CAREER PATHS OF BOARD-CERTIFIED CLINICAL SPECIALISTS IN GERIATRIC PHYSICAL THERAPY WITH IMPLICATIONS FOR HIGHER EDUCATION

DISSERTATION

Presented to the Graduate Council of the University of North Texas in Partial Fulfillment of the Requirements For the Degree of

DOCTOR OF PHILOSOPHY

By

Mary E. Thompson, M.S., PT, GCS

Denton, Texas

August, 1996
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Geriatric board-certified specialists (GCSs) address health care needs of the growing geriatric population. The study's purposes were to: examine career paths of GCSs, identify influencing factors, and explore implications for higher education. Twelve of 14 original 1992 GCSs participated. Data included document collection and interviews. Using a qualitative methodology, commonalities were sought among individuals and HyperRESEARCH software was used for data management.

The participants were adventurous, valued education, and were enthusiastic about physical therapy (PT), geriatrics, and specialization. Their career path began with choosing PT as a career, professional education, and their first job. One GCS moved directly into geriatrics. Others went to different settings before geriatrics. As participants recognized they "fit" in geriatrics, they pursued postprofessional education to increase knowledge before choosing board certification.

In choosing PT, volunteer experience and personal research were common influences. In choosing to work with elders, influences throughout life gradually built a social context supporting the decision. GCSs chose specialist certification to assist in professionalization of geriatric PT, because they were highly skilled, for career advancement, and for self professionalization.
Specialist certification had few financial consequences. Participants gained friends and professional networks. They experienced improved patient care, increased educational opportunities, and/or increased professional service.

GCSs' vision was for a better society and health care system. This vision included successful aging - that it is possible and would benefit society. To bring about global change, GCSs perceived they had to influence older individuals, legislators, PT students, peers, and other professionals.

Implications for higher education are as follows. Professional schools should not base admission on expressed intentions to work with elders. Curricula and clinical experiences should be such that a nonageist generalist is produced. Higher education's role postprofessionally can be through continuing education, formal degrees, and geriatric residency programs. Gerontology programs also could meet educational needs. Higher education can play an important role in the professionalization of individuals and ultimately the profession itself.
ACKNOWLEDGMENTS

This dissertation came about through the help and support of many people. While I cannot thank all of them, I would like to acknowledge a few whose contributions were especially significant.

I could not have begun this journey without the support and encouragement of my husband, Ray, and daughters, Sarah and Rachel. In addition, the faculty, staff, and fellow graduate students of the University of North Texas and Texas Woman's University enriched the journey and my life.

Special appreciation go to the members and staff of the Texas Physical Therapy Association and the American Physical Therapy Association (APTA). This dissertation was supported by a grant from the Texas Physical Therapy Education and Research Foundation, and by the APTA Section for Education Doctoral Scholarship. I was able to complete this dissertation in a timely manner because members financially supported the value of research and lifelong learning.

To the first "class" of Geriatric Specialists in Physical Therapy, I remain especially grateful because this dissertation is our story. Thank you for sharing your lives.
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CHAPTER I

INTRODUCTION

In 1994, 12.7% of Americans were 65 years of age or older (Fowles, 1995). The number of older Americans increased by 24% since 1980, compared to an increase of 9% for the under-65 population (Fowles, 1992). Continued growth of the older population is anticipated with the most rapid increases expected between 2010 and 2030 when the baby boom generation reaches age 65. By 2030, elders may represent 20% of the population if current immigration and fertility levels remain stable (Fowles, 1995).

The vast majority of the older population lives in the community, with only about 5% residing in institutions at any moment. While most community dwelling elders view themselves as healthy, 28% assessed their health as fair or poor in 1993. Most older people have at least one chronic condition and many have multiple conditions. The 5 most common occurring conditions in 1993 were arthritis (49%), hypertension (35%), hearing impairments (31%), heart disease (31%), and orthopedic impairments (18%). In 1986, 23% of community dwelling elders had health-related difficulties with one or more activities of daily living, including eating, toileting, dressing, transferring, walking, and bathing. Twenty-eight percent had difficulty with one or more instrumental activities of daily living. These are tasks required to maintain an independent household such as using the telephone, shopping, managing
money, meal preparation, and getting around the community. The percentages needing
and receiving help with these activities increased sharply with age (Fowles, 1995;
Kane, Ouslander, & Abrass, 1994).

In addition, older people are the largest health care consumer group across
delivery settings. In 1993, they accounted for 36% of all hospital stays and averaged
more contacts with physicians than did persons under 65 (Fowles, 1995). Kemper and
Murtaugh's 1991 study projects that a person age 65 in 1990 has a 43% chance of
spending some time in a nursing home before death. Of those at least 25 years of age
who died in 1986 and entered nursing homes, 51% lived there 1 year or less, and 17%
lived there 5 years or more. The authors found that the percentage with 5 or more
years of lifetime nursing home use tended to increase with age so that 42% those who
survived to very old age (≥ 95) lived 5 or more years in nursing homes.

Despite heavy medical usage as a group, most elders do not fit the traditional
medical model where the symptom is directly related to a disease that once identified,
is cured (Fried, Storer, King, & Lodder, 1991). Many problems facing elders cannot
be cured but health and independence are possible. A geriatrician is a physician who
learns methods that enable disabled elders regain health. These methods have been
developed in the practice of physical medicine and rehabilitation (Lippmann, Fishman,

Physical therapy is an important part of the rehabilitation process. Physical
therapy is the assessment, evaluation, treatment, and prevention of physical disability,
movement dysfunction, and pain resulting from injury, disease, disability and other
health-related conditions. Therefore, it is the mission of physical therapy to expand and use its body of knowledge to increase functional ability, decrease disability, educate patients/clients to enable them to assume responsibility for their health, and reduce the financial and personal costs of disability to society (American Physical Therapy Association [APTA] Education Division, 1995, February). Physical therapy addresses the needs of older people with the goal of progressing the individual toward optimal health. According to Kane and associates (1994), small changes in function can make an enormous difference in the individual's quality of life. Therefore, physical therapists, especially board-certified clinical specialists in geriatric physical therapy, could have an impact on the lives of elders and our aging society.

However, many physical therapists are not interested in working with older people (Noonan, 1992; Wong, 1990). This lack of interest, together with increasing demands for physical therapists in all settings (U.S. Department of Labor, 1994), leaves many older people without services that can make a significant difference in their quality of life. Unless more physical therapists choose to direct their careers toward a geriatric practice, the needs of older people may not be adequately met given current demographic trends.

Statement of the Problem

The problem this study addressed was the career paths of board-certified specialists in geriatric physical therapy with implications for higher education.
Purposes of the Study

The study had three purposes: (a) to examine the career paths of board-certified specialists in geriatric physical therapy, (b) to identify internal and external factors that influenced them toward a geriatric practice and specialization, and (c) to explore implications of career paths of board-certified clinical specialists in geriatric physical therapy for higher education.

Research Questions

1. What career paths lead to board certification in geriatric physical therapy?
2. What do board-certified geriatric physical therapists perceive as important internal and external influences on their career decision to work with older people?
3. What do board-certified geriatric physical therapists perceive as important internal and external influences on their career decision to specialize?
4. What is their perception of the consequences of those career decisions?
5. What are their perceived missions in choosing aging and specialization?
6. What do they perceive as barriers or aids in carrying out that mission?
7. What are the implications of the career paths of board-certified clinical specialists in geriatric physical therapy for higher education at the professional and postprofessional levels?

Significance of the Study

Despite the growing geriatric population, their health needs, and the ability of physical therapy to address those needs, future plans of most physical therapy students
do not include a geriatric practice. Geriatrics has often been viewed as less rewarding than other areas of physical therapy resulting in a shortage of geriatric physical therapists (Dasch & Finney, 1991). Only 24% of the 314 physical therapy students surveyed in 1986 intended to work primarily with elders during the 5 years following graduation (Coren, Andreassi, Blood, & Kent, 1987). Nosse and Wilson (1994) surveyed 65 physical therapy students and only 30.6% intended to work primarily with older people in the next 3 to 4 years. Neither of these studies followed students to see if any actually worked primarily with older people following graduation. Dunkle and Hyde's (1995) study did contact 91 physical therapy students following their internships to determine whether the students had taken jobs working with older people. Sixty-two percent of the physical therapy students stated positive intentions to work with older people, but only 45% selected employment working primarily with geriatric patients. Therefore, researchers found a significant ($p = .01$) but very low Spearman's correlation (.26) between the expressed intentions of students and their actual behavior as new graduates working with older people.

Many factors, both internal and external, influence career choices and directions. Factors may include attitudes, knowledge, and experience. Attitudes toward elders held by students during their professional education influence their decisions to work with this population after graduation (Coren et al., 1987; Dunkle & Hyde, 1995; Green, Keith, & Pawlson, 1983). As health care providers in the community, a negative predisposition toward elders, or "ageism," may persist and influence clinical decision making (Baker, 1984; Kane et al., 1994; Kvitek, Shaver,
Blood, & Shepard, 1986). In addition, knowledge and experience may influence an individual's attitude toward elders (Gardner & Perritt cited in Brown, Gardner, Perritt, & Kelly, 1992; Todd, Rider, & Page-Robin, 1986). However, just spending time with older people may not guarantee the acquisition of the knowledge and attitudes for appropriate geriatric care (Brown et al.; Dunkle & Hyde, 1995; Steel, Norcini, Brummel-Smith, Erwin, & Markson, 1989).

It is assumed that board-certified clinical specialists in geriatric physical therapy represent success stories in that these individuals are addressing the needs of older people, an increasing portion of our society. By examining the career paths of board-certified specialists in geriatric physical therapy, it may be possible to identify commonalities that influenced them toward a geriatric practice and specialization. If the purpose of higher education is to help meet societal needs, then it is important to develop strategies that could positively motivate students toward a geriatric practice.

Limitations of the Study

This study is limited in that it was exploratory in nature and restricted to the first "class" of board-certified clinical specialists in geriatric physical therapy. According to Hopfl (1992), to give episodic order to their experience, individuals tend to assume a fixed point - the present - from which to anticipate the future and survey the past. However, the changing vantage point of the present will alter perceptions of past and future when experience has intervened. We are not the same people we were last month or yesterday. Therefore, the findings of the study are valid only for the
participants at the time of their interview, January through March of 1996. In addition, since changes occur with humans in different contexts and over time, some temporal perspective was added by interviewing participants with different career paths and time in physical therapy.

Other limitations can result from the use of qualitative methods. These include threats to external and internal validity. Threats to external validity found in qualitative studies are problems with population validity and experimenter effect. According to Borg and Gall (1989), analysis of a few nonrandom cases leads to bias because of the unique characteristic of those cases. Therefore, any generalization of results to the target population must be made carefully. Information on the typicality of the observed phenomena helps provide evidence of external validity in qualitative studies. Unfortunately, little is known about board-certified clinical specialists in geriatric physical therapy.

Because qualitative methods such as participant observation and interview are highly subjective, they are subject to experimenter biases. The interviewer's unconscious biases or expectations may distort the data (Borg & Gall, 1989). This was guarded against throughout the study by adherence to the unstructured interview process, where the participant provides the structure. Data analysis followed the technique developed by Lofland and Lofland (1995) to decrease the likelihood of experimenter bias and to ensure a full elaboration of the phenomenon. All interviews were audiotaped, transcribed, and repeatedly played and read to (a) verify the accuracy
of participants' career paths and factors that influenced them toward a geriatric practice and specialization, and (b) reflect on the abstraction of themes in the data analysis.

The most serious internal validity threat in qualitative research is instrumentation. Instrumentation refers to biases that are introduced when the data collection instrument changes. The researcher is the main instrument for data collection in qualitative studies. Changes in what is observed and how it is interpreted can be serious threats to validity. To reduce instrumentation effects, changes were carefully recorded (Borg & Gall, 1989).

While not generalizable to other geriatric specialists or physical therapists, the study contributes to the body of knowledge regarding the career paths of board-certified clinical specialists in geriatric physical therapy and the factors that influenced them toward a geriatric practice and specialization. This may have important implications for higher education as professional and postprofessional education programs prepare physical therapists to meet the special needs of the fastest growing portion of the U.S. population, those 65 years of age and older.

Definition of Terms

A board-certified clinical specialist in geriatric physical therapy (GCS) is a physical therapist that has successfully completed the certification process developed by the American Board of Physical Therapy Specialties in the area of geriatrics (American Board of Physical Therapy Specialties [ABPTS], Guidelines).
A career path is a route taken in a person's life in the world of work. For the purpose of this study, the definition was limited to the individual's career path as it pertains to working with older people within the profession of physical therapy. The career path began with choosing physical therapy as a career and continued to the point in time in which the interview occurred.

Internal and external factors that influenced a GCS toward a geriatric practice and specialization were identified and described by the participants through verbal descriptions of their experiences expressed in interviews. The study details in each participant's own language the factors that influenced them toward a geriatric practice. Factors varied depending on the particular context or culture of each individual, however, factors included attitudes, knowledge, and experiences. The essential themes derived from the data analysis are understood within the context of the whole phenomenon.

Professional education is the first level of education preparing students to enter the practice of physical therapy (APTA Education Division, 1994). There are four controlling assumptions about physical therapy professional education in the APTA Education Division's working document, A Shared Vision for Physical Therapy Professional Education. Professional education (a) will be at the postbaccalaureate degree level, (b) will be based on a mission of practice, (c) will prepare the generalist practitioner, and (d) is only the first phase on a continuum of phases to mastery and competence.
Postprofessional education consists of educational opportunities for physical therapists following their professional education. Nondegree, master's degree, and doctoral degree programs are available and the degrees offered are not necessarily in physical therapy ("Educational programs," 1995). Postprofessional education is defined in its broadest sense and encompasses professional development.

Organization of the Dissertation

An overview of the study was given in Chapter I. Chapter II examines relevant literature and provides the theoretical basis of this study's conceptual framework. Chapter III briefly discusses qualitative research as a methodology. The participants, data collection and analysis, and strategies to achieve rigor also are discussed in Chapter III. Findings and analysis are reported in Chapter IV. The research purposes are illuminated by identifying major themes that emerged from the data. Themes are used to illustrate the conceptual framework that emerged from the data. Chapter V summarizes the study's findings. Also presented are implications of the career paths of GCSs for higher education, both at the professional and postprofessional levels.

Chapter I References


CHAPTER II

REVIEW OF THE LITERATURE

The purpose of this chapter is to examine relevant literature and provide a theoretical framework for the study. It begins with a brief history of American medicine and of physical therapy as a profession. The literature concerning physical therapy education is examined followed by a discussion of physical therapy specialization and specialization in geriatric physical therapy. The chapter concludes with the search for a theoretical framework by examining the literature on professionalization and career theory.

Brief History of American Medicine

"Until the advent of World War I medicine was the domain of the general practitioner" (Sacks, 1993, p. 14). In those horse-and-buggy days the physician, usually male, often rode many miles in the middle of the night to set a bone, deliver a baby, or to care for a child's high fever. He was a figure of high respect, honored staff member of any hospital, taking care of charity work on the wards, and visiting his own hospitalized patients (Sacks; Starr, 1982). It was at this time that the scientific method was introduced into medicine and medical education was consolidated under the authority of the American Medical Association. Basic medical sciences and technology began and soon experienced rapid growth. As a result, the
predominant health problems in the U.S. changed from acute events, trauma, or infections affecting individuals to chronic diseases such as heart disease, cancer, and stroke (Williams & Torrens, 1993).

In response to the development of medical knowledge, techniques, and technology following World War I and their immense proliferation since World War II, the practice of medicine changed in two ways (Williams & Torrens, 1993). One change was the shift toward specialization. According to Sacks (1993), as late as the 1950s, 80% of practicing physicians were general practitioners. General practitioners, now called family practitioners, account for only 10% of all practicing physicians today. Since the medical profession is so broad and the fund of medical knowledge so immense, it is impossible for any one physician to know it all. It is still possible for individuals to become quite knowledgeable in their particular specialty or subspecialty. The vast majority of students leaving medical school today will specialize, choosing among 24 accredited major specialties and approximately 45 major subspecialties. The other change in American medicine was the development of allied health professionals who supported the physician's professional role. As specially trained but less skilled workers, they extend the professional role of physicians and function under their direction. Physical therapy is one such profession born out of medicine.

Brief History of Physical Therapy

The profession of physical therapy arose out of the reconstruction aides of World War I who worked closely with orthopedic physicians in the U.S. Army Medical
Corps. Their goal was to rehabilitate injured and disabled servicemen to as near normal as possible. Initially, the reconstruction aides were poorly received by the medical community, but the medical staff came around as wounds healed, and muscles and joints regained function (Murphy, 1995). In the 1920s and 1930s, physical therapy education and clinical practice were refined. During the polio epidemics (1930-1950s), physical therapists responded to the national health crisis and assumed a major role in the rehabilitation of civilians (Bartlett, 1991). The Social Security Act of 1935 paved the way for new and expanded programs for disabled children as the Federal government began efforts to care for those who could not care for themselves (Williams & Torrens, 1993). During World War II physical therapists again took an active role in the rehabilitation of servicemen, both in the U.S. and overseas (Murphy).

In the decades that followed, the physical therapy profession was influenced by new socioeconomic factors rooted in postwar prosperity and supported by medical advances and resources that focused national attention on mental health and chronic illness. The American Physical Therapy Association (APTA) debated the profession's responsibility to the public and its membership in the new era. As society began to view health care as a right, the Federal government took a more active role in matters of health care. In this atmosphere, many power groups (including physicians) within American society became vulnerable. New groups wishing to exercise their potential opportunity for status and power challenged or modified the roles of traditional power groups. It was during this time that physical therapy began to gain prominence in health care (Bartlett, 1991; Williams & Torrens, 1993).
Socioeconomic prosperity quickly turned downward in the 1980s and continues today. In this time of limited resources, public policy has turned to cost containment in health care. Health services are being reorganized in terms of financing methods and care delivery (Williams & Torrens, 1993). Thus far, the APTA has strengthened its status as a profession in a rapidly changing social environment. However, Bartlett (1991) hopes physical therapists entering practice will recognize and cherish the important social value in their work. Beyond any financial rewards, Bartlett wishes that physical therapists gain their greatest satisfaction from knowing they have served others.

