PHYSICAL THERAPY CLINICAL INSTRUCTOR SHORTAGE: WHY NOT BE A CLINICAL INSTRUCTOR?

By

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Abstract

This study measured the extent of the effect that benefits and barriers have on physical therapy clinical instructors, examined relationships between demographics and benefits and barriers, and discovered additional benefits, barriers, and incentives. Participants included 168 physical therapy clinicians. They completed self-developed demographic, benefit, barrier, and incentive questionnaires that were received through email. According to the mean score on a Likert scale, external benefits and organizational barriers have the largest effect on clinicians. Independent *t*-tests and ANOVAs indicated that facility, degree, and years of experience before supervising students had a significant effect on at least one of the benefit or barrier categories. An inductive approach indicated that the most common theme for each qualitative question was the benefit of growing as a clinician, the barrier of schedules/caseloads, and the incentive of free/discounted education. Overall, many current benefits and barriers were supported by this study. Some of the top benefits were associated with the university. This could allow universities to continue/improve their benefits as incentives for clinicians. Many top barriers, however, are not able to be controlled by the clinician or the university. It may also be that universities need to address the benefits and barriers on an individual basis.

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Statement of Purpose

The primary purpose of this study was to fill existing gaps in physical therapy clinical education research involving clinical instructors. To do so, known benefits and barriers of becoming a clinical instructor were assessed based on the extent to which they affect clinicians. This research also filled existing gaps in research by utilizing quantitative research and clinical staff regardless of their previous clinical instructor experience. Secondary purposes of this study were to discover other perceived benefits and barriers as well as to learn what types of support or incentives would increase the likelihood of clinicians to become clinical instructors. A tertiary purpose of this study was to examine relationships between the benefits and barriers to gender, job title, level of education, amount of experience, number of students supervised, and practice area.

Introduction

Many healthcare related fields require clinical education as part of the curriculum; physical therapy is no exception. Clinical education allows for students to apply knowledge obtained in the classroom to real clinical situations with the help of a clinical instructor. A clinical instructor in physical therapy is a licensed physical therapist or physical therapist assistant who volunteers to supervise students in the setting where he/she is employed for a set number of weeks. Despite the importance of clinical education, it is apparent from personal experience and review of the literature that clinical placements are becoming more difficult to find (Davies, Hanna, & Cott, 2011; Mooney, Smythe, & Jones, 2008; Stern & Rone-Adams, 2006; Hanson 2011; Thomas, Dickson, Broadbridge, Hopper, Hawkins, Edwards, & McBryde, 2007). Because of this decline, it is important to evaluate reasons individuals are and are not accepting positions as clinical instructors.

Review of current research regarding clinical education from the perspective of clinical instructors uncovered various benefits and barriers of being a clinical instructor. The benefits discovered can be organized into four categories including intrinsic benefits, professional growth and development, future profession benefits, and extrinsic benefits. The barriers of being a clinical instructor can be sorted into three major themes including personal, organizational, and demand barriers.

Some benefits of supervising a student are largely concerning intrinsic values. These benefits can be thought of as very internal and personal benefits; they are mainly focused around emotions. The intrinsic benefits as perceived by clinical instructors

include: personal satisfaction (Davies et al., 2011), pride in student growth (Davies et al., 2011; Hanson, 2011), enjoyment of teaching (Davies et al., 2011), increased recognition (Davies et al., 2011; Greenwood, Ha, Harris, Knabe, & Bahner, 2009), increased interest in work (Greenwood et al., 2009), feeling like an expert (Greenwood et al., 2009), and sensing appreciation from students (Greenwood et al., 2009).

Other benefits seem to aid with professional growth and development. These benefits come from various sources of inspiration that a student brings into the clinic. The clinical instructor takes advantage of what the student brings in and applies it to himself/herself, which leads to an advancement in professional performance. The professional growth benefits identified by clinical instructors include: encouragement of reflective practice (Davies et al., 2011; Hanson, 2011; Thomas et al., 2007; Greenwood et al., 2009), introduction to current knowledge/new ideas (Davies et al., 2011; Hanson, 2011; Thomas et al., 2007; Greenwood et al., 2009), facilitation of evidence-based practice (Davies et al., 2011; Hanson, 2011; Thomas et al., 2007), increased energy/excitement (Davies et al., 2011; Hanson, 2011; Thomas et al., 2007), increased confidence (Davies et al., 2011), improved patient care (Davies et al., 2011; Greenwood et al., 2009), improvement in overall clinical skill (Hanson, 2011; Thomas et al., 2007; Greenwood et al., 2009), increased team development (Thomas et al., 2007), and greater connections with universities (Hanson, 2011; Thomas et al., 2007; Greenwood et al., 2009).

Another benefit category involves the promotion of one's profession by helping to mold the young professionals who will sustain the profession in the future. The future

profession benefits of being a clinical instructor include contributing/giving back to the profession (Davies et al., 2011; Hanson, 2011; Thomas et al., 2007), being involved in the curriculum/part of the academic community (Davies et al., 2011), educating the next generation (Davies et al., 2011; Hanson, 2011; Thomas et al., 2007), and ensuring the competence of future clinicians (Greenwood et al., 2009).

The last set of benefits is based strongly on external incentives. These are more tangible benefits one receives for supervising a student, which are traditionally thought of as rewards. Clinical instructors suggested that some external benefits include promotion of the clinic (Thomas et al., 2007), access to continuing education (Davies et al., 2011; Hanson, 2011; Greenwood et al., 2009), access to university libraries (Hanson, 2011), recruitment potential (Davies et al., 2011; Hanson, 2011; Thomas et al., 2007), and fulfilling organizational goals and objectives (Thomas et al., 2007).

The first category of barriers incorporates personal reasoning. This category of barriers is very intrinsic in nature. Some of the personal barriers identified by clinical instructors are increased stress (Davies et al., 2011; Hanson, 2011; Greenwood et al., 2009), change in routine (Davies et al., 2011), lack of knowledge about the student (Davies et al., 2011; Hanson, 2011; Thomas et al., 2007), fear of a difficult student (Davies et al., 2011), professional burnout (Davies et al., 2011), decreased autonomy and flexibility (Davies et al., 2011; Hanson, 2011; Anderson, Cosgrove, Lees, Gigi, Gibson, Hall, & Mori, 2014), lack of recognition (Davies et al., 2011), feeling unvalued by students (Davies et al., 2011), increased commitment (Hanson, 2011), demoralized psyche (Mooney et al., 2008), fear of discrepancy in expectations (Hanson, 2011),

unwanted increase in work (Hanson, 2011), fear of conflicting learning styles (Davies et al., 2011; Thomas et al., 2007), fear of personal incompetence (Thomas et al., 2007), and difficulties with the Clinical Performance Instrument (Anderson et al., 2014).

Another category of barriers involves the organization for which one works. These barriers are less controllable and are often the result of one's work environment. The organizational barriers identified include: space constraints (Davies et al., 2011; Thomas et al., 2007), lack of organizational support (Davies et al., 2011; Hanson, 2011), busy or variable caseloads (Davies et al., 2011; Hanson, 2011; Thomas et al., 2007), poor reimbursement (Stern & Rone-Adams, 2006; Hanson, 2011; Greenwood et al., 2009), staffing issues or shortages (Stern & Rone-Adams, 2006; Hanson, 2011; Thomas et al., 2007), lack of physical resources (Hanson, 2011; Thomas et al., 2007), lack of learning experiences available at the facility (Hanson, 2011), safety concerns (Hanson, 2011), part-time or unsteady schedules (Hanson, 2011), date of rotations (Thomas et al., 2007), excessive traveling (Hanson, 2011), single therapist facilities (Thomas et al., 2007), and new businesses (Thomas et al., 2007).

The last type of barriers involves healthcare and facility demands. These barriers are the most uncontrollable and are often due to strict federal, state, or facility requirements and demands. Some demand barriers according to clinical instructors are productivity standards (Davies et al., 2011; Stern & Rone-Adams, 2006; Hanson, 2011; Thomas et al., 2007), time constraints (Davies et al., 2011; Stern & Rone-Adams, 2006; Hanson, 2011; Anderson et al., 2014), increased documentation requirements (Hanson, 2011), the impact of healthcare reforms (Mooney et al., 2008; Hanson, 2011; Thomas et

al., 2007), changing professional requirements (Mooney et al., 2008; Hanson, 2011; Thomas et al., 2007), and decreased insurance funding and reimbursement (Stern & Rone-Adams, 2006; Thomas et al., 2007).

Within current research, clinical instructors have also mentioned various supports and incentives that would decrease the burden of having a student and, likewise, increase their willingness to take a student. The research regarding this question can be categorized into three inclusive themes. The first theme pertains to training and support; the clinical instructors want more tips for supporting and dealing with students (Hanson, 2011). They also mentioned that more opportunities for structured clinical instructor training would be beneficial (Hanson, 2011). A second major theme explains the need for more information about the school and the student (Hanson, 2011). Clinical instructors suggested more defined expectations/objectives for the clinical, a breakdown of the curriculum, frequent contact with the institution, access to student profiles, and information about student learning preferences would be helpful in tailoring clinical education experiences to specific institutions and students (Hanson, 2011). The last major theme involving the incentives for taking a student was not as prominent in the research; however, some of these external incentives included university library access (Hanson, 2011), discounts at the university bookstore (Greenwood et al., 2009), and access/discounts for continuing education courses (Davies et al., 2011; Hanson, 2011; Greenwood et al., 2009).

Much of the research on the subject of benefits and barriers regarding clinical education from the clinical instructor's perspective is qualitative. There are many

different benefits and barriers now known, but it is not as obvious to what extent these affect clinicians' decisions to become clinical instructors. Many studies also focused on past and present clinical instructors for their data collection; there does not seem to be much data involving clinical staff members who have not been clinical instructors. No existing research was found on the relationship of demographic information to the benefits and barriers of being a clinical instructor. There is also a lack of research on the topic of support or incentives that would increase the willingness of clinicians to become clinical instructors. This research will focus on four research questions: 1) To what extent do the known benefits and barriers of becoming a clinical instructor affect clinicians in the physical therapy profession?, 2) Are there any relationships between demographic information and the benefits and barriers of being a clinical instructor?, 3) Are there other benefits or barriers that have been missed by other researchers?, and 4) What type of support or incentive would increase the likelihood of clinicians to become clinical instructors.

Method

Participants

One hundred seventy four physical therapy clinicians in contract with the University of Indianapolis started the survey. Six participants completed less than one percent of the survey and were not included in data analyses. Number of participants within demographic categories are presented in Table 1.

