ROLE AUTONOMY AND JOB SATISFACTION OF OCCUPATIONAL AND PHYSICAL THERAPISTS IN NIGERIA.

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DEPARTMENT OF EDUCATIONAL ADMINISTRATION

DEDICATED TO THE MEMORY OF

MY FATHER

LATE SAMUEL OGUNLEYE

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ABSTRACT

The major thrust of this study was to determine the relationship between role autonomy and job satisfaction of occupational and physical therapists in Nigeria.

Role autonomy as used in this study is the degree to which work could be carried on independently of organizational or medical supervision, and the degree to which it could be sustained by attracting its own clientele independently of organizational referral or referral by other occupations, including physicians. Job satisfaction on the other hand was operationalized as a combination of psychological, physiological and environmental circumstances that cause a person truthfully to say "I am satisfied with my job".

The data were gathered from registered, active members of the Nigerian Association of Occupational Therapists and the Nigeria Society of Physiotherapists. A questionnaire was used in data collection from the subjects of the study.

The major hypothesis for the study stated that occupational and physical therapists' orientation with respect to role autonomy is positively related to their job satisfaction. Eight additional hypotheses were developed to examine factors which tended to influence role autonomy.

On the whole, no significant relationship was found between occupational and physical therapists' orientation to role autonomy and job satisfaction. Also, no significant relationships were found among occupational therapists' orientation between role autonomy and job satisfaction using such biographic variables as sex, age, marital status, present employment and academic qualifications as test factors. On the other hand, physical therapists' sex, age and academic qualifications were significant predictors of their orientation toward role autonomy and job satisfaction.

This study has implications for the therapists, health administrators, policy planners and the educational system. Since the occupational and physical therapists are now becoming more sensitive to the power structure in the health field by their significant preference for role autonomy, there is need for health administrators to involve them more actively in health planning and administration. To this end, a collegial decision-making structure is advocated. The paucity of occupational therapists in the country today, suggests a need for local production of such personnel by universities. To meet the present shortage in the post-graduate education of occupational and physical therapists, there may be need to pursue master's and doctoral study in both fields.

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CHAPTER ONE

THE PROBLEM TO BE INVESTIGATED, ITS BACKGROUND AND THEORETICAL PERSPECTIVE.

Introduction

Occupational and physical therapists, and the nature of their work are little known in the Nigerian society and even among the medical fold in which they work. The reason for this may be due to the fact that their existence in the country's medical establishment dates back to just over three decades ago. In comparison, whereas in the countries of Western Europe and America, the practical application of occupational and physical therapy in the treatment of the physically and mentally disabled began in the last quarter of the eighteenth century (Hopkins and Smith, 1978).

Occupational therapy has been described by Hopkins and Smith (1978, p.27) as the art and science of directing man's participation in selected tasks to restore, reinforce and enhance performance, facilitate learning of those skills and functions essential for adaptation and productivity, diminish or correct pathology, and to promote and maintain health. On the other hand, physical therapy was described by Owoeye (1985, p.5) as the treatment and rehabilitation of diseases,

deformities (either congenital or acquired), and traumatic injuries by means of physical exercise, massage, manipulations (of soft tissues or the musculoskeletal system), and the use of physical agents such as: water (at varying temperature), light (or radiation), heat, electricity (both low and high frequency currents), ice, and mechanical vibrations including ultra-sound.

Both professions belong to the medical rehabilitation team which includes specialist physicians, speech therapists, orthotists, clinical psychologists, social welfare officers and nurses which applies their coordinated services for the restoration of both the physically and the mentally disabled to their highest potential in all aspects of their function.

The first Nigerian qualified occupational therapist, trained by the defunct Western Regional Government started work at the Aro Neuro-Psychiatric Hospital, Abeokuta in 1960. By 1968, when the Nigerian Association of Occupational Therapists was inaugurated at the Psychiatric Hospital, Yaba, Lagos, the number of qualified therapists had risen to about ten. As at today (1988), there are only thirty-two registered occupational therapists in the country, working in ten States of the Federation. The low level production of qualified therapists in the country may be due to the lack of training facilities in the country, ~~today~~. The first attempt at starting a school of occupational therapy was initiated by

the department of medical rehabilitation of the Faculty of Health Sciences, Obafemi Awolowo University, Ile-Ife in 1977. The Nigerian Association of Occupational Therapists was approached by the Faculty to provide qualified educators in the field for this purpose. The attempt failed because none of the members of the association at the time had adequate academic qualifications to be considered for the posts. Realizing that the profession is gradually disappearing from the medical field as a serious discipline, the Nigerian Association of Occupational Therapists initiated talks recently with the Federal Ministry of Health on the possibility of starting a school in the country. The results of the talks which have reached an advanced stage are still being awaited.

On the other hand, physiotherapy has witnessed a tremendous growth rate since the first set of practitioners appeared on the scene in the late fifties. The early practising physiotherapists were mainly expatriates (women) who accompanied their husbands to Nigeria on duty assignments (Oparinde 1985, pp. 8-11). Physiotherapy as a practising profession came under the umbrella of the Nigeria Society of Physiotherapy which was inaugurated on the 29th August 1959 at the Physiotherapy Department of the University College Hospital, Ibadan. In order to ease the shortage of practitioners in the field, the Federal Government, in March 1963, gave its consent to the setting up of a school of physiotherapy under

the auspices of the University of Ibadan Authorities with an initial grant of twenty thousand pounds (about ~~₦120,000~~ ₦140,000) ~~in today's second tier foreign exchange market (SFEM) rate).~~ According to Oparinde (1985), this development was followed by the establishment of other physiotherapy schools in the University of Lagos and Obafemi Awolowo University, Ile-Ife in 1971 and 1977 respectively. Today (1988), physiotherapy services are provided by over 200 practitioners, registered with the society in private, government and missionary establishments in the fifteen States of the Federation. There are 21 states!

