

Excerpts of an interview with Jody Gandy, PT, DPT, PhD, American Physical Therapy Association

What were the primary drivers in your consideration of the doctorate?

The first program that graduated the DPT or the doctor of physical therapy was Creighton University in 1996 and today we have 93.8 percent of our programs; or (another way to look at it) only 13 out of 211 programs remain of the master's level. So that is a pretty clear majority. The first (DPT) was in 1996 and we are now in 2009 so that would be 13 years, ok. And that is a fairly rapid transition. And (just to put that in perspective) the first one from the baccalaureate to the master's (degree) took us 23 years.

Some of the considerations: back in 1979 there was a motion that came before our House of Delegates, which is our governing body, to move the professional education from the baccalaureate to the post-baccalaureate. Now initially it was a mandate but then we heard back from the colleges that the awarding of a degree is an "institutional prerogative," not the profession's.

One is, when moving to the graduate level – and specifically the doctoral level – faculties degrees needed to be at a level consistent with what is considered graduate and graduate doctoral prepared faculty, who can teach at that level. So one of the problems having done it earlier is: we did have sufficient faculty who held doctoral degrees. So one of the things that facilitated the change was the number of faculty that now had doctoral degrees and they could be EdD or DPT or DScPT or number of types but I have a doctoral degree in order the program to qualify for a doctoral degree.

A second issue is that our programs, although predominantly master's, were inching up from two year-master's to two and a half, to two and three quarters and student's curricula, the depth and breath of what is required to be in an entry-level curricula, were increasing such that the work that they were doing; the rigor and their clinical education, was more consistent with clinical doctoral preparation than it was master's. So master's degree programs typically have an additional 40, 50, 60 credits and we are looking at 110 (for the doctoral) so that is not a master's program any longer. So one of the things was within the institution, the degree requirements – in terms of depth, breath, and rigor – were no long consistent with what would be master's preparation.

A third element – although we still have freshman admission programs – one of the things that was discussed was: where should be the entry point to professional education? And we had previously, two years of undergrad plus three years or two plus two or something; it became apparent that the preferred model was that the learner would have their undergraduate degree in a related field with their prerequisites for admission and then would go on to a more traditionally professional education, which is.....then the professional preparation. Part of that was: one, it tended to be a more mature learner; two it also gave people the chance to have a successful experience in getting a degree and

three, not to obligate the learner in their second year of an undergraduate program to determine what they want to do for the rest of their life, basically in a profession.

Now, so far most of the drivers that you have heard came from that academic community. The clinical community; there was a lot of debate in the clinic about the DPT. And partly – and that answers another question – what is one of the things that we make sure that you do is: that you get buy-in of your PA clinicians while you are also getting buy-in from the Academy. That was a short-coming that we had and it plagued us for years and there is still on occasion, debate about whether we should be where we are - although the horse is so far out of the barn it is not funny. But the clinician was not probably embedded into the discussion as strongly as the Academy because the Academy was feeling the pinch of trying to put everything into the curriculum that was required by accreditation and running out of time; plus our clinical education, the doctoral program is a fully time clinical education, is longer than it was in the master's. The proportion of the curriculum that is dedicated to clinical practice is higher.

It is very encouraging hearing about these experiences from another health care profession. Now, you have sort of answered the next question but here it is: Was there an identifiable "tipping point" or landmark event that made your professions' decision making clearer?

You know, I wish I could point to a sentinel event; that was it! But what I think happened to be honest with you – and this is as honest as I can be – a new program offers the DPT in 1996 and every around starts thinking: well, is that heresy? Maybe not. But then, as soon as one (program) offers, the topic has to come up as a discussion point. And we held a number of forums that I actually have articles about (which she sent us), different forums that were held, the debates – you know, should we or should we not go (to the doctoral), letters to the editor about the DPT and they range from every side to, self aggrandizement to you know, its time and we need to do this.....

So, I think the tipping point was when one program in a region moved to the DPT and despite whether the institution wanted to or not, very shortly afterwards, it started a whole series of debates in those institutions that surrounded that one. Now, I will tell you one of the other sentinel things that happened. Applications to physical therapist programs started to drop during the Balanced Budget Act (of 1997) when there was higher unemployment of the health care worker workforce and that happened to everybody. Ok, I am competing for admissions, and I am starting to see trends that the doctoral programs are starting to get more applicants than the master's, what am I going to do? I am going to start talking at my program about doctoral level.

