Administrative Patterns in Curriculum-Clinic Interactions

administration, academic and hospital relationships)

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A questionnaire was sent to directors of occupational therapy curricula and faculty members, to directors of occupational therapy clinics and clinicians, to deans of medical schools, and to hospital administrators in order to determine the professional and administrative relationships between occupational therapy academic programs and clinical programs. Results of the survey, analyzed by groups, indicated that informal relationships were prevalent, whereas other relationships were poorly delineated. Strengths and weaknesses of formal and informal relationships are presented. Finally, a model for interaction is proposed.

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Relationships between curricula and clinics in occupational therapy (OT) are diverse and unique. The development of cooperative relationships is thought by many to be mutually beneficial for academicians, clinicians, and students for maintenance of clinical skills, professional development, and training. Because OT is identified as a profession, classroom and clinical education must combine to produce a professional entity—a therapist rather than a technician. Clinical and classroom experiences must complement and supplement each other for optimal use of personnel and time. The presence or absence of a reciprocal attitude among faculty members and clinical staff influences the development and continuation of a professional identity.

This study was undertaken to determine the administrative patterns that describe the relationships between OT curricula and OT clinics and to determine perceived strengths and weaknesses of various patterns. It was prompted by a request from a department of medical allied health professions in a school of medicine to evaluate existing administrative and professional relationships between a university OT curriculum and a hospital OT clinic. The significance of the study is based on the premise that curricular and clinical interchange are necessary to establish and maintain meaningful academic and clinical programs, and to provide excellence in student training. The study, then, is to assess what relationships exist, and to propose a model for interaction.

Review of the Literature

The Veterans Administration (VA) adopted a policy to affiliate its hospitals with medical schools and to assume full responsibility for patient care, and the medical schools' would have responsibility for graduate education and training (1). This mutual dependence was viewed as beneficial and positive. For the VA, the benefit was improved acute inpatient care. For the medical schools, the benefit was access to acute-care patients for teaching and training purposes. Thus, both health care and education goals were accomplished.

Derzon (2) supports the interdependence of teaching hospitals and medical schools because of the physical and technical resources of hospitals, the intricate financial arrangements between hospitals and physicians, and the multidisciplinary professional corps required to treat complex illnesses. He maintains that the following concepts are necessary for a healthy relationship (2, p 20):

1. The successes of the school and hospital are interdependent. One cannot succeed if the other fails; one cannot be excellent if the other is only good.
2. There must be recognition that the hospital is first and foremost a hospital, and that it is a hospital for teaching.
3. Leadership must be bilateral and reinforcing.
4. The two organizations must clarify roles and objectives and develop mechanisms to resolve conflicts.
5. The hospital director and staff must be dedicated educators. In turn, the dean and department persons must know how to deliver medical services.

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6. Organizational alignment must permit a partnership. Also, strong partnerships rely on strong partners.

Models of Motivation, Management, and Needs. Maslow (3) proposed a priority of needs that serve to motivate behavior: basic physiological needs, safety and security, belonging and social needs, esteem and status, and self-actualization and fulfillment. According to Maslow, these needs must be met in order to foster a feeling of security, job satisfaction, and dignity.

McGregor (4) proposed three forms of need satisfaction—physical and security needs, social needs, and egoistic needs. Egoistic needs relate to the desire to be independent, to do things on one’s own, and to sense accomplishment. If one accepts these forms of need satisfaction, direct administrative ties will be viewed as limiting independence and fostering dependence. He formulated two theories, X and Y, which describe ways managers and decision makers can understand their attitudes about people and can understand the motivation of employees. An autocratic or authoritarian style of management based on strong centralization of control is characteristic of Theory X. It assumes that people dislike work, avoid it, must be forced to work, seek close direction, avoid responsibility, and want security. Management following Theory X is not effective over a long period of time, especially not in the health care field (7, p 275). Theory Y is more applicable to health care organizations. It is based on the belief that working with people is more effective than using them. Thus, the relationship is one of co-action rather than coercion.

Hertzberg, Mausner, and Snyderman (5) proposed motivational and maintenance factors that lead to job satisfaction or dissatisfaction. Satisfiers, or motivational factors, include achievement, recognition, advancement, work itself, possibility of growth, and responsibility. Dissatisfiers, or maintenance factors, include company policy and administration, technical supervision, interpersonal relationships with supervisors, interpersonal relationships with peers, interpersonal relationships with subordinates, salary, job security, personal life, working conditions, and status. Many of these factors are perceived by managers as motivators, but they are more potent as dissatisfiers when they are absent. Motivational factors are generally job centered and related to job content, whereas maintenance factors are generally environment centered and related to job context.

