Faculty Practice in an Age of Entrepreneurship: Can Occupational Therapy Educators Add Yet Another Role?

Occupational therapy faculty members who seek tenure at research universities rarely focus on one role at a time. It is the nature of the faculty appointment to produce in a minimum of three areas—teaching, research, and service, which includes practice. Outstanding performance in these areas has served as the criterion for the awarding of tenure; an important career goal for most academicians. To successfully achieve tenure, a faculty member must obtain multiple benefits from each endeavor of teaching, research, and service.

Decreased financial support for public universities has profoundly affected faculty roles and responsibilities, especially in research-oriented academic health centers. One response to these economic changes is the formalization of faculty practice plans. In these plans, teaching faculty members provide clinical services as a means of generating institutional funds. When the primary goal of faculty clinical practice is shifted from academic purposes to revenue production, the interests of the faculty members are at risk of becoming subservient to the needs of the university and the service contract. Our issue is, how can occupational therapy educators in academic health centers meet the expectations of their academic appointments while simultaneously generating revenue for their university? In this article, we discuss our experiences as educator-clinicians and make suggestions regarding the essential components of successful faculty practice.

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Review of the Literature

The literature that addresses faculty practice in occupational therapy and physical therapy is limited and primarily emphasizes its role in teaching (Abreu, Neville-Jan, 1995; Borden, 1974; Klasson & MacRae, 1985; McMillan, 1974; Sands, 1994). Discussion of the role of faculty practice in research production or income generation was sparse or absent. Thus, we turned to the academic nursing and medical literature, which defines and reports the benefits and disadvantages of faculty practice (Barger, Nugent, & Bridges, 1992; Bingham, 1992).

Budden (1994) defined faculty practice as "a formal arrangement which exists between a clinical setting and a university which allows nurse academics to consult and deliver client care resulting in research and scholarly outcomes" (p. 1241). Starck, Walker, and Bohannan (1991) made it clear both philosophically and practically that faculty practice must fit within the mission and business of the university. To be relevant to the mission of the university, faculty practice must be integrated within the context of the "knowledge business" (Starck et al., 1991, p. 23), which involves the generation, transmission, and application of knowledge. As nursing education has transitioned from hospitals to academic centers, academic nursing has long advocated for faculty practice as a means of maintaining the important connection between practice and theory. Nursing faculty practice has sought to serve an important professional function aside from patient care.

Algase (1986) observed that faculty practice must contribute to the advancement of the nursing discipline, and Ford and Kurzman (1983) stated that faculty practice should be scholarly in orientation with associated scholarship outcomes. Budden (1994) identified five models of faculty practice:

1. Unification: Teaching and clinical responsibilities are organized through one administration. The chair of the academic department is also the clinical department

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Clinical practice. Educational programs included faculty practice to students, educational programs, clinical sites, and faculty members. Klasson and MacRae (1985) used this model in their university-based occupational therapy practice for clients with chronic schizophrenia.

3. Integration: Faculty members and students practice under the auspices of the academic department. Klasson and MacRae (1985) used this model in their university-based occupational therapy practice for clients with chronic schizophrenia.

4. Private practice: The faculty members provide direct care to clients, often with the assistance of assigned students.

5. Moonlighting: The faculty member's delivery of care is separated and removed from his or her academic appointment. Budden does not regard this model as a true form of faculty practice because it generally lacks the research and teaching components found in the other models.

**Benefits**

The literature described the benefits of faculty practice to students, educational programs, clinical sites, and faculty members. Klasson and MacRae (1985) concluded that "occupational therapy students demonstrated increased awareness of their professional roles and greater confidence in their ability to function as therapists" (p. 11). Nursing students demonstrated higher self-esteem and self-concept and increased sense of internal control and were able "to integrate more theory to practice" (Kramer, Polifroni, & Organek as cited in Budden, 1994, p. 1244) when taught by faculty members engaged in clinical practice.

