This study examined the experience of occupational therapy clinicians who do research to illuminate factors that influenced their research, the processes involved, and the outcomes. The qualitative approach of grounded theory was used. Purposive sampling of all research-productive clinicians in acute care hospitals in one Australian city occurred. Fifteen clinicians participated in in-depth interviews that explored their experiences of research. Results were analyzed with the constant comparative method, and six conceptual categories were developed. These categories were further analyzed in terms of their relationships, and a core category that explained and synthesized the data was identified—becoming a clinician-researcher. This category encompassed a process of role change during which the person changed from clinician to clinician-researcher. Conditions for this change were identified, and three key concepts were derived to elaborate the core category. In becoming a clinician-researcher, the person was active in (a) identifying research as significant, (b) constructing actions in relation to research, and (c) evaluating the experience. The findings further the understanding of clinician-researchers through the description of their experience and the empirically based theoretical formulation that explains it.


Only a minority of practitioners in applied fields such as occupational therapy are involved in research. This low level of involvement in research has been consistently demonstrated in a number of surveys of research involvement over the past 3 decades (Colborn, 1993; Cusick, 1995; Cusick, Franklin, & Rotem, 1999; Cusick & Rotem, 1994; Fisher, Kielhofner, & Davis, 1989; Gillette, 1982; Hathaway, 1974; Hunter, 1976; Taylor & Mitchell, 1990; Waine, Magill-Evans, & Pain, 1997). This lack of research involvement has occurred despite the encouragement of professional leaders over many years (American Occupational Therapy Foundation [AOTF], 1979, 1983; Christiansen, 1983; Dunn, 1985; Gillette & Mitcham; 1994; Rogers & Holm, 1994; Yerxa, 1987), the use of research development and support strategies by occupational therapy associations and departments (AOTF, 1995; Ballantyne & Ross, 1992; Clark, 1986; DePoy & Gallagher, 1990; West, 1981; Yerxa & Gilfoyle, 1976), and the inclusion of research training in many professional preparation and postgraduate programs for occupational therapists (Boyle, Dunn, & Kielhofner, 1990).

Although the low level of research involvement by occupational therapy practitioners is well established, far less is known about the experience of those practitioners who are “research active.” This study examines the experience of occupational therapy clinicians working in acute
care hospitals who are active in research. The purpose is to characterize the phenomenon of occupational therapy research from the clinician-researcher point of view. A theoretical formulation of the research experience of these clinicians is generated.

**Literature Review**

Although research is not the primary role of occupational therapy practitioners, low levels of involvement can be seen as problematic. Occupational therapy proclaims itself to be a profession (Graham & Irvine, 1994; Wallis, 1987a, 1987b); as such, it requires a demonstrably unique and significant knowledge base from which practitioner service can be derived (Pavalko, 1971). Research plays an important part in the development of this knowledge base (Cusick, in press), and practitioners play a role in doing research and publishing what they do (Harrison, 1996).

Occupational therapy is also a service profession. If clinicians are not actively involved in research, then there is a risk that the knowledge developed for the profession will be irrelevant to practice (Greenwood, 1984). A low level of practitioner involvement is also a problem because research in an applied field such as occupational therapy is developed to be used (Brown & Rodger, 1999; Ottenbacher, Barris, & Van Deusen, 1986). Use of research in service delivery and policy development is less likely to occur if the questions asked and findings generated are not seen as relevant, that is, directly related to practitioner and consumer needs (Bond, 1991; DePoy & Gitlin, 1998; Hunt, 1981; Royeen, 1988). Finally, as a service profession, occupational therapy must safeguard the public trust through “responsible (scientifically based) clinical practice” (Gilfoyle & Christiansen, 1987, p. 7). If practice is conducted in the absence of research, then the profession as a whole suffers in credibility because competent practice depends on a sound knowledge base (Krefting, 1985). Such a credibility problem can ultimately undermine occupational therapy’s status as a viable health service (Christiansen, 1983). All of these problems have been recognized for many years (Basmajian, 1975; Ottenbacher, 1987).