Table 1
Number of Participants in Demographic Categories

		n
Gender	Male	32
	Female	136
Job Title	Physical Therapist	136
	Physical Therapist Assistant	32
Degree	Associate's	16
	Bachelor's	40
	Master's	45
	Doctorate	66
Facility	Other	22
	Inpatient	39
	Outpatient	84
	Rehabilitation Hospital	23
Years of Experience	<1-10 Years	73
	>10 Years	95
Clinical Instructor	Yes	155
	No	13
Number of Students	>5 Students	108
	0-5 Students	47
	Not Applicable	13
Experience Before Students	0-1 Years	63
	2-3 Years	56
	>3 Years	36
	Not Applicable	13

Measures

The questionnaires used for this study were self-developed administered through the survey-building site *Qualtrics*. The survey included a consent document and the questionnaires described below. The Institutional Review Board (IRB) approved consent document is included in Appendix A.

Demographic Questionnaire. The Demographic Questionnaire included questions asking participants to select their gender, job title, years of experience, and

practice area. Participants were also asked to report if they had been a clinical instructor. Previous clinical instructors were then asked to report how many students they had supervised and how many years of experience they had before supervising their first student.

Benefits Questionnaire. The Benefits Questionnaire included 26 benefits of being a clinical instructor discussed in the literature. Participants were asked to rate the extent to which each benefit applied or would apply to them as a clinical instructor. The questionnaire utilized a Likert scale from 1 (*none at all*) to 5 (*a great deal*). Some of the benefits included in survey were personal satisfaction, introduction to current practice, educating the next generation, and continuing education. The benefit items were categorized into four subscales for further analysis. The *intrinsic benefits* subscale included 7 items (α = .85), *personal growth and development benefits* included 9 items (α = .93), *future profession benefits* included 5 items (α = .86), and *external benefits* included 5 items (α = .81). In addition to the Likert scale items, participants were asked to list any benefit not mentioned in the questions above.

Barriers Questionnaire. The Barriers Questionnaire included 33 barriers of being a clinical instructor discussed in the literature. Participants followed the same procedure for this questionnaire as they did for the Benefits Questionnaire. Some of the barriers included in survey were increased work, feeling undervalued, lack of resources, and high productivity standards. The barriers were categorized into three subscales for further analysis. The *personal barriers* subscale included 16 items (α = .93), *organizational barriers* included 13 items (α = .88), and *demand barriers* included 6

items (α = .88). In addition to the Likert scale items, participants were asked to list any barrier not mentioned in the previous section.

Incentive Questionnaire. The Incentive Questionnaire consisted of one qualitative question. This questionnaire asked participants to list any incentives or support that would increase their willingness to become a clinical instructor. A sample of the full survey is included in Appendix B.

Procedure

The study was approved under an "exempt" status from the Institutional Review Board (IRB). The IRB approval letter is located in Appendix C. Researchers also completed protection of human subjects training through the Collaborative Institutional Training Initiative (CITI) Program. Proof of CITI training is located in Appendix D.

Participants were recruited through an email that provided them with the purpose of the research, the link to the survey, and instructions for completion. The email was sent to the Center Coordinators of Clinical Education (CCCE) of all the clinics/hospitals that have a contract with the physical therapy school at the University of Indianapolis. The email encouraged the CCCEs to complete the survey and forward the survey on to all of their clinical staff, regardless of previous clinical instructor experience. The content of the email is included in Appendix E.

Data Analyses Plan. The data obtained from the questionnaires were exported to Statistical Package for the Social Sciences (SPSS) for data analyses. First, descriptive statistics including, the means, standard deviations, and Pearson correlations were run. Second, independent *t*-tests and ANOVAs were performed to examine the mean

differences on the benefits and barriers among the demographic variables. Specifically, independent *t*-tests were run for gender, job title, years of experience (0-10 years or >10 years), participation as a clinical instructor, and number of students supervised (0-5 students or >5 students). Responses for years of experience and number of students supervised were categorized into two groups in order to perform ANOVAs were run for degree, facility, and years of experience before supervising a student. Finally, the qualitative data obtained from the questionnaires were analyzed using an inductive approach to create common categories.

Results

Preliminary Analyses

First, the data were analyzed to ensure the assumptions for the independent *t*-tests and ANOVAs were met. Through visual inspection of the box plots, one to six outliers were identified for the dependent variables. These outliers were replaced with the next highest/lowest value that was not an outlier. Correlations for the dependent variables are presented in Table 2. Number of participants, means, and standard deviations for the dependent variables and individual Likert scale questionnaire items are presented in Table 3.

Normality assumption was assessed through skewness and kurtosis. Assumption was met with $z < 2.58$ for intrinsic benefits, professional growth and development benefits, and extrinsic benefits. After performing log transformation for variables with $z > 2.58$, the normality assumption was met.

Table 2
Correlations Between the Dependent Variables

	Intrinsic Benefits	Personal Growth & Development Benefits	Future Profession Benefits	External Benefits	Personal Barriers	Organizational Barriers	Demand Barriers
Intrinsic Benefits		.718**	.678**	.560**	-.214*	-0.047	-0.068
Personal Growth and Development Benefits			.726**	.563**	-.195*	-0.014	-0.063
Future Profession Benefits				.579**	-.225**	-0.101	-0.129
External Benefits					0.004	0.131	0.091
Personal Barriers						.672**	.686**
Organizational Barriers							.709**

** Correlation is significant at the .05 level.*
*** Correlation is significant at the <.01 level.*

Homogeneity of variance assumption was met except for organizational barriers on degree, $F(3, 136) = 2.78$, $p = .04$, personal barriers in facility, $F(3, 130) = 3.90$, $p = .01$, future profession benefits in job title, $F(143) = 5.78$, $p = .02$, professional growth and development benefits in number of students supervised, $F(142) = 5.59$, $p = .02$, and professional growth and development benefits in years of experience, $F(142) = 5.33$, $p = 0.2$. The homogeneity of variance assumption for these variables was met by using *t*-test values where equal variance was not assumed or by correcting for sample size.

Table 3
Descriptive Statistics for Dependent Variables and Individual Items

	n	Mean	Std. Deviation
Intrinsic Benefits	145	2.33	0.76
Personal Satisfaction	147	1.86	0.90
Student Growth	149	1.59	0.69
Enjoy Teaching	149	1.64	0.84
Increased Recognition	148	3.34	1.24
Increased Interest in Work	149	2.61	1.23
Feeling Like an Expert	149	3.00	1.28
Appreciation	148	2.26	1.03
Personal Growth and Development Benefits	144	2.33	0.88
Reflective Practice	146	2.05	0.98
Introduced to Current Practice	148	1.89	0.91
Facilitation of Evidence Based Practice	149	2.06	0.99
Increased Energy/Excitement	148	2.30	1.09
Increased Confidence	148	2.46	1.19
Improved Patient Care	149	2.44	1.19
Improved Clinical Skills	149	2.31	1.13
Team Development	149	2.54	1.18
Connection to University	148	2.93	1.23
Future Profession Benefits	145	2.32	0.79
Giving Back	148	1.88	0.93
Involvement in Curriculum	148	3.27	1.18
Be Part of the Academic Community	148	2.98	1.19
Educate the Next Generation	147	1.87	0.88
Ensure Future Competence	149	1.63	0.80
External Benefits	145	2.92	0.90
Promote Workplace	148	2.41	1.14
Continuing Education	149	2.84	1.27
Access to University Library	148	3.78	1.25
Recruitment	147	2.78	1.17
Fulfill Organization Requirements	148	2.81	1.14
Personal Barriers	134	3.95	0.68
Increased Stress	144	3.14	1.12
Change in Routine	144	3.32	1.14
Not Knowing the Student	143	3.97	1.03
Fear of Difficult Student	144	3.41	1.18
Professional Burnout	144	3.87	1.17
Decreased Flexibility	144	3.52	1.18
Lack of Recognition	143	4.34	1.10
Undervalued	143	4.21	0.94
Increased Commitment	144	3.63	1.20
Demoralized Psyche	144	4.67	0.71
Fear of Different Expectations	144	4.30	0.80
Increased Work	144	3.60	1.13
Fear of Differing Learning Styles	144	4.10	0.80
Fear of Feeling Incompetent	144	4.28	0.87
Difficult CPI	143	3.96	1.11
Not Asked to be a CI	138	4.93	0.35

Organizational Barrier	141	4.40	0.53
Space Limits	144	3.94	1.15
Lack of Organizational Support	144	4.36	1.02
Caseloads	144	3.40	1.29
Lack of Reimburse	144	4.40	1.05
Staffing Issues	144	3.99	1.19
Lack of Resources	144	4.40	0.95
Lack of Educational Experiences	143	4.68	0.70
Safety Concerns	143	4.52	0.76
Schedules	144	4.26	1.15
Date of Clinical Rotation	144	4.18	1.09
Excess Traveling	144	4.82	0.67
One Therapist Facility	144	4.94	0.40
New Business	143	4.92	0.43
Demand Barriers	144	3.92	0.84
High Productivity Standards	144	3.67	1.26
Time Constraints	144	3.35	1.27
Documentation Requirements	144	3.51	1.25
Healthcare Reforms	144	4.24	1.02
Changing Professional Requirements	144	4.26	0.94
Decreased Insurance Funding	144	4.43	0.82

Quantitative Analyses

Independent *t*-tests revealed no statistical significant differences between genders, years of experiences, participation as a clinical instructor, and number of students supervised on the dependent variables (i.e., intrinsic benefits, future profession benefits, professional growth and development benefits, extrinsic benefits, personal barriers, organizational barriers, demand barriers). Dependent variable means and standard deviations according to independent variables are presented in Table 4.

An independent *t*-test suggested that physical therapists ($M = 2.36$, $SD = 0.82$) rated future profession benefits higher than physical therapist assistants ($M = 2.12$, $SD = 0.56$) with marginal statistical significance, $t(51.56) = 1.83$, $p = .07$.

Difference in facility on organizational barriers approached significance $F(3, 137) = 2.27$, $p = .08$. Post-hoc Least Significant Difference (LSD) results indicated that clinicians from other facilities ($M = 0.24$, $SD = 0.16$) rated organizational barriers

significantly higher that clinicians in both outpatient facilities (M = 0.17, SD = 0.13) and rehabilitation hospitals (M = 0.15, SD = 0.10). There was no statistically significant difference between facilities on external benefits overall, $F(3, 141) = 2.20$, $p = .09$, but post-hoc LSD results indicated that participants from outpatient facilities (M = 3.11, SD =0.93) rated external benefits significantly higher than participants in inpatient facilities (M = 2.71, SD = 0.08). Individuals in outpatient facilities (M = 3.11, SD =0.93) also rated external benefits higher than those in rehabilitation hospitals (M = 2.69, SD = 0.81) with marginal significance.

