from an entry level OTD into what's called the advanced practiced OTD without any clinical experience and they wear that doctor like it's a crown. And I mean they call themselves doctors and you know they're just blowing smoke. It's hard for me to respect someone who hasn't earned their stripes in the profession and I just see their clinical doctorate as giving people a way to – it's like they're creating a sense of credibility that they can't back up.

P13 I feel, again, the master's or the MOT's, I guess, sorry, do have a better role with taking on some of those roles too. I feel like the eOTD's kind of are – how do I say it, maybe like stuck in their ways like, "I have a doctor's degree so this is what – I don't really need to take as much direction," or, "I should be able to manage because of my degree," if that kind of makes sense?

P13 They have that; "I'm a little bit higher up because of my degree, so I should handle responsibility more than somebody else who doesn't."

P13 I just think that the biggest difference is just some of that professionalism and just understanding their roles as just out of school anyway. Right out of school, you shouldn't have these expectations if you have an eOTD, that you are – should have a higher pay, you should have a higher position because, in reality, you're all at the same place just being entry level anyway. And I feel like sometimes there's that miscommunication in terms of what that eOTD is actually indication and that sometimes plays to on a level, at least in the clinical rotations that, "Why should I – if there's someone who's a master's who's my CI why should I listen to them if they're just a master's and I have an eOTD?" Does that make sense?

P13: Well, I was gonna say just, with how our clinical rotation's set up, I actually see a lot more professionalism or better preparation for, we require all of our students to do interviews before placement. I feel like those MOT's are a lot more prepared, like they've actually done their research on what the facility is looking at, what their

responsibilities would be then the eOTD's who just come in, just basically coming into an interview without any preparation at all, too. So, I mean, overall it's significant.

P14 We just did an interview, and the girl was, I can't even begin to, tell you. She was awful. [Interviewer asked, "Awful in personality, in expectations, in demands?"] We interview students because we want - It's like a job. You should know what you're getting into and make sure it's a good fit for you, as well as we want to make sure it's a good fit for us. We ask questions about what do you know about your facility and so these [eOTD] students say, "You do peds." Why do you want to come here? "Well, because it's in [city name]". So in terms of that, they're not prepared.

They haven't done their research and then we ask them some more professional questions, like, "Have you ever been recognized in a situation at work," or something like that. One girl literally told me that the cleaning lady liked her. I was like, your friend [the MOT] has more professional level preparation. They [the eOTDs] walk in, and I don't – and I'm going to go off a little bit on this, but they walk in and they think "I'm this OTD person, you should take me." Whereas I feel like the masters students walk in and they're like, "I might be a step behind because I have a masters and I'm going show up and knock your socks off" and they do! I haven't accepted an OTD student in about two years because they haven't passed the interview process.

P14 We have not – we do interviews with our students and we have not accepted an entry level OTD in a couple years because they have been atrocious previously.

JR: Direct Pt Care

Statements that related to the new OTs with the different degrees abilities to provide direct patient care interventions.

P1 No difference.

P1 I have no idea.

P1 Just that it requires a lot of tuition to acquire and I'm not sure that it necessarily makes a better treating therapist because it does a lot of research, et cetera, which isn't getting paid for.

P2 I do not see a difference.

P2 I don't know that I'm seeing a huge difference in patient treatment.

P3 In general, I can't tell the difference if I didn't know their degree coming in. So, whether they're a Master's level or a doctorate, usually there's no difference in their clinical skills or experience providing patient care.

P3 No difference.

P3 None.

P4 I think I probably haven't seen enough to really correlate other than the fact that there's additional kind of fieldwork or post or professional requirements in the doctorate programs. So they have an opportunity to have more – seek out more expertise in specific areas than at the Master's level.

P5 None.

P5 I would say they both seem pretty lost. I have to start with even the most basic what to do with like a normal, plain hip patient.