Baillie (1994) also cited several studies that reported enhanced student learning when faculty members are engaged in clinical practice. Educational programs benefited through increased relevance of the curriculum, strengthened clinical ties with treatment centers, increased knowledge of health care delivery issues and policy decisions, grassroots participation and problem solving (Starck et al., 1991), and income generation (Burger, Nugent, & Bridges, 1993). The clinical sites benefited from the cost savings of acquiring expertise (i.e., experienced educator-clinicians) at a lower cost, the intellectual stimulation of the staff members, clinical research and leadership expertise, and the recruitment of new employees through student practice (Starck et al., 1991). The benefits for faculty members included increased clinical competence and access to research subjects and case study material for teaching (Starck et al., 1991). Baillie summarized the benefits for nursing faculty as follows: greater validity and credibility in reaching, opportunities to apply theory, personal satisfaction, and the development of theory from practice.

With all of these advantages, why would faculty practice be questioned? The answer is found in the stressing of revenue generation over academic responsibilities. For the educator, this could result in role overload and inhibit research generation. Additionally, clinical practice typically was not regarded as a valued component of academic performance appraisals.

**Disadvantages**

The disadvantages of faculty practice, as cited in the nursing literature, were primarily experienced by the faculty members and secondarily by the students and clinical staff members. Nursing students reported increased difficulty in contacting faculty members engaged in practice activities off campus (Starck et al., 1991). Members of the clinical staff reported that because of their academic schedules, the faculty members were not available when needed to provide treatment. For educators, there were three difficulties: role expectations and time usage, the academic value of faculty practice, and research productivity.

**Role expectations and time usage.** Nursing faculty members reported experiencing increased stress as a result of the multiple and conflicting roles of educator, researcher, and clinician (Nugent, Burger, & Bridges, 1993). Anecdotally, faculty members reported difficulties with the perceptions of clinical nursing personnel about the faculty's role. The clinical staff members felt threatened by the faculty members because they believed that the faculty members observed and critiqued their performance. On the other hand, some faculty members believed that the clinical staff members were simply using them as a "pair of hands" (Baillie, 1994, p. 155), overlooking the contributions the faculty members might make.

Success in both roles of educator and clinician was also seen as a problem. Nursing faculty members believed that their academic role would suffer with the additional responsibilities of clinical practice (Baillie, 1994). McMillan (1974) suggested that physical therapy "faculty members engaging in clinical practice might find the time and energy requirements of the roles of faculty members—practitioner to be too demanding to allow effective participation in either role" (p. 187). Performance of clinical duties was also affected by confidence in clinical skills. Nursing faculty members who engaged in practice after pursuing careers in education reported a perceived lack of confidence in their clinical skills (Baillie, 1994; Nugent et al., 1993).

In examining medical school faculty practice plans, Petersdorf (1994) summarized the challenge of combining the roles of educator and clinician: "There is no evidence that growth [of faculty practice] has been accompanied by an improvement of teaching" (p. 175).

The academic value of faculty practice. Another major drawback to clinical practice was the lack of value the university placed on it. This lack of value was demonstrated by the absence of release time to practice as well as a lack of recognition for practice activities in faculty evaluations, such as promotion and tenure reviews (Baillie, 1994; Clifford, 1995; Nugent et al., 1993).

Clinical practice is generally not seen as part of the role of a college professor. For example, faculty members in the school of education do not fill in as substitute teachers for local school districts simply because they can generate...
income for the program in education (J. Van Deusen, personal communication, February 1996). Often, university tenure committees are composed of academicians who are uninformed about clinical practice and do not recognize it as a form of service. This overlooks the important contribution of clinical practice in training allied health students. When clinical practice is recognized as service, it is not perceived to be as valuable as such activities as serving as an officer on a national committee.

Research productivity. Possibly the most important disadvantage concerned the generation of research. Although studies of research productivity were few, the results were not encouraging. This was important because research opportunities are viewed as an important advantage of clinical practice and because research productivity was a primary evaluation criterion of faculty members. Barger and Bridges (1990) reported that nursing faculty practice does not directly contribute to research productivity. Azorn (1991) found no major difference in the rates of research productivity between faculty members engaged in clinical practice and those who were not. Shnorhokian and Zullo (1993) observed that faculty practice plans "reportedly had little impact on the teaching and research functions of the institution" (p. 320) in 39 dental schools in the United States and Canada.