Providing a match between the characteristics of the job and the need of the individual is a determining factor in job satisfaction (6). Other factors include expectations, self-evaluation, social norms, social comparisons, input/output relations, commitment, and pride. These factors, in affecting not only job satisfaction, but also the meaning of work and the meaning of life, are variables to consider when determining administrative and professional relationships.

This literature provides documented information on the relationships between academic programs and hospitals, and identifies some of the factors seen as important to sustain a relationship between these two groups. The literature also provides some theories that help in understanding why working relationships between professionals may or may not be successful in meeting the needs of all persons involved.

Procedure

To obtain preliminary information regarding the extent of the problem addressed in the study, individual discussions were held with directors of ten occupational therapy curricula during an annual meeting of The American Occupational Therapy Association (AOTA). These discussions helped the researchers to identify issues and formulate questions, and provided insight into the rationale for a variety of interaction patterns.

Groups. Questionnaires were formulated to obtain responses from six groups of people: deans of medical schools, hospital administrators, OT curriculum directors, OT faculty members, OT clinical directors, and OT clinicians.

Questionnaires. The questionnaires were sent to two individuals from each group as a pilot test. Responses from the pilot test were used to modify and finalize the questionnaires. The questionnaires were designed to determine the relationship between the OT clinical program and the OT educational program to obtain information regarding personal perspectives on the relationship between the OT clinics and the OT educational program. Since all responses were anonymous, no comparison or matching of responding units was possible.

All OT programs listed in the AOTA directory (8) located at educational systems with a medical school were included in the survey. Medical schools and deans were identified in the Journal of the American Medical Association, listing (9). Deans or directors of medical allied health programs were also identified (10). Questionnaires were sent to the deans of 32 medical schools and the curriculum directors and faculty members at 32 OT educa-
tional programs. Another AOTA directory (11) was used to identify the 40 OT clinics located at or near the above-mentioned OT educational programs. The clinical director, one staff therapist, and the administrator at each of the 40 hospitals housing the OT clinics were sent questionnaires.

Results
Deans or Directors of Medical Allied Health Programs. Of the 32 questionnaires sent, 36 percent or 11 were returned. Eight, or 75 percent, of the respondents indicated that the curriculum director was not responsible for the OT clinical program; three indicated that the curriculum director was responsible for the clinical program.

In general, deans of educational programs that have no ties to clinical programs (75%) failed to identify positive aspects of their independence, whereas deans of programs with ties tended to recognize the bridge between educational and clinical experiences as a positive factor with implications for patient care. The problem of educational programs in creating or maintaining an administrative tie to hospital programs rested in the areas of budget, communication, and workload for faculty and clinicians.

The official recognition of clinicians by educational programs and vice versa was not identified as common, universal, or well conceptualized, and was identified as a problem area by the deans. To have a successful professional relationship, the deans felt that the two organizations when working together should be "up-front" in goals, priorities, standard operational procedures (SOP), and appointments; define roles/responsibilities, privileges, and functions for all involved in the programs; and allocate funds appropriately for all concerned.

Hospital Administrators. Of the 40 questionnaires distributed, 30 percent or 12 were returned. Of hospital administrators responding, 85 percent stated that their OT clinical programs do not have ties to the curriculum. They viewed the positive aspects of their independence as increased communication within the hospital, smoother administration, and better mutual understanding of administrative and programmatic concerns within the hospital.

Administrators identifying OT clinical directors as having a relationship with a curriculum (17% or 2) cited positive aspects as fostering opporunity for clinical staff to expand teaching and clinical skills, promoting integration of academic and clinical skills, and expediting communication between hospital and school. All administrators, with and without ties, identified no weaknesses with their particular administrative model.

Concern was evident in both groups, those with and without relationships, that establishing a relationship would require time for negotiating mechanisms for interactions and for identifying variances in priorities that might be better spent elsewhere.

Curriculum Directors. Of the 32 questionnaires sent to curriculum directors in OT educational programs, 75 percent (or 24) were returned. Of the 24 respondents, 20 identified their curriculum as being part of either a school—7, or a department—8, of Medical Allied Health Professions, or as part of the Medical School—5.

Seventeen of the curricula indicated that their educational facilities maintained a university-related hospital; three reported no university-related hospital; and three indicated that their hospital was not related directly, but was associated with the educational facility.

Four curriculum directors (19%) indicated they were administratively responsible for the clinical occupational therapy program, 14 (67%) stated they were not responsible, and 3 (14%) indicated some minor responsibility for the clinical program. Of the curriculum directors with administrative ties—4, three stated that such a relationship was desirable, and one, that it was undesirable. Of the 14 curriculum directors without administrative ties, 4 indicated that some administrative relationship was desirable, 6 indicated that it was not desirable, 3 did not respond, and 1 proposed another option.