P6 I don't see any difference at all –

P7 Well the biggest difference there was an OTD student, we were able to be more flexible in what the OT services that she was involved with in terms of agency services, in terms of – she did more teacher consultation with some of the inclusion support. She ran some groups, she – there was additional responsibilities and activities that she was able to do that, we typically don't have or Masters level students do. They are just learning to be an OT in our practice site through their field work

P7 There were more flexibility and we had an established learning contract for the OTD students, where it was less about direct client intervention and treating the child, then about some of the other more emerging area of OT practice, I guess that she was able to do

P8 Where I feel like the MOT students have done a lot more as far as preparing for interventions.

P9 I think that just that level of experience in having those different projects or different experiences –

P10 There is no difference. The difference comes from the quality of, in my case, pediatric instruction that they got. It's the program itself, it's the instructor that they have that [inaudible] and what to expect at the clinic. The degree has absolutely no bearing on their entry level skills.

P10 I just haven't seen evidence of that additional training. I know that you need – they're supposed to come in with a better appreciation for the literature, but we have not seen that.

P11 No [I have seen no difference].

P11 Compared for newer therapists who haven't – didn't have as much experience, I didn't see a difference between MOT and the OTD.

P11 Again, I didn't see a difference for therapists who were more recent graduates

P12 I have not seen a difference.

P12 I haven't noticed any differences in patient treatment.

P13 I feel like there's a huge difference in terms of professionalism and how things are delivered that way, and it's kind of a negative difference that I see, between the two degrees. I feel like actually the master's, the MOT have a little bit more professionalism or they're willing to take direction in terms of delivering – and I'm gonna talk about that too, I'm talking about also dealing with the parents, because we have to work a lot with the parents. And I feel like the MOT's have a better way of interacting with the parents then those with the eOTD do.

P13 I feel, again, the master's or the MOT's, I guess, sorry, do have a better role with taking on some of those roles too. I feel like the eOTD's kind of are – how do I say it, maybe like stuck in their ways like, "I have a doctor's degree so this is what – I don't really need to take as much direction," or, "I should be able to manage because of my degree," if that kind of makes sense?

P13 I don't think it results in any differences in patient treatment, the only unrelated areas in some of the schools that we are having contact with is more of just research-based. I don't really feel like there's a leadership component that's higher, I don't really feel like there is any sort of piece of that that leads to that the eOTD is better than the MOT really. I haven't seen any differences other than that research component.

P14 We take students from all over the country, from a variety of programs. I see no difference in terms of their clinical skills in terms of what they come out of school with.

P14 Zero [difference].

P14 I would tell you that every master student that I have had has been better than any entry level student I have had which I know probably may surprise. Well, I don't know. I guess this is why you're doing research.

JR: Advocacy for Patients

Statements that related to the new OTs' with the different degrees abilities to advocate for their patients. The type of advocacy was not defined in the interview question, to allow the research participant to interpret this term in the way most appropriate for their treatment area.

P1 I didn't see any difference.

P2 I do not see a difference in that.

P3 No [difference].

P4 I'm not seeing that.

P5 No [difference].

P6 I don't really

P7 That kind of is where some of the activities that we have the OTD students be involved in, but more of that consultation with teachers, helping, and that was just specific to the activity that we have her do. But advocating for what the child needed in the classroom or with the parents and in daycare class settings.

P8 I've never really seen much of a difference. I think they're both quite dedicated to our patients and really go above and beyond for that [inaudible] [00:05:49] of care.

P9 I will say that I don't know that I saw a difference

P10 No, I don’t see any difference, not at all.

P11 No [difference].

P12 No difference.

P13 No, I don't see a difference in that at all.

P14 Zero [difference]

.

JR: Clinical research: Use/conducting

Statements made that indicated the new OTs with the different degrees ability to either use, or conduct clinical research.

P1 They [eOTDs] were comfortable with research [Research Note: general, summary statement, which contradicts the answer to the direct question about use of, or conducting of clinic research later in interview].

P1 I didn’t really see any difference.

P2 The doctoral students definitely have a good grasp of the researching perspective. A good portion of the Master's students do, as well. There are some Master's programs that do not have that.

P2 So far, they [eOTDs] have all been very aware of how to seek that out. And I would say there is a small percentage of the Master's students who are not as savvy with that.