Summary

From the nursing and medical writings on faculty practice, we draw several conclusions. Nursing faculty practice primarily emphasizes its benefits to teaching, research, and the advancement of the profession. The generation of revenue for institutional goals is not a primary focus of nursing practice (Starck et al., 1991). Medicine, on the other hand, has accepted and encouraged the production of revenue through faculty practice (Grabois, 1992; Petersdorf, 1994; Shnorhokian & Zullo, 1993) primarily through the appointment of a person to either a clinical or an academic position. This was clearly seen in the remarks of Petersdorf, the past president of the Association of American Medical Colleges. He observed that the concept of the "triple threat academic" (1994, p. 175) in medical education (i.e., one who excels in teaching, research, and practice) has been abandoned, and a new approach that organizes faculty members into "two platoons—one consisting of investigator-teachers and the other of clinician-teachers...is now solidly ingrained in the academic medical culture" (p. 175). Despite the possible success of this division of labor, Grabois (1992) warned of the risk of too much emphasis on income production and the need to balance practice and academic pursuits as medical school revenues were increasingly derived from service income.

Our Experiences

Our recent clinical experiences have paralleled the benefits and disadvantages previously described in the literature. However, we experienced new complications when a clinical role was added to our preexisting academic role.

In August 1995, the occupational therapy curriculum of the College of Health Professions at the University of Florida in Gainesville contracted for 1 year with the occupational therapy department of the affiliated teaching hospital to provide clinical services. The hospital occupational therapy department allocated one unfilled full-time position to be staffed by five faculty members. The educator-clinicians each provided 8 hours of clinical service as needed to the hospital occupational therapy department. This arrangement most resembled the collaborative model (Budden, 1994). The adult and pediatric service coordinators of the hospital occupational therapy department served as supervisors and assigned tasks, monitored performance, and assured compliance with departmental policies and productivity standards. All funds generated from this practice were issued to the occupational therapy curriculum and the college.

Initially, the authors were the only faculty members engaged in clinical practice, and we provided inpatient and outpatient care on the physical disabilities, psychiatric, and pediatric teams. The first author, who specializes in physical dysfunction, covered for any therapist on leave and lightened the caseload of other therapists by evaluating and treating neurologic, orthopedic, and burn patients. The second author, who specializes in psychosocial occupational therapy, provided coverage for a staff therapist on maternity leave. This entailed evaluating and treating adolescent patients as well as providing treatment for children on an inpatient pediatric behavioral unit. The third author's clinical practice entailed covering an interdisciplinary outpatient clinic that was held one afternoon each week for children and adults with myelodysplasia. Her responsibilities included screening, evaluating, and referring patients for community-based services. Although our individual experiences varied, issues in the following areas emerged: role expectations, valuing of faculty practice, and research productivity.

Role Expectations

The first and second author's practice was completed in either one 8-hour period or two 4-hour periods per week. During this time, they were expected to perform as staff therapists, executing departmental treatment protocols and meeting productivity standards. The expectations of shifting from the classroom to the clinic and vice versa made both roles difficult. Limited time in the clinic did not provide faculty members who were contracted to the facility with sufficient opportunity to learn hospital procedures before the expectations of competence and productivity were imposed. This role shift, coupled with the changing of treatment tasks on a weekly basis, created a feeling of being off balance and delayed a sense of clinical mastery important for job satisfaction.

Faculty members were expected to achieve rates of productivity equal to that of the full-time therapists. Productivity was calculated as a ratio of billable patient hours per hours worked. The faculty members had difficulty achieving adequate productivity ratios for various reasons. First, scheduling of the clinic time was interspersed between teaching and research tasks, and as a consequence, there was little time to reschedule delayed or canceled treatments. This resulted in wasted time spent reading charts and preparing for treatments that...
were never rendered. Second, hospital clinicians reported that they often complete documentation after hours or at home in order to maintain adequate productivity levels. This option was less available to faculty members because they were expected to perform their treatment duties within the contract period. Third, time-limited work schedules also made professional contacts with interdisciplinary team members difficult, and the faculty members were instructed to forego treatment team meetings, which did not generate income, for the sake of productivity.

The third author's experience differed somewhat because of the nature and flexibility of her treatment setting. Working on an interdisciplinary team with a specific population (children and adults with myelodysplasia) enabled development of a clinical-research specialization and facilitated collaboration with other team members. The third educator-clinician worked and billed only for time spent attending clinic and providing follow-up services, generally less than 8 hours per week. Although the third author's experience was more in concert with her academic role, productivity issues of a different kind were raised. Patient consults often lasted only a few minutes or were follow-ups that were not billable. For a full-time therapist, this “downtime” can be absorbed into the daily workload, maintaining adequate productivity ratios. For a person working only 4 hours a week, however, any downtime severely affects productivity.