A number of reasons have been put forward to explain the low levels of involvement in research by health care practitioners. These reasons are primarily based on opinion rather than empirical evidence. The first reason relates to role definition, whereby practitioners in clinical settings are primarily concerned with service delivery, thus making research a low-priority role (Barlow, Hayes, & Nelson, 1984; Greenblatt, 1971). Second, there is a perception of conflict between the varying philosophical assumptions and value orientations of research and service (Dunn, 1985). Research and its emphasis on rigor is perceived to be at odds with practitioner approaches of humanism and holism (Bohannon & Le Veau, 1986; Fisher et al., 1989). In addition, researchers are perceived to be more interested in generating and expanding knowledge, whereas practitioners are more interested in applying it and knowing whether it is adequate and plausible (Hardy, 1988). The third reason is that practitioners do not see research as clinically relevant. The extent to which this perception is true in occupational therapy has not been explored to any notable degree; however, it has been seen as a major issue for practitioners in other health fields, particularly nursing (Greenwood, 1984; Hunt, 1981; Kirchoff, 1993) and physiotherapy (Bohannon & Le Veau, 1986; Le Roux, 1988). Fourth, lack of practitioner knowledge and skill in research has been considered to be related to low levels of involvement (Dunn, 1985) as well as negative attitudes toward research resulting from low self-confidence (Dunn, 1985), hesitancy (DePoy & Gitlin, 1998), or a sense that research is not important to service delivery (Royeen, 1988). Finally, barriers to research involvement, such as lack of financial support, productivity requirements, and inadequate staffing, have been identified (Bailes & Baldwin, 1995).

Occupational therapy enters the new century facing a major challenge. As previously stated, a consistent pattern of low involvement by occupational therapy practitioners in research constitutes a problem for the profession in terms of the clinical relevance of research; research utilization; accountability in practice; and, ultimately, professional status. It is timely to revisit clinician involvement in research to explore the issue anew. A good starting place is to ask clinicians themselves about their research views and experience.

Few studies in occupational therapy have explored the clinician point of view of research. Cusick et al. (1999) and Cusick and Rotem (1994) asked clinicians the meaning of the term research and about their views of researchers. Colborn (1993) and Waine et al. (1997) also examined the attributes and activity of occupational therapy practitioners who did research; however, their studies were descriptive surveys that did not present the experience of research from the practitioner point of view. They measured the extent to which practitioners perceived specified factors to be related to research activity, such as clinical environment, educational experiences, workplace learning, and circumstances leading to involvement. If practitioners are important in occupational therapy research, then their points of view need to be considered, a suggestion Taylor and Mitchell (1990) made a decade ago. Because the pattern of research involvement by occupational therapy practitioners seems consistently low and reasonable suggestions have been made in the literature to account for this, something new may be learned by examining the experience of those few clinicians who are different—those who are involved and productive in research.

**Method**

A qualitative approach (Creswell, 1994) was used to explore the phenomenon of research from the point of view of clinicians who did research. Grounded theory was chosen for two reasons. First, grounded theory has been identified as a
useful method “when a new...outlook is needed in familiar settings” (Holloway, 1997, p. 81). The issue of clinician involvement in research is a familiar one that may benefit from a new outlook. Second, grounded theory, particularly the approach advocated by Strauss (Glaser & Strauss, 1967; Schatzman & Strauss, 1973; Strauss, 1987; Strauss & Corbin, 1990), provides a means not only to describe the experience, but also to contribute “explanatory power” (Holloway, 1997, p. 81) to the understanding of any phenomenon through theory. This approach is particularly important for this topic because empirically based explanations of why practitioners do or do not engage in research activity are lacking in the literature.

The scope of this study was limited to the experience of occupational therapy clinicians who were active and productive in research and who worked in patient service positions in metropolitan university–affiliated acute care hospitals. The study explored key concepts of the research experience revealed through in-depth interviews, site visits, and follow-up interactions with participants. A detailed description of study sites, sampling, data collection, data analysis, and issues relating to trustworthiness was presented in Cusick (2000). The present study extends the analysis, interpretation, and application of those earlier findings. A brief summary of method is presented here.