The Background to the Problem to be Investigated

In the literature on organizations, a great deal of attention is usually devoted to employees' satisfaction with their work and working conditions. The role autonomy of these employees on the other hand has been given less attention (Onuoha, 1980), and whenever this matter has been addressed, it has usually been incidental to the main concern of how administrative action relates to the satisfaction of employees. The quest for role autonomy in the fields of occupational and physical therapy began almost two decades ago and has continued to feature in occupational and physical therapy journals since. The journal articles which contain the views and speeches of many prominent practitioners and educators in these fields have dwelt mainly on the inevitable

price the professions stand to pay by assuming subservient roles within the health care system (Yerxa, 1967, p.2). It must be noted, however, that the medical profession has been instrumental to the development of occupational and physical therapy. As a result, they have been subordinate to pressures and directives of the medical profession for some time.

who? the medical profession or the therapists?

According to Illich, Zola, McKnight, Caplan and Shaiken (1977), autonomy has been described as a professional power to recommend not only what is good, but actually ordain what is right. They further asserted that neither income, long training, delicate tasks nor social standing is the mark of the professional. Rather it is his authority to define a person as client, to determine that person's need and to hand the person a prescription. Scott in Etzioni (1969) also defined autonomy as the wish of professionals to exercise maximum discretion in carrying out their professional activities, free from hierarchical interference or confining procedural regulations.

Although the above definitions appear germane to the current study, ~~yet~~ the one given by Freidson (1970, p.53) appears most appropriate.

He defined autonomy as,

> the degree to which work can be carried on independently of organizational or medical supervision, and the degree to which it can be sustained by attracting its own clintele independently of organizational referral or by other occupations including physicians.

Closely related to the issue of role autonomy is a theoretical assumption that differences in satisfaction level are relatively easy to relate to autonomy. Leavitt (1951) asserted that positions which limit independence of action would be unsatisfying. While discussing the role of money as a satisfier or dissatisfier, Sergiovanni and Carver (1980, p.110) noted that many well-paid assembly-line workers would gladly swap their jobs for those which paid less money, and autonomy. Research studies conducted in occupational and physical therapy fields in recent times have linked the lack of job satisfaction to the lack of role autonomy among occupational and physical therapists studied (Barnes and Crutchfield, 1977; Maxwell and Maxwell, 1979). Perhapb with the increasing advancement in educational standard, occupational and physical therapists are now demonstrating, more than before, orientation toward service, knowledge and autonomy usually associated with professional groups. It is, therefore, not surprising to find that among the numerous problems that currently beset occupational and physical therapy, the first and most essential one is autonomy

(American Occupational Therapy Association, 1969; Jarvis, 1979;Johnson, 1973; Lehmann, 1973; Maxwell and Maxwell, 1979; and Ogunleye, 1980).

Blazing the trail, in the quest for role autonomy, the American Occupational Therapy Association (1969, p.211) recommended that the service of qualified occupational therapists be provided to those in need of that service, directly without the requirement of a physician's referral. The association's argument was predicated on the belief that today's multi-disciplinary case conference wherein health professions pooled both the findings of their respective evaluation, and their recommendations for programming had made unrealistic the concept that the physician was the only member of the health team who suggested services from each discipline and does so in writing.

In June 1978, the Canadian Physiotherapy Association, at their annual general meeting voted unanimously to remove compulsory referral from the association's code of ethics. To buttress their decision, the association claimed that their educational preparation had provided them with the appropriate knowledge and skills to give adequate care to their numerous patients. While also noting then, the prevailing consumer's growing dissatisfaction with accessibility to health care, the association appealed to the Government to implement the Pickering report (1973)

which noted, among other recommendations, that,

> without the need for physicians' referral, patients could consult a physiotherapist as needed, either for a first incident of dysfunction or with reocurring symptoms for the same problem. Physiotherapy would be an alternative entry into recognised health services (OPA, p.42).

The first known study on the attitudes of occupational therapists toward role autonomy was conducted by Lehmann (1973) in the United States of America. In his doctoral dissertation which studied the job attitudes of some health professions, Lehmann found that although the majority of subjects agreed that occupational therapy should be more autonomous than it was at the time, most of them felt that complete independence from the physician's referral was not necessary. Using some of the questionnaire items employed by Lehmann (1973), Ogunleye, (1980) conducted a study of the job attitudes of occupational and physical therapists in the Alberta province of Canada for a Master's thesis. The study found that occupational therapists showed higher preference for role autonomy than the physical therapists. The preference for role autonomy was, however, most significant among the graduate occupational and physical therapists.

From the foregoing, it appears that both the occupational and physical therapists showed some degree of preference for role autonomy.

It could, therefore, be inferred that since most of the Nigerian occupational and physical therapists were trained abroad, they would probably have the same orientation toward role autonomy as their overseas counterparts.

The Problem to be Investigated

This study is an attempt to determine the extent to which occupational and physical therapists in Nigeria desire autonomy and the extent to which lack of it is related to job satisfaction. Generally, the central issue in the problem of autonomy at the level of the individual practitioner is the therapist's relationship to the physician.

As noted earlier, the medical profession has been instrumental to the development of occupational and physical therapy and the relationship extends to the therapeutic setting. However, as the educational requirements for the occupational and physical therapists have risen, the qualified occupational and physical therapists in Nigeria like their counterparts abroad might also be seeking autonomy to provide their services to those in need of them directly without the requirement of a physician's prescription.

Purpose of the Study

This study, therefore, is specifically designed to investigate the existence of relationship between role autonomy and job satisfaction among the practising occupational and physical therapists in Nigeria.

Theoretical Perspective

Several major studies have investigated the relationship between autonomy and job satisfaction. Porter (1963) in his adaptation of Maslow's (1943) Hierarchy of Needs theory added autonomy needs i.e. the desire for control over one's environment or destiny. Supporting Porter's (1963) adaptation, Argyris' (1973) predisposition model for motivation asserts that jobs that allow an individual to develop many abilities and to have increasing autonomy would allow for maximum satisfaction.

Leavitt (In Pugh, 1979) asserted that differences in satisfaction levels were relatively easy to relate to autonomy. He further noted that in the Western culture in which needs for autonomy, recognition, and achievement were strong, it was to be expected that positions which limit independence of action (peripheral positions) would be unsatisfying.