Physical Therapy Education

Professional Education

Before the beginning of World War I there were only a few physical therapy apprenticeship programs in the U.S. (Daniels, 1974; Ketter, 1995). In 1918, physical therapy education began to grow in the U.S. Army in the training of reconstruction aides. By the end of World War I, as large numbers of disabled servicemen returned to the U.S., it became obvious that the physical therapy program needed to be expanded (Murphy, 1995). Technical programs were developed in a few colleges but hospitals were the predominant setting for physical therapy education (Daniels). Students entering these programs had a baccalaureate degree, usually in physical education or nursing. Upon completion of the curricula, the institution awarded postbaccalaureate certificates (Warren & Pierson, 1994).
The American Physiotherapy Association, later renamed the APTA, took an active role in refining physical therapy education in the late 1920s. It consulted with established physiotherapy programs in Europe and Australia in creating a 1,200-hour minimum curriculum in theory and practice. To enroll in the physical therapy course, the applicant was required to be a graduate of a recognized school of physical education or nursing (Hazenhyer, 1946; Murphy, 1995). By 1956, baccalaureate programs represented most U.S. physical therapy education programs as hospital based programs gradually closed. The first entry-level masters degree programs began in the 1960s (APTA, 1984).

Physical therapists have been debating the appropriate level of professional physical therapy education for decades. In the late 1970s, an APTA task force formed to study the issue (APTA, 1984). The study cumulated in the 1979 APTA House of Delegates adoption of policy RC 14-79 mandating entry-level education at the postbaccalaureate level by December 31, 1990. Many within the profession, in higher education, and in state legislatures opposed this mandate (Morton, 1986). While the House of Delegates later amended the policy from a mandate to a recommendation, the APTA Education Division still supports the transition to graduate-level profession education for all physical therapists (APTA, 1995). Rather than mandate change, APTA's Education Division, under the leadership of Joseph Black, began a consensus-building process in 1993. The purpose was to develop a new consensus-based normative model of professional education - a voluntary standard. This normative model of professional physical therapy education is meant to reflect the profession's
future directions, articulate values shared by the profession, and be responsive to change (Murphy, 1995).

As of December 1995, there were 137 entry-level professional programs in the United States accredited by the Commission on Accreditation in Physical Therapy Education, APTA ("Educational programs," 1995a). Of these programs, 63% were in public colleges or universities. Profession education occurs at a variety of educational levels - 61 offered bachelor's degrees, 79 awarded master's degrees, 4 were certificate programs, and 1 awarded doctoral degrees. Eight institutions offered professional programs at multiple educational levels. APTA allocated resources in 1994 to academic programs requiring assistance in making a transition to postbaccalaureate professional programs. Ten of the 56 programs contacted in 1994 had approval for transition by the end of 1996. Twenty-three other programs began the process and are optimistic about the outcome (APTA, 1995).

Currently there is much discussion taking place regarding the creation of an entry-level doctoral degree in physical therapy (Deusinger et al., 1993; Dunleavy et al., 1993; Horn, 1992, 1993; Johnson, 1992; Kleponis, 1992; Soderberg, 1989; Winter, 1992). Creighton University in Omaha, Nebraska admitted its first doctoral class in the Fall of 1993 and other institutions are considering the transition. However, many physical therapists oppose this move. They want to keep the doctorate at the postprofessional level as the terminal degree in clinical education. Their concern is that there will be too much diversity within the programs and the doctorate will lose value and meaning.
While there is continued debate on the appropriate educational level, there is consensus on the mission of physical therapy professional education.

The mission of physical therapy professional education is to graduate knowledgeable, self-assured, adaptable, reflective, and service-oriented practitioners who by virtue of critical thinking, life-long learning, and ethical values, render independent judgments concerning patient/client needs, promote the health of the client, and enhance the professional, contextual, and collaborative foundations for practice. These practitioners contribute to society and the profession through practice, teaching, administration, and the discovery and application of new knowledge about physical therapy. (APTA Education Division, 1995, September, p. 6-7)

*Postprofessional Education*

A distinguishing feature of belonging to a profession is a commitment to lifelong learning. As professionals, physical therapists strive to maintain a high level of competence in practice and theory. Postprofessional education in the broadest sense is education beyond one's professional training. It comprises a variety of activities that the physical therapist undertakes to keep stimulated and to grow within the profession. Activities may include continuing education, specialist certification, formal graduate work, active participation in professional meetings, personal study of the literature, and exchanging ideas with students and colleagues (Echternach et al., 1994; Greenwald, 1993).

Individual physical therapists are responsible for their own growth in the profession. According to Figuers in Echternach et al. (1994, p. 32), "The individual needs to develop a vision . . . But vision - and the ability to be a self-directed learner - evolves over time and with experience, which is why students and younger PTs [physical therapists] need reinforcement from older, more experienced professionals."
External guidance comes from higher education, employers, state licensing boards, and the APTA. Former faculty and clinical educators set the tone for the new graduate. By providing opportunities for independent and collaborative learning, students become self-directed, lifelong learners (Echternach et al., 1994; Greenwald, 1993). In addition, higher education may play a role in formal postprofessional education. As of December 1995, the APTA listed 54 institutions in the United States offering education programs leading to postprofessional degrees for physical therapists ("Educational programs," 1995b). These programs are directed toward advanced research and/or clinical specialization. Also, physical therapists have earned advanced degrees in related fields such as anatomy, business, education, and kinesiology.

Employers help develop a framework for professional growth by broadening the individual's professional horizons. Employers also have a responsibility to identify an individual's weaknesses and thus guide ongoing learning (Echternach et al., 1994).

Postprofessional education may be guided by the requirement of continuing education units (CEUs). Twenty-one state licensing boards require continuing education for licensure renewal (Hruska & Harden, 1994). While there is a diversity of opinion surrounding mandatory continuing education for relicensure, all respondents in Finley's 1988 national study stressed the importance of continued clinical development to maintain practitioner currency with a growing concern for a system to ensure clinical competence. This concern was also expressed by the Pew Health Professions Commission (1995). They rejected continuing education requirements as a viable method for ensuring continuing competency after initial licensure since recent
research indicates a poor relationship between continuing education programs and clinical outcomes. Instead, the commission recommended a combination of approaches including peer review, retesting, board certification and recertification. Packard (1996), commenting on the Pew Commission’s report, noted that this recommendation would have implications for the Federation of State Boards of Physical Therapy and the APTA specialty councils even as state legislatures continue to mandate continuing education.

In response to this growing concern regarding continued clinical competency, and as part of its goal to promote innovation in physical therapy education at all levels, APTA in 1993 commissioned an extensive study of the professional development needs of current and future APTA membership. Based on the findings from the study indicating that APTA should increase its involvement in professional development, APTA formed a comprehensive three-year plan. A major initiative in the plan was the development of quality standards for professional development programs. The goal was to provide the foundation for the development of a national system for conferring CEUs and to establish a clearinghouse of professional development offerings (APTA, 1994). By the end of 1994, APTA had developed the Continuing Education Service to approve physical therapy continuing education providers, to track continuing education offerings, and to provide a CEU transcript service to participants (APTA, 1995). However, Harden (in Hruska & Harden, 1994, p. 73) asks the question, "If there is no evidence to suggest that mandatory continuing education in individual states has ensured currency and competency in practice, why
would a centrally monitored mandatory CEU system be any better?" While extending the role of APTA in this area is questioned, clearly APTA serves an important role in professional development by providing leadership opportunities at the local, state, and national levels.

Physical Therapy Specialization

Following World War II, the information explosion in health care was rapidly overwhelming the capacity of most generalists to keep informed in all areas of practice (Starr, 1982; Williams & Torrens, 1993). Physical therapists felt this pressure but less urgently. The road toward specialization began with the proliferation of special interest sections within the APTA (Murphy, 1995). At the 1996 APTA Combined Sections Meeting in Atlanta, GA, there were 19 sections - Acute Care, Administration, Aquatic Physical Therapy, Cardiopulmonary, Clinical Electrophysiology, Community Health, Education, Geriatrics, Hand Rehabilitation, Neurology, Oncology, Orthopaedic, Pediatrics, Private Practice, Research, Sports Physical Therapy, Veterans Affairs, Women's Health, and Health Policy, Legislation, and Regulation.

According to Crutchfield (1984), the move toward the creation of specialization in physical therapy was not popular and change occurred slowly. A 1974 APTA membership survey ("Policy Statement," 1975) indicated considerable conflict of opinion on the desirability of a specialty certification program. When the APTA first contemplated specialization, Rothstein was concerned about the specialization process. I feared that specialization would be self-aggrandizing. I feared that specialization would be predicated not on true clinical competence but rather on
the ability of applicants to echo dogma and demonstrate adherence to the latest and most popular clinical fads. I feared that the process of specialization would bring out the worst, and not the best, in the profession I love so dearly. I worried about whether we knew what to test and what not to test and whether people would seek to be specialists to enhance themselves or to enhance their ability to provide services. (1994, p. 56)

APTA's leadership was concerned about the possible fragmentation of the profession; afraid specialists would view "their patients only in a narrow context and not as the complex human beings they really were" (Murphy, 1995, p. 199). However, they also thought that specialization and advanced academic opportunities offered the only realistic means to generating better clinical science.

Other therapists had different concerns as they saw various occupational groups replace physical therapists, often much less qualified, knowledgeable, and prepared (Murphy, 1995; Crutchfield, 1984). The emergence of these "fringe" groups within the U.S. health care system led physical therapists to express interest in developing a specialist certification program during the June 1975 meeting of the House of Delegates of the APTA. After discussion, the House decided to move forward with the concept of specialization and concluded that a specialist certification program should (a) emphasize clinical skills, experience, and knowledge rather than formal educational background; (b) be available to any physical therapist interested in specialization; and (c) be nonrestrictive in that specialists should not be restricted to their area of specialization ("Policy Statement," 1975).

The House formally approved the idea of specialization and established the Task Force on Clinical Specialization in 1976 (Murphy, 1995; Woods, 1994). The
Task Force subsequently developed the *Essentials for Certification of Advanced Clinical Competence in Physical Therapy*, which the House adopted in 1978. The House later revised this document in 1985 as the *Essentials for Certification of Physical Therapy Specialists* and formed the Commission for Certification of Advanced Clinical Competence, now named the American Board of Physical Therapy Specialties (ABPTS) (Guccione, Brown, & Wong, 1990; Woods). The ABPTS is the governing body over the entire specialist certification process with each specialty council working under it (Sweeney, Greathouse, & Cox, 1991). To date, the House of Delegates has recognized seven specialty areas: in 1981, cardiopulmonary, orthopaedics, pediatrics, and sports physical therapy; clinical electrophysiology and neurology in 1982; and geriatrics in 1989 (Guccione et al.). Special interest groups such as oncology, women's health, and general physical therapy have begun to investigate establishing a specialist certification process (Specialist Certification Department, 1996).

From the beginning it was understood that the certification process must be valid, fair, attainable, and legally defensible (Crutchfield, 1984). It was the responsibility of each specialty council to accomplish this by delineating the advanced body of knowledge from which competencies were developed. Each council then had to validate the competencies to provide a basis for validity of the specialty examination (Crutchfield; Murphy, 1995; Woods, 1994).

The APTA established the specialist certification program as a means to encourage and facilitate professional growth. The central goal is to provide formal
recognition for physical therapists who have acquired advanced clinical knowledge, skills, and experience in a special practice area (Ferrier, 1991).

According to Woods (1994), as the numbers of board-certified clinical specialists in physical therapy increase, the benefits to the profession become more apparent. First, certification provides an alternative career ladder for advanced clinicians, allowing them to stay in the clinic as experts versus moving to management positions. Secondly, specialists collectively contribute to the physical therapy knowledge base. Finally, the process has created a formal mechanism to identify those with specific expertise. This provides a way to make referrals within the physical therapy profession, increasing the responsibility and ability of each therapist.

Specialization in Geriatric Physical Therapy

"Geriatric physical therapy has been identified as a physical therapy specialization in order to acknowledge advanced level skills of physical therapists who seek to address the unique medical and functional problems of older persons" (Guccione et al., 1990, p. vi). The terms "geriatric specialist" or "specializing in geriatrics" is not limited to board-certified clinical specialists in geriatric physical therapy. Any physical therapist may deliver care to older people. However, the ABPTS encourages noncertified specialists to use the terms such as "focusing" or "emphasis" in geriatrics to describe their practice (ABPTS, Guidelines).

Guccione et al. (1990) give a brief history of the development of specialization in geriatric physical therapy through 1989, updated and summarized in the time line
below (APTA, 1996):

1978  The APTA's Section on Geriatrics was formed.

1982  Neva Greenwald authored the first report on geriatric physical therapy specialization for the Section.

1987  The Section on Geriatrics appointed the Specialization Task Force.

1989  Specialization Task Force submitted petition to be recognized as a specialty area.

1989  The ABPTS appointed the first Geriatric Specialty Council.

1990  Geriatric Specialty Council prepared *Geriatric Physical Therapy Specialty Competencies*.

1992  First specialist certifying examination in geriatric physical therapy.

1995  Specialization Academy of Content Experts appointed by the ABPTS to write and edit items for the specialist certification examination (6 GCSs)

An applicant for clinical specialist certification in geriatric physical therapy must have a minimum of 4 years of practice with the equivalent of 3 years full-time employment (6,000 hours) in geriatrics within the last 10 years. At least 4,000 of those hours must be in direct patient care in at least 2 different areas of practice - home health, nursing home, etc. (ABPTS, Geriatrics Specialty Council, 1996). The remaining requirements are common to all specialty areas (ABPTS, 1996; Ferrier, 1991). An applicant must (a) hold a current license to practice physical therapy in the United States or its territories; (b) have knowledge of administration, consultation or communication; (c) have knowledge of the research process by reviewing scientific literature and/or directly participating in research; (d) have knowledge of teaching
through the development or implementation of educational programs; and (e) submit three letters of reference from a supervisor and health care providers attesting to the applicant’s character and clinical skills. The Geriatric Specialty Council, assisted by the Specialist Certification Department, reviews the application and Self-Assessment Checklists in the competency areas of teaching, administration, consultation, communication, and research. The Geriatric Specialty Council then determines if the applicant meets the criteria to sit for the written certification examination.

Initially the eight-hour written examination was given annually at the APTA Combined Sections Meeting. In 1994, the examination was converted to electronic testing, available at multiple sites during a one month "window." Since 1995, the test is available only electronically during March at more than 120 sites across the U.S. (APTA, 1995; Specialist Certification Department, 1996; Woods, 1994).

The examination consists of 200 multiple choice questions based on the knowledge, skills, and abilities related to geriatric clinical practice. These are outlined in the Description of Advanced Clinical Practice, formerly called Geriatric Physical Therapy Specialty Competencies (Reynolds, 1992; Woods, 1994). The geriatric specialty competencies represent a distillation of information and knowledge culled from studies, surveys, and experts in the field of geriatric physical therapy. The competencies serve as a guide to what knowledge and skill a geriatric physical therapy specialist should obtain. The competency areas (Guccione et al., 1990) and their approximate distribution on the examination (ABPTS, 1991a, 1996) are listed in Table 1. Expertise is required in all seven competency areas to pass the examination.
Table 1

*Geriatric Specialty Competency Areas and their Approximate Distribution on the Geriatric Specialty Examination*

<table>
<thead>
<tr>
<th>Competency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Physical Therapy Geriatric Clinical Specialist will be able to:</td>
<td></td>
</tr>
<tr>
<td>1. Apply knowledge of the major components of the biology, psychology and</td>
<td>25.0</td>
</tr>
<tr>
<td>sociology of aging to geriatric client management. (p. 1)</td>
<td></td>
</tr>
<tr>
<td>2. Screen assess, evaluate, treat, reassess and modify treatment for a</td>
<td>50.0</td>
</tr>
<tr>
<td>geriatric patient. (p. 8)</td>
<td></td>
</tr>
<tr>
<td>3. Communicate effectively with clients, patients, members of the</td>
<td>5.0</td>
</tr>
<tr>
<td>interdisciplinary team, families and caregivers, members of the health</td>
<td></td>
</tr>
<tr>
<td>care community, legislative representatives, and members of the general</td>
<td></td>
</tr>
<tr>
<td>public. (p. 17)</td>
<td></td>
</tr>
<tr>
<td>4. Identify, implement and evaluate appropriate educational experiences</td>
<td>2.5</td>
</tr>
<tr>
<td>for the client, patient, family, staff, students, and community. (p. 22)</td>
<td></td>
</tr>
<tr>
<td>5. Plan, implement and evaluate administrative components of physical</td>
<td>7.5</td>
</tr>
<tr>
<td>therapy services or programs designed for the geriatric client. (p. 26)</td>
<td></td>
</tr>
<tr>
<td>6. Provide consultative services to appropriate health care professionals,</td>
<td>2.5</td>
</tr>
<tr>
<td>clients, patients and their families, professional and community</td>
<td></td>
</tr>
<tr>
<td>organizations and agencies, and to members of the general public. (p. 32)</td>
<td></td>
</tr>
<tr>
<td>7. Identify, investigate, interpret, report or publish on problems in</td>
<td>7.5</td>
</tr>
<tr>
<td>geriatric physical therapy and related health care issues. (p. 36)</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* Adapted from *Geriatric Physical Therapy Specialty Competencies* edited by A. A. Guccione, M. Brown, and R. A. Wong, 1990.
After successful passage of the examination, the GCS agrees to abide by the APTA's *Code of Ethics* and the accompanying "Guide for Professional Conduct" (ABPTS, 1991b). Certification is for a period of 10 years. Therefore, the first GCS "class" is certified until April 2002. The Geriatric Specialty Council and the ABPTS have not completed the recertification procedures. However, current licensure and a minimum of 2,080 hours of direct patient care will be required. In addition, GCSs may sit for the current examination or submit a professional development portfolio documenting teaching, scholarship, professional service, and clinical supervision activities (Specialist Certification Department, 1996).