Sample

Purposive sampling (Babbie, 1986) was used to identify and locate all occupational therapy practitioners who were research active and productive and who were working in direct patient service roles in university-affiliated acute care hospital occupational therapy departments. Twenty of 150 occupational therapy clinicians working in these departments met the inclusion criteria (Cusick, 2000), and 15 participated in the study. All participants were women. Their mean age was 36.2 years, and their mean years of practice was 15.8. Thirteen participants held or were completing postgraduate qualifications; 3 of these were qualifications based on the completion of one large research project.

Trustworthiness

Trustworthiness of the study findings was enhanced through research plans and procedures that were reproducible and had high levels of investigator engagement in the field over a number of years, participant cooperation, and the development of “theoretical sensitivity” by the investigator through the course of the study (Jorgensen, 1989; Strauss & Corbin, 1990).

Study Sites

At the time of the study, there were nine occupational therapy departments in university-affiliated acute care hospitals in Sydney, the largest city in Australia. Six departments agreed, through their managers, to participate. Acute care hospitals in Australia are similar to large university-affiliated hospitals in North America. Practitioners belong administratively to an occupational therapy department and are supervised by an occupational therapy manager; however, they work in specialist units, departments, or wards, often with interdisciplinary teams. Budgets are tight, and close monitoring of clinician service costs and performance occurs. The acute care nature of these six hospitals means that the primary model of hospital practice is biomedical, and the role of physicians as senior managers and unit team leaders is dominant. Occupational therapy practitioners use a range of occupational therapy models of practice within this environment.

Data Collection

Data collection occurred primarily through in-depth interviews, follow-up interviews with 7 participants, related site visits, and informal communications where field notes and diary entries were made. An interview guide was used that sought comments from participants about their experiences. Interview technique was based on ethnographic approach (Le Compte & Preissle, 1993; Spradley, 1979). Audiotapes were transcribed, and field notes and diary entries were managed through separate files for each level of analysis as suggested by Miles and Huberman (1994).

Data Analysis

The data analysis aimed to investigate “interactions, behaviors and experiences as well as individuals’ perceptions and thoughts about them” (Holloway, 1997, p. 80). Data were analyzed with the constant comparative method (Glaser, 1965). The first phase of coding involved examining tape transcriptions and field note data in great detail. Six categories were generated (see Cusick, 2000). The relationships between and within these categories were further analyzed to explain the conditions that gave rise to clinician involvement in research, the context in which the clinician experience occurred, the strategies clinicians used to engage in research, and the consequences of these strategies for the clinicians themselves and for others. These areas are suggested by Strauss and Corbin (1990) as useful starting points for inquiry using a grounded theory approach. Together they help explain how a phenomenon such as the clinician experience of research “works,” that is, how all the different interactions, behaviors, experiences, and perceptions fit together to make a feasible “story line.” As a result of this story line analysis, a “core concept” (Strauss & Corbin, 1990) was identified in the data that provided the basis for the theoretical formulation.

The grounded theory approach “stresses the importance of context in which people function and the roles they adopt in interaction” (Holloway, 1997, p. 80); consequently, the theoretical formulation focuses on roles and their context. Role is a term used broadly here to mean “the
entire person–behavior matrix” (Thomas & Biddle, 1966, p. 19). Throughout the analysis, theoretical sampling was used to investigate emerging relationships, so differences in the data were sought and further interviews or information collected. The results of this analysis are presented in this article.

Results

Description of the Clinician-Researcher Experience

Data were initially formalized into six conceptual categories and related subcategories (Cusick, 2000). The first conceptual category, being a real clinician-researcher, was a process whereby the study participants identified characteristics of “real research,” that is, research that they considered to be high quality, rigorous, and peer reviewed. Further, they identified themselves as “wanting more” from their jobs than purely patient service and having “predispositions” to be persons who did real research. Participants implemented strategies over time that helped them do this research and now identified themselves as “real clinician-researchers.”