In explaining further, his existing views on motivation, Herzberg (1966, pp. 71-91), maintained that as well as economic needs, human beings have psychological needs for autonomy, responsibility, and development which have to be satisfied in work. He advocated the "enrichment" of jobs through additional responsibility and authority in order to

promote improved performance and increased mental health. But, Herzberg was quick to caution that the individual who concerned himself largely with vague aspirations, completely unrelated to his abilities and to the actual situation was simply one kind of hygiene seeker. He opined that such a person did not seek satisfaction in the job itself, but rather in those surrounding conditions that included such cultural noises as "any American boy can be president" or "every young man should have a University degree".

Reviewing several perspectives on organizational structure in the delivery of complex services, Checkland (1984) reiterated the notion that effective professional activity occurs in conjuction with some degree of professional autonomy. He explained further that an organizational structure that enables the service deliverer to remain an agent of his profession is likely to provide better and more innovative service.

Other relevant studies have provided insights that are of practical value to the administrator in a bureaucratic organization who wants to facilitate the delivery of human services. Participative decision making, colleague supervision - including control of ethical standards, and minimal formalization of procedures for service delivery - are repeatedly identified as managerial strategies/mechanisms that

recognise and encourage the responsible application of professional judgement to complex duties (Angona and Williams, 1982; Hall, 1975; Marjoribanks, 1977).

The paired concepts of the "zone of indifference" and the "zone of retained authority" seem to have significance in this study. Tosi and Carroll (1976, p.50) articulated the idea that workers are indifferent towards some administrative activities and decisions; indeed they do not wish to be involved with them. Reciprocally, Mohr (1977, pp. 919-947) pointed out that professionally trained workers expect to influence and participate in the making of those decisions which within their perceived area of expertise, that is, their zone of retained authority.

In what Scott (1975, p.98) describes as the heteronomous professional organization - that is, in libraries, schools, or social service agencies - the bureaucratic structure should be made to accommodate some degree of professional autonomy on the grounds that the goals of these organizations and of their professional employees are congruent. The organization structure offers a context in which employees may accomplish the complex tasks that result in the delivery of the agreed - upon service.

In his own contribution, Fagbamiye (1981) lamented the gradual erosion of autonomy by the erstwhile Federal Military Government of Nigeria when the latter ordered the University Councils to sack University teachers without taking cognizance for statutory procedures for removing them. He also noted that the idea of a visitor to the federally owned universities was not popular among intellectuals. This was because the visitor was vested with the power to supervise and discipline employees instead of the University Council. Fagbamiye's other important findings revealed that those lecturers who were married, more qualified, and more experienced in University teaching in Nigeria were the most dissatisfied with the university system on the basis of the remunerations and other conditions of service. He also found that the more experienced and the older respondents expressed greater dissatisfaction with the existing level of university autonomy than the younger and less experienced lecturers.

In the fields of occupational and physical therapy, job satisfaction studies have been rather scanty and the existing ones have barely scratched the surface in assessing the extent to which therapists have role autonomy and enjoy job satisfaction. However the most notable one to date is that conducted by Barnes and Crutchfield (1977, pp. 35-40) who examined job satisfaction - dissatisfaction factors among

a sample of twenty-five physical therapists engaged in private practice and twenty-five physical therapists employed as chiefs of departments in a survey research. The purpose was to determine the meaningfulness of work for physical therapists and to compare private practitioners with therapists who worked for public institutions. They found that ten factors out of the sixteen studied were significantly satisfying or dissatisfying for all therapists. Institutional therapists were satisfied with the work itself and valued recognition for their efforts, whereas private practitioners were more concerned with personal responsibility. Institutional therapists experienced periods of unhappiness with autonomy and some policies of the organization, and private practitioners were unhappy with long working hours.

From the foregoing, it would seem that jobs which facilitate autonomy for employees and provide them with opportunities for participation in decision making particularly over those policies which have direct influence on their work and similar hygiene matters are crucial to the satisfaction or otherwise of employees.

Conceptual Hypothesis

Considering the two variables - role autonomy and job satisfaction identified in the foregoing analysis, the conceptual hypothesis which arises is:

The extent to which role incumbents perceive job autonomy is a crucial variable in the level of satisfaction expressed by them.

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CHAPTER TWO

REVIEW OF THE LITERATURE

Role Theory

In discussing role theory, Lonsdale (1964, p.149) saw organizations as social systems which are made up of people who occupy various positions in vertical as well as horizontal relationships to one another. He believed that the way people behave in their various positions depend in part on how they think that they are expected to behave and on how others actually expect them to behave.

In their own contribution, Getzels, Lipham and Campbell (1968, pp. 52-78), asserted that role could be used in relation to society as a whole, by regarding role as being synonymous with patterns of observed behaviour, and also in relation to specific groups or institutions in a social system, by thinking of roles as the structural or normative elements defining the behaviour expected of role incumbents, that is, their mutual rights and obligations.

However, according to Parsons and Shils (1951, p.23) role is defined as,

> Organized sector of an actor's orientation which constitutes and defines his participation in an interactive process. It involves a set of complementary expectations concerning his own actions and those of others with whom he interacts.

For purposes of this research, it is the above definition of role, which relates to specific groups, or institutions in a social system, that appears useful for the analysis of the therapists' behaviour within the health care system.

Role Autonomy

Among the many characteristics that differentiate a profession from an occupation, autonomy, self-regulation and self-control which are synonymous with freedom in regulating work behaviour appears the most important (Etzioni, 1969; Freidson, 1970; Katz, 1968; Lieberman, 1970; and Vollmer and Mills, 1966) to professionals. This point of view was implicitly recognized by Illich, Zola, McKnight, Caplan and Shaiken (1977, pp. 17-18), when they noted that professional authority comprised three roles,

> the sapiental authority to advise, instruct and direct; the moral authority that makes its acceptance not just useful but obligatory; and charismatic authority that allows the professional to appeal to some supreme interest of his client that not only out-ranks conscience but sometimes even the raison d'etre.