In a 1993 APTA survey (Woods, 1994), clinical specialists (no GCSs included) said certification had a positive influence on their lives. They reported increased patient care, self-confidence, consultations, employment opportunities, number of referrals, and professional activities. Increased professional activities included invitations to present instructional courses, consult with other physical therapists, and contribute book chapters. GCS, Celinda Evitt, said in a 1994 interview (Woods) that becoming board-certified has provided her with recognition of her advanced skills as a clinician; a way to advance without having to move into an administrative position.

The physical therapy specialization process is not without its growing pains. ABPTS member Frank Stritter, psychologist and tests and measurements expert, says that the ABPTS must reexamine examination prerequisites and procedures (Woods, 1994). Issues to be considered in the next five to ten years are the addition of a practical component to the examination, and the possibility of residency programs as a
requirement for certification. The current certification process is self-declared in that no formal education past the professional level is required. Some GCS do have advance degrees. For example, GCS Evitt earned a master's degree in gerontology before sitting for the geriatrics specialty examination. However, self-study is the predominating method to prepare for the exam with continuing education classes, on-the-job training, and clinical experience also cited. This process is very different from medicine where a formal education program in a specialty area is required before a physician may sit for board certification. Physicians sitting for the certifying examination in geriatric medicine come by way of four training pathways (Steel et al., 1989): (a) completion of two years of advanced training in geriatric medicine, (b) completion of two years of advanced fellowship training in general internal medicine with one year of geriatric medicine training, (c) subspecialty certification by the American Board of Internal Medicine and completion of one year advanced training in geriatric medicine, or (d) at least four years of substantial practice experience involving elderly patients. Physical therapy must decide if it will walk down the specialty path cut by physicians. If so, physical therapy educational programs must decide if they are willing and able to support residency, fellowship, and/or advanced master's or doctoral degree programs in geriatrics and the other specialty areas.

Theoretical Framework

The experience of career can be approached from several perspectives and at several levels of explanation. Career and professionalization theories may be
appropriate perspectives for inquiry. Therefore, these theories in education, sociology, and psychology were examined before and during data collection to identify an initial theoretical framework for this study.

Because the career path began with choosing physical therapy as a career, a theoretical model of career decision-making (Holland, 1966, 1985) seemed be the most appropriate theoretical framework through which to examine the data. This initial selection was later discarded because the bulk of the career path extended beyond that first decision and included the choice to work primarily with older people, specialization, and changes following specialization. This part of the study was more reflective of theories relating to professionalization.

In reading the literature, professionalization clearly occurs at individual and collective levels. Occupational sociologists have focused their attention on the collective level. In the 1960s, research focused on the essential traits of professions (Montagna, 1977) and the degree of professionalization or deprofessionalization (Torstendahl, 1990). Within this framework, Senters (1972) and Morrow (1983/1985) identified physical therapy as an occupation that was becoming professionalized. This line of investigation was largely abandoned as neo-Weberian and Marxist thought gained prominence. They view professionalization in terms of power and control, criticizing trait theories as naively depicting professional ideology rather than work reality (Saks, 1983). More recently, researchers have criticized neo-Weberian and Marxist-based theories as lacking a temporal dimension and as bound to Anglo culture (Torstendahl). While these theories may be helpful in understanding the broader
context of the profession in which GCSs work, they are not congruent with the interpretive approach of this study and its focus on individual careers.

According to Ritzer (1973), occupational sociologists have largely ignored the question of individual professionalism. He argues, "There is not one professional model, but two, and occupational sociologists must keep them distinct" (p. 61). While there is a relationship between individual and occupational professionalism, the relationship is not perfect. For example, medicine is an established profession and most physicians act professionally on an individual level. However, some may be relatively nonprofessional (e.g., unethical or incompetent). In turn, driving a taxi is nonprofessional, yet some taxi drivers may be viewed as professional on an individual level (e.g., service oriented and knowledgeable about their car and city). Ritzer then presents a six-dimensional model of individual professionalism based on occupational trait theory. This model may be helpful in understanding the individual professionalization of GCSs, but excludes the GCS's entrance into the profession.

Young and Collin's approach to career theory (1992) was found to address the entire scope of this study of the career paths of GCSs. In contrast with the dominant trait-factor theories in career research, Young and Collin argue for the interpretive study of career that is based on the historically and socially constructed nature of social meaning. Their thesis is that, to make sense of the events of their world, people must interpret those events in terms that are meaningful to them. In addition, career researchers have to be aware of the impact of society, culture, and economy on individual experience - the dialectic between individuals and their context. In Young
and Collin's approach, career embodies both practical action and one's thoughts about that action. The interpretations of these actions depend on a creative process through dialogue to penetrate their mode of existence. Career interpretation also involves the iterative process of movement between wholes and parts through which an empathic but objective understanding can be achieved. "Thus the researcher is able to achieve an understanding of career in context and to recognize the impact and control of social institutions and socialization of the individual's experience" (p. 7).

Summary

Chapter II began by laying a historical foundation of American medicine and of the profession of physical therapy. The focus then turned toward relevant literature relating to physical therapy education and specialization, and specialization in geriatric physical therapy. The chapter concluded with the search for a theoretical framework by examining the literature of professionalization and career theory.

Chapter II References


Chapter III briefly discusses qualitative research as a methodology. Also discussed in this chapter are the participants, data collection and analysis, and strategies to achieve rigor.

Qualitative Research as a Methodology

In considering research questions focused on the career paths of board-certified clinical specialists in geriatric physical therapy, a qualitative approach seemed the most appropriate strategy. While both qualitative and quantitative investigators are concerned about the individual's viewpoint, qualitative researchers attempt to capture the subject's perspective through detailed observation and/or interview (Denzin & Lincoln, 1994). A qualitative approach is not only appropriate for the questions asked, it is also appropriate to the nature of the problem. "Qualitative research typically explores what at base is incommensurable" (Glesne & Peshkin, 1992, p. xii). A career is a process made up of interrelated, overlapping, and interacting personal and environmental factors without absolute boundaries. The control and circumscription required for quantitative analysis were not realistic in this study. Earned degrees and jobs held can be obtained through survey, but only through an interpretive approach can we seek to understand personal stories and the ways in which they intersect - the
participant's lived experience (Ermarth, 1978) of becoming and being a board-certified clinical specialist in geriatric physical therapy (GCS), internal and external factors, and complex interactions.

Since the research centers on participant perceptions of career development, in-depth interviews seemed the most effective way to elicit that type of narrative. One form of interviewing used by qualitative researchers is the career history interview (Goetz & LeCompte, 1984). The goal of the career history interview is to elicit narratives from subjects that provide a broad account of their professional life. Career history interviews can be semistructured or unstructured. In a semistructured interview, the interviewer follows an interview guide but some deviation from it is permitted. Unstructured interviews have been described as a series of friendly conversations in which the researcher builds rapport and gradually introduces new elements. According to Borg and Gall, "the unstructured interview best fits the qualitative paradigm" (1989, p. 397).

Participants

According to Colaizzi (1979), anyone can serve as a participant provided they have experienced the investigated topic and can intelligently communicate it. Potential participants consisted of the first "class" of GCSs. There is a total of 14 GCSs, 13 women and 1 man, who obtained board certification in 1992. They live in various states across the U.S.
Protection of Participants' Rights

The University of North Texas Institutional Review Board for the Protection of Human Subjects in Research approved this study before data collection. Initially, prospective participants were contacted by letter (see Appendix A) asking them to participate in a study involving the audio recording of descriptions of their career path toward a geriatric physical therapy practice and specialization. This letter included all elements of informed consent (an explanation of the study, the purpose and methods, and an explanation of their rights as participants). Participants then returned a signed form. A telephone call one to two weeks following the letter was made to potential participants to schedule the interviews. GCSs were reminded at the time of the interview that they could decline any question and stop the interview at any point without penalty. Their only benefits in participating in the study were opportunities to express their lived experiences and to help the profession of physical therapy assist others toward a specialized geriatric practice.

Data Collection Procedures and Analysis

In qualitative research, data gathering, data preparation, analysis and writing occur simultaneously. The process is not stepwise, but is interactive, interdependent, and overlapping (Bogdan & Biklen, 1992; Erlandson, Harris, Skipper, & Allen, 1993; Lofland & Lofland, 1995; Spradley, 1979, 1980; Strauss, 1987).

Data were gathered over the telephone or at the American Physical Therapy Association Combined Sections Meeting (APTA-CSM) held in Atlanta, GA, in February
Many GCSs attended this national meeting, allowing for economical face-to-face unstructured interviews.

The data consisted of intensive interviews conducted in January through March 1996. Participants described their career paths as they pertain to working with older people within the physical therapy profession. The career path began with choosing physical therapy as a career and continued to the point in time in which the interview occurred. Each interview began with guiding questions, but overall, this was an unstructured interview with the GCS directing the conversation (see Appendix B). Interviews ranged from 45 to 90 minutes in length, recorded on audio cassettes, and then transcribed verbatim. As a validating step, participants were asked to read their own transcript to verify the accuracy, delete any material they felt did not reflect what they meant to say, add additional material they remembered, or emphasize anything said previously.

To safeguard confidentiality, individual transcripts were assigned a code and identifying information such as name and place of employment was omitted. Transcripts, audiotape recordings, and computer diskettes were kept in a locked file cabinet. The information obtained through the interview was available only to the investigator and the dissertation committee.

According to Bogdan and Biklen (1992), qualitative researchers systematically search and arrange the data to increase their own understanding and to share that understanding with others. The basic function of data analysis is data reduction leading to phenomena description and/or explanation.
To ensure a deep and full elaboration of the phenomenon, Lofland and Lofland's method (1995) of data analysis was followed to analyze the data. This involved logging and coding data, writing analytic memos, and using diagrams to help explain data. Logging data included interviews and any supplemental data available on the individual (e.g., a résumé or curriculum vitae). Analysis continued by asking questions about the topic's types, frequencies, magnitudes, structures, processes, conditions, and consequences; and by framing generic propositions that summed up data and provided order. Analytic coding involved conceptualizing units of data by labeling them. Initial codes were many but later become more focused as the researcher elaborated, collapsed, or dropped initial codes. Memoing and diagraming involved the use of words and graphics to summarize what emerged from coding (Bogdan & Biklen, 1992). The basic purpose of memos and diagrams was to document the researcher's thoughts and feelings about the research process and the phenomena under study.

The researcher constantly compared the codes and emerging themes within each interview and across interviews. This process required the researcher to become immersed in and interact with the data, for it was out of the data that themes emerged (Erlandson et al., 1993; Lofland & Lofland, 1991; Strauss, 1987). To facilitate the constant comparative approach, the HyperRESEARCH (1993) software program was used for data management. It permitted the easy organization, storage, and retrieval of coded text. HyperRESEARCH sorted codes and then exported results to a word processor for more in-depth analysis.
Data analysis continued until an in-depth understanding was achieved, and the saturation point was reached when nothing new could be added (Erlandson et al., 1993; Lofland & Lofland, 1991; Strauss, 1987). Generalizations reported and discussed in the following chapters are grounded in the data and are based on dominant themes expressed by most participants. Quotes from a particular interview are illustrative of the themes that emerged from the data.

Strategies to Achieve Rigor

The aim of phenomenologic inquiry is understanding truth (Benner, 1985; Ermarth, 1978). In qualitative research, truth is participant-oriented, not researcher-defined. Therefore, the "artistic" approach to qualitative inquiry precludes the replicability of the research process and product associated with quantitative research (Sandelowski, 1986). Sandelowski's strategies to achieve rigor in qualitative research were used in this study. They include achieving auditability and credibility.

The researcher achieves auditability with a clear decision trail. Any reader should be able to follow the study's progression and understand the logic. In this study, auditability was achieved primarily in the description, explanation, and justification of the study.

Sandelowski (1986) states that qualitative research is credible when it presents such a familiar description or interpretation of a human experience that the people having the experience would immediately recognize it as their own. An investigator also achieves credibility when other researchers can recognize the experience after
having read of it in a study. Strategies for ensuring credibility included: (a) obtaining validation from four participants in different practice settings, (b) checking that significant statements and meanings contain the typical and atypical elements of the data, (c) examining the literature to support the statement of the phenomenon's fundamental structure, (d) obtaining validation from the dissertation committee, and (e) triangulation of methodology. Triangulation of methodology is used in qualitative research to understand complex reality and serves as a criterion to judge validity (Shipman, 1981; Smith, 1978). In this study, triangulation was achieved by using multimethods - the unstructured interview, document collection, and APTA's 1995 Survey of Certified Clinical Specialists for GCSs.

Summary

A qualitative research approach was chosen for the study because it is best suited to evoke and to describe the participants' lived experience of becoming and being a GCS, internal and external factors, and complex interactions. Potential participants for the study consisted of 14 GCSs who obtained board certification in 1992. Data were generated using unstructured interviews focusing on their career paths. Lofland and Lofland's method (1995) of qualitative data analysis was followed. Triangulation of methodology (Shipman, 1981; Smith, 1978) and Sandelowski's (1986) qualitative research strategies of auditability and credibility were used in this study to achieve rigor commonly associated with scientific inquiry.
Chapter III References


CHAPTER IV

FINDINGS AND ANALYSIS

Chapter IV begins with an overview of the population and participants. Information on the population is given to preserve the confidentiality of participants on important but readily identifiable characteristics. These findings came from the interviews and documents obtained from the participants and/or the American Physical Therapy Association (APTA). Documents included participant submitted résumé or curriculum vitae, and biographical information listed in Ceremony for Recognition of Clinical Specialists (American Board of Physical Therapy Specialties [ABPTS], 1993). The perceived context in which the participants find themselves also is addressed because career decisions are based in part on the individual's view of one's world (Hopfl, 1992). The remainder of the chapter focuses on the major themes that emerged from the data related to the first six research questions: participants' career paths and perceived influences, consequences, and missions.

Overview of the Population and Participants

The Population

There are 14 clinical specialists in geriatric physical therapy (GCSs) who obtained board certification in 1992. Figure 1 illustrates their geographic distribution at the time of the study: 11 states and the District of Columbia. All but one have spent
most of their careers in the states illustrated. The specialist who recently moved, previously practiced in New York and moved to Pennsylvania.

In 1994, 52% of older people lived in 9 states (Fowles, 1995). California had over 3 million elders. Florida and New York had over 2 million each. Pennsylvania, Texas, Ohio, Illinois, Michigan, and New Jersey each had over 1 million people age 65 or older. Half (7) of the first GCSs practice in one of these states.

In the summer of 1992, all the new specialists sent biographical information to the ABPTS for publication in Ceremony for Recognition of Clinical Specialists. This booklet was made available to attendees of the February 3, 1993 awards ceremony recognizing the 136 individuals in the 7 specialty areas who achieved board-certification during 1992. Biographical information included the GCS's education and current work setting. While the entire work history on all GCSs was not available, common settings can be identified. Primary work settings listed included nursing homes (5), acute care hospitals (3), college/university (2), private practice (2), rehabilitation center (1), and home care (1).

Table 2 lists the educational background (as of winter 1996) of the entire population. The specialists have 11 to 40 years of physical therapy experience (mean, 21.5 years). Physical therapy was their only career with most receiving a bachelor's degree in physical therapy followed by a postprofessional degree or certificate 4 to 30 years later (mean, 12.8 years). The most frequently cited postprofessional education (completed, n = 18) included degrees in physical therapy (4), gerontology (3), and public administration (3), and certificates relating to aging (4).
Table 2

*Educational Background of All GCSs Certified in 1992 as of Winter 1996*

<table>
<thead>
<tr>
<th>Into PT</th>
<th>Postprofessional Master's Degree</th>
<th>Other Degree/Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. BS in PT, 1981.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Note. Values enclosed in parentheses represent the number of degrees or certificates earned. PT = physical therapy; BS = bachelor of science; EdD = doctor of education; PE = physical education; MPT = master of physical therapy; PhD = doctor of philosophy; BHS = bachelor of health science.

The Participants

Of the 14 GCSs, 12 (86%) agreed to be interviewed. Seven of the interviews occurred via telephone and five were face-to-face interviews. All participants reviewed their transcripts for accuracy and eleven made minor changes. In addition, all 12 participants also submitted a résumé or curriculum vitae. The interviews and additional documents provide a general picture of the participants. Before we can address the study's research questions, the participants must tell us who they are. Out of the data, three broadly descriptive characteristics emerged and are now reported.

Enthusiastic about Physical Therapy, Geriatrics, and Specialization

During the interviews and listening to the audiotapes, the participants clearly were enthusiastic about their profession, geriatrics, and specialization. This enthusiasm was evident in their voices and gestures. Vocal expression of emotion falls into two broad categories, normal and intensive vocal quality (Fields & Bender, 1949). Normal vocal quality is the natural voice used in daily communication. Intensive quality is used to express deep and sincere feeling. As GCSs talked about physical therapy, geriatrics, and specialization, voice pitch and intensity varied. The specialists would begin their responses in a normal vocal quality. Often as they continued to speak on a topic, vocal quality would become intensive - the pitch tended to rise and volume
increased. Some also showed their enthusiasm by increasing their speed. Gestures and other action patterns normally accompany speech (Fields & Bender). Participants' enthusiasm also was evident in the face-to-face interviews. The GCSs leaned forward when talking and many used facial expressions and hand gestures to emphasize the point they were trying to make. Sometimes, as the participant became more excited, expressions and gestures increased in frequency and speed.