Table 4
Dependent Variable Means & Standard Deviations According to Independent Variables

	Mean (Std. Deviation)						
	Intrinsic Benefits	Personal Growth & Development Benefits	Future Profession Benefits	Extrinsic Benefits	Personal Barriers	Organizational Barriers	Demand Barriers
All	2.33 (0.76)	2.33 (0.88)	2.32 (0.79)	2.92 (0.90)	3.95 (0.68)	4.40 (0.530	3.92 (0.84)
Gender = Male	2.36 (0.76)	2.41 (0.84)	2.50 (0.86)	2.97 (0.87)	3.98 (0.71)	4.41 (0.46)	3.81 (0.93)
Gender = Female	2.32 (0.76)	2.30 (0.89)	2.28 (0.77)	2.91 (0.91)	3.94 (0.67)	4.39 (0.54)	3.95 (0.82)
Job Title = PT	2.32 (0.78)	2.36 (0.91)	2.36 (0.82)	2.91 (0.90)	3.92 (0.68)	4.38 (0.55)	3.87 (0.86)
Job Title = PTA	2.37 (0.69)	2.15 (0.70)	2.12 (0.56)	3.00 (0.92)	4.11 (0.58)	4.46 (0.43)	4.17 (0.71)
Facility = Other	2.23 (0.78)	2.29 (0.82)	2.47 (0.86)	2.88 (0.99)	3.94 (0.75)	4.14 (0.71)	3.94 (0.86)
Facility = Inpatient	2.22 (0.67)	2.32 (0.76)	2.18 (0.65)	2.71 (0.80)	3.95 (0.49)	4.35 (0.47)	3.88 (0.75)
Facility = Outpatient	2.44 (0.77)	2.39 (0.94)	2.42 (0.88)	3.11 (0.93)	3.90 (0.75)	4.46 (0.51)	3.92 (0.89)
Facility = Rehabilitation Hospital	2.14 (0.74)	2.09 (0.79)	2.14 (0.73)	2.69 (0.81)	4.21 (0.38)	4.54 (0.38)	3.92 (0.95)
Degree = Associate's	2.34 (0.78)	2.14 (0.77)	2.11 (0.74)	2.97 (1.11)	4.38 (0.49)	4.59 (0.32)	4.38 (0.54)
Degree = Bachelor's	2.42 (0.70)	2.36 (1.04)	2.31 (0.79)	2.97 (0.86)	3.93 (0.63)	4.46 (0.37)	3.81 (0.88)
Degree = Master's	2.32 (0.85)	2.41 (0.93)	2.42 (0.80)	2.88 (0.89)	3.95 (0.71)	4.35 (0.56)	3.87 (0.94)
Degree = Doctorate	2.26 (0.74)	2.26 (0.75)	2.31 (0.81)	2.89 (0.90)	3.89 (0.63)	4.34 (0.65)	3.93 (0.76)
Years of Experience = 1-10	2.28 (0.73)	2.29 (0.75)	2.30 (0.77)	2.91 (0.90)	3.85 (0.65)	4.35 (0.63)	3.92 (0.77)
Years of Experience = >10	2.36 (0.78)	2.35 (0.96)	2.34 (0.82)	2.93 (0.90)	4.03 (0.64)	4.42 (0.48)	3.95 (0.83)
Number of Students = 0-5	2.30 (0.73)	2.27 (0.71)	2.30 (0.81)	3.00 (0.83)	3.89 (0.58)	4.36 (o.60)	3.89 (0.80)
Number of Students = >5	2.34 (0.77)	2.35 (0.94)	2.34 (0.80)	2.89 (0.93)	3.99 (0.67)	4.40 (0.52)	3.93 (0.86)
Experience Before = 0-1yr	2.25 (0.73)	2.16 (0.77)	2.15 (0.74)	2.90 (0.87)	4.04 (0.56)	4.40 (0.54)	4.03 (0.76)
Experience Before = 2-3yrs	2.39 (0.79)	2.51 (0.96)	2.50 (0.78)	2.94 (0.92)	3.84 (0.76)	4.32 (0.55)	3.65 (0.94)
Experience Before = >3yrs	2.35 (0.78)	2.33 (0.91)	2.38 (0.83)	2.93 (0.96)	4.02 (0.60)	4.53 (0.41)	4.19 (0.68)

Difference in degree on personal barriers approached significance, $F(3, 129) = 2.36$, $p = .07$ with LSD results showing that therapists with bachelor's ($M = 0.30$, $SD = 0.13$), master's ($M = 0.29$, $SD = 0.15$), and doctoral degrees ($M = 0.31$, $SD = 0.13$) rated personal barriers significantly higher than therapists with associate's degrees ($M = 0.19$, $SD = 0.13$). Overall mean differences in demand barriers based on degrees were not statistically significant $F(3, 139) = 1.66$, $p = .18$. However, LSD post-hoc analysis revealed that participants with a bachelor's degree ($M = 0.31$, $SD = 0.17$) rated demand barriers significantly higher than participants with an associate's degree ($M = 0.18$, $SD = 0.15$). Participants with master's ($M = 0.29$, $SD = 0.19$) and doctoral degrees ($M = 0.29$, $SD = 0.16$) also rated demand barriers higher than participants with associate's degrees ($M = 0.18$, $SD = 0.15$), but only with marginal significance.

Differences in years of experience before having a student on future profession benefits approached significance, $F(2, 142) = 2.39$, $p = .06$. According to post-hoc analyses, clinicians with 2-3 years of experience before supervising a student ($M = 2.50$, $SD = 0.78$) rated future profession benefits significantly higher than clinicians with 0-1 year of experience ($M = 2.15$, $SD = 0.74$). Demand barrier mean differences based on years of experience before having a student were also significant, $F(2, 141) = 4.39$, $p = .01$. Specifically, LSD results showed that individuals with 2-3 years of experience ($M = 0.34$, $SD = 0.18$) rated demand barriers significantly higher than individuals with 0-1 year of experience ($M = 0.26$, $SD = 0.17$) or greater than 3 years of experience ($M = 0.23$, $SD = 0.15$). Differences in experience before having students on professional growth and development benefits was not statistically significant overall $F(2, 141) = 2.25$, $p = .11$;

however, post-hoc analysis revealed that participants with 2-3 years of experience (M = 2.51, SD = 0.96) rated professional growth and development benefits significantly higher than participants with only 0-1 year of experience (M = 2.16, SD = 0.77).

Qualitative Analysis

Benefits. The first qualitative question asked participants to list any benefits that had not been mentioned in the Likert scale questions. A total of 16 participants answered this question; two of these participants had never been a clinical instructor. The most common theme that emerged was the benefit of *growing as a clinician* (6). Within this theme, one participant stated, "Each presentation of a concept to a student deepens the instructor's comprehension and facilitates modification of the point of view over time." The second most common theme was that *all the benefits were already included in the Likert scale questions* (4). The next theme was *giving back* (3). One participant's response demonstrating this theme was, "I make time to be a CI so that I can be part of the process to educate new PT clinicians…I feel that is important to make a commitment to making sure that we move our profession forward." Another theme that emerged was *better patient care* (2). An example of this theme was, "Student participation is generally well received by the patients which only enriches the experience for them." The next theme was *the formation of new relationships* (2). One participant example stated, "[Another benefit is] the opportunity to meet enthusiastic, interesting, intelligent young people who have a goal in life."

One of the themes mentioned the least was *recruitment* (1). This participant reported, "It also is a great recruitment tool for us as we have a very thorough interview

experience when we have a former student interested in an open position." The last theme that emerged from this question was the benefit of *continued education* (1). One participant stated, "Another benefit of being a CI is fulfilling CEU just by being a CI."

Barriers. The second qualitative question asked participants to list any barriers that had not been mentioned in the Likert scale questions. A total of 21 participants answered this question; all of these participants had been clinical instructors. The most common theme that emerged from this question was the barrier of *schedules and caseloads* (10). One participant example stated, "[My] schedule is very flexible and ever changing which may not be conducive to student learning via repetition/practice." The second most common theme was *lack of time to teach* (5). A participant reported, "I feel it is a lot to expect of someone with a full caseload of clients to be able to take the time to explain and be a good CI. I would enjoy being a CI much more if I had the time I felt I needed to explain and discuss things with students." Another theme was *lack of support/understanding* (5). This theme included a participant who stated, "[The] primary barrier is employer productivity expectations with or without a student." *Increased work* was another theme that emerged from this question (4). One participant reported, "Students can be a huge challenge. Schools do not always present an accurate representation of student's academic preparation which causes additional stress."

A slightly less common theme to emerge was *documentation* (3). In one example, a participant stated, "[Another barrier is] electronic medical records and the feeling that it would be faster if we did it ourselves rather than take the time to teach." Another theme was *student assessments* (3). One participant reported, "[The] CPI is horrible...[it is] far

too involved and redundant, especially for a PTA who is here for 5 weeks. A PT with a 3-4 month rotation, maybe. Takes too much time for people who have busy patient schedules. If I choose not to keep being a CI, this will be the reason." One theme that emerged was *lack of comfort* (3). This theme included a response in which a participant stated:

> I am always a little apprehensive with a new student, because they are learning things that are now 11 years more advanced than when I graduated with a Masters and it is fresh in their minds. I am a very good clinician, but as with all clinicians, some of the detailed specific book knowledge is lost over the years. I want the student to think I am competent.

The first of the least common themes was *the date of clinical rotations* (2). One participant reported, "Many schools have the same dates or very close to the same so we are limited at how many schools we can accommodate in that time period." Another theme was *lack of compensation/appreciation* (2). One participant stated, "I would also enjoy [being a clinical instructor] more if I felt it was appreciated." The next theme that emerged was that *clinicians have a life outside of work* (2). In one example a participant reported that another barrier is the "inability to stay later to accommodate for increased time it takes students to complete work secondary to picking children up from childcare or other schedule restraints." Having a *management role* was another theme that emerged from this question (2). One participant in this situation claimed, "[The] number one reason I don't have more student is that I moved from full time patient care to management position…[I] don't have a consistent patient care schedule now to have students." The least common theme to emerge was *inadequately prepared students* (1).

This participant reported that “schools frequently send students on first rotation who are ill-prepared for the challenge of this clinic which results in us having to move students around.”

Incentives. The final qualitative question asked participants to offer incentives that would increase willingness to be a clinical instructor. A total of 80 participants completed this question; of these participants, 5 had never been clinical instructors. The most common theme to emerge was the incentive of *free or discounted education* (27). One participant who demonstrated this theme stated, “The current CEUs offered for being a CI are extremely valuable. Additional opportunities for discounted clinical education or free opportunities for clinical education for affiliating facilities would be nice.” The second most common theme was *monetary compensation* (19). One participant suggested that another valuable incentive would be “getting paid by the university to help defray the cost of student loans that most of us are still paying…some loan forgiveness would go a long way to motivate CIs.” The third most common theme was that *no incentives were needed* (14). An example of this theme came from a participant who reported, “I have always loved being a CI; I don't need any additional incentives.” Another very common theme was *decreased productivity standards or increased time to teach* (13). This theme included responses such as the following in which a participant reported that another incentive would be “decreased productivity requirements in order to have the time to actually teach the student…[currently] I would likely have to stay much later in the beginning of the clinical in order to meet productivity standards to keep my own job.”