Lieberman (1970, p.58) also concurred with this view when he noted that because a professional could do a "specialised task" which by definition no one else could fully comprehend, he would demand autonomy in order to enforce and preserve his standards. But Clark (1966, p.286) noted that all professional groups would not need the same degree of autonomy. According to him,

> professionals who largely give advice or follow the guidelines of a received body of knowledge require extensive but not great autonomy for the individual and the group. They need sufficient leeway to give an honest expert opinion or to apply the canons of judgement of their field. Those requiring great autonomy are those who wish to crawl along the fontiers of knowledge, with flashlight and flood-light in hand, searching for the new — the new scientific finding, the new re-interpretation of history, the new criticism in literature or art.

However valid the professional's argument for autonomy and self-control, the views of other writers who have arguments against complete autonomy for the professional are also worthy of consideration. Schwartz (1952, p. 31) emphasisized that,

> It is regrettable that the public has to be on its guard whenever an occupation sets out to establish its status as that of a profession. For one thing, customers tend to be transformed into clients, which means that pounds are automatically converted into guineas. More serious is the fact that the occupation almost invariably lays claims to powers of self-regulation which insensibly or deliberately entail monopoly.

As a result of the foregoing, the concept of role autonomy used in this research was given by Freidson (1970, p.53) who conducted a sociological study of the medical profession. This definition is contained in the introductory aspect of chapter one of this thesis.

Pavalko (1971, p.26) affirmed that a firm core of theory and intellectual knowledge are crucial to the concept of role autonomy. In his conceptual model of occupation - profession continuum, Pavalko listed six other dimensions of work which were considered important in differentiating occupations from professions. These are: relevance to social values, long and specialised training period, motivation influenced by service, long term commitment, high sense of community, and highly developed code of ethics.

These dimensions approximate the two main characteristics viz knowledge and service which Gross (1966, p.9) described as the most important criteria of an ideal-type profession.

He noted that,

> As any occupation approaches professional status, there occur important internal structural changes and changes in the relation of the practitioners to society at large.
> A useful way of discussing these changes is by reference to the criteria of professionalization: the unstandardized product, degree of personality involvement of the professional, wide knowledge of a specialized technique, sense of obligation (to one's art), sense of group identity, and significance of the occupational service to society.

Professional Knowledge

In describing a group of professions whose claim to the status of doctors and lawyers was neither fully established, nor fully desired, Etzioni (1969, p.v) referred to these professions as semi-professions.

> Their training is shorter, their status is less legitimated, their right to privileged communication less established, there is less of a specialized body of knowledge, and they have less autonomy from supervision or societal control than "the" professions.

Etzioni was, however, careful to point out that the term "semi-professions" was not used in a pejorative sense.

Goode (1969) also noted that many aspiring occupations and semi-professions would never reach the levels of

knowledge and dedication to service which society would consider necessary for a profession.
He gave examples of school teaching, nursing, librarianship, pharmacy, stock-broking and others as some of these semi-professions and occupations.

Freidson (1970, p.69) intimated that,

> Those paramedical occupations which are ranged around the physician cannot fail to be subordinate in authority and responsibility and, so long as their work remains medical in character, cannot gain occupational autonomy no matter how intelligent and aggressive its leadership. To attain the autonomy of a profession, the paramedical occupation must control a fairly discrete area of work that can be separated from the main body of medicine and that can be practised without routine contact with or dependence on medicine. Few if any of the present paramedical occupations deal with such potentially autonomous areas.

Perhaps part of the dependence of paramedical occupations on medicine could be explained by what Pavalko (1971) referred to as "Professional marginality".
He described this phenomenon as "contradictions or inconsistencies in the extent to which work groups exhibit professional elements or characteristics that constitute the occupation-profession continuum". He cited occupational therapy as an example of a profession experiencing incomplete professionalization. Noting several factors in the historical development of occupational therapy that had prevented

the emergence of a high degree of autonomy, Pavalko (1971, p. 36) concluded that,

> The physician's prescription has remained, however, as a symbol of his control over treatment and is an apparently thorny reminder of the occupational therapist's subordinate status.

The issue of prevalence of women in most semi-professions was recognised as one reason for lack of autonomy and professional status for these occupations.

Simpson and Simpson (1969, p.199) noted that,

> The predominantly female composition of the semi-professions strengthens... bureaucratic control in the organizations in which they work. The public is less willing to grant autonomy to women than to men. A woman's attachment is to the family role; women are therefore less intrinsically committed to work than men and less likely to maintain a high level of specialized knowledge.

Service Ideal or Collectivity Orientation

Hoy and Miskel (1978) pointed out that one of the characteristics of professional orientation is the extent to which a practitioner provides service to his clients. They believed that this service ideal is of pivotal importance in legitimizing professional status. The professional is expected to subordinate his own intersts and act in the

best interests of the client. They reasoned that if a professional acts primarily in self-interest, then the condemnation and the sanctions of his colleagues and of the community usually hurt that very self-interest. Thus, the "altruism" of professionals is maintained because failure to conform to the service norm is less rewarding than conformity.

Concept of Job Satisfaction

Ever since the pioneering efforts of Hoppock (1935), numerous attempts have been made to identify those factors which affect job satisfaction. The definitional problem was recognised by Ejiogu (1981, p.6) when he stated that although there was an enormous output of literature on job satisfaction written by industrial and occupational sociologists and psychologists, there was yet to emerge a universally acceptable definition of job satisfaction. However in spite of this, attempts have been made at plausible definition of the concept of job satisfaction.

Vroom (1964, p.99) defines it as "the positive orientation of an individual towards the work role which he is presently occupying". Locke (1969, p.310) sees it as "the pleasurable emotional state resulting from the appraisal of one's job as achieving or facilitating the achievement of one's job values".

Guion (1958, p.59), on the other hand, describes it as "the extent to which the individual perceives that satisfaction as stemming from his total job situation". In all these definitions, job satisfaction started and ended with the individual.

Cameron (1973, p.7), however feels that true satisfaction should go beyond the individual. He feels that even if his needs and values are satisfied on the job, yet his satisfaction will not be complete "if he perceives some comparable job as satisfying his needs better or with less effort required".