P3 No [difference].

P4 In general, the – one of the attributes that I notice differently is the evidence-based practice and use of current – most current literature to support the treatment intervention that's being provided [for the eOTDs].

P4 Well again, I think it's – it kind of boils down to the fact that we're looking for evidence to support, and we're documenting- providing the evidence to support what we're doing. We're making sure, for an area that's been trialed, and if not, we're trialing it. And we're documenting along the way. And we're trying to support what we've seen happen out there and use the most literature out there [for the

eOTDs].

P5 I think they both seem very able to do research projects and very aware of psych diagnoses.

P5 They [eOTDs] may be better at research. I really haven't had a research project here that a student participated in.

P6 I do not feel like there's a difference in how the students perform –

P7 Well, because at our site our master's students aren't really involved in that. And the OTD student wasn't either. There wasn't something that our site does regularly.

P8 I find that the doctorate students are more prepared for the research portion

P8 I find that the OTDs are much more up to date on the latest techniques. We've done a lot research, especially if they're going to work in a field that they – a certain section that they love, [like] in mental health. They're really, really up to date on the latest studies and evidence based practice, whereas

P9 More of research and theory within the doctoral program,

P9 I think the use of clinical research I think, yes, I would see a difference [for the eOTDs].

P9 Looking into research and looking at evidence-based practice and sort of having a feeling of the disciplinary practice of occupational therapy as a whole [for the eOTDs].

P9 But I think maybe understanding all the pieces of it together, the – looking at outcomes, looking at outcomes, looking at assessment tools, what are the – understanding the psychometrics. I think that some of those things I felt that some of those things are more at the doctoral level.

P10 No, no, no! [difference].

P10 I just haven't seen evidence of that additional training. I know that you need – they're supposed to come in with a better appreciation for the literature, but we have not seen that.

P11 But for therapists who had many years of experience and had a bachelors, I saw a difference, because the difference that I saw was related to the focus on using

evidenced based treatment.

INTERVIEWER: Okay, so let me just make sure I understand. What you're saying is that between the new therapists with the eOTD and the MOT, you did not see a difference in, so there wasn't really a difference between the two degree levels, just those recent grads versus the ones who'd been out for awhile. Is that correct?

Again, I'm gonna say it's variable, depending on the therapist. Going back to a previous point I made, was that I think that possibly the difference in the preparedness for research and evidenced based treatment based on, possibly, the school that the person attended.

P12 I haven't noticed any difference.

P13 No, I don't feel like there is. I mean, I think equally they will try, if they are having a hard time with identifying treatment plans or things like that or not familiar with the diagnosis, they'll do research. But beyond that, I don't see either one of them going above and beyond to participate in research or to really incorporate that into their treatment sessions.

P14 Zero [difference]

.

JR: Had advanced population training

Statements that indicated that the research participant believed that the additional training that is required for the eOTD degree made a difference in performance skills.

P7 I think, well, for the OTD students who I supervise had additional training I guess. Because you would have additional coursework and you know by the time that she came to us, her coursework and her doctorate project were both related to pediatric, so she had more of a breath in depth of pediatric knowledge which was relevant for our site.

P9 I think that just that level of experience in having those different projects or different experiences –

JR: Knowledge for general entry-level practice

Statements made throughout the interviews that referenced the new therapists' knowledge for entry-level practice.

P1: I don't see any difference.

P2: To be honest, as a clinician coming in, I don't feel like the entry-level doctorate new grads, as students, particularly as students, I don't feel like they're really that much different from our Master's-level students.

P2: No, I do not see a difference.

P2: They seem to have the same education and preparedness to be a therapist and same as when we look for our new hires. It seems like most of the ones we're hiring, of course, it's a fairly new thing. Most of them tend to be − they're new grads that we're hiring for the most part. And so they seem to be just as prepared as our Master-level students. So I can't say that I have seen a huge different in that.

P3: No difference.

P4: I think today certainly the knowledge is anticipated that there's an undergraduate degree in the making or that they've already completed an undergraduate degree. So they've had both life experiences as well as clinical and research experience going into the profession.