For all respondents, close relationships were identified as facilitating better educational programming, better sharing/communication between schools and clinics, and better faculty involvement in treatment settings. The major problems with administrative ties centered on responsibility overload for curriculum directors, differences in priorities and goals, and lack of adequate communication between educational and clinical facilities.

Curriculum directors did not identify the existence of standardized or generally accepted appointment procedures, duties, responsibilities, or rights and privileges for clinical appointments of faculty, and their responses indicated little consistency in a faculty appointment policy for clinicians. Although privileges were frequently ill defined, some responsibilities for clinicians were always identified.

As with responses from deans, the relationship between educational and clinical settings is not consis-
tent in OT according to curriculum directors; however, whatever the relationship, certain factors create a positive climate for all: specifying interactions via SOPs and policies; defining roles and responsibilities, privileges, and functions; and allocating funds.

Faculty. Of the 32 questionnaires distributed, 55 percent (or 17) were returned. In 13 cases the faculty members were not responsible for clinical programs; in 4, faculty members were administratively responsible. All with responsibility wanted a close administrative relationship. Those without responsibility differed in their feelings about the desirability of a close relationship.

The identified strengths of a close relationship were varied, but focused on improved exchange of information, formulation of research ideas and new theories, better student education, and greater opportunities for continuing education and faculty/practitioner practice. The major weaknesses identified were different depending upon the respondents. Those with close ties saw problems with priorities and personality clashes. Those faculty members who favored the closeness but did not have ties thought that, in addition to differences in priorities and personality conflicts, problems would occur in the areas of budgeting, time constraints, role confusion between therapists and teachers, and coping with bureaucracy. The faculty members without ties and not desiring ties stated the major problem as the magnitude of the task.

There were eight hospital appointments of faculty, but few responsibilities were consistently identified. The most frequently cited responsibilities were demonstration, program formulation, and student supervision. Even when faculty had no clinical appointments, some had responsibilities for treatment and consultation.

Clinic Directors. Of the 40 questionnaires distributed, 48 percent (or 19) were returned. The results showed that 79 percent (or 15) of the clinic directors were not tied administratively to the curriculum with which they were associated, and 10 of those who were not were content with their separateness. All four clinic directors with direct administrative ties to the curriculum favored such a relationship. Of those 15 clinic directors with no direct administrative ties, 4 were discontented with the status quo, and all 15 felt they should have input and be reimbursed for curricular service such as student training. In general, it appears that those clinic directors who do not have ties felt at times “put-upon,” and that all the educational facility coes is “take,” whereas all the clinical facility does is “give.” Several clinic directors expressed resentment about the time spent training students without getting reimbursement for services rendered. It became apparent that, whether or not there was a direct administrative relationship, clinic directors assumed a number of curriculum responsibilities, the most frequent of which were teaching and the exchange of equipment. In all facilities where clinicians have faculty appointments, they have responsibilities as a consequence of those appointments. These responsibilities involve teaching, supervising, and related tasks; however, appointments of faculty members to clinical positions involved varying responsibilities and, in some cases, no responsibilities. Most facilities without administrative ties to academic programs did not have clinicians appointed to the faculty or faculty members appointed to the clinic programs.

No written agreements, contracts, or documents were returned by respondents. In all instances, the only written agreements/contracts in effect concerned fieldwork experiences for students.

Therapists. Of the 40 questionnaires distributed, 48 percent (or 19) were returned. Most therapists (79%) did not identify a direct administrative relationship with the academic curriculum, and none in this group felt that such a relationship would be desirable because of problems in logistics as a result of distances between schools and clinics, in priorities, budgeting, and personalities. The major responsibility of therapists to curricula was in the area of student supervision (95%). Most therapists (75%) did not have faculty appointments for their service to the educational program. In 95 percent of the cases, the entire salary of the therapist was paid by the hospital.

Discussion

The results of this study indicate the need to specify and clarify relationships between hospital OT clinics and university OT programs in order to improve and sustain beneficial working relationships within the profession. Many clinics and curricula tend to separate their personnel and do not exchange or share roles. This lack of sharing and mutual understanding creates a potential for resentment by clinicians for educational programs that “take advantage of them” by “sending students” without offering a “fair exchange” of reimbursement, financial or bartered, for student training. The clarification of administrative and informal ties between the two groups can or
might help to alleviate negative feelings of the participants. Such relationships would identify potential problem areas and needs of the participants. The advisability for such action is substantiated by Derzon's identification of necessary factors that create a healthy relationship between hospitals and universities (2).