In this study therefore, job satisfaction is seen as the totality of what a man expects and gets from his job, "a combination of psychological, physiological and environmental circumstances that cause" a person trutufully to say "I am satisfied with my job" (Hoppock, 1935; p.47).

Theories of Job Satisfaction

Although different theories of job satisfaction which have been advanced, have some relevance in this study, only the salient ones will be reviewed in this section. These are: Maslow's (1943) Hierarchy of Needs, Schaffer's (1953) Fulfilment and Herzberg's (1959) Two-Factor theories.

Maslow's (1943) Hierarchy of Needs

This theory has become one of the more popular conceptualizations for human motivation. It is based on the assumption of a state of imbalance or dis-equilibrium in an individual which he or she seeks to restore to normality or to a state of homeostasis. Human needs, according to Maslow, can be classified into five distinct hierarchical categories ranging from the lowest to the highest order needs. This formulation specifies that the most basic needs must be reasonably satisfied before the next higher level needs are satisfied.

The physiological needs are those basic needs of the human organism which are controlled by chemical and neural conditions within the body. They include food, water, air, sleep and sex. Maslow regards these physiological needs as the most urgent of all needs.

Safety needs constitute the second group of Maslow's needs hierarchy; they are the needs of an individual for an environment that is free the threat to his or her needs. The safety needs involve the avoidance of such physically harmful situation as excessive heat and cold, poisonous chemicals, accidents and pain.

Love needs rank third in Maslow's needs hierarchy. These relate to an individual's need for affection from other people: the need to be accepted by one's colleagues or peers. Love needs manifest themselves in the individual's hunger for friends, sweet-heart, wife, children and a general longing for affectionate relationships with others.

Is 'sweet heart' used exclusively by women? If not, the word sweet-heart is sufficient here; wife is unnecessary.

Next in Maslow's order of needs come esteem need, which is the need for self esteem and the respect of others. Maslow sub-classifies esteem needs into those which relate to the desire for strength, achievement, adequacy and self-confidence and those which relate to a desire for reputation or prestige.

Self-actualization is the highest in the hierarchy of need and it is the individual's search for self-fulfilment. It is "the desire to become more and more what one is capable of becoming" (Maslow 1970). In a job situation this need, it is argued, manifests itself in the desire to do work that is itself satisfying and rewarding; a desire or need to achieve one's full capacity for doing a thing. Self actualization is considered to be a "growth need" while the rest are regarded as "deficit needs" which must be satisfied before any "growth" can take place. Maslow argues that not everyone can function on the self-actualization level. For him self-actualizing persons are essentially motivated

by the sheer enjoyment which they derive from using and developing their capacities.

Maslow's work has generated many studies either to support or disprove it. Maslow was even reported to have said that "it is not nearly as rigid as he may have implied". A modification of Maslow's theory which is treated by some researchers as a theory on its own is Alderfer's (1969, pp. 142-175) E.R.G. Theory. He compressed Maslow's five hierarchy of needs into three which he named Existence, Relatedness and Growth (E.R.G.). Existence approximates Maslow's Physiological and Safety needs, Relatedness equates Love and Esteem needs while Growth is likened to Self-actualization need. Alderfer rejected Maslow's postulation that some needs ceased to play an active determination or organizing role as soon as they are gratified.
Instead he believed that all needs could be concurrently active.

Another major criticism of Maslow's theory is in his ordering of needs into a hierarchical form. It is argued that much depends on an individual's other characteristics such as his idiosyncratic talents and constitutional peculiarities.

Friedlander (1965) in his study of the relative importance of job aspects for 1,468 government employees, has shown that Maslow's hierarchy of needs theory cannot claim universal applicability. Self-actualization needs were found to be more important to white collar workers while interpersonal values were more important to blue-collar workers. He further stressed that some people might be naturally creative and this creativeness would dominate everything else.

In spite of the various criticisms of Maslow's theory such as that it is idealistic and sometimes vague, its strength lies, as earlier mentioned, in its conceptualization of the complex nature of human needs or motivation, (Ejiogu, 1980, p.12).

The Fulfilment Theory

Believing that "work is a special area of human behaviour" and that "whatever psychological mechanisms operate to make people 'satisfied' or 'dissatisfied' in general, also make them satisfied or dissatisfied in their work". Does not quite flow into the next paragraph & next page.

Schaffer (1953, p.3) added the intensity dimension into the Needs theory, known as fulfilment theory. It states that,

> Overall job satisfaction will vary directly with the extent to which those needs of an individual which can be satisfied in a job are actually satisfied. The stronger the need, the more closely will job satisfaction depend on its fulfilment.

In other words, fulfilment theory is based on an assumption that the extent to which an individual feels satisfied or dissatisfied depends on the strength of his or her needs and desires and the degree to which he or she can visualise and make use of opportunities in the job situation for the satisfaction of those needs.

Schaffer recognises twelve categories of needs and he formulated a questionnaire to test the strength of each of the twelve need categories, the degree to which each of the needs was being satisfied in the individual's job and the individual's overall job satisfaction.

In a study of seventy-two employees made up of thirty-seven professional - managerial staff, twenty clerical - sales, eight skilled and six semi-skilled workers, from four different organizations - an industrial manufacturing plant, a departmental store, a government agency and a vocational

guidance agency, Schaffer found that creativity and challenge, mastery and achievement and helping others (similar to Maslow's higher order needs) were the strongest needs. Nevertheless, the findings may have been influenced by the dominance of professional - managerial and skilled personnel - forty-five out of seventy-two.

The major criticism of this theory comes from Locke (1969). In his observation, he indicated that people's job satisfaction seems to be a function not only of how much they receive but also of how much they feel they should receive.

Herzberg's Two-Factor Theory

This theory is also known as motivation - hygiene theory of job attitudes. It was first drawn from an examination of events in the lives of engineers and accountants by Herzberg, Mausner and Snyderman (1959). Since then, it has been reported that at least sixteen other investigations, using a wide variety of populations (including some in the communist countries) have been completed, making the original research one of the most replicated studies in the field of job attitudes. The central theme of this theory is that job factors which satisfy workers and job factors which dissatisfy workers are not arranged on a conceptual continuum but are mutually exclusive.