Increased connections to the university was another theme that emerged from this question (8). One participant stated that an additional incentive would be "Increased 'perks' from [the] university such as being made adjunct clinical faculty if frequently a CI…[or] increased recognition from universities and facilities." The next theme included *the formation of a new student assessment* (7). An example came from one participant who reported that he or she "would like to see the CPI change so [it is] not repetitive in [the] feedback given. [This would] help with the paper work load required to have a student…feedback [is] important, just would like to see it changed or modified." Another theme suggested *free or discounted educational tools and materials* (6). One participant reported, "There is one school that offers a gift certificate for a reference text book and my CIs always find that to be a pleasant surprise upon completion of the rotation." A less common theme was *time off* (3). One suggestion was that "facilities need to provide additional time off for CI's because of the increase demand on a PT who also works as a CI." The next theme was *having students interested in the clinical rotation* (3). One participant suggested that "students don't always want to come all the way to [my city] for a clinical." Another theme was to have *different expectations during the clinical* (3). One therapist mentioned that he or she would like to be able to "[feel] good about sharing [a] student and having [the] student be [fully] aware that other therapists might have [the] student." *Better prepared students* was another theme that emerged (2). One participant stated that he or she was "really starting to burn out as there have been a large number coming out unprepared from other Universities and taking on

students has been increasing my work hours to in excess of 55 hours per week as a result."

The first of the least common themes was the incentive of *advancement in career* (1). This participant reported that "serving as a CI may qualify as element in career ladder and advanced proficiency advantage at my institution." The next theme was *change in job position* (1). This participant stated that he or she "would gladly continue to be a CI if [he/she] changed roles." Another theme was *recruitment* (1). This participant suggested that an incentive would be "to have potential future employees from students." The last theme to emerge involved *changes in Medicare* (1). This participant stated that an additional incentive would be "allowing PT students to treat and still be reimbursed…[because they] provide direct supervision at all times with [their] students including pre-planning, the session, and assistance in modification based on patient response so treating the patient is no different than no student presence."

Discussion/Conclusion

The purpose of this study was multifold. The first goal was to measure the extent to which the known benefits and barriers of being a clinical instructor affect physical therapy clinicians. The second goal was to examine the relationships between demographic information and the benefits and barriers. The third goal was to discover unknown benefits and barriers. The final goal was to learn what incentives would increase the likelihood of clinicians to become clinical instructors.

Extent of Benefits and Barriers

The results of this study indicated that physical therapy clinicians rated external benefits as having a moderate effect, which was the highest among all the benefit categories. External benefits included promotion of workplace, continuing education, access to the university library, recruitment, and fulfillment of organizational requirements. External benefits were followed by intrinsic benefits, personal growth and development benefits, and future profession benefits with all having only a small effect on clinicians. These results were inconsistent with qualitative research done by Davies et al. (2011) that suggested most benefits of being a clinical instructor are intrinsic; however, the results of the current study were consistent with quantitative occupational therapy clinical education research done by Thomas et al. (2007). In their study, Thomas et al. asked occupational therapists filling a similar role to clinical instructors in physical therapy to rate benefits on a Likert scale. Three of the top benefits for occupational therapists (recruitment, promotion of clinic/hospital, meeting organizational goals) were also included in the highest rated benefit category for physical therapy clinicians. The extrinsic benefits category in the current study, however, were rated as only a moderate effect, whereas the three benefits had a moderate to very large effect on occupational therapy clinicians.

The five highest rated individual benefits were access to the university library, increased recognition, involvement in curriculum, feeling like an expert, and being part of the academic community. All five were rated as having a moderate effect on clinicians. Three of the top rated benefits are related to the university. The idea that

connections to the university may be one of the most useful benefits to clinical instructors is supported by Hanson (2011) who suggests that communication and exchange between the university and clinicians is key to increasing the satisfaction related to clinical education. It is possible that benefits provided by and connections with universities are some of the most valuable benefits offered to clinical instructors and can be utilized to help with the shortage of clinical instructors.

Physical therapy clinicians rated organizational barriers the highest compared to the other barrier categories. Organizational barriers included space limits, lack of organizational support, caseloads, lack of reimbursement, staffing issues, lack of resources, lack of educational experiences, safety concerns, schedules, date of clinical rotations, excess traveling, single-therapist facility, and new business. Clinicians rated these barriers as having a large effect according to the Likert scale. These results are consistent with quantitative occupational therapy clinical education research done by Thomas et al. (2007). Three of the top barriers for occupational therapists (lack of space, workload/caseload, decreased reimbursement) were also included in the highest rated barrier category for physical therapy clinicians and were rated as having a large effect on clinicians.

The five highest individual barriers were single-therapist facility, not asked to be a clinical instructor, new business, excess traveling, and lack of educational experiences. The first four were rated as having a very large effect, with the fifth having a slightly lesser effect. It should be noted that the five highest rated barriers when it comes to being a clinical instructor are mainly out of the clinician's control. This idea is largely in

agreement with Davies (2011) who reported that most prominent barrier is increased stress caused by external barriers that cannot be controlled by the clinician. This may suggest that universities are not able to assist in lessening the effects of the most bothersome barriers involved in becoming a clinical instructor.

Demographic Relationships

Many relationships between demographic information and the benefits and barriers of being a clinical instructor were not significant. These demographics include gender, years of experience, participation as a clinical instructor, and number of students supervised. This indicates that clinicians differing in these ways feel the effects of the benefits and barriers of being a clinical instructor in a similar way.

Other relationships suggested that there might be a significant difference in the effects of benefits and barriers based on demographics. One of these relationships is that physical therapists may feel like they are helping their future profession more than physical therapist assistants. This may be because a physical therapist assistant only supervises physical therapist assistant students, who cannot practice the profession without a physical therapist. Without future physical therapists, the profession cannot continue, whereas the profession could survive without physical therapist assistants. Outpatient therapists might be more motivated by extrinsic benefits than therapists in rehabilitation hospitals. Therapists in rehabilitation hospitals may have greater access to resources such as continuing education courses or journal access through their institution than therapists in outpatient facilities; this would make the extrinsic benefits less valuable to the therapists in rehabilitation hospitals. Clinicians with master's and doctoral degrees

may feel the pressures of the demand barriers more than clinicians with associate's degrees. The difference in these degrees often indicate the difference between physical therapists and physical therapist assistants as well. Based on that information, the increased pressure felt by the clinicians with master's and doctoral degrees may be due to the increased responsibilities of a physical therapist as compared to a physical therapist assistant.

There were also some relationships that were significant. According to the results of this study, clinicians in facilities categorized as other (inpatient and outpatient combined, schools, the "other" option) experience the pressures of organizational barriers more than clinicians in outpatient facilities and rehabilitation hospitals. Facilities within the other category would likely cause clinicians to have more variable schedules and caseloads than clinicians in outpatient facilities and rehabilitation hospitals. Clinicians in outpatient facilities enjoy extrinsic benefits more than clinicians in inpatient facilities; outpatient facilities may need to promote their workplace more than inpatient facilities or inpatient facilities may have greater access to continuing education courses through their workplace. Individuals with higher degrees reported feeling higher effects in regard to personal barriers than individuals with associate's degrees. Individuals with higher degrees are likely physical therapists and may be supervising physical therapist students instead of physical therapist assistant students; the increased responsibilities of being a physical therapist and longer clinical rotations could increase the stress felt by the clinical instructor. Clinicians with 2-3 years of experience before supervising a student experience future profession benefits, professional growth and development benefits, and

demand barriers more than clinicians with 0-1 year of experience. Clinicians with 2-3 years of experience may have waited until they felt they had a foundation of clinical skills before accepting a student. If this is the case, these individuals may be more likely to accept different perspectives that allow them to grow as a clinician, whereas a more recent graduate may feel threatened by different perspectives. More experience may also allow the individual to see the importance of continuing to build the future of the profession. Being involved in the profession for a longer amount of time may allow for clinicians to become more understanding of the strict requirements, which could lead them to feel the increased pressure of the demand barriers. Clinicians with 2-3 years of experience before having a student also rated demand barriers higher than those who had greater than three years of experience. Individuals with greater than three years of experience may have been able to comply with the strict requirements more often than individuals with 2-3 years of experience and therefore did not feel as much pressure.

Greenwood et al. (2009) suggested that future research should examine relationships between demographics and the benefits and barriers of being a clinical instructor; their suggestion was adopted as a part of this study. There were only a few statistically significant differences in the various benefits and barriers based on the demographic information; however, interpretation of the data still suggests that there are significant differences in the extent to which benefits and barriers affect different groups of clinicians. Therefore, the benefits and barriers of being a clinical instructor may need to be addressed differently depending on the specific clinician. Maybe clinicians would

be more likely to become clinical instructors if the benefits and barriers could be addressed on a person-by-person basis.

Discovering Benefits, Barriers, and Incentives

Many of the themes that emerged from the first question asking for additional benefits were already included in the Likert scale questionnaire. These themes included *growing as a clinician*, *giving back/contributing to the profession*, *better patient care*, *recruitment*, and *continuing education*. *The formation of new relationships* was the only additional benefit of being a clinical instructor that emerged; this was also the only additional benefit that had not been listed in previous research. For the most part, the findings of this study are supported by the research of Davies et al. (2011) that found *reflective practice*, *better patient care*, and *preparing the next generation* as key benefits to physical therapy clinical instructors; however, the overall theme found in their research was *love of teaching*. This benefit of being a clinical instructor was not mentioned in any of the participant responses in this study.

Many of the themes that emerged from the second question asking for additional barriers were also already included in the Likert scale questionnaire. These themes included *schedules/caseloads*, *lack of time*, *lack of support*, *increased work*, *documentation*, *student assessments*, *lack of comfort*, *date of clinical rotation*, *decreased appreciation*, and *difficult student*. *Life outside of work* and *a management role* were two additional barriers to becoming a clinical instructor and the only two additional barriers not mentioned in prior research. *Time*, *caseloads*, and *student performance* are three of the most common barriers seen in previous research (Davies et al., 2011; Hanson, 2011;

Thomas et al., 2007). *Caseloads* and *time* were the two most common themes in the current study, but *student performance* was one of the least common. This could indicate that students are more prepared for their clinical rotations now than the students were in 2007, or that barriers other than *student performance* have become of greater concern.

The last question discussing incentives to become a clinical instructor contained many themes that were included in the Likert scale questionnaire as well. *Free/discounted education*, and *connection with the university* are two themes that were already included as benefits. This suggests that these are incentives that the universities should continue to provide and/or need to be even better than they are currently. *Decreased productivity standards/increased time to teach*, and *a new student assessment* are two themes already mentioned in the barriers. Neither of these are things that universities can change, but it may be something the profession as a whole will need to look at if finding clinical instructors becomes even more difficult. *Monetary reimbursement* was also mentioned, but is likely not an option for universities. One theme that universities may be able to address is *free or discounted educational tools and materials*. If universities could find a way to offer these incentives, it could result in an increase of clinical instructors.