Most of the specialists expressed their excitement either directly or indirectly. For example, in talking about providing physical therapy to older people, one specialist said, "So at the same time it is exciting to get somebody and help them regain their functional status as well. It is a challenge too, I think, because of the comorbidities" (IS, p. 4). In speaking about specialization, another GCS said, "We were sort of there on the very beginning of things and there is kind of an excitement of being in the first class" (VD, p. 5). One participant expressed her own excitement in contrast to her coworkers:

I am the only "me" there. There is no other "me." When I am with you guys, I feel like, . . . it's not just that we were the first ones but we were soul mates or something. . . . There are just no other people that are that excited professionally at work. Excited, but they are just not excited about therapy or about personal growth. (BA, p. 15)

Adventurous Nature

An unexpected theme to emerge from the data was the adventurous nature of many participants. While sitting for the first geriatric physical therapy specialty examination may involve more risk than subsequent years, many participants expressed adventurous at different points in their lives beginning before physical therapy school:
I wanted to go out-of-state. I guess I'm adventuresome. I was the first of my siblings to leave home. Even back in [year] PT school was very competitive. I applied to and was accepted by [out-of-state research university approximately 1000 miles from home]. They had a good PT school and were one of the few that accepted a few out-of-state students each year. (VD, p. 1)

After being accepted to physical therapy school, two other participants postponed their educations (one to three years) for the opportunity to travel overseas. During their professional educations, three participants chose uncommon elective courses or clinical experiences.

The first job of most new graduates is a staff position at an acute care hospital, often a familiar clinical education site (Buchanan, Noonan, & O'Brien, 1994; Ciccone & Wolfner, 1988; Emery, Gandy, & Goldstein, 1996). Half the participants did so, with one taking a director's position at a small hospital. The remaining participants had first jobs in a variety of settings ranging from the military and the U.S. Public Health Service, to rehabilitation centers, private practice, and home health. As a second job, one participant practiced overseas for three years. Therefore, the participants demonstrated their adventurous nature throughout their careers in the choices they made.

**Education Valued**

Obviously from Table 2, the first geriatric specialists value formal education for themselves. In addition to the formal education listed, two GCSs planned to start advanced degrees in the near future. Two other participants exemplified this valuing of education in the following statements:
I definitely value education. I finished my PhD - what do I do? I sign up for Italian. I think I am going to learn Italian now. My chair just told me I need to take an extra physiology course. I mean, "You need more systems physiology in your background." Okay. But I have my PhD now. I am not supposed to be doing any of this. I am supposed to be finished. So yes, I value education. I will even go for the extra physiology courses. (ER, p. 8)

I sought out the master's in _____ because it was there and I liked what I got at combined sections and I wanted more. I don't know what it is about me that I need to be enjoying increased education and that I feel fulfilled seeking them out. (BA, p. 7)

Besides the formal education completed, in process, or planned, all participants sought out more informal educational opportunities such as continuing education courses, APTA's Combined Sections Meetings, and/or self-study. Throughout one interview, as the conversation went from one topic to another, the specialist indicated self-study in comments such as "I dig a little deeper, I research it [geriatric patient problems] a little more," and "[I am] reading more and watching more and being much more aware of what is happening in that [political] arena" (AD, p. 6, 12).

The participants also valued education for others. Currently, most are involved with physical therapy students as clinical instructors and/or by hold teaching positions. In addition, peers and community groups frequently ask the participants to speak:

One of the things that I must say that I have done a lot of is Senior Health Fairs. Boy, every chance I get, I have been out there talking about exercise. . . It is fun and you get a good immediate response anyway. (OA, p. 17)

They expressed joy when sharing success stories of changed attitudes and behaviors, and expressed frustration when others did not heed their message. These specialists see education as the key to changing behaviors and attitudes about aging and thus hold it in high regard for themselves and others.
Context: Participants' Views of Health Care

Young and Collin (1992) argue that career can no longer be adequately understood in terms of objective and intraindividual factors alone; its context and the individual's subjective experience of it have to be considered. The context of career is important because it is through this "lens" that we understand the career path of these geriatric specialists from their point of view. Secondary to the qualitative methodology and the use of Young and Collin's framework to understand career, the findings presented in this chapter are based primarily on participant perceptions. This may lead some to question the validity of the data and the findings on which they are based. Frequently perceptions do not totally agree with fact. However, perceptions are an integral part of a study involving career and one's life plan. For the most part, we give little thought to the interpretation of events, behaviors, and consequences of our daily life (Berger & Luckmann, 1966). Yet, it is through reflections on experience and expectations of the future that the individual makes meaning of one's world - integrating past, present, and future into the present moment (Hopfl, 1992). Because the participants' perceptions shaped their personal decisions about life and career and, thus their choices and actions, these perceptions are assumed to be valid information for this study.

Health Care Past to Present

Some temporal perspective of health care is gained through the participants' 11 to 40 years of physical therapy experience. All perceived that health care had changed since they had become therapists. They talked about health care changes in general
and in their specific settings. The participants noted the 1980s as a transition time with changes accelerating in recent years due to cost containment pressures: "I would certainly say the availability [of health care for elders] is much better than 50 years ago of course, but [when] I think all the [recent] changes . . ." (AD, p. 7). Two participants practiced primarily in settings where Medicare was not the primary payer. However, the other participants thought that Medicare had increased older peoples' access to rehabilitation services. The participants also thought Medicare had been "good" to physical therapists in terms of reimbursement. Across all settings, the current feeling was that therapists were being asked to do more (patient treatment, marketing, etc.) with fewer resources (people, time, and/or funds).

Hospital physical therapists have had to deal with increasingly shorter hospital stays for Medicare beneficiaries beginning in 1983 when Congress enacted the Tax Equity and Fiscal Responsibility Act of 1982 (PL 97-248). Medicare began using a new payment method called the prospective payment system (PPS). Before that time, hospitals received Medicare fee-for-service reimbursement based on costs. Under the PPS, hospitals receive a flat fee based on the average cost for treating a particular diagnosis. The intended purpose was to hold down hospital costs by rewarding hospitals for providing necessary care as efficiently and effectively as possible (U.S. Department of Health and Human Services [USDHHS], 1989). Hospitals adapted to this new payment system by emphasizing efficient staffing, discharge planning, and movement toward vertical integration (Newscomer, Wood, & Sankar, 1985). The emphasis on efficient staffing has lead to an increase in the use of nonlicensed
personnel, downsizing of licensed personnel, and pressure for increased productivity 
(Haglund & Dowling, 1993). One participant told this story to illustrate changes in 
staffing - less staff with more contract and temporary workers:

Let me give you a story. An older lady was in a private for-profit hospital that 
used to be run by nuns. Well the nuns are out and the bottom line is in. She 
was so weak, by the time she got the soup spoon to her mouth, the soup had 
fallen back into the bowl. It took 24 hours before she got the straw she asked 
for. She hid the straw on her gown, fearing that they'd take it away and 
wouldn't give her another. She emptied her own bed pan. In her 10-day 
hospital stay, her sheets were never changed and she never was cleaned. 
Where was the care in the health care she received? Everyone - young or old, 
insured or uninsured - in today's system needs an advocate and older people are 
especially vulnerable. (VD, p. 4)

The strong incentive for hospitals to discharge patients has contributed to the 
movement toward vertical integration - linking together different levels of care. While 
vertical integration may affect hospital use and market share positively (Haglund & 
Dowling, 1993), two participants had concerns:

Just recently the hospital where I live took on a contract for a nursing home. It 
was a business deal, but none of the therapists in the hospital department 
wanted to go there, so they are forcing them to go there on a rotating basis 
now. You know that is not going to be good geriatric therapy. (OA, p. 5)

And then in the mid-1980s the hospitals in the area all started doing home care. They expected the hospital PTs to do both. They [hospital PTs] didn't have the 
time or inclination. The PTs made the visits but they were getting lots of 
denials so I did some consulting for them since I had been doing home care for 
years. The bottom line was that they needed to hire someone who enjoyed 
working with the elderly, liked the pace and patient load of home health, and 
took the time to document well. (VD, p. 6)

Clearly, the PPS affects not only health care providers in the hospital setting, 
but those in other settings as well, especially home care. Home health care has shown 
a tremendous growth as care has shifted from the hospital to outpatient settings.
While home care has diversified to include services from birth through old age, most patients are over 65 - nearly 75% in many states (Benefield, 1988; Mundinger, 1983). And, as early as 1984, home care patients were more acutely ill, needed higher levels of care, and required some complex treatments (Shaffer, 1984).

Of all health care settings, perhaps the most dramatic changes have occurred in the nursing home. Documented problems included everything from lack of human dignity, to negligence leading to injury or death. Change began slowly in the mid-1970s as nursing home deficiencies and abuses became known. Much of this work was due to Frank E. Moss, Utah's U.S. Senator from 1959-1976. As the Subcommittee on Long Term Care chair from 1965-1976, he conducted about 60 hearings dealing with aspects of long term care. Moss took the lead in attempting to reform inadequate nursing home laws and took the Department of Health, Education, and Welfare to task for failing to implement and enforce these laws (Glasscote et al., 1976; Moss & Halamandaris, 1977). Responses were increased government regulation and moves within the industry to improve quality (Mitchell, 1989). One therapist working in nursing homes during that time said:

At that point [through the 1970s], physical therapists were just welcomed with open arms by nursing homes and all the things we could do with training aides and things. They just thought we were wonderful . . . and they were so appreciative which was not the case anymore. What happened? I don't know. In 1980 I went back to a hospital but still in geriatrics as a therapist for a geriatric team. So between '80 and '89 I was out of nursing homes. I went back and I don't know, it had really changed. I think that nurses - it was like them vs. us. There wasn't the [camaraderie] . . . not at all . . . I guess that is when salaries really started to really go up and therapists were there for other reasons . . . And possibly part nursing resentment . . . that they were working so much harder than we . . . Whereas boy, in the '70s I really think that physically
we were a lot busier and worked harder, I don't know. Anyway I have seen a change and that is a shame. (OA, p. 4-5)

While relationships between the nursing and therapy staff may have suffered during the 1980s and 90s, other participants focused on improved quality and level of care in many nursing homes since the passage of the Nursing Home Reform Act incorporated into the Omnibus Budget Reconciliation Act of 1987 (OBRA 87). This law made significant changes in how nursing homes operate and are evaluated, focusing on empowering residents, creating restraint-free environments, and upgrading nursing aide training (Evashwick, 1993; Shore, 1993). As noted by one participant, OBRA 87 also had the effect of increasing the number of staff in nursing homes, including physical therapists. The participants admitted that there are still nursing homes with problems but the evolution of restraint removal and certified nurses' aide training was "exciting to see and it is also comforting that when we get there, maybe, it will be up to speed" (WC, p. 6).

Participants who spoke about nursing homes noted that more physical therapists were choosing to practice there. They thought this trend was due to several factors including better conditions, good salaries, job availability secondary to downsizing in other health care settings, changing attitudes, and opportunities to provide rehabilitation. Intensive rehabilitation, especially neurological rehabilitation, moved out of the hospital because of shortened stays due to the PPS. Therefore, physical therapists interested in this area of physical therapy moved to rehabilitation centers and nursing homes. As one participant said, "SNFs [skilled nursing facilities] are really
doing a lot of intensive rehab and being recognized for it” (WL, p. 2). Another participant started working primarily with older people through an interest in neurological rehabilitation:

Well, it [working with older people] was something like most things in my life, I fell into it. And it was a position in a nursing home to start a rehab center. I looked at it more from the rehab perspective and we were going to do short term rehab and that's how I got into the nursing home side of things. . . . I felt comfortable [in nursing homes in general] and I wanted to do more rehab so I felt okay going into this nursing home. (RA, p. 2-3)

The most recent and dramatic change in our health care system is managed care as a means of cost containment. According to Williams and Torrens (1993), managed care is a generic term that encompasses a variety of managed fee-for-service and prepaid health care models. It began in the 1970s with the development of health maintenance organizations (HMOs), but has since evolved and spread throughout the U.S. health care system. General concepts of managed care programs include (a) the primary care physician as gatekeeper, (b) utilization oversight, (c) provider networks, and (d) consumer controls through case management. Medicare beneficiaries may now choose to enroll in managed care plans, most of which are HMOs (USDHHS, 1995). In the context of the participants' geographical location and practice setting, managed care heavily affected only a few. Most GCSs were just beginning to encounter managed care plans and others had seen very little, at least among older people. One GCS living in a state heavily involved in managed care saw it this way:

I have no problem with it. I think in a way it is very good because we have to be accountable and I think there is no problem with that at all. Yeah, I also feel that if there is one job opening then there is three PT's applying for the job, I think that is okay too. Because if we . . . are going to be marketing
ourselves we are going to be working on self development and involved in professional development activities. I think that is good for our profession. So, I think that that [managed care] would be one of the very best things that could happen for our profession. (IS, p. 11-12)

Participants were asked their perceptions of how older people fare in today's health care system. Responses fell along a continuum from "well off" to "not too bad but at risk" to "poorly." Those that thought older people were doing fairly well or were well off in today's health care system did so with reservations:

Well, right now, before anything has changed [italics added], I think that they are very well off. I think the opportunities for them to receive care in many ways - like meals on wheels, and other federal government and state supported programs - are quite good. (RA, p. 4-5)

I am very happy to see the many housing options that are now available, a continuum of assisted living especially for those who can afford it [italics added]. And community services - adult day care - so that many of the gaps between total independence and nursing home are filled. (OA, p. 20)

They perceived older people as doing fairly well, especially those with traditional Medicare, compared to those on a managed care plan. Yet, another GCS saw both groups - those with traditional Medicare and those in a Medicare HMO - as doing fairly well. In fact, those in an HMO "have a little bit more prevention and wellness benefits and prescription drugs" (WW, p. 12) compared to the others. This participant thought how an older person fared in today's health care depended more on the education of the provider - how well they knew the system and how to get whatever the patient needed in terms of care, supplies, or equipment. However, another participant said, "I think they [elders], and a lot of other people, are quite at risk with all the managed care" (AD, p. 7). Several others agreed, saying there was a need for
advocacy among older people, especially the very old. One GCS noted that many young-old people were assuming a self-advocate role aided by the educational efforts of groups such as the American Association of Retired Persons. Those that thought older people were having difficulty cited transportation problems and limitations put on therapy by managed care programs. The latter was a concern because the GCSs thought older people, especially the frail old-old, tended to take longer to rehabilitate because of the prevalence of comorbidities. However, during one interview, a participant had a different perspective on the cause of the perceived negative changes. This GCS thought it was due not to managed care per se, but to the corporate mentality - one company consuming the next, putting profit before people (workers and patients/residents).

Health Care in the Future

The participants were well aware of the projected increase in the age and percent of older people in the U.S. In looking toward the future, a few participants were fearful. One GCS was acutely aware of the coming social and economic pressures as the old to young ratio increases and was concerned:

With the way things are going, it may be that in the future "nonproductive" people will be terminated for their own and society's good - back to the survival of the fittest. (VD, p. 4-5)

According to Callahan (1989), this concern may be justified. He says the pressure's magnitude will depend on the general health of the elderly in the decades ahead and the reliability of projected health care needs and costs. The predicted "compression of morbidity" just before death has not occurred. Instead, most studies indicate that
increased longevity has been matched by an increase in chronic illness (Ingegneri, 1993/1994; Verbrugge, 1984). Therefore, health care needs will continue to grow at a stunning rate, especially among the very old, leading to higher costs. Increasing taxes to fund programs for the elderly and growing pressures on families to provide greater social and informal support may become burdens too heavy to sustain (Callahan).

Despite, or perhaps because of these potential social and economic pressures, most participants were cautiously optimistic or positive about the future. From their point of view, things must change. The participants, as they looked into the future, saw continued interrelated changes in elders, health care, and in the profession of physical therapy. They thought that in the future everyone will need to be more accountable, both providers and patients:

Part of it I think is my own wishful thinking. I am hoping that as consumers we're going to be more educated about what to expect from our medical system and we are going to challenge our medical system and make our medical system meet our needs versus theirs. . . I feel that as our society ages, we will have greater expectations. I think we are staying more active. The baby boomers are trying to maintain their youth and I feel like that is going to change demands on health care disbursements. I think they're going to stay more active in a literal sense. You know, keeping people moving - wellness. I think some of the present talk about raising retirement age will affect that too. They have to stay well to work until they are seventy. (SA p. 4)

As illustrated in the following comments, the participants saw the role of physical therapists changing within the changing health care system. However, not only will therapists be needed in the future, but they may be uniquely suited to meet those needs in the changing environment:

I think it is going to be different. I don't think our role is going to be as much in delivering the care as it is in teaching and training, maybe others to deliver
the care. That's something that I think is hard as a physical therapist to swallow but I see the roles changing but I don't think the need is going to go away. I think older people are still going to continue to need care. The way we deliver it is going to change though. We just need to be ready to meet the change. (WC, p. 12-13)

I am looking forward to managed care in that sense [demanding outcomes]. I know it is going to be really hard with some of these really old and frail people because the amount of sessions is really not enough for them to learn, I don't think, but we are just going to be really innovative. I am not looking at it and just saying, "Oh, it is hopeless." . . . I think therapists will rise to the top of managed care very quickly because they are going to be the people that get people better still in a short amount of time. (ER, p. 20)

Career Paths Leading to Board Certification in Geriatric Physical Therapy

"What are the causes of X?" is the most frequently asked question in social science. (Lofland & Lofland, 1995). Qualitative studies are not designed to provide definitive answers to causal questions. Instead, themes emerge in the data that seemed to describe influences in the lives of these GCSs. While all participants share a common moment in time (becoming a GCS in 1992) their career paths before and after are quite different. Still, there are some important commonalities that will be presented and discussed here.

A career is a continuum made up of a series of choices. In the study, the participants had three choices in common that serve as landmarks along their career paths: choosing physical therapy, to work with older people, and specialization.

Choosing Physical Therapy

The first landmark along the career path was choosing physical therapy as a career. While some chose physical therapy directly, most participants initially
narrowed the choice down to health related fields and then quickly selected physical therapy specifically. Seven participants made this decision during high school. This is consistent with Astin's (1977) findings. Initial career choice at college entrance tends to be the single best predictor of career choice at graduation, and the occupation actually entered. Despite this tendency, college students frequently change their plans during college (Astin). This is the case with three of the five participants who chose physical therapy during the first two years of college. There was no common reason for changing their initial career choices. One had difficulty in a required course in a highly competitive health related field. In reexamining career options, this GCS chose physical therapy, a related field and one in which she had personal experience. Another GCS, aware of only five-year programs, initially excluded physical therapy but transferred when a four-year program was found. The last GCS was an accounting major. Through a volunteer experience the participant found that physical therapy was a better "fit," "I have always been kind of a people person" (WW, p. 1).