In a survey conducted by Herzberg and his associates, they stated that there were two sets of needs for a man -- "his need as an animal to avoid pain and his need as a human to grow psychologically" (Herzberg et al., 1966, p.71). The first set of needs they termed "motivators" which consist of achievement, recognition, work itself, responsibility and advancement. The other "dissatisfiers" or hygiene factors which tend to produce short-term changes in job attitudes include company policy and administration, supervision, interpersonal relationships, working conditions, status, salary and security.

Hoy and Miskel (1978, pp. 102-107) assert that Herzberg's two-factor theory's appeal lies in its close conceptual relationship with Maslow's popular hierarchy of needs theory. Both theories emphasize the same set of relationships. Maslow focuses on the general human needs of the psychological person, while Herzberg concentrates on the psychological person, in terms of how the job affects his basic needs.

Herzberg's two-factor theory has also been subject to criticisms. Ejiogu (1980) argued that people find it difficult not to see job satisfaction and dissatisfaction as opposites or on a continuum with dissatisfaction on the negative side and satisfaction on the positive side.

As Herzberg (1968, p.56) himself explains,

> Stating the concept presents problem in semantics, for we normally think of satisfaction and dissatisfaction as opposites i.e. what is not satisfying must be dissatisfying, and vice versa. But when it comes to understanding the behaviour of people in their jobs, more than a play on words is involved.

Another criticism of Herzberg's theory maintains that it is tied to its method. In other words, Herzberg's results are replicable only when his critical incidents technique is used. Soliman (1970) notes that most of the studies using Herzberg's technique support the motivation - hygiene theory.

The most often mentioned criticism is the fact that it used recall method. This might lead to selective bias in recall and projection of individual failure on to external sources. Supporting this view-point, Vroom (1964) theorizes that bias is injected because individuals tend to see causes for satisfaction as coming from themselves (motivators) and to attribute dissatisfaction to forces in the environment (hygienes).

Role Autonomy of Occupational Therapists

According to Bridle (1979, pp. 105-111), occupational therapy has received a legacy of subordination and submission to external pressures and commands because of its historical

background under the aegis of medicine. Because of this, the issue of professional autonomy has become a major issue confronting occupational therapy (American Occupational Therapy Association, 1969; Jarvis, 1979; Johnson, 1973; 1977; and Tate, 1974).

Yerxa (1967, p.2) had earlier noted the changes and development that were then apparent in the field of occupational therapy and declared,

> the written prescription is no longer seen by many of us as necessary, holy or healthy... The pseudo-security of the prescription required that we pay a high price. That price was the reduction of our potential to help clients because we often stagnated at the level of applying technical skills.

It is however interesting to note that the above views were not supported by the findings of Lehmann's (1973) study. In his doctoral research designed to determine the attitudes of occupational therapists toward role autonomy, complete independence from the physician's referral or prescription was not fully endorsed.

The Need for Professional Knowledge in Occupational Therapy

One cannot under-estimate the fact that the existence of a body of knowledge serves as the basis for legitimizing the action of professionals.

After reviewing the characteristics of a true profession widely accepted as criteria of professionalism in relation to occupational therapy, Yerxa (1967) concluded that occupational therapy was on the threshold of becoming a true profession according to the accepted criteria of professionalism. She listed the development of a systematic body of theory and knowledge as one of the characteristics which appeared to need the greatest strengthening.

Supporting this view-point, Reilly (1969, p.300) advocated that occupational therapy should move away from the medical model in order to create its own knowledge base as an orientation to a way of thinking. This way of thinking should start with a clear delineation of the therapist's role within the medical millieu. She stated emphatically that,

> we have identified the critical difference between medicine and occupational therapy as: it is the task of medicine to prevent and reduce illness; while the task of occupational therapy is to prevent and reduce the incapacities resulting from illness.

Lamenting the inadequacy of knowledge in occupational therapy, Fidler (1977, p. 655) noted that,

> to expect that the art and science of occupational therapy can be learned, that the attitudes, the cognitive, research, and judgement skills required of a professional can be developed within a four or five year post-high school education, strongly suggests that we misunderstand the breadth and depth of a profession and that we are indeed caught in the dilemma of saying one thing (we are a profession) and doing another (providing vocational education for our practitioners).

She therefore advised that only graduate level education could provide the profession with a unique body of knowledge.

Maxwell and Maxwell (1979) also noted that if occupational therapy was to avoid "mobility deprivation", graduate training should be encouraged. In their study, the authors noted that a significant percentage of occupational therapists felt threatened or somewhat threatened by other professions making in-roads. They felt that many of these problems could be resolved to a very large extent by the development of graduate programmes in occupational therapy which would provide therapists with the opportunity for further training in the various specialities in the profession.

This issue of specialization in occupational therapy as a way of applying new knowledge to the improvement of care

was given ample support by some writers. In a key-note address to an annual general meeting of the American Association of Occupational Therapists, Silver (1979, pp. 15-19) advised that there was a need for specialization in all the professions, arising from "the inexorable and necessary aspect of the growth of knowledge and social demand" and resulting in "the compulsion to continually relate specialism to the common good".

Gillette and Kielhofner (1979, pp. 20-28), also drew some helpful perspectives on the evolution of specialization in occupational therapy. While Kielhofner saw specialization as possibly leading to fragmentation and precluding development of a stronger generic identity, Gillette viewed specialization as one aspect of the drive toward professionalization and the autonomy implicit in the achievement of that goal.

Diasio (1979), drawing upon General Systems Theory, argued for the need of specialization in occupational therapy but cautioned that integration with the whole, namely a generic or core knowledge base, was essential. Fidler (1979, pp. 34-35) also supported this view. Clark (1979, pp. 36-37), writing in the same vein, advised that the direction of new graduates toward specialities was inevitable, but warned of "elitist" attitudes that usually resulted from specialization

expertise.