Strengths and Limitations

This study featured many strengths. The first strength of this study was the use of multiple types of questions that complemented each other. This study was one of the first to focus mainly on quantitative data, which allowed clinicians to answer the extent to which they were affected by the benefits and barriers of being a clinical instructor.

However, it also included qualitative questions in order for participants to comment on missing benefits or barriers. This study also included demographic questions which were used to examine differences in the effect of benefits and barriers according to demographics. Unlike previous studies, this study also included clinicians who had not been clinical instructors in at least some of the analyses.

There were also several limitations to this study. First, some of the dependent variables are highly correlated, suggesting that these variables could be measuring very similar concepts. Another limitation is that answers from clinicians without previous clinical instructor experience were excluded from the mean difference analyses, except for the analysis that specifically looked at mean differences between clinicians who had been clinical instructors and clinicians who had not. This exclusion was due to different wording of questions for these individuals as well as the small number of these individuals who completed the survey. The difference in number of participants between previous clinical instructors and individuals who had not been clinical instructors also may have influenced the results of the comparisons between these two groups. Furthermore, the lack of incentive to complete all questions lead to missing data and an unequal number of participants for each question. The survey was also long with over 60 questions, which also played a part in the missed data. Self-report utilized by this study may also decrease its reliability. A final limitation is that the survey was only available to physical therapy clinicians in contract with the University of Indianapolis, which means that the results cannot be generalized to all clinicians.

Conclusion

Many of the benefits and barriers in past qualitative studies gained additional support from this study. This research also provided additional benefits and barriers of clinical education including the benefit of relationships, the barrier of life outside of work, and the barrier of a management position. Some of the top benefits, as determined by the current study, were associated with the university. This knowledge could allow universities to continue providing and/or improve their benefits as further incentive for clinicians to become or continue being clinical instructors. Many of the top barriers from this study cannot be controlled by the clinician or the university. This likely means that universities cannot decrease the burdens of being a clinical instructor, and will need to increase the benefits instead. Based on the demographic relationships with the benefits and barriers of being a clinical instructor, it may also be that universities need to address the benefits and barriers on an individual basis. Further research should focus on determining how universities can increase the effects of the most appreciated benefits and decrease the effects of the most troublesome barriers, while keeping in mind that demographics may influence those effects. With all future research, the goal should be to gain information that will help universities increase physical therapy clinician participation in clinical education.

Reflection

Completing an honors project is not nearly as easy as it sounds. I started off interviewing staff members to help me brainstorm ideas; I had many great ideas for projects, however, finding a realistic topic that was "honors-worthy" was much more difficult. After sitting down with my former physical therapy assistant professor, Tammy Simmons, I finally decided on a topic that peaked both of our interests. I had difficulties finding clinical rotations as a student and Tammy had difficulties as the clinical education coordinator. I decided that I wanted to know why physical therapy clinicians did not want to be clinical instructors. After struggling to find a topic, I thought the hard part was over. Little did I know that it had just begun.

I had done a lot of research for papers before, but nothing had been as difficult as it was to find research on physical therapy clinical instructors. I was sure I was going to have to find a different topic. After asking several others for advice, I finally realized that good research can also pull from other professions in health care. Once I found the information, I had to filter it down into something manageable that I could put into a survey. Once again, I thought the hard part was done.

When it came to writing the survey, I realized I had no idea how I was going to politely ask people why being a clinical instructor was so bad. After plugging different types of questions into Qualtrics, I decided that the best way would be to give the participants a list of what was good and what was bad about being a clinical instructor and to have them rate how good or bad they were. Wording the questions was another

struggle that I was not anticipating. I had to have Tammy look over the survey several times in order to get the correct wording.

After I had everything ready, it was time to write the proposal. I had written papers before, but the proposal was completely different. It was difficult to pull all of the pieces of the project together into a document and have it make sense to others. Eventually, I was successful. As any honors student would have, I thought my proposal was perfect. It was somewhat hard to swallow when I found out that I received a "revise and resubmit" from the honors committee. I sat frustrated trying to figure out how I was supposed to revise what I thought was fine the way it was. It was then that I realized that I could not do this on my own. I went to the writing center and it was one of the best decisions I made regarding this project. The feedback was incredibly helpful and it was encouraging to shift my point of view and realize the changes that could make my proposal even better. Through this part of the project I realized that everybody needs help sometimes and being stuck just means that you need to change your perspective. I also learned that nothing is ever perfect.

Going through the IRB process was not nearly as painful as everyone made it sound. I met with the Human Protections Administrator before starting my application. He was very particular about the details when we were discussing my study, so I knew to be very detailed in my application. Although it took a while for my application to be reviewed, it was accepted the first time with very minor changes.

Actually collecting data took very little effort. The survey was sent out to all the CCCEs and they sent them to their clinical staff. Participants took the survey and

Qualtrics recorded their responses. For once, it seemed like something about this project was "easy." Once again, I had no idea how difficult it was about to get.

I had 174 surveys recorded and was ready to start data analysis. I had basic knowledge of statistics from my introduction to statistics course that I took as a freshman. I thought I would be able to do the analyses on my own. Shortly after transferring the data into SPSS, I knew I was in trouble. Luckily I had discussed my project with Dr. Dobersek when initially deciding what types of analyses I was going to do with the data. I contacted her again and asked for help. I had no idea that I would not be done with SPSS until I had spent a total of at least 24 hours in her office. Something I thought would be so simple turned out to be incredibly difficult and time consuming. I had not realized what it truly meant to prepare the data. Preparing the data included making sure that the assumptions for the planned statistical tests were met. I thought the long and difficult part of data analysis was actually analyzing the data; I was wrong. Over eighty percent of the time with Dr. Dobersek was spent preparing the data. This was by far the most eye-opening experience of the entire project.

This project has challenged me in ways that I never could have imagined. I was challenged to accept the fact that I cannot do everything on my own and that everything can be made better. I learned to form professional relationships and to rely on others as part of a team. Going into the project, I thought I had pretty good critical thinking skills but every problem and difficulty along the way challenged me to go one step further. One of the most important things this project has taught me is to never underestimate a challenge. Even after this project is packed away with all of my undergraduate

achievements, the skills and lessons learned will continue with me and prepare me for life’s next big project.

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Appendices

Appendix A: Informed Consent Document

EXEMPT UIndy Study# 0774
Study Version: 1.0
Study Version Date: June 6, 2016
ONLINE Informed Consent Document (ICD) Version: 1.0
ONLINE ICD Version Date: June 6, 2016

Principal Investigator: Tammy Simmons, PT, MHS
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Informed Consent for Participation in Human Subjects Research

This questionnaire is part of a research project involving Physical Therapy clinical education in facilities with University of Indianapolis contracts. The purpose of this research is to fill existing gaps in physical therapy clinical education research involving clinical instructors. To do so, the known benefits and barriers of becoming a clinical instructor will be assessed based on the extent to which they effect clinicians. Possible contribution to this effect by factors such as gender, job title, level of education, amount of experience, number of students supervised, and practice area will be investigated. This research will also fill existing gaps by discovering perceived benefits and barriers not mentioned in the research as well as what types of support or incentives would increase the likelihood of clinicians to become clinical instructors.

Participation in this research is strictly voluntary. Participants may withdrawal from the study any time prior to the end of the survey by closing the browser. Data from participants who choose to withdraw from the study will not be included in data analysis; only data from submitted surveys will be included.

This survey is designed to be completely anonymous through the anonymous survey link generated by Qualtrics. Identifying information, including Internet protocol (IP) addresses will not be collected. In order to ensure the survey remains completely anonymous, please do not include any individually identifiable information such as name, initials, email address, ID numbers, etc.
The survey will be sent to the Clinical Coordinator of Clinical Education (CCCE) of approximately 250 physical therapy facilities with University of Indianapolis contracts. The CCCE from each facility will also be asked to forward the survey to all of physical therapy clinical staff at their facility.

Participants will only encounter two mandatory responses. This means that participants must answer the question before proceeding. The first of these questions is in regard to consent. Participants must agree to the consent before proceeding to the survey. The second mandatory response asks about participation as a clinical instructor. This question is a mandatory response question because the participant's answer determines what questions will follow. If a participant chooses not to answer either of these questions, he or she may withdraw from the survey by exiting the browser as mentioned above.

The research project, including this survey was submitted for human research protections review and was approved as with "exempt" status. Human research protections review was conducted by the Human Protections Administrator, who is responsible for protecting the rights and welfare of people participating in research that is exempt from Institutional Review Board (IRB) review. For questions or information regarding this process, please contact Dr. Greg Manship at manshipg@uindy.edu.
For questions regarding the project in general, contact Tammy Simmons, PT, MHS at simmonst@uindy.edu or Barbara Kimmel, PTA at kimmelb@uindy.edu.

Appendix B: Sample Survey

CI Benefits and Barriers

Consent Block Options

Q31

EXEMPT UIndy Study# 0774
Study Version: 1.0
Study Version Date: June 9, 2016
ONLINE Informed Consent Document (ICD) Version: 1.0
ONLINE ICD Version Date: June 9, 2016

Principal Investigator: Tammy Simmons, PT, MHS
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Informed Consent for Participation in Human Subjects Research

Study Title; *Physical Therapy Clinical Instructor Shortage: Why not be a Clinical Instructor?*

This questionnaire is part of a research project involving Physical Therapy clinical education in facilities with University of Indianapolis contracts. The purpose of this research is to fill existing gaps in physical therapy clinical education research involving clinical instructors. To do so, the known benefits and barriers of becoming a clinical instructor will be assessed based on the extent to which they effect clinicians. Possible contribution to this effect by factors such as gender, job title, level of education, amount of experience, number of students supervised, and practice area will be investigated. This research will also fill existing gaps by discovering perceived benefits and barriers not mentioned in the research as well as what types of support or incentives would increase the likelihood of clinicians to become clinical instructors.

Participation in this research is strictly voluntary. Participants may withdrawal from the study any time prior to the end of the survey by closing the browser. Data from participants who choose to withdraw from the study will not be included in data analysis; only data from submitted surveys will be included.

This survey is designed to be completely anonymous through the anonymous survey link generated by Qualtrics. Identifying information, including Internet protocol (IP) addresses will not be collected. In order to ensure the survey remains completely anonymous, please do not include any individually identifiable information such as name, initials, email address, ID numbers, etc.
The survey will be sent to the Clinical Coordinator of Clinical Education (CCCE) of approximately 250 physical therapy facilities with University of Indianapolis contracts. The CCCE from each facility will also be asked to forward the survey to all of physical therapy clinical staff at their facility.