P5: My experience with entry-level doctorates has been the most frustrating, I think because they seem to come out feeling very – almost superior, and yet the least ready for the nuts and bolts hands-on clinical reasoning, what do I do with this patient in front of me? And overall for my occupational therapy students, it's almost to the level of embarrassing, and when I compare them with the same education level, physical therapy students. Because those students know what to do with a patient, at least on a basic level. My **girls** don't even know how to complete a transfer, use a sock aid. They don't seem to have ever seen any of these invasive lines. Very unprepared for real live work.

P5: I think they both seem very able to do research projects and very aware of psych diagnoses.

P5: I would say they both seem pretty lost. I have to start with even the most basic what to do with like a normal, plain hip patient.

P6: I don't, not for general practice of my area.

P7: Yeah, yeah, I would just say that OTD students – we have – we have certainly had more depth and breadth of knowledge and skills. So we were able to use her in different or you know have her participate in activities in different ways at the Masters level.

P7: We were able to ask more of the OTD student and provide her opportunities to be involved in more of the emerging area of practice instead of just typical treatment.

P7: I think, well, for the OTD students who I supervise had additional training I guess. Because you would have additional coursework and you know by the time that she came to us so, her coursework and her doctorate project were both related to pediatric so she had more of a breath in depth of pediatric knowledge which was relevant for our site.

P8: Not quite as prepared in communication skills and the general social skills that the therapist needs.

P9: I think that the creativity and things that they wanted to do were similar. I don't know that that made a difference.

P10: Absolutely none, yeah.

P11: The difference that I saw was a slightly better understanding of how to do literature reviews.

P 12: In my experience, I haven't seen a difference.

P13: I feel the knowledge is about the same, just basic understanding of clinical skills, population, delivery of services, evaluations, that I feel is about the same. Across, obviously I'm in pediatrics, but I feel like just their general knowledge about rehab in general is about the same too.

P14: We take students from all over the country, from a variety of programs. I see no difference in terms of their clinical skills in terms of what they come out of school with.

JR: Sup/management Responsibilities

Statement related to the new OTs abilities for supervisory or management responsibilities.

P1 No difference.

P2 I don't know that I've challenged any of them in that respect, from a manager perspective. So I can't say I've seen a difference, but I don't know that I have also looked for a difference in that respect.

P3 No difference.

P4 I think there's a little bit higher caliber with the eOTDs just from the fact that their life experiences they've had and they've been out in the working force a little bit longer than our Master's level students or therapists had. And so that experience with communication and scholarly ability, the scholarly research and support that they're doing there.

P4 Well, I think there's more leadership opportunities with an entry-level doctorate program than there is with a Master's level. Leadership opportunities such as looking, being involved in a higher capacity within a department, looking at the financial aspects of the department, the business aspect of the department, or just the clinical and providing care aspect.

P5 No. And I still – maybe it's because of my experience and my frame of reference, but I cannot imagine how you're going to manage something that you don't seem to have any idea and any clue of how this discipline functions on a day-to-day level.

P6 So again, I guess comparing the students that have a master's versus entry-level doctorate – I don't because I don't see that difference at that point.

P7 there's not a – there is no super[vision]– because we don't have COTA or aids at our site. So there was no supervision that any of the student have to that were – they weren't responsible for supervision.

P7 I would say, I know when I started my job at the agency I'm currently in, and that's correct and the time for all those eight years. Other disciplines commented, and my supervisor as well, that I seem to have, you know, additional knowledge or was able to take on leadership roles quicker than they would have anticipated of other new graduates starting. And then that I was able to transition into a leadership management role within seven years of practice

P8 They're pretty much equal as far as management responsibilities and supervision.

P9 So I don't know that it's generalized

P9 Ask students to take on more either supervisory roles or – with either students or within the agency, I do see the difference in the doctoral level feeling more prepared to do that at an earlier time.

P9 Well, I definitely think that the – I think it can still be an individual thing. I had two and they would've – I would respond, maybe differently, to each of them.

P10 No, I don't see any difference.