In a more succinct way, Grant (1984, pp. 643-645) tried to identify factors currently affecting occupational therapy educational programmes. He specifically referred to critics who voice two major areas of concern about educational standards set by professional organisations as also applicable to occupational therapy. First, that academic degree levels specified by professional organizations are too high, and second, that educational standards are not sufficiently related to practice demands. But Tanguay (1985, pp. 466-468) disagreed. In his opinion, he felt that a vibrant and successful profession must move forward, and should have a group of academic leaders in addition to respected providers of service. He warned that,

> if occupational therapy remains solely a profession, with little emphasis on academic matters, it is in great danger of disappearing as a serious discipline.

Professional Knowledge and Research

Since the inception of the Master's programmes in occupational therapy, some researchers have carried out studies to determine the need and adequacy of such programmes. Lucci (1974, pp. 292-295), in a survey of programmes identified as the "basic master's" and of graduates who had passed through it, found that 80 per cent of the respondents stated

that their educational programme prepared them to be competent therapists, 10 per cent indicated it did not, 8 per cent were ambivalent and 1 per cent questioned the degree of competency.

Christiansen (1975, pp. 352-355) randomly selected recent graduates of occupational therapy to determine their perceptions of the adequacy of their professional training. Based on the findings of the research, he concluded that,

> Perhaps more consideration needs to be given to the alternatives of either extending the length of program to allow more in-depth courses, or allowing specialization at some point during the student's advanced training. Additional study on the questions of specialization and basic program length seems warranted.

Believing that occupational therapy education was inadequate to prepare the therapists for managerial positions, Gilewich (1979, pp. 131-137) conducted a survey to gain a perspective of occupational therapists engaged in managerial positions across Canada. She found that 53 per cent of the respondents reported no specific course work (either in university undergraduate, graduate, continuing education or other form) prior to assuming a managerial position. Eighty-three per cent of these respondents were reported to have taken courses specific to management prior to or since assuming a management position.

In a well documented study of occupational therapy in Canada, Maxwell and Maxwell (1979) reported the findings of their study on graduate education of occupational therapists. In the survey, the authors asked occupational therapists and those medical practitioners and administrators in health care field most closely associated with occupational therapy the type of degree requirements they envisaged for entry into practice in various positions in occupational therapy between 1980 and 85. The authors reported that a very small percentage of each group saw staff therapists as requiring more than a bachelor's degree. Some felt the old style three-year diploma was still adequate. A relatively high percentage of the therapists saw the bachelor's degree as adequate for both private practice (68 per cent) and community team therapists (82 per cent).

When the authors looked at the percentages of each group recommending master's or doctoral degrees for the broad range of positions in occupational therapy, the percentage of medical specialists and administrators recommending these graduate degrees was higher than the percentage of occupational therapists themselves who thought graduate education was required. They also found that 25 per cent of the respondents experienced the need for someone with greater expertise in their departments either daily or at least twice a week.

However, in a related study, Clark, Sharrot, Hill and Campbell (1985, pp. 155-162) found that both undergraduate and post graduate occupational therapy students felt that post graduate education of specific kind and quality enhances the professionalism of occupational therapy other than undergraduate education.

The Need for Service Ideal or Collectivity Orientation in Occupational Therapy

According to Maas, Specht and Jacox (1975), accountability should be required of professionals in their own interest to discourage the misuse of autonomy. They noted that functionally, autonomy and accountability could not be separated.

Writing on accountability programming for occupational therapists, Dunning (1975, p.38) suggested that,

> since occupational therapists work in a variety of settings with different age groups and with both normal and disabled clients, each therapist must create an accountability plan appropriate to the setting and client group.

Realizing the concern for ethics today, both in education and in the delivery of health services, Welles (1976, p.44) agreed that in reality if an association of

providers accepted a uniform set of principles, it would enhance the stature of all of them far more than if each individual was held responsible only for his own. She advised that,

> occupational therapy as a discipline accepting concern for those it serves must establish a broad, inclusive code of ethics, together with accompanying guides and education, consultation, and problem-solving services to facilitate their implementation.

On challenges facing occupational therapy, Johnson (1977, p. 113) intimated that,

> occupational therapists have always valued humanitarianism but the imposition of accountability today creates innumerable conflicts as one attempts to balance personal and professional values or ideals within the realities imposed by the system, culture, or society within which one works or lives.

In the past, occupational therapists had apparently used strategies of diffidence and deference which they now perceive to be ineffective for professional development in an era of accountability and financial restraint. Political strategies have therefore been recommended as appropriate and effective for achieving professional goals (Maxwell and Maxwell, 1977; O'Shea 1979).

In a study of occupational therapy (Maxwell and Maxwell, 1977), 78 per cent of the respondents were dissatisfied with the recognition given occupational therapy as a profession by society at large, 58 per cent were dissatisfied with the recognition given by other professionals, and 90 per cent of those surveyed thought that the public under-valued the profession.

Concerned with the lack of acquisition of professional identity, O'Shea (1977, pp. 101-108) investigated occupational therapy students' acquisition of professional identity during initial praticum experiences. She found that students' belief in their performance as occupational therapists, was weakened by inattention to the "dramaturgical elements" of their performance. This led to the students' difficulty in eliciting a sincere response from clients; she also found that students also lacked preparation in appropriate role behaviour which resulted in advertent role confusion and presentation of an unconvincing performance.
Based on these findings, she noted that,

> absence of cognitive awareness of our interactional behaviour not only potentially restricts our own effectiveness in promoting personal professional development but in addition perpetuates through education, behaviour patterns which are maladaptive for professional change.

Role Autonomy of Physical Therapists

The general desire for more autonomy has been apparent in the physical therapy literature for some time and has usually called for increased autonomy in colleague relationships with physicians (Bartlett, 1979; Goetz, 1978; Magistro, 1976; Mathewson, 1974; Ontario Physiotherapy Association, 1979; Rosen, 1978; Semple, 1974).

In his presidential address, Magistro (1975, pp. 1199-1208) listed lack of autonomy as one of the critical issues acting as road-blocks to a rapid development of the profession. The Canadian Physiotherapy Association (CPA, 1979, pp. 41-43), was no less vocal in its demand for role autonomy when the body unanimously resolved to remove compulsory referral from the Association's code of ethics at its annual general meeting of 1978.