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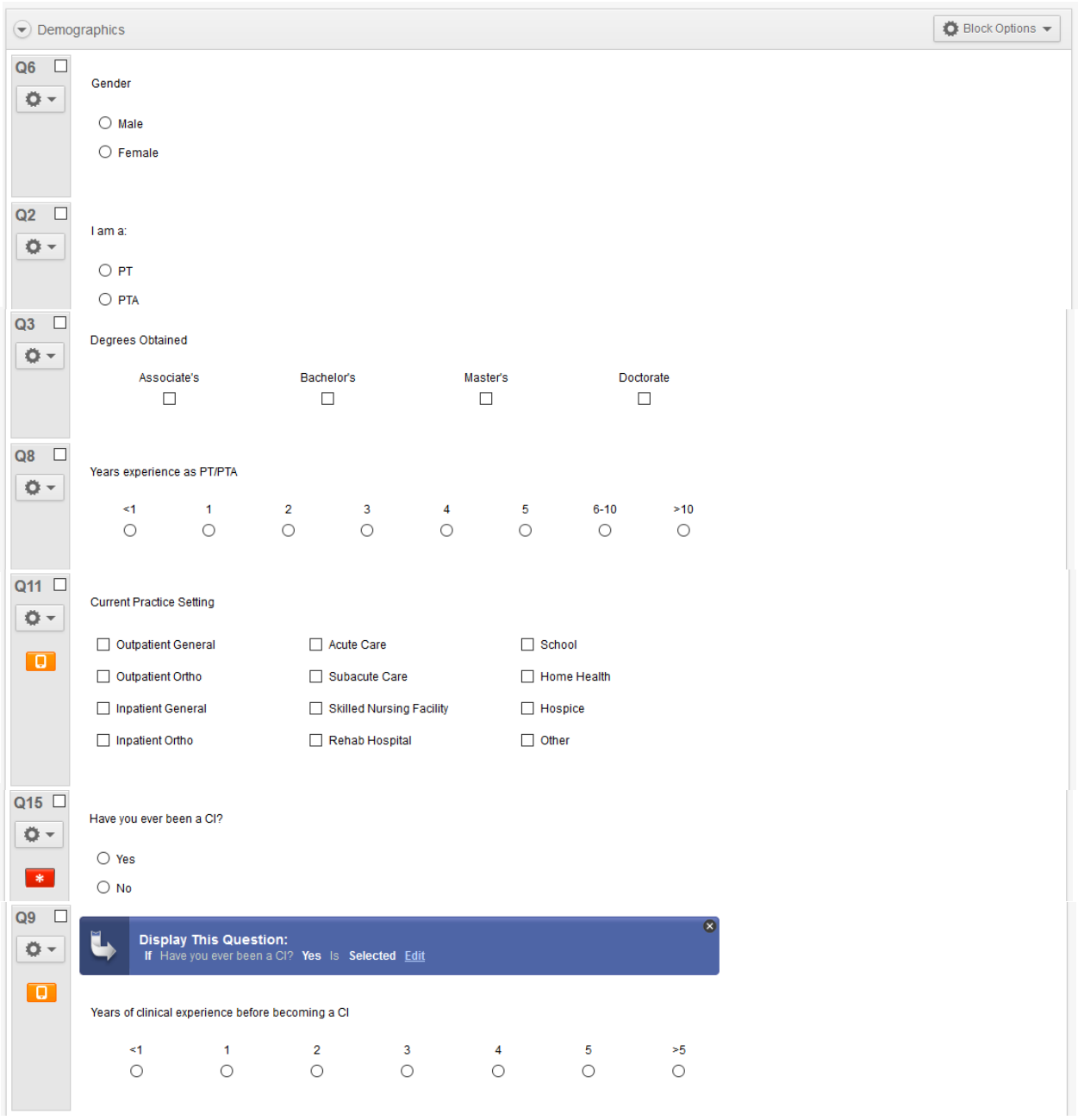
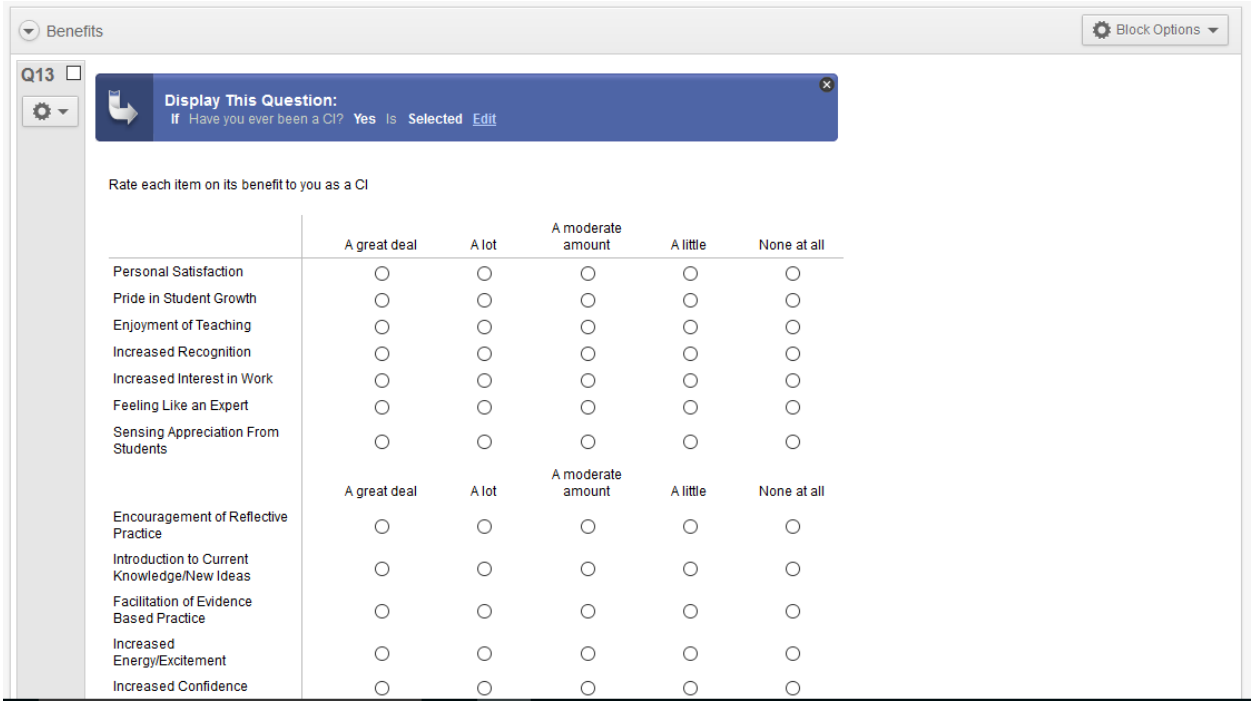
For questions regarding the project in general, contact Tammy Simmons, PT, MHS at simmonst@uindy.edu or Barbara Kimmel, PTA at kimmelb@uindy.edu.

- ○ I understand that proceeding with this survey is indicative of voluntary consent to participate in research.
- ○ I do not consent to participate in research.


Demographics
Block Options
Q6
Gender
Male
Female
Q2
I am a:
PT
PTA
Q3
Degrees Obtained
Associate's
Bachelor's
Master's
Doctorate
Q8
Years experience as PT/PTA
<1
1
2
3
4
5
6-10
>10
Q11
Current Practice Setting
Outpatient General
Outpatient Ortho
Inpatient General
Inpatient Ortho
Acute Care
Subacute Care
Skilled Nursing Facility
Rehab Hospital
School
Home Health
Hospice
Other
Q15
Have you ever been a CI?
Yes
No
Q9
Display This Question:
If Have you ever been a CI? Yes Is Selected Edit
Years of clinical experience before becoming a CI
<1
1
2
3
4
5
>5


Q10
Display This Question:
If Have you ever been a CI? Yes Is Selected Edit
Number of students to date
0 1 2 3 4 5 >5
Q20
Display This Question:
If Have you ever been a CI? Yes Is Selected Edit
Do you plan to continue being a CI in the future?
Yes
No
Q21
Display This Question:
If Have you ever been a CI? No Is Selected Edit
Do you anticipate becoming a CI in the future?
Yes
No


Benefits
Block Options
Q13
Display This Question:
If Have you ever been a CI? Yes Is Selected Edit
Rate each item on its benefit to you as a CI
A great deal
A lot
A moderate amount
A little
None at all
Personal Satisfaction
Pride in Student Growth
Enjoyment of Teaching
Increased Recognition
Increased Interest in Work
Feeling Like an Expert
Sensing Appreciation From Students
A great deal
A lot
A moderate amount
A little
None at all
Encouragement of Reflective Practice
Introduction to Current Knowledge/New Ideas
Facilitation of Evidence Based Practice
Increased Energy/Excitement
Increased Confidence

	A great deal	A lot	A moderate amount	A little	None at all
Improved Patient Care	○	○	○	○	○
Improvement in Overall Clinical Skill	○	○	○	○	○

	A great deal	A lot	A moderate amount	A little	None at all
Increased Team Development	○	○	○	○	○
Connection with University	○	○	○	○	○
Contributing to/Giving Back to the Profession	○	○	○	○	○
Involvement in Curriculum	○	○	○	○	○
Part of the Academic Community	○	○	○	○	○
Educating the Next Generation	○	○	○	○	○
Ensuring Competence of Future Clinicians	○	○	○	○	○

	A great deal	A lot	A moderate amount	A little	None at all
Promotion of Workplace	○	○	○	○	○
Access to Continuing Education/Continuing Education Units (CEUs)	○	○	○	○	○
Access to University Library	○	○	○	○	○
Recruitment Potential	○	○	○	○	○
Fulfillment of Organizational Goals and Objectives	○	○	○	○	○

Q12 ☐

Display This Question:
If Have you ever been a CI? **Yes** Is **Selected** Edit

Are there any benefits to being a CI that are not listed here? If so, please list them below.

Q24 ☐

Display This Question:
If Have you ever been a CI? **No** Is **Selected** Edit

Rate each item on its perceived benefit if you were to become a CI

	A great deal	A lot	A moderate amount	A little	None at all
Personal Satisfaction	○	○	○	○	○
Pride in Student Growth	○	○	○	○	○
Enjoyment of Teaching	○	○	○	○	○
Increased Recognition	○	○	○	○	○
Increased Interest in Work	○	○	○	○	○
Feeling Like an Expert	○	○	○	○	○
Sensing Appreciation From Students	○	○	○	○	○

	A great deal	A lot	A moderate amount	A little	None at all
Encouragement of Reflective Practice	○	○	○	○	○
Introduction to Current Knowledge/New Ideas	○	○	○	○	○
Facilitation of Evidence Based Practice	○	○	○	○	○
Increased Energy/Excitement	○	○	○	○	○
Increased Confidence	○	○	○	○	○
Improved Patient Care	○	○	○	○	○
Improvement in Overall Clinical Skill	○	○	○	○	○

	A great deal	A lot	A moderate amount	A little	None at all
Increased Team Development	○	○	○	○	○
Connection with University	○	○	○	○	○
Contributing to/Giving Back to the Profession	○	○	○	○	○
Involvement in Curriculum	○	○	○	○	○
Part of the Academic Community	○	○	○	○	○
Educating the Next Generation	○	○	○	○	○
Ensuring Competence of Future Clinicians	○	○	○	○	○

	A great deal	A lot	A moderate amount	A little	None at all
Promotion of Workplace	○	○	○	○	○
Access to Continuing Education/Continuing Education Units (CEUs)	○	○	○	○	○
Access to University Library	○	○	○	○	○
Recruitment Potential	○	○	○	○	○
Fulfillment of Organizational Goals and Objectives	○	○	○	○	○

Q25 ☐

Display This Question:
If Have you ever been a CI? **No** Is **Selected** Edit

Are there any perceived benefits that are not listed above that could result if you chose to become a CI? If so, please list them below.