P10 I have, you know we have a leadership team, with a staff that big and when they're working in hundreds of schools. We have a leadership team, too, and every single person on my leadership team is an entry level Bachelor's person. And the majority of those – so, the one of the least experienced in that group right now has been working 13years and well, you know, back when Bachelor's was the entry level and these are my strongest, most reliable, most well-rounded therapists and yet they're just Bachelor's level, they're OTR/L

P11 No [difference].

P12 I have not seen a difference.

P13 I feel, again, the master's or the MOT's, I guess, sorry, do have a better role with taking on some of those roles too. I feel like the eOTD's kind of are – how do I say it, maybe like stuck in their ways like, "I have a doctor's degree so this is what – I

don't really need to take as much direction," or, "I should be able to manage because of my degree," if that kind of makes sense?

P14 I would tell you that every master student that I have had has been better than any entry level student I have had which I know probably may surprise. Well, I don’t know. I guess this is why you’re doing research.

MOTs over eOTDs

Statements that indicated that those with the MOT degree had skills and abilities above those with the eOTD degree.

P8 I find that the doctorate students are more prepared for the research portion, but maybe not quite as prepared in communication skills and the general social skills that the therapist needs. Where I feel like the MOT students have done a lot more as far as preparing for interventions.

P10 But I have to say my strongest therapists, if I was comparing between MOTs and MSOTs, that I have- another really strong, younger therapist who, I think she’s been working seven or eight years now, who went to Illinois to school, to MSOT ,and she’s in front of the pack. And I would argue that she’s got it going on over any of my OTDs and I’ve got six or seven OTDs.

P13 I feel like there's a huge difference in terms of professionalism and how things are delivered that way, and it's kind of a negative difference that I see, between the two degrees. I feel like actually, the master's, the MOT have a little bit more professionalism or they're willing to take direction in terms of delivering – and I'm gonna talk about that too, I'm talking about also dealing with the parents, because we have to work a lot with the parents. And I feel like the MOT's have a better way of interacting with the parents then those with the eOTD do.

P13 I feel, again, the master's or the MOT's, I guess, sorry, do have a better role with taking on some of those roles too. I feel like the eOTD's kind of are – how do I say it, maybe like stuck in their ways like, "I have a doctor's degree so this is what – I don't really need to take as much direction," or, "I should be able to manage because of my degree," if that kind of makes sense?

P13 Well, I was gonna say just with how our clinical rotation's set up, I actually see a lot more professionalism or better preparation [because] we require all of our students to do interviews before placement. I feel like those MOT's are a lot more prepared, like they've actually done their research on what the facility is looking at, what their

responsibilities would be than the eOTD's, who just come in, just basically coming into an interview without any preparation at all, too. o, I mean, overall it's significant.

P13 I, honestly, feel like the MOT's have a little bit more of that professionalism when they're coming in and I don't know why. Honestly, I don't know why, but I feel like the eOTD's definitely don't have that. I mean, their interview skills are really poor, they're not prepared for anything. Clinical skills, I think it's good, but those interview skills carry over to evaluations; we do a lot of parent report in our evaluations and so they struggle with that, because they can't do it themselves, then so they can't sit there and talk to a parent in an appropriate way. Not like they're acting like they're better than that parent, like really getting onto that parent, so they'll understand what it is that's going on, what do they want help with? And so that's kind of what I see a little bit of that carry over is.

P14 Whereas, I feel like the masters students walk in and they're like, I might be a step behind because I have a masters and I'm going show up and knock your socks off, and they do:! I haven't accepted an OTD student in about two years because they haven't passed the interview process.

P14: I taught in an OTD program for five years. Yeah. I'm teaching both programs now. I am telling you these masters degrees are by far better than these entry level.

P14 I would tell you that every master student that I have had has been better than any entry level student I have had

Negative comments toward eOTD

Statements made with a negative connotation toward the eOTD, which did not fit more appropriately fit under another code, such as *JR: Direct pt care.*

P6 The students that I had I really felt like, I didn't – I didn't feel like there was a difference in how they were prepared beyond their fieldwork. Maybe that would come later in their schooling, but I know from classmates that I've had that have gone on to get the doctorate and vs me with the master.

