Contact: James Gordon

Phone: 323 442 1538

E-mail: jamesgor@pt.usc.edu

**PROPOSED BY:**

James Gordon, University of Southern California

**That the following be adopted:**

ACAPT opposes Recommendation 1 in “[Best Practice for Physical Therapist Clinical Education](http://www.acapt.org/docs/default-source/hot-topics/best-practice-for-physical-therapist-clinical-education-%28rc-13-14%29-report-to-2017-house-of-delegates.pdf%29)” (“That formal preparation for practice includes physical therapist professional education, followed by a clinical internship and mandatory postprofessional residency, and is accomplished through a process of staged licensure and specialty certification”) on the grounds that it would result in removal of the most significant portion of clinical education from academic oversight and accountability.

**Support Statement:**

The Best Practice for Physical Therapist Clinical Education Task Force (BPCETF), created by the APTA Board of Directors in November 2015, recently completed its work with a Report to the 2017 House of Delegates ([RC 13-14 - Annual Report to the 2017 House of Delegates](http://www.acapt.org/docs/default-source/hot-topics/best-practice-for-physical-therapist-clinical-education-%28rc-13-14%29-report-to-2017-house-of-delegates.pdf%29)). In this report, BPCETF made a series of recommendations, the most important and far-reaching of which was the first recommendation:

*That formal preparation for practice includes physical therapist professional education, followed by a clinical internship and mandatory postprofessional residency, and is accomplished through a process of staged licensure and specialty certification;*

Recommendation 1 envisions that the terminal clinical internship will be done *after* graduation from the professional education program. Indeed, the report states, “One goal should be a reduction in the total amount of time required to attain the DPT degree, shifting a significant portion of the clinical training to the postgraduate phase.” The report suggests that professional education should be reduced in length to 2-2.5 years and include 2 clinical education experiences of 8-12 weeks each.

This motion does not ask ACAPT to take a position on the second part of the recommendation, that is, a mandatory postprofessional residency along with staged licensure and specialty certification. Rather the motion is focused specifically on the first part of the recommendation which removes the most critical portion of clinical education from academic oversight and accountability.

The most important reason to reject this recommendation is that it distracts from our most important task – to strengthen academic DPT programs to ensure that graduates are worthy of the title Doctor of Physical Therapy, with all the rights and responsibilities that are identified in our profession’s mission and vision statement. The fundamental problem with Recommendation 1 and, indeed with the original charge to the BPCETF, is that it is based on an incorrect assumption – that clinical education is separate from professional education and that issues related to clinical education can be solved without addressing the major issues and problems facing professional education.

Furthermore, removal of the terminal clinical experiences from professional education would have serious consequences for the future of DPT education and for the profession itself. These consequences include the following:

**Loss of accountability for outcomes of clinical education**. If the terminal clinical internship occurs after graduation, as is recommended, the academic programs would no longer determine whether the “intern” passed, that is, met all the requirements and objectives. This would presumably be determined by the clinical instructor, and the clinical internship would need to be “credentialed.” Who would oversee this process? The report does not address this crucial issue. Moreover, disconnection of the most significant portion of clinical education from other aspects of professional education would fracture the already challenging pathway from knowledge to clinical practice and very likely put at risk the hard-won gains in evidence-based practice across the profession.

**Increased rate of DPT program proliferation**. Academic programs would no longer be responsible for placing students in their terminal clinical experiences (approximately one-half the total clinical education time). Thus, it would be much easier to start new programs, because the most difficult hurdle for new programs is demonstration of adequate numbers and quality of clinical sites. The result would be an increase in the number of physical therapists entering the profession with inadequate and inappropriate preparation.

**Potential for shortages of internships.** As new programs develop and existing programs expand without the responsibility for placing their graduates in clinical internships, it is probable, even likely, that a significant number of DPT graduates would not be able to find jobs in “credentialed” internships and would thus be unable to progress to full licensure. There would be a “downskilling” of physical therapist service provision as lesser-skilled graduates would be stuck in lower-paid positions. Clinical sites and systems have little incentive to prioritize clinical education structures and outcomes in the face of significant threats to their economic survival and instabilities in reimbursement for services. Academic programs, on the other hand, increasingly face requirements to demonstrate the quality of their student products. The educational mission should remain the responsibility of academic institutions.

**Loss of credibility of academic DPT programs and downgrading of the DPT degree.** When the DPT degree was first developed, academic physical therapy made a commitment – that the degree would involve rigorous doctoral-level preparation and that the graduates would be deserving of the title “doctor.” If Recommendation 1 were implemented and a year lopped off of most DPT programs, academic physical therapy would be, in effect, reneging on that commitment. From now on, we would proclaim, to achieve a DPT degree will not require as much time, nor as many credit hours, nor mastery of the same level of skill. In fact, most reputable academic institutions would never approve such a drastic reduction in the requirements for a degree.

The report of the task force does a creditable job of identifying critical problems that we face in preparing the next generation of doctors of physical therapy. These include rising student debt, shortages of adequate clinical education sites, lack of agreed upon clinical education models, and proliferation of DPT programs in institutions with inadequate infrastructure and commitment to doctoral-level healthcare education. ACAPT, whose vision is to be “the leading voice to promote, achieve and sustain excellence in academic physical therapy,” should be attacking these problems with the urgency that they demand. If we allow the most important part of professional education to be amputated from academic physical therapy, we will be failing in our most important responsibility.

**RELATIONSHIP TO PURPOSE AND OBJECTIVES OF THE ACAPT:**

This motion speaks directly to the strategic objective to lead the exploration and creation of best practice standards in academic physical therapy.

**RELEVANT POSITION/STANDARD/GUIDELINE/POLICY/PROCEDURE:**

[Include current standard, position, guideline, policy or procedure if applicable]