Barriers — Block Options

Q12 ☐

Display This Question:
If Have you ever been a CI? **Yes** Is **Selected** Edit

Rate each item as it applies to being a barrier to your desire to be a CI

	A great deal	A lot	A moderate amount	A little	None at all
Increased Stress	○	○	○	○	○
Change in Routine	○	○	○	○	○
Lack of Knowledge About Student	○	○	○	○	○
Fear of Difficult Student (struggling student in danger of failure; difficult personality e.g., overly emotional, overconfident, etc.; strong students who threaten your knowledge/experience)	○	○	○	○	○
Professional Burnout	○	○	○	○	○
Decreased Autonomy/Flexibility	○	○	○	○	○
Lack of Recognition (in the form of institutional and academic support)	○	○	○	○	○

	A great deal	A lot	A moderate amount	A little	None at all
Feeling Undervalued by Students	○	○	○	○	○
Increased Pressure of Commitment	○	○	○	○	○
Demoralized Psyche (loss of hope or confidence)	○	○	○	○	○
Fear of Discrepancy in Expectations	○	○	○	○	○
Unwanted Increase in Work	○	○	○	○	○
Fear of Conflicting Learning Styles	○	○	○	○	○
Fear of Personal Incompetence	○	○	○	○	○

	A great deal	A lot	A moderate amount	A little	None at all
Difficulties with the Clinical Performance Instrument (CPI)	○	○	○	○	○
Space Constraints (lack of office or clinic space for an additional person)	○	○	○	○	○
Lack of Organizational Support	○	○	○	○	○
Busy or Variable Caseloads	○	○	○	○	○
Lack of Reimbursement	○	○	○	○	○
Staffing Issues/Shortages	○	○	○	○	○
Lack of Physical Resources	○	○	○	○	○

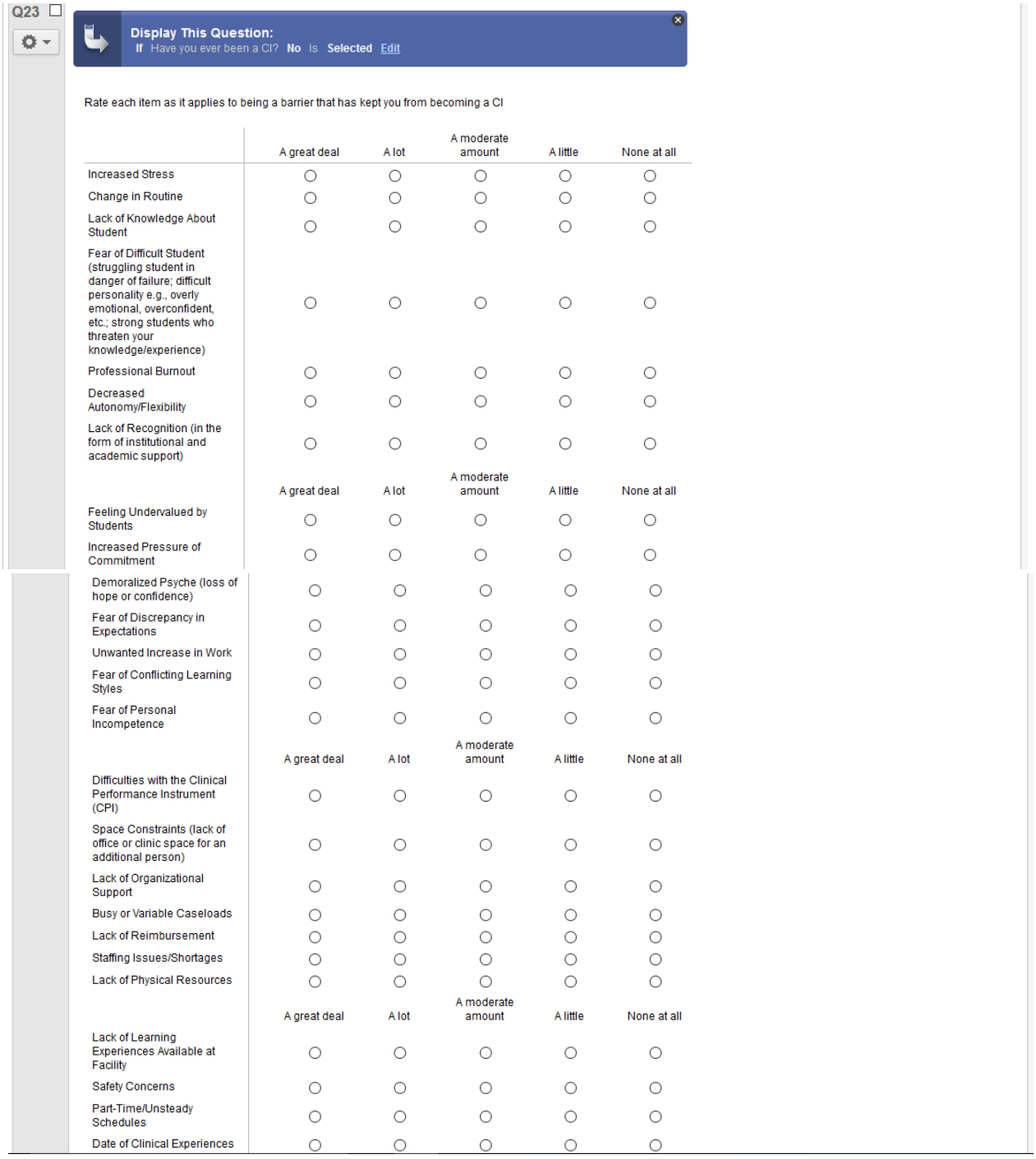
	A great deal	A lot	A moderate amount	A little	None at all
Lack of Learning Experiences Available at Facility	○	○	○	○	○
Safety Concerns	○	○	○	○	○
Part-Time/Unsteady Schedules	○	○	○	○	○
Date of Clinical Experiences	○	○	○	○	○
Excessive Traveling Required	○	○	○	○	○
Single Therapist Facility	○	○	○	○	○
New Business	○	○	○	○	○

	A great deal	A lot	A moderate amount	A little	None at all
High Productivity Standards	○	○	○	○	○
Time Constraints (too much to do within working hours to accept students)	○	○	○	○	○
Documentation Requirements	○	○	○	○	○
Healthcare Reforms	○	○	○	○	○
Changing Professional Requirements	○	○	○	○	○
Decreased Insurance Funding/Reimbursement	○	○	○	○	○
Have Not Been Asked to be a CI	○	○	○	○	○

Q13 ☐

Display This Question:
If Have you ever been a CI? **Yes** Is **Selected** Edit

Are there any barriers to being a CI not mentioned here? If so, please list them below.



Q23

Display This Question:
If Have you ever been a CI? **No** Is **Selected** Edit

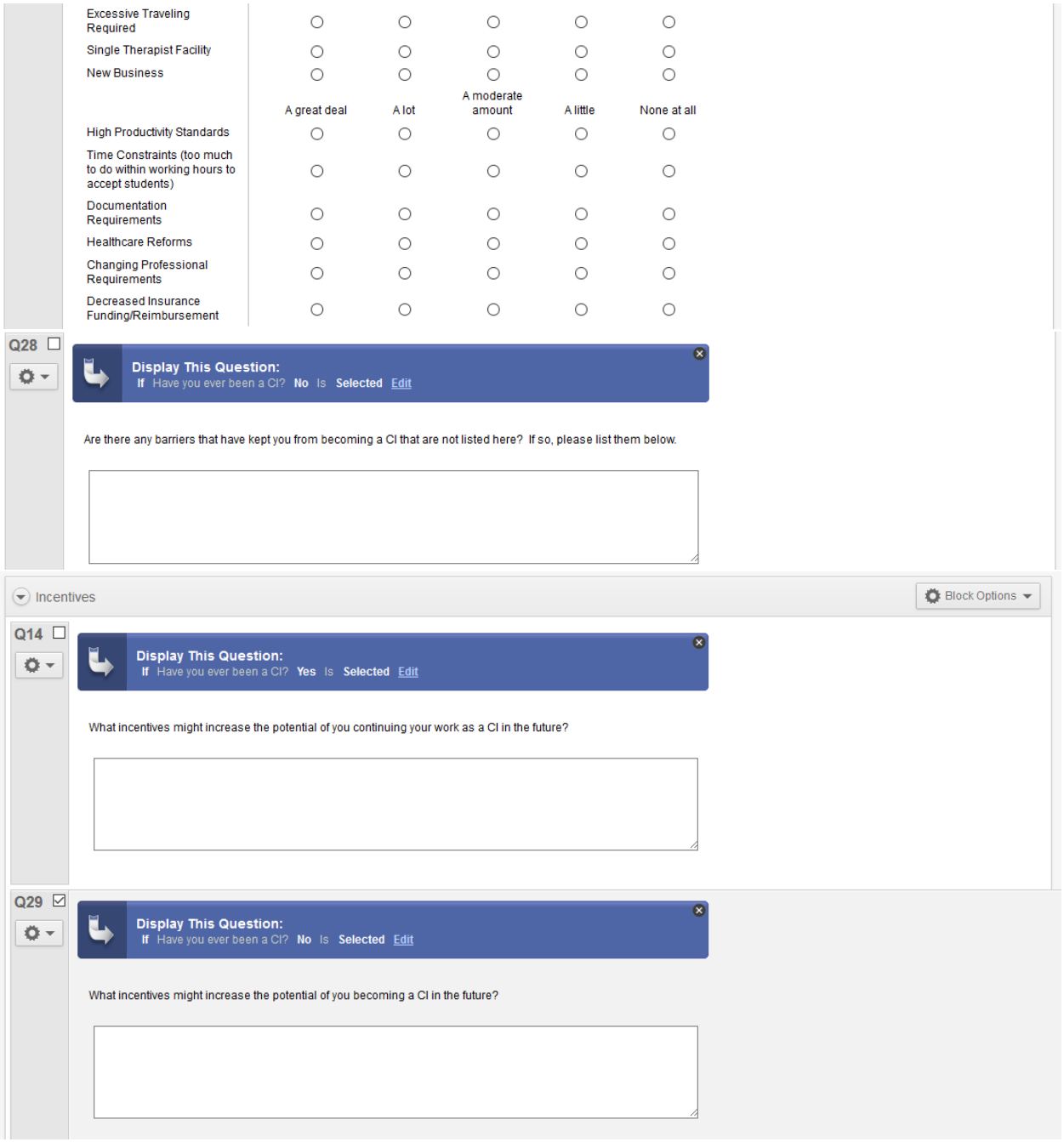
Rate each item as it applies to being a barrier that has kept you from becoming a CI