Knowing other occupational therapists was a process whereby participants made judgments about attributes of other practitioners in relation to professional, personal, and research areas of activity. These “other occupational therapists” were managers, academics, and clinicians who did no research as well as other clinicians who did research but of a lower quality than real research. The participants considered this lower quality research as weak; for example, it was poorly designed, lacked conceptual frameworks, was not peer reviewed, and focused on the busywork of research (e.g., data collection). This subcategory of other occupational therapists was thus labeled “busy researchers” to reflect the different type and quality of research activity. Having identified various types of other occupational therapists, participants then judged the quality, quantity, and impact of these therapists’ involvement in research in relation to the hospital. On the basis of this judgment, participants decided whether to include other occupational therapists in research activity.

Driving the research was a process whereby participants accepted responsibility for the conduct and completion of their research. They then implemented strategies to ensure the conduct and progress of their research in the context of their busy professional and personal lives.

Negotiating the system was a process whereby participants demonstrated a familiarity with the nature of hospital and professional “systems.” Having this awareness, participants actively managed the related administrative and social processes of the system to “maximize their own autonomy” and thus ensured the progress of their research. Specifically, they were managing gatekeepers, managing people of influence, and managing people in the occupational therapy department.

Doing research was a process whereby participants engaged in specific learning activities to do real research and complete projects. These events and activities were starting research, developing research knowledge and skill, doing steps and stages of research, and demonstrating research activity and productivity.

Weighing outcomes was a process whereby participants reflected on the effort involved over time in doing real research and being a clinician-researcher. They considered costs and benefits derived from this effort for themselves and others, including patients, the profession, the occupational therapy department, and the hospital. Finally, participants considered research and other life plans on the basis of this experience.

The Story Line: Integrating the Descriptive Categories

The categories presented previously describe the participants’ experiences. Through further analysis, which involved extensive theoretical sampling and teasing out possible relationships between categories in the data, relationships were identified that together provide a picture of the clinician-researcher experience as a whole—the story line.

The story about clinicians who do research is fundamentally about change. Clinicians who do real research engage in an active process of moving from being a clinician to being a clinician-researcher. They move from being similar to other clinicians to being different. They move from working within a system to provide service to working through a system to do research. Clinicians who do real research have different attributes from other clinicians. They use their time differently, do different activities, and are involved in networks and relationships that are different from other clinicians and occupational therapy managers.

The story of clinician-researchers starts with self-selection for the role because they have a predisposition for it and want more from their work than a purely service role can offer. They are predisposed by their family and social background, education, and learning experiences to value the role of researcher and to do research. They perceive their desire for increased credibility, autonomy, and status at work to be met through the role of researcher. Their genuine interest in patients, clinical questions, and evidence-based practice focused their research efforts in the hospital.

To become a clinician-researcher, the participants actively manage the development of this role, “driving it” through the course of their lives and the systems in which they work. They adopt a number of strategies to construct this role in their lives. These strategies include forward planning, active time management, developing knowledge and skills, and developing and maintaining networks.

Where they work and with whom they work are also important to what they do and how they do it. The specialty unit in which the clinician-researcher works is critical to facilitating real research activity. It provides an environment where others are actively involved in real research; research
topics are specialized; high-status members of the hospital, particularly physicians, are active in research work; and entry into and continued involvement in the high-status networks in the unit depend on clinician-researchers’ own high-quality research activity. Gatekeeping decisions by high-status members in the unit and hospital, such as physicians, are critical to the clinician-researchers’ access to resources (i.e., time, activity flexibility, expertise, research participants) and the conduct of the research. These resources are accessed as needed in the project.

The occupational therapy department is also important for clinician-researchers. The department can facilitate or impede research activity through the gatekeeping functions of the manager, who permits or facilitates access to research-related resources. Although research is more easily done with department support, it is not essential to clinician-researchers—they will do it anyway. Helpful resources include manager approval of time use and activity flexibility for research; access to administrative and information supports, such as library or clerical staff; and social support. The clinician-researcher seeks these resources as they are needed, usually in relation to a specific project.