Valuing of Faculty Practice
Faculty members discovered that clinic personnel had only a limited understanding of the duties and expectations of the faculty. Whereas faculty members were concerned with generating research questions and collegial relationships with medical staff members, clinic personnel were primarily concerned with providing patient care. This difference in focus led to the perceived devaluing of each other's roles and use of time. Additionally, because of the nature of the contract relationship, the faculty members were requested to cover clinic absences and vacations in excess of the prearranged 8 hours. Faculty members were then forced to choose between helping out and being seen as a team member or declining these work requests because of their teaching and research duties. In these instances, it was not uncommon to feel like "a pair of hands" (Baillie, 1994, p. 155) and to have the sense that one's role as an occupational therapy educator was not valued.

The third author was better able to combine both the practice and academic portions of her job. Working in a specialized area of practice was conducive to teaching in her specialty area of pediatrics and was consistent with her research interests related to community-based care. The organization of patient services within the contracting occupational therapy department facilitated the better fit of this situation for the third author than for the other two. This was partially because of the clinical occupational therapy department providing a wider variety of pediatric services, such as the outpatient clinics, than did the physical disabilities and psychiatry teams.

Research Productivity
The first and second authors discovered that the greatest impediment to research was the source of reimbursement for their time. Because personnel monies supported the faculty position, the priorities of productivity and departmental demands preempted their research needs. When in the clinic, the faculty members' efforts were to be directed to patient care and, because of their unfamiliarity with procedures and frequently changing clinical assignments, little time was left to raise questions, develop research liaisons, and enact research protocols. Another obstacle to research was coordinating or carrying out research protocols when data collection methods and hospital procedures were not amenable to each other.

On the other hand, the outpatient clinic setting enhanced the third author's research opportunities. The clinic has a diagnostically consistent population that was seen during a regularly scheduled time. The third author organized the evaluations, treatments, and referrals and had the opportunity to integrate research protocol with practice. The collaborative relationship that developed with hospital staff members previously responsible for this clinic encouraged the development of research questions and possible joint research projects.

Discussion
The literature suggested that successful faculty practice has some common traits, including good communication and collaboration between centers and faculty members regarding expectations and duties (Acorn, 1991; Budden, 1994), an understanding of the often conflicting forces that arise in attempting to successfully accomplish two different roles (Acorn, 1991; Budden, 1994), and flexibility of scheduling and release time to practice (Arthur & Usher, 1994; Barger et al., 1993; Budden, 1994; Starck et al., 1991). Evaluation of faculty performance must be in agreement with expected duties, and a shared vision of practice must be maintained between administration and faculty members (Walker, 1994). Clinical practice must be respected and valued by the academic institution as demonstrated by the inclusion of faculty practice as a factor in the tenure and promotion review process (Barger et al., 1993; Budden, 1994; Starck et al., 1991).

As can be seen from the experiences of the first two authors, faculty practice initiated primarily for revenue production conflicts with many of these traits and the fulfillment of the educator-clinician's academic roles. The third author's experience in the outpatient clinic better reconciles the divergent purposes of academia and clinical practice; however, the nature of the setting made it difficult to achieve the level of patient billing required to maintain expected clinician productivity levels. If our experiences are a sign of things to come, occupational therapy educators who work in academic health centers will need to be aware of possible conflicts between faculty practice for institutional revenue and their ability to successfully meet university academic work requirements. They will need to negotiate and structure educator-clinician positions to resemble the more successful examples of nursing and
generating, transmitting, and applying knowledge (Starck et al., 1991), faculty practice must be more than revenue production. For faculty members to flourish in the academic world, but also providing opportunity to contribute to the research base of the profession while meeting other goals. For faculty members to remain true to the academic mission of generating, transmitting, and applying knowledge (Starck et al., 1991), faculty practice must be more than revenue production; it must also enhance teaching and support the research necessary to validate occupational therapy treatment in an increasingly competitive health care market.

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References