Career theory research examines why individuals choose various careers. Much of this literature takes a personality or developmental perspective with career counselors focusing on the functional analysis of skills, strengths, interests, and values (Young & Collin, 1992). While traditional career theory follows a quantitative paradigm, this study centered on the perceptions of the participants using a qualitative approach to career. Figure 2 illustrates perceived factors that primarily influenced the choice of physical therapy as a career. The most frequently cited factors included volunteer experiences (4) and personal research (3). Other factors cited included others
Figure 2. Perceived factors that primarily influenced the choice of physical therapy as a career.
(friends or family), college counseling services, and personal experience. While not perceived as a primary factor influencing their career choice, two participants mentioned role models as reinforcing the decision. One GCS said:

I was one of those people that became interested in physical therapy back when I was in high school. I can't tell you exactly what directed me to that career but somehow I focused in on it and I was able to spend my summers and vacation in high school working at a small community hospital in our area... They had one therapist at the hospital... She was a recent graduate and... she encouraged and backed up all my thoughts on the profession with a real positive role model for me so that kind of firmed up some of my beliefs about going into that profession. (AD, p.1)

These results are similar to those of Rozier and Hamilton (1991) who surveyed 622 first-year physical therapy students in the U.S. to learn why they choose physical therapy as a career. The authors found that other people can influence career decisions. Family members (16%), friends (15%), and physical therapists (6%) were most frequently identified as people influential in their career decision. In addition, 70% had worked in a physical therapy department and 27% had experienced physical therapy as a patient. However, their questionnaire did not ask about choosing physical therapy through independent personal research outside work or patient experiences. Three participants chose physical therapy through independent personal research while in high school as described here by one GCS:

I had always had an interest in medical kind of stuff. And nursing didn't really appeal to me in particular for hours reasons and just whatever, that just didn't seem to be exactly what I wanted to do. I didn't have aspirations at that time for anything beyond a bachelor's degree. I didn't really consider medical school... So when I was a sophomore or junior in high school, I toured the local hospital and made different appointments with different fields and I talked to a dietitian, I think, and I remember going to the x-ray department and I went to physical therapy. I was very impressed with that and decided, this looks...
good, okay, I am going to be one of those... We didn't have great guidance counselors or anything, so I think I did that [organize the visits]. (HL, p. 1-2)

All three independently sought out career information through library books and by making appointments to observe and/or speak to people in various careers. Once the participants chose physical therapy as their career, prerequisites (volunteer experiences and/or course work) confirmed their choice, "nothing ever changed my mind" (BA, p. 1).

Choosing to Work with Older People

Overview

Figure 3 illustrates the career path and perceived factors that primarily influenced the career decision to work with older people. It is important to note at the outset that none of the 12 participants had the initial career goal to primarily work with older people. Influences in the participants' early years, during their professional education, and while practicing physical therapy, gradually built a social context that supported the decision to work with older people. While every participant did not experience all the influences, the summation of the influences experienced (positive, negative, or neutral) did lead them to, and support, their decisions. The decision was a gradual one that occurred during or after the first job of each participant.

Influences During the Early Years

Individual influences occurring in the participants' early years where positive, negative, or neutral. Together they provided a background supportive or neutral toward older people.
Figure 3. Career path: Perceived factors that primarily influenced the career decision to work with older people.
Positive family attitudes toward older people was a predominant theme. These positive family attitudes were expressed directly in the interview or, more often, indirectly as expressed through behaviors toward older people. For example:

I had great-aunts and uncles who are older. I had a great-uncle Bart who was a bachelor and he would come up to our house once a week, my grandparents ate with us once a week, we would visit our aunt Mary and she would baby-sit us. . . They were probably 70 or 75 or 80 when I was growing up. So there were always old people [around]. . . [I was] comfortable with the aging. I had no problem; that [older people] did not depress me ever. (ER, p. 4)

Another predominant theme was personal relationships with elders. Most participants talked about very positive relationships. A few had neutral relationships (an older person in their lives but not particularly close) and one spoke about a negative relationship. These relationships with older people together with family attitudes toward elderly influenced the participants' perceptions of elders as positive, negative, or neutral. For example, the GCS who had a negative relationship with an older person, also had a positive perception of elders. The negative influence was balanced out by a very positive relationship with another older person and a family attitude that elders are to be treated with respect even if they do not deserve it because of their bad behaviors.

After choosing physical therapy as a career in high school, two participants had geriatric volunteer experiences. Neither specifically looked for geriatric settings. One GCS volunteered in the physical therapy department of a Veterans Administration (VA) hospital because it was within walking distance. According to the other GCS, one volunteer experience lead to a dynamic physical therapist who happened to work in
nursing homes, and he became this GCS's mentor in physical therapy and in geriatrics:

I always had an aversion to nursing homes but even in high school when I started volunteering in the hospital I got connected with this fellow who was a physical therapist. His primary contract was with nursing homes and I would go into work with him all through high school... So I quickly got immersed in the geriatrics early in, before I even got into physical therapy school. I loved working with older people... He was my influence. Without a doubt he was the influence that brought me into the profession and also gave me the love to create. (WC, p. 4)

In both cases, the geriatric volunteer experiences confirmed their choices to become physical therapists but did not set their course directly toward geriatrics. It did give them positive experiences with elderly in the context of physical therapy that they would remember later.

These findings are consistent with other studies that surveyed physical therapy students (Coren et al., 1987; Dunkle & Hyde, 1995; Nosse & Wilson, 1994). Among these studies, factors influencing intention to work with older people include (a) student attitudes, (b) student perceptions regarding their families' attitude toward geriatric work, (c) a significant relationship with an elderly person, and/or (d) work experiences with elders. What is important to note in the present study in contrast to the other studies is that none of the participants intended to work with older people and yet, not only did so, but also became board-certified in geriatric physical. Another difference is that in the interviews, the factors were clearly interwoven and influenced one another. Therefore, the different factors among the quantitative studies may not reflect true differences.
Influences During Participants' Professional Education

The participants' relationships, family attitudes, perceptions, and/or volunteer experiences during their early years formed a neutral or positive backdrop for the new influences while in physical therapy school. These new influences included a geriatric elective, geriatric clinical exposure, the attitude of professors, and professor or clinical instructor (CI) as role model or mentor.

Professional education for the participants spanned a 30-year period from the mid-1950s through the mid-1980s. Amazingly, their entry-level education in geriatrics was identical - none. Neither geriatrics nor gerontology were normal parts of the entry-level curriculum. When asked about this, one GCS said, "No, it was really unheard of. In fact, geriatrics was held in low opinion by one of the professors there at that time" (WL, p. 2). However, 2 of the 12 participants (16.7%) attended schools that offered a geriatric elective. One was a multidisciplinary didactic course and the other was an independent study with a physical therapy mentor at the local VA hospital.

These results appear to conflict with a Spring 1982 survey designed by the Competency Committee of the APTA's Section on Geriatrics. It came in response to strong member interest in entry-level geriatric competency development (Greenwald, 1982). The survey's purpose was to identify education and research activities related to geriatrics currently taught in entry-level and postprofessional programs. In the 1982 survey, 31 entry-level programs (64%) included a geriatric course in the curriculum and in 54% of the programs, the course was required for graduation. However, only
one GCS was in physical therapy school at the time of the survey and the survey only examined current geriatric content and future plans. No studies were found that examined entry-level curriculum related to geriatrics before 1980 when the most GCSs were in physical therapy school. In 1980, Jackson reported that very little or no content in gerontology or geriatrics in physical therapy was currently presented at the entry- or postprofessional levels. The disparity may also be explained in light of findings from a more comprehensive survey sent in 1985, three years after the Section on Geriatrics survey. Granick, Simson, and Wilson (1987) found that although 92% (74) of entry-level programs offered at least one curriculum area containing aging content, only 10% (8) offered a formal course in geriatrics. Geriatric content tended to be limited (10 to 15 clock hours total) and fragmented among one or more course offerings. Therefore, students may not perceive they learned anything about aging or geriatrics.

In addition to the two participants who choose geriatric electives, six others (50%) did have some clinical exposure to older people during their professional educations (1950s - 1980s). This is much higher than the 4% of programs surveyed in 1985 who offered clinical work in geriatrics (Granick et al., 1987). One participant had a negative experience - students were expected to dance with the patients at the local VA hospital. This made the participant very uncomfortable. Another had a one hour observation at a nursing home that left a memorable but neutral impression. The remaining four had more extensive geriatric clinical experiences, usually as part of a long-term affiliation toward the end of the curriculum. According to Coren and
associates (1987), there was a significant correlation between the experiential factor of a geriatric clinical affiliation and physical therapy student intention to work with older people. While participants reported these geriatric clinical experiences as very positive, none of the GCS selected sites because of opportunities to work primarily with older people and none intended to work with older people after graduation. The clinical site was chosen for its location, because it sounded exciting, or because it was a rehabilitation center.

Two participants were particularly aware of their professors' attitudes toward geriatrics. In one case, the professor expressed a negative attitude toward geriatrics with a real bias against chronic care settings. During the early 1970s at that physical therapy school "the prevailing opinion was that real PT's don't work in nursing homes" (WL, p. 2). The other participant was very aware of the professor's positive attitude toward working with older people. This was very evident in how he taught the geriatric elective course. In speaking about the course the GCS said the professor was someone...

"I enjoyed and admired. I really enjoyed the class. . . I never thought of him as a role model but I guess he was. I did admire him. He was an excellent teacher who obviously cared about his students and patients. He used clinical examples so it seemed to me he was a good PT." (VD, p. 2)

The research on the influence of professors in changing students' attitudes toward older people is mixed. Tobiason, Knudsen, Stengel, and Giss (1979) hypothesized that one factor contributing to nursing students' more favorable attitudes toward older people was the presence of an enthusiastic teacher who served as a
positive role model. However, in a study with physical therapy students (Coren et al., 1987), there was no correlation between students' intentions to work with elderly people and enthusiastic instructor.

Two other participants had clinical instructors (CI) that became role models or mentors. This GCS's story is typical:

I can't say I was really interested in geriatrics as a PT student or even coming out of school. But probably significant was that one of my clinical internship sites happened to be at the ____ [state] Veteran's Home. Again, why I chose that was probably [because] I was newly married and it was close to my husband. . . but it turned out to be one of the most interesting experiences. I actually had to live on site with the residents. I ate my meals with them. . . You know this was a huge acreage, multibuilding setup with levels from very active residential care on to ICF and SNF care. . . It was staffed by what I would call today a very unique therapist, a very strong person. . . They had what I would call today your team concept with goal setting. . . They were also charting by exception. . . They were years ahead of us. I found it a very positive experience. I think a lot of kids didn't go there because of how it sounded - the ____ [state] Veteran's Home. (AD, p. 1-2)

Most participants had no role models or mentors in geriatrics and they perceived professors' attitudes as neither positive nor negative. However, those that had a geriatric elective, clinical affiliation, and/or a role model or mentor perceived these as strong positive influences. Even so, during their professional education, none planned to work primarily with older people. As the participants reflected back on their initial career plans, half (6) planned to follow the advice still given to new graduates today - at least two years of acute care hospital experience before moving to other settings. What this advice may imply is that geriatric settings require special skills beyond entry-level. The initial career plans of the other six participants were equally divided between orthopaedics/sports medicine, pediatrics, and rehabilitation.
Influences On Participants as Physical Therapists

The first jobs of the participants can be categorized as one working primarily with young adults, a mixed case load, or primarily with elders (see Figure 3). Many chose familiar facilities, a former affiliation site or hometown facility, and this is consistent with the literature (Buchanan, Noonan, & O'Brien, 1994; Ciccone & Wolfner, 1988; Emery et al., 1996). Table 3 contrasts the participants' initial plans and actual first job.

Table 3

Participant Initial Plans and First Employment Settings: Frequency

<table>
<thead>
<tr>
<th>Practice Setting</th>
<th>Initial Plans While in PT School</th>
<th>First Employment Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Orthopaedic/Sports Medicine</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Private Practice</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Note. Arrows show the shift in settings.

Those who expressed initial plans in areas other than acute care did seek employment first in an acute care hospital with the idea to move to their preferred
setting after they gained experience. The only exception was one GCS who planned to work in a rehabilitation center and did so.

Influences on the participants' career decisions to work with older people during this portion of the career path involved life events and/or dissatisfaction. The exception was one therapist initially planning a career in sports medicine, who over a period of years became very skilled in neurological rehabilitation. This participant took a position in a nursing home to start a short term rehabilitation center: "A lot of the choice to work with the elderly is being able to do neurological PT. So, that's a given there; they [elders] have more neurological [problems] than some age groups" (RA, p. 6).

Life events influencing the participants' career paths included marriage, moving secondary to a spouse's job or education, and the birth of children. Life events influenced career decisions of two participants seeking their first jobs. Both sought a job in an acute care hospital (initial plans were pediatrics and rehabilitation) but they were unsuccessful. As one said, "Because I ended up already having a child when I did my last year of PT, the only job I could get was part-time in a private practice. I did that for two years" (WL, p. 2). The second had difficulty finding an acute care job due to a combination of factors in the participant's life and community. This participant married and moved to a small town due to the spouse's job:

I interviewed at the local hospitals. The one with an opening was a bad situation for a new grad. - a turnover of four PTs in six months and the PT they had at the interview was leaving the next week! Well, my last affiliation was a 23 bed rural hospital. We saw in- and outpatients in the morning and did home health in the afternoon. I liked home health so when an acute care
hospital job wasn't possible I asked around to find out who provided home health services. That was [agency]. They were thrilled to have me and I loved working there. In addition to home patients I also saw hospice and nursing home patients through [same agency]. (VD, p. 2)

This was the only participant whose first job involved primarily older people. This GCS had positive early experiences with older people and positive experiences in geriatrics while in physical therapy school. It appears that these prior experiences provided a positive context so that when the job search did not go as planned, this individual actively sought out an unusual (for a first job) (APTA, 1992) but somewhat familiar setting that was primarily geriatric. This was also the situation in which others found themselves later in their careers.

Gradually, participants made the decision to work primarily with older people, usually after their first jobs as physical therapists. The decision was based on the interactions of the various influences from early in one's career, during physical therapy school, and while a physical therapist. The excerpt presented in Table 4 exemplifies the influences the GCSs perceived as important in the career decision to work primarily with older people. The only influence in this excerpt not experienced by most of the other participants was peer influence and not all participants experienced all influences. In the context of the story, interactions between these influences can be seen - no single factor directed the participant to choose geriatrics.

In summary, the participant's work environment had been wonderful but there were philosophical and management style differences with the director. A halftime job was attractive because of a major life event, children. A friend brought the part-time
Table 4

**Coded Transcript: The Decision to Work Primarily with Older People**

*Participant (HL, p. 6-7)*

<table>
<thead>
<tr>
<th>Influences</th>
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</thead>
<tbody>
<tr>
<td>First Job</td>
<td></td>
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<tr>
<td>Peer</td>
<td></td>
</tr>
<tr>
<td>Geriatric clinical exposure</td>
<td></td>
</tr>
<tr>
<td>CI as mentor</td>
<td></td>
</tr>
<tr>
<td>Peer</td>
<td></td>
</tr>
<tr>
<td>Life event - children</td>
<td></td>
</tr>
<tr>
<td>Eliminating initial career plan</td>
<td></td>
</tr>
<tr>
<td>Geriatric clinical exposure</td>
<td></td>
</tr>
<tr>
<td>Job dissatisfaction</td>
<td></td>
</tr>
</tbody>
</table>

This [large tertiary hospital] was as good as it gets and that was wonderful, wonderful first job and wonderful job for 9 years and then a friend [called]... [Friend] is another clinical specialist. Her [sic] and I were friends and I don't know how we got to be friends, well she lives in [same town]. But she was working at hospital and they had a geriatric program there and the home care program (which is the program, much more developed now, that I had done this little independent study with [CI mentor] in). She [friend] had since taken [mentor's] job. [mentor] was still at [hospital] but was doing geriatric inpatients and outpatient clinic... [mentor] was in there and [friend] had taken this home care job. I knew [friend] and [friend] was in grad school and was leaving her job and so she called me and said, I am trying to find someone for my job. This is a small core group and would you be interested in this. I think casually over probably a few years, I knew her job and at that time it was a half time job and I was working 60%, I believe, at the [first job], I had two kids at this point... So her job was open and that seemed very appealing. When I knew she would be leaving I had somewhat sought out a [another] friend who needed some fill in therapy coverage in a pediatric setting. So before I really took that leap to decide, yeah, I am really going to do geriatrics and really would be kind of focused in that, I gave that peds one more shot... so I filled in a day a week for a couple of months and on maternity leave for this friend in this school system setting again just to make sure before I made this decision that peds really wasn't an area I wanted to go into... Which was clear after that, this [peditcires] is not what I like... But then this home care program position opened up and I decided, "Okay, let's go for it."... The geriatrics, that seemed perfectly acceptable. I had had a fair number of geriatric patients in rehab and throughout - tertiary hospitals get a lot of geriatrics too. Not solely, but I knew that would always be appealing... And the management also at [first job] I was very frustrated with. It was a dictatorial sort of... The director at that time, we had a lot of philosophical and sort of management style differences. Like here there wasn't management. He was sort that thought the less you knew the better. Not at all what management things we are supposed to [be].
geriatric job to the participant's attention, the same job that the GCS experienced as a student as part of a geriatric elective. While the participant's mentor was no longer in the position, she was still in the organization. However, the participant's initial plan while in physical therapy school was to be a pediatric therapist after more general acute care experience. So before changing the direction of her career to geriatrics, the participant worked part-time with pediatric patients and found that it was not a good "fit." In the end, geriatrics seemed perfectly acceptable as a career move.