So, the tipping I think is when more and more programs got to the point where the faculty said, we have to go because blank schools around us are going or how would you like to be the only school on the Eastern Seaboard that does not have a doctoral program. So at a certain point, the tipping point is: you have more than 50 percent of your program that have moved there (to the doctoral). And now it is sort of a fait accompli, with the 93 percent that are there. Does that make sense?

Now, here is other hitch that will happen. Some of the other side that you (PAs) are going to have issues with are going to come from clinicians who say: “Well, if I get a doctoral of physician assistants, does that mean I am going to make more money?” In our case it did not because it is still an entry level degree. What we don’t know and we are just starting to get some hints at this point, does the person with a doctoral degree advance more quickly within their career? We don’t know but there are some trends that it might do that. What we don’t know is: will there come a point in time where the tipping point is there are more clinicians that hold the doctoral degree than other degrees so when they advertise of positions, it will say doctoral preferred only! That is another tipping point that happen in clinical practice.

So, there is probably one other tipping point that allows it to be easier to go to the DPT. You have a lot of clinicians who still have baccalaureate and/or master’s as a PA. You cannot as a profession advance to the next generation without having a mechanism to advance the current generation of practicing PAs. So, one of the things that helps us move is that we developed a mechanism for those who are already practicing licensed physical therapists could go back and get what we call a “Transition DPT.”

So, one of the cautions that I give you is if you elect to move forward, you will have clinicians very angry at you if there is not a way for them to get a comparable degree so that they are not left behind; you don’t want the good, the bad and the ugly PA.

Our association has a Vision 2020 which says: “Physical Therapists by 2020 will be provided by doctors in physical therapy.” That is what is driving the train and that vision is there. So our resources to making that vision happen! So, there is a driver which is the vision and then there is a mechanism for the licensed physical therapist to be able to go back and get comparable knowledge and skill to where contemporary graduates are coming out. And is one piece of advice I give to you guys (and gals), bring the clinicians into the conversation, up front; talk about the pros and cons and advantages and disadvantages and find out if they want a transition program. You can’t leave them behind or that will tick them off. You don’t want to be grandfathered without the knowledge. We raised the bar on the whole entry level and we also dealt with practitioner who needed the opportunity to go back for a clinical doctorate.

I guess in many ways you have answered questions three and four, but here they are: Can you identify up to five pieces of evidence that supported your decision to move forward with the doctorate? What advice would you give the profession, based on your experience, for its consideration of this issue? Is there something that you want to add that you did not already?

I think our vision is one; Vision 2020 (see above); certainly the number of course credits that learner were taking. It was in some ways it was somewhat duplicitous; where you are saying take 100 and something credits and you are only getting a master’s and your colleagues in pharmacy are going to get a doctorate so it was not even equitable.

I don't mean to interrupt you, but that is the same argument the Army gave me for starting the doctorate. Why have PAs go through 18 months of training and only get a certificate? Does that sound familiar?

Yep and in their case they are looking for a post entry level, post profession and in ours we said that it is occurring in the entry level curricular. Again, the other decision had to do with health care itself and what patients were asking for and the fact that our profession was changing from a physician referral-based to various modes of direct access. And with direct access comes increased liability and increased risk but also with increased knowledge you need to do that.

One of the big issues in the PA community is: whether a PA earns a clinical doctoral or not, they still need to have physician supervision.

That is one that is very important or else you meet from a lot of resistance from a lot of your physician colleagues. The second thing is: what does the.....what are you going to call it, the DPA? What does that entitle the clinician to be able to do? Here are a couple of things: what acronym are behind their name, under what circumstances can they use that, can they call themselves doctor; that is whole issue that we have been dealing with. We had to say, you can sign Dr. Jody Gandy but I have to say that I am doctor of physical therapy and I am your physical therapist so they know that I am not a physician. You (PAs) may have the same problem.

The last thing it has opened up and I can tell you it has happened, on some of the marquees; like in a private practice, the names of the therapists are listed along with their degrees. And there have been situations where the patient comes in and sees the person who is the doctor, the physical therapist; they may be out only one year, as opposed to others and wants that person to be their therapist because they have the doctor of physical therapist degree. And it has nothing to do with what the profession is saying, it has everything to do with the perception of the public and the public understands the concept of the word doctor better than any other concept. They understand doctor anything, not that you are a physician but they understand that there is more schooling and they understand what that is and when given a choice, they will take the person with that initial behind their name. So that is some of the things to deal with that may come down the pike and one way or another will rear their heads. It's too bad I can't be there, it will be fun to listen to the *deja vu*.