P6 I don't feel like there's any pull really or any salary advantage, or – I think from what I've heard and what I've seen it seems like people almost don't know what to do with this extra degree people have – for OT at least. I don't feel like there's any pull really, or any salary advantage, or – I think from what I've heard and what I've seen, it seems like people almost don't know what to do with this extra degree people have – for OT at least.

P10 I think that's the way the programs sell their program over another. I have a lot of pre-OTs here, you know, moms and dads and people calling me and saying – because in our community, there's an MOT program and an OTD program, eOTD, and I have a lot of people interested in entering our profession calling or emailing me and asking me the difference and I tell them the exact thing I've been talking to you about, there is no difference.

P10 So, I just roll my eyes…. It's really about who's teaching you what you need to know to be a therapist to me. The degrees don't mean a thing.

P12 So I haven't discussed it at length with anyone else, besides just maybe to discourage it. I will say—and again, this is personal—but my sister is also an OT, and I discouraged her from doing the OTD program for all the reasons we've sort of discussed for this, because you don't make more money, you spend more time at school, and you have much higher loans to pay back when you are done, and I think you end up with good training either way. So I guess that's my experience with that question.

P12 I guess that's my only point. I, like I said, graduated with an OTD, but I honestly haven't noticed any difference, from a career standpoint, in what I've been able to do with it or with the patient care, or salary. And like I said, my sister is also an OT and I discouraged her from doing it for all those reasons.

P14 No, but thank God you're doing this research because I don't think we should go to

the eOTD personally

RECG: "Doctor" only for Physicians?

These statements were given to indicate that who was allowed to use the title "doctor" in the work environment.

P1 It's per person's choice.

P2 You know, we've never discussed that. Being in pediatrics, I don't think anybody introduces themselves that way, because I think they use their first name, because it's more child-friendly. Children tend to be afraid of doctors. So I don't think anyone does that here, but we've never said they could not.

P3 Physicians.

P4 It's reserved, in our institution, for the physicians.

P5 No, none of the doctorate PTs I work with in acute care ever say anything about it. The outpatient physical therapists, there are at least two of the few of them we have that require their patients to call them doctor.

P6 I think I've heard one therapist that I work with – it was actually a therapy student, but the therapy student was not mine, but they – I think they had called themselves doctor. As far as speaking with MS OT and the entry-level doctorate students I have had, no, and again I do not work with any OTs that have a doctorate.

P7 We don't have physicians that work directly at our site. We all introduce ourselves with our first name.

P9 I think they [those with the clinical doctorates] might introduce themselves as a doctor in [team meetings] – but not with the families.

P10 It's reserved for Ph.D.s and physicians in my facility. I have never heard one of my OTD therapists refer to themselves as doctor. I see it all the time in the professional programs.

P11 Just for physicians.

P12 No, it's reserved for a physician.

P13 No, we do not refer to ourselves as doctors. And it's pretty much around this area that I don't really know of any eOTD's that do doctor or PT's or any other profession other than an actual physician.

P14 No, there are some [with the clinical doctorates] that completely introduce themselves as doctor.

RECG: Degree on Name Badge

These statements indicate whether the professional degrees of the therapists appear on their name badges where patients, families, and other professionals can see them.

P1 I have no idea.

P2 It used to be, and we have actually gone away from that, and our facility has gone to just putting the licensure on there. So it just says OTRL or OTL, instead of putting the degrees on there, partially because there were so many other things you could – extra things you could get, specialty certifications and things like that that people were wanting to add in. Our facility decided to just do away with all of that, to do away with all the different letters. We felt like it confused patients, and it did kind of undermine people who had 50 years of experience but didn’t have that Master’s or doctorate. It felt like they were being undermined. So they’ve completely done away with that.

P3 The credentials are, but going back to the patients, the patients don’t know what that means.

P4 Only if you’re at a doctorate level does it say OTD. Only [then] does it distinguish. Otherwise, it just says OT.

P5 Yes.