As a group, the participants recognized geriatrics as the place for themselves. With more advantages than disadvantages, they persisted in geriatric settings or moved into academia to teach geriatrics to physical therapy students. The participants were aware of both the disadvantages and advantages of working with older people but perceived the advantages as much greater. Disadvantages fell into three categories, physical and psychological aspects of aging, and disadvantages associated with the setting. Physical disadvantages mentioned included incontinence, slowness of movement and rehabilitation, and/or extreme frailty as stated by this participant:

I think the disadvantage is because of what I was talking about today - the frailty . . . and the comorbidities. Sometimes we are not able to do a lot for them. I think we can try, but we may be getting people so far down the line. They are too far down, absolutely, there are some of them that really are. I mean, we get called in, they are bed bound, they have lost all of their reserves and any infectious process will just take them out. So, I think those are the challenges. (IS, p. 4)

Disadvantages in working with older people also included psychological ones. These included severe cognitive impairments more common in the very old and/or personality factors:
Probably the only disadvantage is coming across with a person that is really pretty set in their ways and they weren't going to change lifestyles is probably the only disadvantage, I think. But I am sure you are probably going to see that no matter what population you are working with. (WW, p. 12)

Disadvantages associated with the setting included the perceived excessive paper work and/or the possibility of isolation in home health and nursing home settings: "You can become isolated if you don't actively do something to stir your brain" (VD, p. 3).

Expressed advantages in working primarily with older people were many. Five major categories emerged from the data. Repeatedly participants talked about (a) the challenge of the work (e.g., frailty, comorbidities), (b) elders' appreciation for care received, (c) their high motivation, especially compared to younger adults in other settings, (d) their willingness to share life experiences, and (e) the characteristics of the practice settings. The following examples illustrate the advantage subcategories:

The advantages are the variety, the challenge, the excitement of not knowing what's next, and how to respond. I think for the most part most of the people I've treated in the elderly category are more appreciative. They are more appreciative of their health so they are more appreciative of someone helping them return them to their health. (SA p. 8)

I found older people to be much more motivated. Much more motivated, much more receptive to care, really wanting to get better, much more so than the young spinal cord patients... and then their gratitude. Oh my God, they are so gracious. Never ending. All you have to do is look at them and touch their hand and that is it... I appreciate their strength in coping, they are good "copers." That [the elder's life experiences] is another big advantage. I love to listen to them. (ER, p. 6-7)

And so in a nursing home, you could just set up a real nice rehab program just the way you wanted it. I just was really enjoying that aspect of it... And I must admit the other thing was the independence. (OA, p. 3)
Through the influence of life events and/or dissatisfaction with other jobs, patient populations, or settings, the participants moved into a setting primarily consisting of older people. They came to realize that the advantages of working with older people outweighed the disadvantages and came to recognize they "fit" in geriatric settings. This is consistent with the career theory purposed by Law in Young and Collin (1992). According to Law, this recognition is an expression of autonomy, larger than career theories that focus on inner-directed liberation (e.g., Maslow) or other-directed control (e.g., neo-Marxist theory). When an individual is convinced of the goodness and truth of what is to be done, Law says it is sometimes experienced as though it were a recognition. With the participants this was expressed several ways:

The only jobs I could get was [sic] working with geriatrics. Then I realized this is what I really wanted to do (WL, p. 1)

So we moved very frequently [due to spouse's employment] and every so often I would say, "Oh, I have to get back in the mainstream." I would take a job in the hospital and just realize that I really wanted to work with geriatrics. (OA, p. 3)

Other participants told of "falling in love" with geriatrics, of trying other settings and patient populations and coming back to geriatrics again. It had never occurred to the participants before that they might work primarily with older people. But once they worked with elders, they knew they would stay. Law describes this phenomenon as something that happens in the interaction of circumstance and self that makes the act "my" act - however external it appeared formerly. Many significant encounters can be made to seem like accidents but with the act of recognition, it is more than an accident. What makes the act of recognition so powerful is that people have so many
choices. Law says that autonomy is no longer "my way" or "other peoples' way," but it becomes "the pursuit of what I say is the chosen way" (p. 161). It is the sense of owned purpose, not the behavior, that identifies autonomy so that a slave may be more autonomous than the master.

Choosing to Specialize in Geriatric Physical Therapy

For all but one participant, recognizing geriatric physical therapy as their chosen way was the first step toward specialization as illustrated in Figure 4. As stated earlier in this chapter, the participants valued education for themselves and it was here at the postprofessional level that they actively pursued it both informally and formally. A few started geriatric interest groups in their work settings, city, and/or state. Most became members of the APTA Section on Geriatrics and some attended the APTA's Combined Sections Meeting for continuing education and informal support from like-minded therapists. Formal education came early for some and years later for others (see Table 2). Regardless of the timing, many participants took advanced degrees or certificates "to gear for a career in geriatrics" (WL, p. 3). This commitment to lifelong learning is a distinguishing feature of belonging to a profession. For the participants, this commitment was internally motivated since only a few live in states that only recently require continuing education units (CEUs) for relicensure.

The one exception to this pattern reversed recognition and education. The social context and previous experience for this individual were positive toward geriatrics (positive family attitudes and experienced a positive geriatric affiliation while in school). After graduation this GCS went to an acute care setting and identified that
Geriatric PT Practice

Recognition of fit

Various Influences

Postprofessional Education

Informal

Formal

Board-certified Specialist

Consequences

Personal

Professional

Financial

Figure 4. Career path: Perceived influences and consequences of the career decision to specialize.
administration was a weak area. In looking for this type of course work, a family friend recommended a certificate program in aging that had administrative courses too:

It [the certificate program] made me very familiar with the network of agencies, the Area Agency on Aging, and a variety of service options out there for the elderly patient which, I kept saying I am going to take this course as long as I feel it is helping me. Well, I certainly felt as a therapist, the more I worked that this helped me because I could refer my clients and patients then back out into the community and know what was out there for them. I felt it was a tremendous help to me... About that time I stopped working in the tertiary hospital setting and did some home health and actually for the first time worked in an ICF setting. I found that real positive and enjoyed it and felt that it was challenging from both aspects. (AD, p. 4)

Postprofessional education exposed this participant to aging in a broader context beyond physical therapy, and was followed by recognition that geriatrics was the way to go. This was not the individual's last learning experience. Like all the other participants, informal learning as described earlier was very important with this individual.

Postprofessional education was very important in the decision to specialized. For many it narrowed the participants' physical therapy focus to geriatrics but within geriatrics, postprofessional education expanded their vision beyond physical therapy. Participants especially noted this outcome in formal multidisciplinary programs. Postprofessional education also had an indirect effect by reinforcing the participants' choice to direct their careers toward geriatrics. This in turn supported the developing influences that they identified as important in their decisions to become board-certified in geriatric physical therapy.
Four broad categories of influences emerged from the data that were related to the individual's time in the profession. There was some overlap but those in the profession the longest tended to see becoming specialized as a way to assist in the professionalization of geriatric physical therapy, "to help get the field recognition... to make people aware that geriatrics can be specialists too, and I wanted to support that concept by being one of them" (RA, p. 10). Those that had not been physical therapists quite as long, tended to see themselves as specialists already. By taking the examination these therapists thought their expertise would be formally recognized by their peers. This influence was one supported by the APTA as one of the main purposes in the creation of specialization (Ferrier, 1991; Woods, 1994). The most frequently expressed influence was the idea of specialization as a career ladder, also a stated purpose of specialization (Ferrier; Woods). For the most part, these were therapists with 12 to 20 years of experience. One participant was ready for a career change, but did not know what direction to take within geriatrics. Specialization was seen as a means to recognize clinical experience and open new opportunities. What those opportunities may be was unknown at the time. Others had a specific destination in mind - up the clinical ladder or over to an academic setting. The youngest participants tended to express the last influencing factor. They were influenced by the perception of specialization as a challenge, as a means to continue learning, and to keep from becoming "stale" professionally.

These results are consistent with unpublished quantitative data. The ABPTS annually surveys all board-certified specialists who have been certified for three years.
In February 1995, of the 217 specialists surveyed, 67% responded. The only GCSs eligible were those who sat for the first examination in 1992. APTA staff extracted GCS data from their survey to provide additional information for the study. Of the 14 surveys distributed to GCSs, 11 were returned for a response rate of 79%. Most of the survey was directed toward professional consequences of geriatric specialization. However, one question did relate to influences leading to specialization (see Table 5).

Table 5

*Why Did You Choose to Take the Specialist Certification Exam?*

<table>
<thead>
<tr>
<th>Survey Responses</th>
<th>Percent</th>
<th>Equivalent Transcript Code</th>
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</thead>
<tbody>
<tr>
<td>Professional career goals</td>
<td>82</td>
<td>Career ladder/building</td>
</tr>
<tr>
<td>Potential for increased job opportunities</td>
<td>82</td>
<td>Career ladder/building</td>
</tr>
<tr>
<td>Potential proof of expertise</td>
<td>73</td>
<td>Specialists already</td>
</tr>
<tr>
<td>Peer recognition</td>
<td>46</td>
<td>Specialists already</td>
</tr>
<tr>
<td>Greater accountability to consumers</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Advancement within employment organization</td>
<td>18</td>
<td>Career ladder/building</td>
</tr>
<tr>
<td>Opportunities for increased salary</td>
<td>18</td>
<td>More money</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>


*Minor influence of one GCS whose major influence was career building; no others discussed secondary or minor influences.*
The results from the ABPTS survey support the qualitative categories of career building and specialists already. In addition, the qualitative findings may give deeper meaning especially as it relates to reasons not listed in the ABPTS survey - professionalization of geriatric physical therapy and challenge/learning. These categories may have been reported as "other." It is unclear what "greater accountability to consumers" means. In the interviews this was not an influencing factor for specialization or a consequence of specialization. The expressions relating to consumers centered on participants' perceptions that they already were practicing geriatric physical therapy and serving their patients at a very high level. The respondents may have interpreted "greater accountability" as keeping up with the literature and dealing effectively with complex patient problems. Thus, this response may correspond with the qualitative challenge/learning category.

Consequences of Geriatric Specialization

In qualitative research, consequential conjectures are legitimate if they are made with qualification and humility (Lofland & Lofland, 1995). One suggested procedure for tracing consequences is to select a specific topic - geriatric specialization in physical therapy - and then survey other topics identified as being affected by the central topic. In the study these other topics included professional, personal, and financial consequences (see Figure 4). Of the three, professional consequences was the most dense category, much more so than the others. The consequences are direct results of geriatric specialization but also are interrelated. For example, professional
consequences lead to additional personal consequences and vice versa. One specialist was very much aware of the national "connectiveness" with other GCSs and new opportunities in the Section on Geriatrics, "It is such a circle. . . Everything is connected" (HL, p. 11).

When talking about the financial consequences of geriatric specialization, most participants said there was no financial consequence, nothing changed. Financial consequences were few. The participants said that was acceptable because becoming specialized was not motivated by financial expectations. However, some participants did gain financially. One GCS worked at a facility with a structured and detailed salary system. Either specialization or an advanced degree results in an automatic raise. Another GCS started a short term rehabilitation program in a nursing home and told the facility "to use my background as a marketing tool. . . Please emphasize that I am a certified geriatric specialist. . . They grabbed a hold of that right away and that was not a problem. . . It helped the marketing" (RA, p. 7). Three other GCS said they did gain a little financially, not from their jobs but through professional consequences of specialization. They earned speaker fees and were reimbursed for expenses.

The study's results are similar to those in the 1995 ABPTS survey whose main purpose was:

to gather information on changes in the clinical practice and professional activities of board certified specialists since their certification, and to assess the degree of impact board certification has had on these activities. The American Board of Physical Therapy Specialties and its Specialty Councils will use the information gathered for this survey to guide the development and marketing of the specialization process. (Introduction)
When surveyed about salary changes as a result of specialist certification, one respondent indicated "major positive effect," two GCSs marked "some positive effect," and eight GCSs indicated specialist certification had "no effect" on salary.

Professional and personal consequences of geriatric specialization for these participants may not be similar to those who became specialized in subsequent years. This is especially true because the 3-member Geriatric Specialty Council brought 11 of the first GCSs together in Alexandria, VA, August 28-30, 1992, for a geriatric item writing workshop. The purpose for the meeting was to add questions to the geriatric specialty examination item bank and to modify and update the data bank. In a June 1, 1992 letter to the first specialists, Rita Wong, Geriatric Specialty Council member, congratulated each GCS. She said there are "responsibilities of being among the first to achieve this career milestone!" Wong asked for assistance in adding to the item bank and reactions to the first exam. "There is no better source of exam items than our board certified specialists." Many participants perceived the August 1992 meeting as a watershed event - the beginning of the professional and personal consequences of geriatric specialization:

I mean being the first class, as you well know, we got together. The networking among our group was fantastic. So the fact that they brought us all together was the biggest thing and now all of the sudden you know fourteen other people. I got a ton of phone calls to do lectures, a ton. So I think people call APTA or the [geriatric] section for people and the section always provided our names so I was like doing lectures everywhere all the sudden. So that was really, really nice and then just meeting with other people. I remember I met [a GCS] and she hooked me up with her activities and [another GCS] with [company] and things like that, just some other stuff so that hooked us up with other things. So yeah, that was really, really good and then the section was always so wonderful about promoting us
and saying "these are our specialist and here they are and they are wonderful" and so I thought that the section was really, really good. (ER, p. 9-10)

The primary consequences of geriatric specialization are professional ones. In examining the phenomena of professional consequences, statements could be further categorized as those relating to job/clinical practice, education/research, and APTA activities. These subcategories did overlap in that a consequence in one subcategory would contribute to a consequence in another subcategory. For example, APTA activities such as participating in item writing lead to invitations to speak. The linkage between clinical practice and education can be seen in this GCS's statement: "I've really grown professionally [since specialization]. To give good care to older patients you have to look below the surface and focus on the total person. You have to know a little about every system and keep up" (VD, p. 5).

As a result of specialization, some GCSs saw no change in their job or clinical practice. However, these are also the same people who perceived themselves as practicing at a very high level before the examination. Other GCSs saw themselves as better, more confident therapists. GCSs in the ABPTS 1995 study (n = 11) reported positive effects in patient care (64%) and self confidence (91%) because of specialization. They also reported more interesting and fulfilling careers (91%).

One participant gave some thoughtful insights on the issue of clinical practice and specialization. The GCS had given this topic much thought after reading an editorial by Jules Rothstein that appeared in the November 1995 journal, Physical Therapy questioning the relationship between practice and specialization:
The question should be, how has specialization helped the patient and we are here for the patient. It is so obvious, it is the pink elephant on the table. What, are we so dumb that we haven't even seen it? Like we do with most things, we just assume. Of course they are getting better care, you know, they are getting treated by a specialist, blah, blah, blah, and I make that assumption and I actually believe in the assumption. I really do. I can't believe that any of the fourteen of us are not going to give better care than, take a random sample of fourteen people out there. I instantly e-mailed the board [ABPTS] and said we need to address this. I would definitely serve on that task force to look out how can we measure the outcome of a specialist vs. a nonspecialist. It is hard for me to talk about other sections but at least for us [geriatrics] I think it will be the utilization of services. I think there is going to be a lot of overutilization with less production in nonspecialists. I see us as being far more efficient. You know you [specialists] are not satisfied that you know, "this is not working I need to try something different" versus "it is not working let's try three more months and see if it starts working." So I am actually thinking that managed care is going to help with that. (WW, p. 19-20)

This GCS perceives specialists as delivering better and more efficient care.

All the participants are now involved in some aspect of education and/or research and this was an expected consequence of specialization. As one GCS said, "[I sought specialization because] I thought it might open some more doors for consultant work and education [and it has]" (WW, p. 10). In reviewing the transcript and résumé or curriculum vitae of GCSs, they participated (or plan to participate) in many educational and/or research activities because of specialization. One GCS plans to write articles for the public so that they might learn how to prevent declines due to hypokinesis. A few are writing books and research articles. All participants are presenting aging information to physical therapy students, their peers, and/or to the public.

Currently, three GCSs hold full time faculty positions and several others mentioned this as a future career goal. While faculty must hold appropriate academic
degrees, specialization may lead some toward an academic career. The Pew Health Professions Commission (1992) highlighted four government reports all projecting worsening shortages of allied health care providers necessary for long-term care of older people. Because faculty shortages constrain growth in supply, the commission recommended more aggressive recruitment of mid-career entrants to both faculty and student roles. Specialization may be one avenue to alleviate the faculty shortage.

Serving as a role model/mentor for others is a result of geriatric specialization for some GCSs. Most participants saw this as coming out of professional consequences related to education. When one participant was asked, "Do you feel like you may be a role model or mentor for other people?" the GCS responded,

Yeah, I think so. Probably in certain students that come through. You know I get my share, various levels of students. I think [I have been a role model for] some of the relatively new grads that we have had working and other professions [that rotate through]. (HL, p. 24)

As a result of specialization, seven participants talked about increased involvement in the APTA. Some were talking an active role in the Section on Geriatrics. Others were serving on APTA boards, committees, or task forces. The perception was that the APTA promoted the specialists as the GCSs promoted the physical therapy profession. The APTA served as a supportive environment for continued individual professionalization. It also served as a network and thus was linked with the final result of geriatric specialization - personal consequences.

In the 1995 ABPTS survey, the 11 respondents reported the percentage of time currently spent in various areas. They then marked whether this percentage had
increased or decreased since becoming a specialist. Between all the respondents, all areas showed some increase in time except the area of patient care which decreased slightly. Activities showing the largest increases included education, professional activities within APTA or other professional associations, and consultation. Research, administration, and community service showed modest gains in the percentage of time. In comparison, decreases were slight in all areas except research and education, both of which only increased. These findings from the earlier survey correspond to participants' comments in the interviews and reflect the content in the available résumés.