The need for some type of tie between the two groups is emphasized when the satisfactions of those organizations with some ties are compared with satisfactions of those programs without ties, of which one third expressed discontent. Although important, the exact responsibilities, relationships, and administrative links between hospitals and curricula do not appear to be as important as the feeling of fair exchange between the groups.

One major problem in establishing administrative ties is that the participants' perceptions of priorities differ, especially in the areas of education and treatment. The participants do not appear to acknowledge the service continuum from patient treatment to student education within the profession, although the relationships among the groups described are interdependent. The groups are not merely aggregates or collectives of people; in their organization, one person's behavior affects another's. The term *mutual contingency* has been given to a true interdependent relationship such as this (12), one in which each person takes into account the other's actions in setting the course of his or her own actions.

*Alternative Models.* It is helpful to develop a model by which to study different perceptions of administrative relationships between curricula and clinics. In the biological sciences, relationships between organisms can be identified as mutualistic, symbiotic, or parasitic (13). In a mutualistic relationship, two organisms are dependent upon one another for their existence and both benefit from the relationship. In a symbiotic relationship, an organism cannot survive without its host; it depends on its host for its existence, but it does not harm or benefit the host organism. In a parasitic relationship, one organism exists or survives by the presence of the other organism, or host, which it gradually destroys.

Keeping these relationships in mind, one can develop three different models involving the four OT organisms: clinicians, educators, students, and patients. For example, in a mutualistic model, the participants perceive that they "give" in the relationship and "gain" or get something in return. This return may be in the nature of treatment, money, continuing education opportunities, practice potential, professional education, research opportunities or student services.

Ideally, all professionals perceive their relationship with other professionals as mutually beneficial. In practice professions such as OT the growth process of each member must be recognized as vital to the continuation of the profession. Students learn from educators and clinicians, and without students the profession will die from lack of new practitioners and educators. Educators teach students and practitioners, and without educators, the profession will have no reasonable place or process by which to pass on or develop the body of OT knowledge, both theoretical and practical. Clinicians practice and train students in their settings; without practice settings and clients, there will be no need for the OT profession, and without student training...
there will be limited transmission of clinical knowledge. It becomes evident, then, that each organism is vital to the continued functioning of the profession. Each part is of equal importance, for without each component the profession cannot survive.

Mutualistic Model. From the general statements summarizing the results of the survey for each group sampled, it is proposed that relationships between hospital programs and university programs can be mutualistic, symbiotic, or parasitic. A mutualistic model of equality and mutual respect, reflecting a need for each other, is proposed as desirable and realistic (see Figure 1). The model places faculty members, clinicians, and students equidistant, with the client in a position of direct interaction with all parties. This model fosters attitudes through which Maslow's lower and higher order needs can be met, including the highest level of self-esteem and fulfillment. Also, Herzberg's motivation and maintenance factors can be incorporated into the mutualistic model. In addition, the job-centered, job content, maintenance, environment, and job context factors can also be accommodated. Finally, McGregor's Theory Y of interaction and co-action can be applied to this model, since lines of communication flow in every direction. In each of the works cited, a mutualistic model of OT education and clinical practice is possible and supported. Yet, based on data gathered in this survey, many individuals in academic and clinical settings do not perceive a mutualistic relationship; rather, they perceive a symbiotic model—one in which there may be interaction, but in which they can exist without others.

Symbiotic Models. Responses of academicians in this study differed from those of clinicians. Faculty perception of OT education and practice demonstrates a symbiotic relationship. Academicians perceive strong impact from faculty to clinicians, faculty to students, and clinicians to students, but weaker influences from clinicians to faculty, students to faculty, and students to clinicians. Interactions with clients appear strong in all directions. This view does not enhance the higher-level needs proposed by Maslow, nor the motivation and maintenance factors of Herzberg. It borders on McGregor's Theory X since the control is centralized in the faculty.

The case made in this paper is that healthy relationships and interactions follow the mutualistic model. Further, members of the profession claim to adhere to this model. Yet, in practice, elements of the symbiotic model or even the parasitic model are evident.

Summary
Clinical settings require substantial attention to interpersonal encounters in order to deliver effective health care (14), and effective skills are required to facilitate the well-being of the therapist/client relationship. In academic settings, mental rigor is more easily acknowledged, accepted, and demonstrated than the behavioral involvement of the helping role, and there is a focus on the learning role. There must be, then, recognition by clinical settings of the importance of cognitive growth, and by academic settings of the importance of affective, interpersonal skills. If there is to be a productive interaction between the two settings, there must be mutual respect for each other's contribution and for each other's needs. It is proposed that the mutualistic model is preferred for the profession of occupational therapy since it involves all four groups participating in professional interactions—academicians, clinicians, students, and clients—respecting the skill, knowledge, and attitude of all individuals; and fosters growth and contributions by all persons in the professional relationship.

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