What happens to these clinicians? They engage in continuous reflection on their own development as researchers. They observe a change in themselves and a change in the outcomes of their activities. The consequence of these actions and reflections is that these clinicians become clinician-researchers who do real research. Their research is identified in their own minds as high quality, rigorous, subject to peer review, and related to key topics in specialty medical fields. They weigh the benefits and costs of this change on their lives as a whole. They consider outcomes of what they have done and experienced and determine whether the outcomes were “worth it” for themselves; their families; and others, including the profession, patients, the department, and the hospital. On the basis of these reflections, they continue their development as clinician-researchers, with forward planning and revised strategies for negotiating the system, doing research, and continuing to refine the role of being a clinician-researcher.

The story presented here has integrated the categories that described the experience of clinicians who do research. The story gives a picture of the phenomenon of clinician research as a whole. To further the understanding of the clinician-researcher experience and to enhance the “explanatory power” of these findings, this story can now be analyzed to identify a central phenomenon.

Explanation of the Central Phenomenon Under Study

The story line revealed the core category of the story as the process of becoming a clinician-researcher. The predispositions, actions, strategies, contexts, and consequences all center on this process. Becoming a clinician-researcher is further explained in terms of conditions forming subsidiary categories of this process. A clinician becomes a clinician-researcher if he or she (a) is predisposed to research; (b) identifies the difference between real research and other research of lesser caliber and quality; (c) identifies real research as a means to attain desired or expected outcomes; (d) actively manages research activities through work and personal life; (e) negotiates the hospital system at all levels to ensure the conduct and progress of the research; (f) engages in real research activities; (g) identifies himself or herself as a clinician-researcher, different from other occupational therapists; (h) weighs the outcomes of this process; and (i) makes decisions about further activity as a clinician-researcher that are based on these experiences and reflections.

Explaining Relationships Among Categories at the Dimensional Level

Now that a central phenomenon and subsidiary categories have been identified, the experience of clinician-researchers can be further understood in conceptual terms through the analysis of properties and dimensions of the original descriptive categories. This level of analysis produces key concepts that will naturally reflect the story line description, but they are at a greater level of abstraction and are more generalized because they are related at the conceptual, property, and dimensional level (Strauss & Corbin, 1990).

Three key concepts were abstracted from the six descriptive categories: identifying, constructing, and evaluating (see Table 1). All three are processes involved in becoming a clinician-researcher. Identifying involves the process of recognizing the role of clinician-researcher as a valued one with a special profile of attributes different from other occupational therapists. Constructing occurs through the active management of research in the clinician’s professional and personal life by driving the research, negotiating the system, and doing research. In evaluating, the therapist reflects on the process of change from clinician to clinician-researcher and weighs the outcomes. On the basis of these reflections, the therapist identifies further goals and makes plans for continued development as a clinician-researcher. The three key concepts provide a way of explaining the processes involved in becoming a clinician-researcher. This is the foundation of the emerging theory.

The Theoretical Formulation

The central phenomenon of becoming a clinician-researcher is explained by the three key concepts of identifying, constructing, and evaluating. The theoretical formulation of the research experience for the study participants follows, using the format recommended by Strauss and Corbin (1990), for the context, phenomenon, conditions, strategies, and consequences.

Clinicians who do real research of high quality and caliber do so in the context of the hospital setting and their personal daily life. These clinicians do not just do research,
they become clinician-researchers. Thus, the core phenomenon is one of role change. Role change occurs under the conditions of being predisposed to research, wanting more from clinical positions, and identifying the role of real clinician-researcher as a valued one when compared with other occupational therapists. The strategies used to construct the role in their lives are driving the research, negotiating the system, and doing research. The consequence of clinicians identifying and constructing this role is that they become clinician-researchers. They are not clinicians who do research on top of everything else. As clinicians become researchers, they use the strategy of evaluating to determine their attainment of the role and weigh the outcomes of this for themselves and for others. As a consequence, they then use these reflections to make plans and continue their development as clinician-researchers.

Discussion

Findings from this study further understanding of clinician-researchers by describing their experience and putting forward without empirical support (Cusick, 2000). Examples of these models are the scientist–practitioner model advocated originally in psychology (Barlow et al., 1984) and then in occupational therapy (Polatajko & MacKinnon, 1987), Colborn’s (1993) practitioner-researcher model as the framework for her study, and the research roles put forward by professional associations (AOTF, 1983).