Seven participants talked about personal consequences of geriatric specialization. These included networking and friendships. The following excerpt is typical:

The networking that I have had just with the fourteen of us that started - it clicked! Right off the bat, it clicked and I feel that closeness all the time. I know that you are there as a resource and others too and that has just been a tremendous boost. And more than just professionally too. You know we are all friends too. I feel that way anyway. I mean, I don't know, that has been a very special thing, I hope the other groups feel that same way but I am not sure that it is quite as personal as our group was. (WC, p. 10)

As a consequence of geriatric specialization, relationships grew among the members, some closer than others. As one GCS said, "We are a support group in many ways" (RA, p. 13). This social support may influence GCSs to choose to continue their individual professionalization in geriatric physical therapy, especially if they lack social support elsewhere. While some GCSs have supportive, intellectually stimulating work environments, others perceive a lack of professionalization among their peers:
They don't think of physical therapy as a career. I think it is a job that they can show up at work at a certain time a day and go home at a certain time a day. It's a job and I think they are very contented with things not changing. It is pretty easy to go down and get Mrs. Jones up, walk her down the hallway and make sure you are adhering to her weight bearing status and let her rest and get her a little water and do a few exercises with her and go home at the end of the day. I think that there is a high percentage, I am not sure how high a percentage, but I have certainly seen it. (IS, p. 6)

For those GCSs without social support for continued professionalization, the personal consequences of specialization may be very important for their continued development.

In understanding consequences related to geriatric specialization, it is important to remember the occurrence of consequences does not mean the participants intended such consequences (Lofland & Lofland, 1995). Most participants had heard about geriatric specialization through the Section newsletter and other APTA publications. While participants were familiar with the stated purposes of specialization, they had little idea what specialization would bring. Most GCSs had few expectations and did not intend the many consequences that followed. However, one GCS had specific expectations concerning the results of specialization and came away disappointed.

I had hoped that with [specialist certification] would be some clout to be had in the political arena. I feel like that's where we need to go as a profession. I am ready to do something or its going to be too late. I always said that I could never be rich, but maybe I could be famous with those letters behind my name. But it hasn't worked that way and I am not sure why. (SA, p. 5)

In this individual's specific context, the goal to be an advocate for older people and health care had not been helped by specialization contrary to expectations. Still, this GCS has much to contribute and did gain something through the specialization process:
What sent me to become a specialist was there was already some background there laid with special [clinical] skills... But the thing in the preparation and the studying - I learned things that have stuck with me. I also think that (and this sounds really strange) after all those years, it [specialization] was the thing that convinced me that I really did know something. Gave me that little added boost of confidence that I need to practice as a confident clinician instead of one who wasn't real sure. So, I think that [specialization] helped my clinical [practice]. (SA, p. 7)

The following excerpt summarizes the consequences of geriatric specialization and ends with this GCS's perceived mission in choosing aging and specialization:

The main consequence of specialization is professionally - I think I'm a better clinician. In studying for the exam, I really got into the literature - focused on geriatrics beyond PT. I keep up with the literature and research more - it came a habit I guess. And I'm doing research now in geriatrics. Teaching at the university supports that role but I don't think I would have been interested if I hadn't starting reading the research that was out there in preparation for the exam. And as I said before, being specialized has allowed me to be an advocate for older people both individually and collectively. (VD, p. 5)

Underlying Vision and Missions

At the end of each interview participants were asked to look back over their careers and decisions. The GCSs were asked if there was an underlying (or overt) mission or vision that developed and tied everything together. Clearly this topic was not something they had thought about before so the responses were tentative at first. Long and short term goals are something geriatric specialists routinely set in patient care and career, but most had not taken a step back and looked at their entire careers. The themes that emerged from the data are reported here (see Figure 5) and are valid for the participants at the time of the interviews. However, it may be that in the future, the vision and missions may become clearer with reflection (Hopfl, 1992).
VISION:
Better Society/Health Care System
A vision of successful aging

Empower elders

Advocacy for elders

Professionalization of physical therapy

Influence elders

Influence legislators

Influence students & peers

Influence other health professionals

Figure 5. Participants' perceptions of their underlying vision and missions.
The overarching theme expressed by the participants was a vision for a better society, or more specifically, a better health care system within our society. This is logical given their perceptions of health care. As stated earlier, GCSs had concerns about the future of health care, and from their point of view, things must change.

The global vision of a better society and one's place in that vision was expressed most clearly by one participant:

Well there is that "always do good" feeling, sort of the betterment of society and good for the masses, and I have that underlying philosophy. I am not sure that I am that morally up there but it is not self serving either. I try to do my share of volunteer thing and community stuff be it work or school or church or give the good example to the kids that this is what you need to be to be a good citizen, a good person in life. (HL, p. 21)

In addition to this global vision was the vision of successful aging:

I would say the vision is probably some of the stuff I was talking about today, I think, and just the successful aging. To really get into helping people maintain their health, maintain their physiological reserve in that arena. Because that really bothers me sometimes with what we are trying to do in therapy. Sometimes it seems asinine what we are trying to do. We have got these people - we use the analogy that no one has changed the oil in their car. Then, finally, it breaks down and you take it in and you tell someone to fix it and then you have to go in and replace all these parts and stuff rather than you doing periodic oil changes. I think we chase symptoms. I think right now the whole medical system, the way we work, is that by the time the symptoms show up, for the most part, we have lost all of this reserve in these people and then we try to just credit their account a little bit or give them a little function back. (IS, p. 13)

The idea expressed is that successful aging is possible through prevention and that it would benefit society as a whole. But for the very frail, the vision was for a better health care system that made any life they had left the best that it could be, to help improve their quality of life however the individual defines it.
The participants' missions related to the vision in that together the missions could make the vision a reality. Missions fell into three general categories: empowerment of elders, advocacy for older people, and professionalization of physical therapy. But, for change to occur at a macro level, the GCSs perceived they had to participate at a micro level by influencing older individuals, legislators, physical therapy students, peers, and other health care professionals. No single participant expressed the entire model as illustrated in Figure 5, however, each spoke of one or more parts.

By influencing older people, giving them knowledge, older people can change behaviors, and add to and maintain their physiological reserve. The participants did not see themselves forcing older people to change. By giving them knowledge about aging and the consequences of behaviors, older people could make informed choices. Two participants in different circumstances specifically talked about knowledge as power. By freely sharing knowledge, the specialists empowered others. The sharing of knowledge can be done in multiple settings in many ways - senior health fairs, group therapy sessions, individual patient treatment, and in teaching new therapists.

As stated earlier in this chapter, many participants voiced the need for patient advocacy in today's health care system, especially among the very old. Because of specialization, one participant's mission became more defined in this area: "I am a much more stronger patient advocate willing to [fight for my patient]. . . This person deserves care and I am not just going to sit back" (WW, p. 16). Some participants expressed their mission to be an advocate for older people directly in the context of
their practice. However, one GCS was involved more politically as an advocate for older people by serving on a state task force to reshape its health care system. Another participant wanted to be an influence, to be an advocate, but so far had been unsuccessful in the legislative arena.

Some talked about their mission in terms of what they were doing now or planning to do to "move the profession ahead" in the area of geriatrics. By sharing knowledge with students and peers, GCSs affected two missions. First, by empowering students and other physical therapists, they multiply the number of advocates for older people. Secondly, GCSs also advance the profession through enlarging the knowledge base and disseminating that knowledge to others. Also, through interactions with GCSs, other health care professionals may come to know GCSs and the roles they can play in making our society and health care system better. This advances the profession. Of all the mission areas and plans, participants perceived this last one as just beginning and the weakest, primarily because geriatric specialization is so new.

Has physical therapy become more professionalized since Senter's 1972 study? Characteristics associated with professionalization include: (a) lengthy and specialized training, (b) a body of specialized knowledge, and (c) extensive autonomy and responsibility. While not a primary focus of the study, it is clear from the interviews that participants see themselves as becoming more professionalized but others in the profession are not. The GCSs commented on the rapidly expanding knowledge base that has lengthened entry-level programs. They feel the pressure to keep up, read, and
attend continuing education:

I actually feel like it [geriatric specialization] made me constantly conscious of the fact that I had to live up to it. I actually read much more now partially because I don't want to dishonor it. That it is kind of like a privilege. Like if I don't keep it up it will be a sham. (BA, p. 8)

Yet all knew clinicians who did not feel or act the same way; therapists who are just getting by. In addition, while physical therapists are not as autonomous as physicians in terms of neo-Marxist power, the participants are autonomous in that they have recognized and pursued their chosen way - geriatric physical therapy (Law, 1992).

Perceived aids and barriers to carrying out participants' vision and missions are listed in Table 6. Some aids and barriers appear on both sides of the table and depend on the individual's specific mission and circumstances. For example, one GCS talked

Table 6

Perceived Aids and Barriers to Carrying Out GCSs' Vision and Missions

<table>
<thead>
<tr>
<th>Aids</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialization (3)</td>
<td>Other's lack of knowledge about GCS (2)</td>
</tr>
<tr>
<td>Availability of choices (1)</td>
<td>Limited time and/or money (4)</td>
</tr>
<tr>
<td>Managed care programs (2)</td>
<td>Managed care programs (1)</td>
</tr>
<tr>
<td>Current employment environment (4)</td>
<td>Current employment environment (3)</td>
</tr>
<tr>
<td>Improving attitudes toward elders (1)</td>
<td>Ageism of other health professionals (3)</td>
</tr>
</tbody>
</table>

Note. Value in parentheses is number of participants that perceived an aid or barrier.
about how specialization helped prepare one to speak to peers and other health care professions about important aging issues. Yet for another GCS, specialization was not an aid or barrier. Instead, this participant perceived others’ lack of knowledge about geriatric specialization to be a barrier. The perception was that people (physicians, administrators, rehabilitation directors, etc.) are unaware of what specialists can offer. Availability of choices was an aid in that there are many opportunities to work toward the various missions. Simultaneously, an individual has a limited amount of time and money to devote to the choices, and yet there is so much work to be done. Some saw managed care as an aid and others, a barrier. However, one GCS said managed care is an opportunity. Some work environments were very supportive of the participants’ vision and missions, others neutral, and still others a barrier. Those that saw the work place as a barrier were thinking about moving so they could be more effective. While many participants observed improved attitudes toward older people among newer graduates and those seeking advanced degrees, one GCS noted this as an aid to achieving one’s mission of being an advocate for older people. This participant attributed the improved attitudes to a "keenness of wanting to learn a new thought" (WW, p. 8). Others specifically noted ageism as being a barrier to their missions, especially if people in authority held ageist views.

Summary

Chapter IV presented the findings and analysis of the study. First, the population and participants were described based on interviews and document
Participants' views of health care in their various practice settings provided a lens through which we could understand the career paths. Major themes emerged from the data that related to the research questions. The results and discussion of career paths leading to board certification in geriatric physical therapy also included important influences along the way. Consequences were also enumerated and discussed. The chapter concluded with the perceived vision and missions in choosing aging and specialization, including aids and barriers to carrying out of those missions.

Chapter IV References


CHAPTER V

SUMMARY, IMPLICATIONS, AND RECOMMENDATIONS

From its inception, the purposes of this investigation were exploratory and descriptive. The study focused on presenting a detailed account of a well-defined group. Board-certified geriatric specialists in physical therapy (GCSs) were chosen because they are addressing the needs of older people, an increasing portion of our society. The study had three purposes: (a) to examine the career paths of GCSs, (b) to identify factors that influenced them toward a geriatric practice and specialization, and (c) to explore implications of their career paths for higher education. Using a qualitative methodology, commonalities were sought among the individuals. The findings and analysis of the first two purposes were presented in Chapter IV and will not be repeated here. Instead, in this concluding chapter, those results are summarized and the third purpose, implications of the participants' career paths for higher education, is presented followed by concluding remarks.

Summary

The participants were adventurous, valued education, and were enthusiastic about physical therapy, geriatrics, and specialization. These qualities facilitated the research process as they, with genuine interest and enthusiasm, shared their lives.
Major themes emerged from the data that related to the research questions concerning the participants' career paths and the factors that influenced their career decisions. The career path leading to board certification began with choosing physical therapy as a career and then progressed to professional education and the first job as a physical therapist. From this point the career path split into two paths. One path led directly to geriatrics with the other path going to other settings and populations before reaching geriatrics. As participants recognized that they "fit" in geriatric physical therapy, they pursued formal and informal education to increase their knowledge and skills before choosing to become board-certified in geriatric physical therapy.

There were many influences on the participants' career decisions. In choosing physical therapy as a career, volunteer experience and personal research were the most frequent factors. In choosing to work with older people, influences in one's early years, during professional education, and as a physical therapist gradually built a social context that supported the decision to work with older people. While every participant did not experience all the influences, the summation of factors experienced did lead them to their decision and confirmed it. The GCSs chose to seek specialist certification for various reasons: (a) to assist in the professionalization of geriatric physical therapy, (b) because participants believed they were already highly skilled and specialized in geriatric physical therapy, (c) to advance their careers, and (d) to keep learning and growing.

Few financial, but many professional consequences occurred as a result of geriatric specialization. In addition, professional and personal consequences were
interrelated. The Geriatric Specialty Council brought most of the GCSs together in August 1992. Participants who attended perceived this meeting as the starting point of the professional and personal consequences that followed. As a result of geriatric specialization, the GCSs gained friends and professional networks. Professionally, they experienced improved patient care, increased research and educational opportunities, and/or increased opportunities for professional service in APTA.

The insights gained from the GCSs' views of health care set their vision and missions in context. The overarching theme expressed by the participants was a vision for a better society, or more specifically, a better health care system within our society. Within this global vision was the vision of successful aging - that it is possible and that it would benefit society as a whole. The participants' missions related to the vision in that together the missions could make the vision a reality. But, for change to occur at a macro level, the GCSs perceived they had to participate at a micro level by influencing older individuals, legislators, physical therapy students, peers, and other health care professionals.

Implications for Higher Education

The participants shared their insights on higher education as it relates to geriatric physical therapy and specialization. The specialists' ideas are based on perceptions of their own lives and our health care system as it pertains to older people. Implications of the participants' career paths for higher education can be logically divided into those related to professional and postprofessional education.
Professional Education

All the participants believe in lifelong learning for themselves and others. They believe a person is never too old to learn, to grow, to change if they choose. Because the GCSs believe attitudes and behaviors can change, they are not bound by a specific list of characteristics or life experiences necessary for admission to physical therapy school. The consensus among participants was that admission should not be based on expressed intention to work in a needed area. After all, none of the participants intended to work primarily with older people and, as one GCS said, "there is just too much need in our field" (SA, p. 9), in all areas of physical therapy.

Built on the foundational ideals of lifelong learning and needs throughout physical therapy, the GCSs believe that professional education should produce a generalist, not a specialist in any one area. Hayes, in Dunleavy et al. (1993), agrees, "No matter what degree they hold, entry-level therapists are generalists. Specialization is not a part of entry-level practice" (p. 47). In the context of professional education training generalists, themes emerged concerning attitudes, curricula, and clinical experience.

Ageism still exists in our society and within our academic institutions (Baker, 1984; Kvitek et al., 1986; Wong, 1990). While participants perceived that attitudes toward older people (and those who work with them) were improving, they still observed ageism in patients and their families, other health professionals, students, and academicians. However, participants believe that attitudes can change, especially in physical therapy school. Pascarella and Terenzini (1991) support this concept in their
extensive literature review, *How College Affects Students*. They say the evidence is consistent and abundant - during the college years there are changes toward greater altruism, humanitarianism, and sense of social conscience and civic responsibility.

Faculty are often the first professional role models of students (Cohen & Jordet, 1988). It is during their professional education that students are exposed to the profession's values. From the lives of the participants, all faculty need not be enamored with geriatrics. As one specialist said, "[We'd be] in bad shape if we all liked the same thing" (HL, p. 24). However, to change attitudes, ageism must be eliminated among faculty members. The influence of an enthusiastic teacher who served as a positive role model may or may not influence students toward geriatrics (Coren et al., 1987; Tobiason et al., 1979). Though the literature is inconclusive on this topic and only two GCSs had faculty members as role models or mentors in geriatrics, some participants still thought an enthusiastic teacher was important:

I truly believe the place to get this started is in the educational system. I really think if there is a dynamo person presenting geriatrics and all the positive aspects [students will be excited too]. . . So I think that has made an impact. Depends on who is doing the teaching and who is presenting it and if there is a real enthusiasm showing all that. I mean, you do have to talk about the negatives but [put them with the] positives together. (WW, p. 13)

Therefore, professional education programs should seek to eliminate ageism among all faculty and seek enthusiastic teachers for geriatric content. Gandy suggested that faculty who are also clinical specialists may serve as role models for future specialists (Reynolds, 1992). This may be true in the future since most participants are currently interacting with students in the clinic or in the classroom.
At this point further questions arise: What geriatric content is entry-level and what is specialized, postprofessional content? How should it be presented - as a thread woven into the curriculum, a required course, an elective? These are not new questions. In the early 1980s, the APTA Section on Geriatrics, Specialty/Competency Committee attempted to answer the first question, what content is entry-level ("Entry level content areas," 1982). The position paper outlined 15 content areas appropriate for an entry-level practitioner. In 1987, the Department of Health and Human Services through the National Projects to Improve Accreditation Requirements in Aging funded an APTA Department of Accreditation study of entry-level curricula. Nieland, Farina, and Edwards published their findings in 1990 with recommendations to the Commission on Accreditation in Physical Therapy Education. The authors recommended content areas similar to those suggested in 1982:

1. Attitudes and Theories of Aging
2. Biological and Physical Changes in Aging
3. Psychological Aspects of Aging
4. Diseases of the Elderly
5. Health Promotion and Disease Prevention
6. Evaluation and Treatment Skills
7. Education Skills
8. Communication Skills
9. Management and Ethical/Legal Issues
10. Socioeconomic Aspects of Aging
11. Basic Research/Problem Solving Skills
12. Community Health Resources
13. Implications of Tests, X-rays, and Drugs
14. Clinical Education in Geriatric Settings
15. Techniques for Promotion Change (p. 11)

The grant authors' vision was "to develop a document which could serve as a rich resource for faculty members who are responsible for the designing, planning, and
instruction of aging-related content in physical therapy curricula" (Nieland et al., 1990, p. iii). Unfortunately, many new faculty members and new professional programs are unaware of this information. One participant, a new faculty member, spoke at length about the need for this information. The GCS was unaware that the work had been done. Clearly, recommended geriatric content must be disseminated again, especially to all new programs.