P6 No.

P7 Yes.

P8 No

P9 We don’t wear name badges

P10 Yeah, it is.

P11 No.

P12 No.

P13 We don’t wear name badges; it is posted on our website, so if families want to look and see, it is listed there and on any documentation that we sign, even as something as simple as a note to the parents it has our degree on there was well. So parents do know, but we don’t wear name badges where it would display that.

P14 No. We don’t wear name badges.

RECG: Resp by Pts

These statements indicate whether those with the eOTDs are more respected by patients than those with lower OT degrees.

P1 No, not that I’ve directly worked with. No.

P2 I haven't noticed with the eOTD versus MOT

P3 No.

P4 I haven't seen patients that really are aware of the difference at this point.

P5 If I mention it, the patients say, “Oh, wow.” But that’s about the most I’ve ever seen.

P6 No difference. I think the patients have no idea.

P7 The majority of families that we work with don’t even know.

P8 Most of the time the patients – I don’t think they notice, care.

P9 No, not at our level, no.

P10 I don’t think so. I think patients just want an OT. I think they wanna like the person, trust the person. Again, my most respect[ed with patients, the ones who have the best patient reputation, are those entry level Bachelors. So it’s really about the person and the skill set they develop.

P11 I couldn't answer that globally.

P12 I disagree. We see hundreds and hundreds of pediatric patients. I have never once had a parent request a therapist with a higher degree. I haven't noticed any difference.

P13 Oh, I don't notice a difference that way. And, again, working in pediatrics I don't think they would notice, I mean, there may be a difference in a hospital setting if they were to know, but I don't know how much they would know of your degree other than you're an OTD or a PT or something like that, so at least where I'm at I don't have that experience, but – I can't answer that 100 percent.

P14 I think they have no clue. I don't know – in terms of clinical skills, they're looking for a good clinician. You could have somebody with a bachelor's degree that's fabulous and my patient wouldn't know the difference between a bachelor's a doctorate degree. They have no idea. They're looking for somebody that fits their family and fits their kid and they don't know. They don't – I don't know that they would even ask.

RECG: Resp of Professionals

These statements indicate whether those with the eOTDs are more respected by other professionals than those with lower OT degrees.

P1 No.

P2 I don't know at this time that it is being recognized as different. I'm not sure that our docs here recognize that there's a difference in the degrees between our therapists. So I'm not sure it's making a difference.

P3 No.

P4 What I pick up on is just the varying degrees of research abilities and knowledge – but not necessarily the clinical care provided. It's more the scientific behind the clinical care. That I think the credibility is a little bit higher.

P5 When you're on the floor treating patients and in the very many multi-disciplinary teams I'm in that include everyone from doctors to social workers, no one even knows.

P6 So again, speaking from experience with the students, I don't work with anyone that has any experience with OTDs out in the profession. Students – I don't feel like there [was a difference in respect from others].

P7 Can I speak from my personal experience I guess, as having an entry-level degree? Okay. I mean, I would say I know when I started my job at the agency I currently in and that's correct and the time for all those eight years. Other disciplines commented and my supervisor as well that I seem to have you know additional knowledge or was able to take on leadership roles quicker than they would have anticipated of other new graduates starting. And then that I was able to transition into a leadership management role within seven years of practice

P8 I don't think that even comes into play a lot of the times because physical therapists have to get a doctorate in order to practice. So I often feel like people don't even know that OTs don't have one. I think they often think, "Well, PTs have one so OTs have one." So I don't really see a difference in respect. Maybe among the actual population where OT to OT we can say, "Well, you have the doctorate. You went through the extra work that I wasn't willing to do. I'm impressed." But other than that…[statement ended].

P9 I don't know that there – I think there was – not to the point upon which the respect was earned

P10 In the facility I work in, I will always be **appealing** with just a Master's degree. The only thing that counts in that facility is a Ph.D., which goes back to something I started to say earlier, I think the Ph.D. carries far more weight than the OTD ever will. And we're having a lot of trouble hiring a Director of Physical Therapy right now. We've had a vacancy for so many years, it's making me crazy because they want a Ph.D., but their profession went to the DPT before we went to the OTD. And so the people out there with the DTPs have hardly any experience, but they're claiming a doctorate and I don't know, I just can't call someone with a clinical doctorate doctor, I can't do it. I will call a Ph.D. doctor, but I won't call someone with a clinical doctorate doctor ever.