	A great deal	A lot	A moderate amount	A little	None at all
Increased Stress	○	○	○	○	○
Change in Routine	○	○	○	○	○
Lack of Knowledge About Student	○	○	○	○	○
Fear of Difficult Student (struggling student in danger of failure; difficult personality e.g., overly emotional, overconfident, etc.; strong students who threaten your knowledge/experience)	○	○	○	○	○
Professional Burnout	○	○	○	○	○
Decreased Autonomy/Flexibility	○	○	○	○	○
Lack of Recognition (in the form of institutional and academic support)	○	○	○	○	○

	A great deal	A lot	A moderate amount	A little	None at all
Feeling Undervalued by Students	○	○	○	○	○
Increased Pressure of Commitment	○	○	○	○	○
Demoralized Psyche (loss of hope or confidence)	○	○	○	○	○
Fear of Discrepancy in Expectations	○	○	○	○	○
Unwanted Increase in Work	○	○	○	○	○
Fear of Conflicting Learning Styles	○	○	○	○	○
Fear of Personal Incompetence	○	○	○	○	○

	A great deal	A lot	A moderate amount	A little	None at all
Difficulties with the Clinical Performance Instrument (CPI)	○	○	○	○	○
Space Constraints (lack of office or clinic space for an additional person)	○	○	○	○	○
Lack of Organizational Support	○	○	○	○	○
Busy or Variable Caseloads	○	○	○	○	○
Lack of Reimbursement	○	○	○	○	○
Staffing Issues/Shortages	○	○	○	○	○
Lack of Physical Resources	○	○	○	○	○

	A great deal	A lot	A moderate amount	A little	None at all
Lack of Learning Experiences Available at Facility	○	○	○	○	○
Safety Concerns	○	○	○	○	○
Part-Time/Unsteady Schedules	○	○	○	○	○
Date of Clinical Experiences	○	○	○	○	○


Excessive Traveling Required
Single Therapist Facility
New Business
A great deal
A lot
A moderate amount
A little
None at all
High Productivity Standards
Time Constraints (too much to do within working hours to accept students)
Documentation Requirements
Healthcare Reforms
Changing Professional Requirements
Decreased Insurance Funding/Reimbursement
Q28
Display This Question:
If Have you ever been a CI? No Is Selected Edit
Are there any barriers that have kept you from becoming a CI that are not listed here? If so, please list them below.
Incentives
Block Options
Q14
Display This Question:
If Have you ever been a CI? Yes Is Selected Edit
What incentives might increase the potential of you continuing your work as a CI in the future?
Q29
Display This Question:
If Have you ever been a CI? No Is Selected Edit
What incentives might increase the potential of you becoming a CI in the future?

Appendix C: IRB Approval Letter

UNIVERSITY of INDIANAPOLIS.

Institutional Review Board
901 South Shelby St.
Room A313
Indianapolis, IN 46203

800/232-8634 x5774
317/781-5774
http://irb.uindy.edu
irb@uindy.edu

Tammy Simmons, MHS
Krannert School of Physical Therapy
University of Indianapolis
1400 East Hanna Avenue
Indianapolis, IN 46227

June 8, 2016

UIndy Study# 0774
Study Title; *PHYSICAL THERAPY CLINICAL INSTRUCTOR SHORTAGE: WHY NOT BE A CLINICAL INSTRUCTOR?*

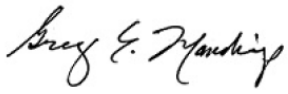
EXEMPTION APPROVAL DATE: June 8, 2016

Dear Ms. Simmons,
The University of Indianapolis Human Protections Administrator (HPA) has reviewed your exemption determination application for the study titled, *PHYSICAL THERAPY CLINICAL INSTRUCTOR SHORTAGE: WHY NOT BE A CLINICAL INSTRUCTOR?*. The HPA finds the study meets the criteria for exemption from ongoing IRB review as set forth in the federal regulations at 45 CFR 46.101(b). Therefore, the HPA has approved this study as exempt from ongoing regulatory review.

Nevertheless, you must submit for HPA review and approval prior to implementation any modifications in the study methodology, protocol, recruitment materials and/or consent form. UIndy requires review and approval in order to confirm that changes do not alter the currently approved exempt status. Submit via email proposed changes to the HPA, Dr. Greg E. Manship (manshipg@uindy.edu). Please submit all changes via email, not through IRBManager.

Per UIndy policy, you must submit an update on the status of this study one calendar year from date of approval. Please submit before or on June 8, 2017 and update to the HPA, Dr. Greg E. Manship. You must submit an update/summary when notifying the HPA of study completion and closure.

Sincerely,



Greg E. Manship, D.Bioethics, M.Div., CIP, CIM
IRB Director & Human Protections Administrator

Cc: Barbara Kimmel

Appendix D: CITI Training Certificate

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COURSEWORK TRANSCRIPT REPORT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Barbara Kimmel (ID: 5328115)
- **Email:** kimmelb@uindy.edu
- **Institution Affiliation:** University of Indianapolis (ID: 473)
- **Institution Unit:** Psychology/OT/PTA
- **Phone:** 574-328-0441

- **Curriculum Group:** Human Subjects Research (HSR)
- **Course Learner Group:** Group 3: Non-Health Related Research
- **Stage:** Stage 1 - Basic Course

- **Report ID:** 18476721
- **Report Date:** 01/25/2016
- **Current Score**:** 88

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT
Students in Research (ID: 1321)	01/25/16
History and Ethical Principles - SBE (ID: 490)	01/24/16
Defining Research with Human Subjects - SBE (ID: 491)	01/24/16
Belmont Report and CITI Course Introduction (ID: 1127)	01/24/16
Records-Based Research (ID: 5)	01/25/16
The Federal Regulations - SBE (ID: 502)	01/24/16
Assessing Risk - SBE (ID: 503)	01/24/16
Informed Consent - SBE (ID: 504)	01/24/16
Privacy and Confidentiality - SBE (ID: 505)	01/25/16
Research with Prisoners - SBE (ID: 506)	01/25/16
Research in Public Elementary and Secondary Schools - SBE (ID: 508)	01/25/16
Internet-Based Research - SBE (ID: 510)	01/25/16
Vulnerable Subjects - Research Involving Workers/Employees (ID: 483)	01/25/16
Unanticipated Problems and Reporting Requirements in Social and Behavioral Research (ID: 14928)	01/25/16
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	01/25/16
Cultural Competence in Research (ID: 15166)	01/25/16
Research with Older Adults (ID: 16502)	01/25/16
Research with Persons who are Socially or Economically Disadvantaged (ID: 16539)	01/25/16
Research with Decisionally Impaired Subjects (ID: 16610)	01/25/16
Illegal Activities or Undocumented Status in Human Research (ID: 16656)	01/25/16
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	01/25/16

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

CITI Program
Email: citisupport@miami.edu
Phone: 305-243-7970
Web: https://www.citiprogram.org

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COURSEWORK REQUIREMENTS REPORT*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Barbara Kimmel (ID: 5328115)
- **Email:** kimmelb@uindy.edu
- **Institution Affiliation:** University of Indianapolis (ID: 473)
- **Institution Unit:** Psychology/OT/PTA
- **Phone:** 574-328-0441

- **Curriculum Group:** Human Subjects Research (HSR)
- **Course Learner Group:** Group 3: Non-Health Related Research
- **Stage:** Stage 1 - Basic Course

- **Report ID:** 18476721
- **Completion Date:** 01/25/2016
- **Expiration Date:** 01/24/2018
- **Minimum Passing:** 80
- **Reported Score*:** 88

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED
Belmont Report and CITI Course Introduction (ID: 1127)	01/24/16
History and Ethical Principles - SBE (ID: 490)	01/24/16
Defining Research with Human Subjects - SBE (ID: 491)	01/24/16
The Federal Regulations - SBE (ID: 502)	01/24/16
Assessing Risk - SBE (ID: 503)	01/24/16
Informed Consent - SBE (ID: 504)	01/24/16
Privacy and Confidentiality - SBE (ID: 505)	01/25/16
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	01/25/16
Illegal Activities or Undocumented Status in Human Research (ID: 16656)	01/25/16
Students in Research (ID: 1321)	01/25/16
Internet-Based Research - SBE (ID: 510)	01/25/16
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	01/25/16
Unanticipated Problems and Reporting Requirements in Social and Behavioral Research (ID: 14928)	01/25/16
Cultural Competence in Research (ID: 15166)	01/25/16
Records-Based Research (ID: 5)	01/25/16
Research with Prisoners - SBE (ID: 506)	01/25/16
Research with Persons who are Socially or Economically Disadvantaged (ID: 16539)	01/25/16
Research with Decisionally Impaired Subjects (ID: 16610)	01/25/16
Research with Older Adults (ID: 16502)	01/25/16
Research in Public Elementary and Secondary Schools - SBE (ID: 508)	01/25/16
Vulnerable Subjects - Research Involving Workers/Employees (ID: 483)	01/25/16

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

CITI Program
Email: citisupport@miami.edu
Phone: 305-243-7970
Web: https://www.citiprogram.org

Appendix E: Recruitment Email

Fellow Physical Therapy Clinicians,

My name is Barbara Kimmel and I graduated from the Physical Therapy Assistant (PTA) program at the University of Indianapolis last August. As I continue my education, I am working alongside Tammy Simmons, Assistant Director of Clinical Education at the University of Indianapolis Krannert School of Physical Therapy, on an Honors College research project involving physical therapy clinical education in facilities with University of Indianapolis contracts.

We are utilizing an anonymous online survey in order to fill existing gaps in physical therapy clinical education research involving clinical instructors. To do so, the known benefits and barriers of becoming a clinical instructor will be assessed based on the extent to which they effect clinicians' willingness to serve as clinical instructors. Possible contributions to this effect by factors such as gender, job title, level of education, amount of experience, number of students supervised, and practice area will be investigated. This research will also fill existing gaps by discovering perceived benefits and barriers not mentioned in the literature as well as what types of support or incentives would increase the likelihood of clinicians to become clinical instructors.

Please consider giving approximately 10 minutes of your time to help a fellow physical therapy clinician by following the link below and completing the survey. When the survey is complete, simply close the browser to exit the survey. Clinicians with and without experience as a clinical instructor are encouraged to participate. **If you are a CCCE please complete the survey yourself if applicable and forward on to all of the physical therapy clinicians at your facility.**

https://uindy.co1.qualtrics.com/SE/?SID=SV_6l1imvehxnpX6rH

Thank you for your consideration,

Barbara Kimmel, PTA
kimmelb@uindy.edu