With agreement in geriatric content area, how should it be presented - as a thread woven into the curriculum, a required course, an elective? Most participants thought that there should be a definite course or part of a course that covered basic aging issues. In addition, geriatrics should be threaded through the curriculum because there are aging implications across all courses - orthopaedic, neurology, and cardiopulmonary physical therapy. The GCSs were very aware of the extensive body of knowledge and the trend to squeeze as much as possible into professional education. They did not recommend adding more hours to curricula. Given time constraints, students need to be shown the breadth of geriatrics because "a student may not consider geriatrics an option if they aren't exposed to it" (VD, p. 6).

Wong (1990) suggests that some negative attitudes toward aging may be linked to negative attitudes toward chronic care intervention. Other authors (Granick et al., 1987; Noonan, 1992) have noted that physical therapy professional programs tend to overemphasize acute care patient diagnosis and treatment. They recommend that curricula de-emphasize acute care and present the entire scope of physical therapy - acute care to chronic care patient management and functional outcomes.
To really do its job, professional education has to do more than teach students anatomy and physical therapy techniques; it must also ready them for practice in a changing world. An important mechanism to do this is clinical experience during professional education. Clinical education ties together theory and practice in the context of the real world. Noonan (1992) suggests exposing students first to elders who are successfully aging before clinical experiences with frail elders. In this way students may better integrate their knowledge about elders with clinical application, experiencing first hand the diversity among older people (Nosse & Wilson, 1994).

Geriatric clinical experiences can also assist in changing attitudes. Brown et al. (1992) found physical therapy student attitudes changed positively toward older people following both traditional and specially designed geriatric clinical experiences.

In 1992, Noonan recommended an increase in the number of available geriatric clinical education sites. All the participants also recommended geriatric clinical exposure but what is a geriatric clinical education site? An ideal geriatric site would have a continuum of care from independent living to skilled care, but these sites are few. Even so, they often have unstable staffs with contract therapists. However, because of changing demographics and the vertical integration of hospitals with multiple levels of care, participants noted that a student could not avoid exposure to older people. Many hospitals have skilled nursing and home health units that students experience. Even rehabilitation centers, in the past full of young spinal cord and traumatic brain injured patients, are now primarily geriatric, filled with stroke patients. Professional schools may not need to develop specific geriatric clinical sites. While
the ideal should be sought after, students will see and treat older patients if professional programs do not allow all clinical affiliations to be limited to pediatric and/or sports orthopaedic facilities. A study with third year medical students supports this idea (Green et al., 1983). The authors' results suggest that quality relationships rather than the quantity of contact with older people increases the likelihood that students will actively seek a geriatric practice. Therefore, it may be more important for professional programs to develop and maintain quality sites (and clinical instructors) of all types.

The academic degree associated with professional education was not a factor, only that the participants saw two distinct levels - professional and postprofessional education. According to the GCSs, professional education should focus on developing realistic, nonageist attitudes toward aging, and initial exposure through didactic and clinical experiences. The depth of geriatrics should be reserved for postprofessional education.

To help span the distances between professional education, practice, and postprofessional education, a GCS saw an additional role of professional education:

I think that is the role of professional education is to make them active consumers. Just like if we want them to be good consumers of literature, I want them to be good consumers of education. I'd love to have my students go to three different geriatric [CEU] courses and critique mine. What did you get that was factual versus what was opinion and was it cited as opinion? Again, can you recognize the difference of an opinion of an expert and a logical argument? You know, that sort of thing. (ER, p. 23)

Another participant had an excellent suggestion to bridge that gap. At the end of the curriculum after all clinical affiliations, students should return to their college or
university for a short course or seminar. This capstone course would put closure on
their lives as students and introduce topics to encourage their individual
professionalization, including physical therapy specialization. A capstone course could
serve as a bridge between professional and postprofessional education.

*Postprofessional Education*

Regardless of degree, the entry-level physical therapist is not a finished
product. As stated by Protas, "Some skills simply must develop through experience
and emerge in the more polished, mature professional" (Dunleavy et al., 1993, p. 44).
Certainly one's first job as a physical therapist is the beginning of that process but
individuals are responsible for their own growth in the profession. As seen in the
career path of one GCS, postprofessional education can lead a therapist into an interest
in geriatrics. However, most participants found themselves in a primarily geriatric
setting first and then, because they recognized geriatrics was a good "fit," directed
their learning in that direction.

As discussed in Chapter II, postprofessional education in the broadest sense is
education beyond one's professional training. It comprises a variety of activities and
may include continuing education, specialist certification, formal graduate work, active
participation in professional meetings, personal study of the literature, and exchanging
ideas with students and colleagues (Echternach et al., 1994; Greenwald, 1993).
Across such a broad canvas, what then are the implications for higher education?

While requirements for continuing education units (CEUs) may guide
postprofessional education, this was not a motivating factor for the participants. Of
the 12 GCSs, only 4 lived in states that recently required CEUs for relicensure yet all participated in educational activities throughout their careers. Participants spoke highly of the Section on Geriatrics' educational programming, especially *FOCUS: Geriatric Physical Therapy*. Several participants took this course before specialist certification when it was taught by academic and clinical physical therapists. *FOCUS* is presented yearly before APTA's Combined Sections Meeting. According to the 1995 brochure, "The information will be of value to therapists beginning preparation for the specialization exam, those in clinical practice wishing to expand their knowledge base or those in academia who desire material to supplement the geriatric content area." Currently, the first GCSs teach most of *FOCUS*.

The quality of some CEU offerings was a concern to a few participants and one GCS was appalled by the poor quality of one geriatric CEU course she attended. In response to growing concerns, APTA developed the Continuing Education Service. It approves physical therapy continuing education providers, tracks continuing education offerings, and provides a CEU transcript service to participants. However, another way to ensure quality CEU programming is sponsorship through colleges and universities. One participant said,

I don't think that is such a bad idea [colleges and universities offering CEU courses]. Essentially these [APTA] conferences are all the educators. Right, everybody is doing research, everybody presenting their research is an educator. So in a sense, I guess it is being done already. (ER, p. 23)

This arrangement could be beneficial to both the profession and higher education institutions. The profession would gain quality CEU courses. The institutions could
benefit financially, but what is more important, would expose clinicians to the campus environment and perhaps ease a return to more formal postprofessional education.

A college or university program could form a peer mentoring group made up of those who plan to sit for a specialty examination. This social support may help retain clinicians when they have inadequate social support for continued professionalization in their individual work environments. The University of Illinois at Chicago, Physical Therapy Department set up a model program for pediatric clinical specialist preparation in which study groups are a central feature (Kolobe & Campbell, 1996). The purpose was to increase the number of board-certified pediatric specialists. Identified barriers related to characteristics of pediatric practice also common to geriatric practice: (a) isolated work environment with limited resources, (b) wide variety of practice settings, and (c) difficulties returning to school. The model program included information about the specialization process, self-assessment of competency, study groups, continuing education workshops, telephone consultation, library access, and short term clinical observation experiences. In the first two years of the program, 26 therapists participated. Thirty-four therapists participated in year three, most of whom were out-of-state residents. In the program's first year, 75% cited the model program as the reason they decided to take the pediatric specialty exam. As of 1995, 27 program participants have taken the pediatric specialty examination, most have passed, and the authors concluded that the model is effective. A college or university could set up a similar program for geriatric specialization. The program
could provide geriatric therapists with information on current/best practice, emotional support via the study group process, CEUs, technical assistance and consultation.

While some participants were successful with self directed, informal learning, others preferred more formal learning environments. Thus, higher education may play a role in formal postprofessional education. Many professional schools offer education programs leading to postprofessional degrees for physical therapists ("Educational programs," 1995). These programs are directed toward advanced research and/or clinical specialization. The APTA made a table available at the 1996 Combined Sections Meeting to display brochures on postprofessional education programs. Many areas of study described in the brochures coincide with the seven recognized areas for specialist certification but few used this fact to market their programs. Higher education institutions with postprofessional physical therapy programs may want to consider marketing this aspect.

In examining the career paths of the participants it was interesting that most postprofessional degrees/certificates came out of a physical therapy program or an aging studies/gerontology program. Participants choose not between the programs but whether to participate in formal education at all. By the time most GCSs choose to go back to school, they were married, had children, and/or jobs that limited their mobility. Which educational program they pursued was more a function of availability and location than anything else. Therefore, higher education may want to consider offering distant learning experiences through interactive video for lecture/discussion courses. Laboratory courses could be offered on a condensed, weekend format. Interestingly,
participants that had the broader, multidisciplinary experience found in the gerontology programs were especially enthusiastic about the experience:

I was just desperate for something [geriatric continuing education] . . . and about that time, accidentally I found that University of _____ had a master's in gerontology. I tried to get geriatrics but they only had it in nursing. Once I got into that master's level program it just so happened that two other therapists in a hospital just down the road a mile or so got into it right after me and there were three of us going through this program all together and all for about the same reasons. We had this intensely geriatric case load that all three of us enjoyed. . . It was the availability of this program that really solidified things into, "Yes, let's get going and get this," partially because it was there but then after I got into it because I just loved it. And it was such a joy. Unlike [professional] physical therapy programs, it was at night. It was one course at a time. And it was sociological based so it enriched every single facet of treating the elderly. It wasn't just clinical. It was about life and death and ageism and all of the other facets of death and dying and treating the elderly and being elderly and how to grow up and become an old person and the physical changes and all of those other things. So accidentally I think [I received] a world of good more than even if I had gone into just a physical therapy geriatric program. (BA, p. 5)

In 1980, Jackson informed therapists of extradepartmental programs and community resources in gerontology and geriatrics, however, the participants in the current study found these programs "accidentally" or through friends. Higher education institutions with aging studies or gerontology programs may want to consider targeting physical therapists. One way to make clinicians aware of what is available would be to present a short lecture at a local APTA chapter meeting. These meetings usually combine a short program with a business meeting. The program would need to be on a topic that would be immediately useful in practice so that the clinicians could see the program's immediate application. By making clinicians aware of the opportunities, more may choose this path.
Another possible postprofessional path is clinical residency. According to Swan (1996), the difference between continuing education courses and residency programs is that residency programs facilitate the assimilation of treatment skills in a clinical setting under master clinicians. Medicine has a long tradition of clinical residencies extending back to the 1870s (Stoeckle, Leaf, Grossman, & Goroll, 1979). But in physical therapy, clinical residency is a relatively recent concept except for multidisciplinary pediatric residencies that began 34 years ago (Tichenor, 1995). Currently there are at least 59 pediatric, 13 orthopaedic, and 8 sports physical therapy residencies in existence (Long & Sippel, 1995; Tichenor). At the 1996 Ceremony for Recognition of Clinical Specialists in Atlanta, GA, Keynote Speaker, Carol Jo Tichenor, urged her colleagues to rethink the paradigm by which they deliver services. She said postprofessional residency training was one way to better position the profession within the health care community by creating a larger base of master clinicians. Tichenor "hopes that one day residency-trained graduates will sit for board certification as a natural part of our educational process, as we are decades behind other health professions that have already made this commitment" (p. 74). For some of the study’s participants in the audience unfamiliar with physical therapy residency, these comments seemed radical. The participants liked the flexibility of the current specialization process and were concerned about rural therapists that may not be able to access colleges, universities, and residency programs. Other participants were more familiar with the concept and one shared the following insights:
I think it [higher education] has a role [in the specialization process] and also like clinical residencies in geriatrics would be nice. It may not be for everybody to pursue that route. I like multiple routes to get to the same thing but some people find different routes more helpful than others. [Some people wanting the structure and some not] and some of us manage to get it or did get it. But I see as the whole science of geriatrics definitely becoming more perfected and more in depth. The pioneers always seem like they were winging it and we did. But, as we [the profession] structure everything (because I see it from a certification process) that it takes a little bit more structure to achieve some of these things too. So I see that [residency] as evolution, but we aren't looking to make it that you had to have had these things in order to qualify [for geriatric specialization]. At least currently, the attitude is that we will not do that. Right now I look at it as avenues, we may eventually get to that [a specific residency requirement], but I see that maybe twenty years down the line, getting that specific. But I think then the specialty may evolve to that point as well, that you recognize the fact that you can't get this but through a residency. (RA, p. 15)

Johnson (1996) examined the feasibility of implementing a residency in Texas Woman's University's postprofessional physical therapy program. He noted that implementation must be compatible with the goals of the student and the university. Given those constraints, implementation of a residency was feasible and a maximum of 5 credit-hours could be substituted for 175 clinical-contact hours. Ultimately the university would have the responsibility of determining if the residency meets the same criteria as the course objectives. To ensure high quality and protect constituencies, accreditation of university affiliated residency programs would occur under the institution's regional accreditation body. The proposed residency in recognized APTA specialty areas, could serve as an alternate method of clinical skill acquisition and partial fulfillment of specialist certification. While completing a residency and/or graduate program does not insure specialist certification, it may assist therapists in gaining needed skills, knowledge, and experience.
Conclusion

While society needs more physical therapists to work with older people, more so in the coming years, there was no single action those in higher education could do to effect change. Therefore, those in higher education need to take a more holistic approach to the problem. Professional schools should admit students who have general characteristics valued by the profession and not base admission on expressed intentions to work with older people. While geriatric content and clinicals are needed, they must be balanced against other curricular needs. The curriculum and clinical experiences should be such that a nonageist generalist is produced, not a specialist. Higher education can have a role in postprofessional education through offering continuing education, formal degree programs, and in the future, geriatric residency programs. These roles are not limited to physical therapy programs within the university. Other university programs, especially aging studies or gerontology programs, could meet the educational needs of geriatric physical therapists. Higher education can play an important role in the professionalization of individuals and ultimately the profession itself.

The lives of 12 of the first GCSs have provided valuable insights on career choices - choosing to be a physical therapist, choosing to work with older people, and choosing to become a board-certified specialist. The participants had different life experiences, different initial career plans, different jobs. But they shared a love of older people and education. They shared a sense of adventure and enthusiasm for physical therapy, geriatrics, and specialization. Following along in their footsteps does
not guarantee one will choose to work with older people. It does not guarantee success in passing the geriatric specialty examination or the occurrence of similar consequences. However, as we look inward into the individual, the greater the understanding of the wider context. In sharing their lives, the participants give us knowledge about career paths, choices made and their consequences. Knowledge is power and by freely sharing themselves, the specialists enable us to become more than we are.

Chapter V References


APPENDIX A

LETTER TO PROSPECTIVE PARTICIPANTS
Dear [Participant's name]:

I am writing to the first "class" of board-certified clinical specialists in geriatric physical therapy. I am working on my dissertation at the University of North Texas and need your assistance. The study, "Career Paths of Board-Certified Clinical Specialist in Geriatric Physical Therapy with Implications for Higher Education," has three purposes: (a) to examine the career paths of board-certified specialists in geriatric physical therapy, (b) to identify internal and external factors that influenced you toward a geriatric practice and specialization, and (c) to explore implications of your career paths for higher education.

Since the study centers on your perceptions of career development, in-depth, unstructured interviews seemed the most effective way to elicit that type of information. We will have a friendly conversation where I will ask you to describe your background and career as it pertains to working with older people. I may ask clarifying questions but you will direct our visit. There is no time limit, but I think the interviews will take about 1 hour. They will be recorded on audio cassettes and then transcribed verbatim. I will then mail the transcript to you so you can verify its accuracy. At that time you may delete any material you feel did not reflect what you meant to say, add additional material you remembered, or emphasize anything said previously, and return the transcript to me.

If you agree to help me, there are no potential benefits to you other than the opportunity to tell your story. However, I hope the results of the study will help us develop strategies that could positively motivate students toward working with older people. Your potential risks involve the potential loss of confidentiality. To safeguard your confidentiality I will remove identifying information from the transcripts such as names and places. Transcripts, audiotape recordings, and computer diskettes will be kept in a locked file cabinet.

If you agree to participate, please sign this letter indicating your informed consent and return it to me in the enclosed envelop. Retain the copy for your records. Also, please indicate the best day and time to call. I will call you in one to two weeks to find out if you would like to participate and to set up a mutually agreeable time to do the interview. Most of the interviews will be done over the telephone but if you are going to Atlanta, GA for the APTA-CSM in February we could talk then if you prefer. I look forward to speaking with you. If you have any questions, please call me at work (214-706-2455) or at home (903-892-0095). My e-mail address is df_thompson@twu.edu or rayt@texoma.com. Thank you for considering this request.

Sincerely

Mary Thompson, MS, PT, GCS

The best day and time to call is __________________________ at telephone #: __________________________

__________________________________________
(Your signature and today's date)

THIS PROJECT HAS BEEN REVIEWED BY UNIVERSITY OF NORTH TEXAS COMMITTEE FOR THE PROTECTION OF HUMAN SUBJECT (phone 817-565-3940).
APPENDIX B

INTERVIEW GUIDE
INTERVIEW GUIDE

Probing questions about background and how you got started in physical therapy (PT)?
   How you came to be working with older people? Current work environment?

Probing questions about education:
   Didactic/clinical geriatric component of entry-level education?
   Faculty/clinical role model or mentor involved with geriatrics?
   Continuing education/ postprofessional course work/ degree?

Out of all the areas in physical therapy, why did you choose aging?
   Consequences (financially, personally, professionally) of that decision?
   Did specialization change any of these consequences?

Probing questions about work experience with older people prior to/after entry-level?

Probing questions about relationships with older people prior to/after entry-level?

Probing questions about perceived societal views of older people:
   How do you think society/ medical community/ family views older people?
   Did any of those views influence your decision to work with older people?

Probing questions about personal attitudes concerning older people:
   What are the advantages/disadvantages about working with older people?

Probing question about perceived need for more PTs to work with older people?

Many physical therapists work primarily with older people and do not choose to go through with the specialization process. Why do you think that is so?
   Why did you seek specialization?

How do you think elderly people fare in today's health care system?

In making these career decisions, do you have a mission, vision, or goal?
   What have you experienced in terms of barriers/aids in achieving your mission?
   Are there some important political issues that may become barriers or aids in your fulfilling your vision for geriatric practice in the 1990s?

Probing questions about recommendations:
   What sort of person should work with older people? Should specialize?
   What do you think we in education should do to encourage more people to work with older people?
   Should higher education have a role in the specialization process?
REFERENCES

Books


Periodicals


**Media and Publications of Limited Circulation**