The assumption of these models is that the practitioner role can be extended to include research. The theoretical formulation presented here suggests that extending the practitioner role to include research may not be realistic. Rather than the practitioner being expected to have a “multifaceted self-concept that includes the role of researcher” (Gillette, 1982, p. 500), something entirely different appears to happen: A distinct role change occurs from that of being a clinician to being a clinician-researcher. The role change is purposeful and active, motivated by the practitioner’s perception of research and the research role as highly valued for a variety of biographical reasons.

The phenomenon of becoming a clinician-researcher, and the key concepts of identifying, constructing, and evaluating that explain how this occurs, are commensurate with and elaborated at the broad conceptual level by the principles and constructs of “symbolic interactionism.”

### Table 1

<table>
<thead>
<tr>
<th>Key Concept</th>
<th>Category</th>
<th>Subcategory</th>
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<tbody>
<tr>
<td>Identifying</td>
<td>1. Being a real clinician-researcher</td>
<td>a. Profiling “real research”&lt;br&gt;b. Profiling ourselves (clinician-researchers)&lt;br&gt;c. Being predisposed to research&lt;br&gt;d. Wanting more</td>
</tr>
<tr>
<td>Constructing</td>
<td>3. Driving the research</td>
<td>a. Accepting responsibility&lt;br&gt;b. Controlling the project&lt;br&gt;c. Using deadlines&lt;br&gt;d. Setting goals&lt;br&gt;e. Integrating activities&lt;br&gt;f. Setting priorities and forward planning&lt;br&gt;g. Scheduling activities&lt;br&gt;h. Articulating values</td>
</tr>
<tr>
<td></td>
<td>4. Negotiating the system</td>
<td>a. Knowing the system&lt;br&gt;b. Managing gatekeepers&lt;br&gt;c. Managing people of influence&lt;br&gt;d. Managing the occupational therapy department&lt;br&gt;e. Maximizing autonomy</td>
</tr>
<tr>
<td></td>
<td>5. Doing research</td>
<td>a. Starting&lt;br&gt;b. Developing knowledge and skill&lt;br&gt;c. Doing steps and stages&lt;br&gt;d. Demonstrating research activity and productivity</td>
</tr>
<tr>
<td>Evaluating</td>
<td>6. Weighing outcomes</td>
<td>a. Benefits and costs to clinician-researchers&lt;br&gt;b. Benefits and costs to hospital&lt;br&gt;c. Benefits and costs to occupational therapy department&lt;br&gt;d. Benefits and costs to patients&lt;br&gt;e. Benefits to occupational therapy profession&lt;br&gt;f. Clinician-researcher plans</td>
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Symbolic interactionism is a tradition of sociology where key authors, such as Mead (1934) and Blumer (1969), explored the self and society through individual experience (Jacob, 1987). This sociological approach explains ways in which people understand and construct meaning in their worlds.

Symbolic interactionist explanations of the phenomenon of becoming a clinician-researcher would start with three assumptions. First, people act toward things based on the meaning these things have for them (Collins, 1985; Jacob, 1987; Rose, 1962). In the present study, research and researchers would be considered a thing (or object) with special symbolic meaning for the participants. Second, these meanings are derived from and arise through social interaction with other persons (Stryker, 1981). According to the participants in the present study, social interaction with researchers and nonresearchers was important. These interactions included persons in the clinician-researchers’ personal backgrounds (relatives, partners, friends), in the hospital (colleagues, patients), in the profession, and so forth. Third, these meanings are actively handled and modified through reflection and interpretation (Blumer, 1969; Vidich & Lyman, 1994). In this reflective process, the person does the following:

- Interacts with himself or herself (“What do I think of what I am thinking?”) to identify things of meaning and determine their importance. In this study, the process of identifying describes this reflection, as participants identified research and researchers as valued objects.
- Considers possible “lines of action” and then directs action regarding the valued object. In this study, the process of constructing describes this reflection, as participants considered strategies and then implemented them to build the research role in their lives.
- Considers again the objects and their importance with regard to further action. In this study, the process of evaluating describes this reflection, as participants weighed the outcomes and considered plans for further action in relation to research.