P11 There wasn't a difference.

P12 I haven't noticed any difference.

P13 You know, in my clinic that we work at, we have speech and physical therapists and we work closely with them daily, hour-by-hour. And I feel like there's not any difference between those either; we do not have PTA's or OTA's, so I wouldn't know of a difference there. But I feel like the doctors and the physicians that we

work with, I don't think to them it makes much of a difference as long as we're professional in how we're communicating, and what we're communicating, and providing thorough documentation, and things like that. I haven't noticed a difference with that.

P14 I don’t think there’s any difference at all.

RECG: Status/Recognition influencing Career Choice

These statements indicate whether the desire for higher status or recognition of a doctorate degree influenced a student’s choice about which healthcare profession they would enter.

P1 No [discussion].

P2 I don't know that I have asked that specifically, but I definitely think that a lot of our therapists were seeking an advanced degree. I don't know that they would have gone into this profession if it was not an advanced degree. But I don't know that I've asked that specifically.

P3 When the two are offered based on the timeframe, like, why they chose to do one versus the other, it wasn't felt as though it was a significant amount of time more to go ahead and get the higher degree, versus what it would take to go back later and get, like, an actual doctorate or a bridge program. They felt that, to get the highest degree, they might as well just go straight through, since it was less amount of time than it would take to go back later.

P4 I have not [had that discussion].

P5 There have been a couple students that, yeah, to be able to say, “I have a doctorate,” was very, very important to them. That was why they got the doctorate versus the master’s.

P6 I don’t think it’s – I’ve never gotten the impression that it’s the full deciding factor. No.

P7 No, I would say not at my agency.

P8 OTs generally become occupational therapists for a desire to help people. Not necessarily for a couple letters after their name.

P9 So, I don't think that the degree is was made a difference about the actual choosing of the profession.

P10 I think that's the way the programs sell their program over another. I have a lot of pre-OTs here, you know, moms and dads and people calling me and saying – because in our community, there's an MOT program and an OTD program, eOTD, and I have a lot of people interested in entering our profession calling or emailing me and asking me the difference and I tell them the exact thing I've been talking to you about, there is no difference.

P11 For choosing the profession, no, but for the choice between MOT and OTD, yes.

P12 I was one of the first OTD classes, and I was accepted to another master's program at the same time. And again, this was 12 years ago now. But I didn't have any training or any prior knowledge of it. So, when I was offered acceptance into two programs, one as a master's and one at a doctorate level, of course that appealed more to me, in thinking like I would be getting a degree where I would sort of be at the end of what I might need or might want at some point. But maybe I should've done more research into that, or—and again, I was a second-year grad of an OTD program, so there wasn't a lot of information on it anyway.

P13 I guess 50/50, I mean I've heard some people say, "I know I wanna go to grad school because I know that it's gonna help me overall, in terms of jobs." But I feel like, at least, the ones who are in more of the pediatric setting, it's because they have that general desire to help, to improve that quality of life. But, I mean, I guess it can go both ways, especially those people [who] are more like maybe in a skilled nursing facility, at least the people that I know.

P14 Oh that's funny. I'm at a table with some colleagues right now. We were just talking about an OTD clinician that we know that requires people to call her doctor and so yes, I would say, I have and I think it's, quite frankly, ridiculous!

SUPPORT: for eOTD

These statements indicate support for mandating the eOTD as the entry-level degree.

P2 And certainly with the physical therapy world going that direction, there's a concern of being left behind if we don't.

P9 I have not read the research for occupational therapy, but we've sort of gone through some of that in physical therapy. And I do think that because they have an extra – extra time you come out with a bigger support base underneath you, sort of technical, as I said before, research looking at outcomes, development measurement tools, psychometric development, a bigger base for that.