Role theory is a derivative of symbolic interactionism, which further helps to explain the phenomenon of the role change that occurred in the experience of clinician-researchers. Specifically, the concepts of role-taking and role-making explain the processes the participants experienced.

Role-taking is the process by which a person imagines the role of another, sees himself or herself in that role, imagines what the other would do in any given situation, and directs himself or herself accordingly (Mead, 1934; Miller, 1981; Hurley-Wilson, 1988; Turner, 1962). Adults are proposed to take on roles quite consciously (Cohen, 1989), so it is not surprising that the participants were able to identify critical events when the decision to pursue research occurred, where particular researchers were described, or when specific strategies or actions were used to “take on” the clinician-researcher role.

Role-making was also important for participants in this study. In role-making, an existing role is modified through social interaction, and new role behaviors are verified by others or new meanings about particular objects are shared (Conway, 1988; Turner, 1962). The participants described events where their clinician-researcher role was verified by others (e.g., senior medical specialists wanting to support the participant’s research with funds). They saw these situations as important times for them in their development. They also described understandings shared with interdisciplinary team colleagues or research peers that were not shared by occupational therapy colleagues in their departments.

The findings of this study have implications for research development strategies in occupational therapy. Models reviewed earlier in this article assume that most, if not all, practitioners could be researchers if the environment, professional preparation, or incentives were “right.” This study suggests that such a scenario is unlikely, given that the participants self-selected the role of researcher. In symbolic interactionist terms, it is the individual practitioner who identifies research as a valued object, who constructs the role in his or her life to attain it, and who determines whether it was worthwhile. Strategies to support research should therefore be targeted to persons who self-select research. These persons can be identified through mechanisms such as expressions of interest, competitive submissions, records of involvement, research-relevant outcomes, and so forth. The focus is thus on specific persons rather than on the environment in general. This is an important shift in research support strategy design. It requires an implicit acceptance of first the reality of diverse roles in the profession (participants identified clinician-researchers, clinicians, managers, academics, and busy researchers) and second the freedom of practitioners to self-select these various roles. Not everybody can do everything.

The focus on role-taking and role-making as key processes suggests the need to rethink what constitutes effective support for clinician-researchers in service settings. Effective research role development requires intensive and extensive social interaction with a range of researchers so that ample opportunities for role-taking and role-making are present. Unless clinicians are able to interact with experienced real researchers, they are not able to engage in the process of reflective thinking that is critical to the development of the self in new roles, the verification of new role behavior, and the ability to share new meanings with persons who value the same things.

Research support strategies that focus primarily on social interaction are not new to researcher development.
The importance of socialization to research has been well documented in the medical (Bland & Ruffin, 1992; Bland & Schmitz, 1986), scientific (Bhathal, 1996, 1999; Pez & Andrews, 1976), and academic (Bazeley et al., 1996) literature that explores the development of successful researchers. This literature suggests the importance of providing socialization opportunities for novices to identify, learn, and take on the role of researcher. Bland and Schmitz (1986) are typical of these authors in suggesting that new researchers “need time to develop and they need role models and conscious socialization” (p. 30).

Conclusion

The experience of clinicians who do research in university-affiliated acute care hospitals was explained by the phenomenon of becoming a clinician-researcher. This phenomenon occurred through the processes of identifying, constructing, and evaluating the clinician-researcher role. The symbolic interactionist perspective elaborated the theoretical formulation presented in this study.

There has been a long-standing interest in increasing practitioner research activity. Good reasons for this exist; however, the pattern of clinician involvement has remained low. New approaches are called for, as Gillette and Mitcham (1994) state: “Is it not always time for new research ideas” (p. 649)? The theoretical formulation put forward in this study suggests a new approach. The focus in discussion about clinician research productivity needs to shift from the common rhetoric about clinician “doing” research to a new focus on clinicians “becoming” clinician-researchers. This new focus requires a consideration of the importance of self-selection for research, of research as a valued object and occupation, and the importance of social interaction in this process. It is these considerations that are critical to the development of clinician-researchers who will produce high-quality research in clinical environments. This shift provides a new outlook in familiar territory, which signals a change in our understanding of clinician research involvement and models of practitioner research.

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