Bartlett (1979, pp. 1378-1387), while offering some caution to those therapists who were demanding complete autonomy of practitioner referral warned that,

> no matter what services are to be provided, the key to better health maintenance and health care is interdependence among members of the health care team.

Rosen (1978. pp. 69-71) who also showed some concern about the militant demand for autonomy warned that,

> we are in danger of trying to usurp the function of another profession, and in so doing we are downgrading our own... we are not licenced to diagnose or prescribe... Our profession should stop confusing "evaluation" with "diagnosis" and our schools of physical therapy should stop trying to make MDs of us.

Noteworthy, however, is that after a long and bitter struggle with the American Medical Association, the American Physical Therapy Association was granted the permission to institute its own accreditation programmes in January 1977 (Bartlett, 1979, pp. 1378-1387).

Prominent among research findings on the issue of autonomy in physical therapy was the Ontario Physiotherapy Association's (1979, pp. 41-43) research on medical referral. In claiming that the referral system was not a successful process, the following data was given. Of the 9,630 charts from 130 institutions in Ontario, only 12 per cent of the referrals provided information on the medical, psycho-social history of the patient relevant to the care required, 7 per cent gave advice on restrictions or contra-indications and 17 per cent provided information on the physian's treatment goal. With the scanty referral information provided, the therapists had to acquire pertinent information from the

patients before commencing treatment. Forty-four per cent of the referrals surveyed requested that the therapist make the decisions regarding care. From the foregoing, the Association reasoned that the referral process alone was not serving the public and it was not providing the therapists with the information necessary to give adequate care.

Another interesting research finding was provided by Seymour, Connelly and Gardner (1979, pp. 399-404) in their attitudinal survey of physical therapists toward continuing education for relicence. They found that, ~~of the~~ majority of respondents, (73 per cent) were in favour of mandatory continuing education for relicence while 24 per cent were against it and 3 per cent had no opinion. When the 73 per cent of the respondents were then asked if (WW the) preferred periodic re-examination rather than mandatory continuing education for relicense, 8 per cent responded affirmatively and 92 per cent said they were not in favour. Based on these findings, the investigators believed that the respondents' argument was based on the need for a profession to prove to the consumer its commitment to improving the quality of health care.

The Need for Professional Knowledge in Physical Therapy

Since the establishment of the first school of

physiotherapy at the University of Toronto, knowledge seems to have proliferated at a fast pace. According to Semple (1974, pp. 28-29), the board of directors of the Canadian Physiotherapy Association had passed a resolution to the effect that only graduates of university based programmes would be approved for membership of the Association in the future. Lubkowsk (1974, pp. 30-31), Pady (1974, pp. 29-30) and Valentine (1973, p. 131) supported the resolution believing that it was only through professional education that students could acquire the knowledge, skills and attitudes to prepare them for complete acceptance of the responsibilities, rights and priviledges of their profession.

Realising the inadequacy of the erstwhile entry level education to physical therapy, Bartlett (1979, p. 1385) recalled Worthingham's (1970) study of basic physical therapy education in which she stated that,

> if physical therapists are to assume a professional role in relationship to other health professions, including medicine, a closer approach to peer equivalence, mutual respect, and recognition of responsibility is essential. When the majority of practitioners are at the baccalaurete level, such an accomplishment is unlikely.

As a boost to the above views, the American Physical Therapy Association's (1979, p. 1397) house of delegates resolved to upgrade the entry level education to post baccalaureate degree.

The association further resolved that all educational programmes for the physical therapist should comply with the policy on the entry level education by December 31, 1990.

Supporting this resolution, Helewa (1979, pp. 41-43), in her presidential address to the Canadian Physiotherapy Association noted that,

> a master of science as a basic educational requirement for physiotherapists is not a novel idea; ... such a degree has the potential of upgrading clinical skills and academic knowledge.

Research has also been a major topic of discussion in educational settings and has had ample priority in the physical therapy activities. Believing that accurate assessment and recording were the basis for research, Scott (1974, p.157) observed that research,

> seems to be the most reasonable way to create a foundation which is essential for substantiation of physiotherapy methods. It allows treatment to be changed whenever necessary, provided the changes and reasons are recorded. It also requires the development of vigorous evaluative procedures.

After specifying areas in physical therapy where research could make great contributions, Basmajian (1977, p.284) declared that,

> research is essential to a profession. It is a true well spring from which physical therapy will derive present and future sustenance, accelerated growth, and the ability to help millions of handicapped people.

He went further by offering an uncompromising recommendation when he stated that research was mandatory if physical therapy was to remain identified as a true profession rather than a respected technology.

The Need for Service Ideal or Collectivity Orientation in Physical Therapy

At the tenth Mary McMillan lecture, Hislop (1975, p. 1078), devoted a substantial part of her lecture to the essence of professionalism in physical therapy. On the survival of the profession, she stated that it is,

> by providing a unique and distinct service to the people -- service not equalled in its excellence, breadth, or comprehensiveness by any other group.

In his presidential address, Magistro (1975, pp. 1199-1208) also noted that one of the militating factors against

professionalism in physical therapy was the standards of all hospital based physical therapists. He was rather emphatic in his opposition to any standard which interposed a secondary physician between the referring practitioner and the physical therapy service.

Addressing also the issue of professionalism in physical therapy, Bartlett (1978, p. 1327) argued that,

> it is an accepted fact that physical therapy during the past five decades has moved to a higher level of professionalism, yet careful evaluation of our current professional status reveals certain shortcomings that continue to inhibit its further growth and development.

Bartlett listed these major deterrents as: lack of an appropriate scientific body of knowledge specific to the profession, lack of broad community sanction by the public with which physical therapy associated and the resulting approval by the public of their professional authority.

While expressing her dissatisfaction with the formulation of moral policy decisions in health care, Purtilo (1978, p. 1076) recommended that health professionals ought to be included in the policy-making process so that they would not cease to feel accountable.

She added emphatically that,

> physical therapists have traditionally been identified as care givers. In the minds of some therapists and many other persons, this tended to exclude them from policy-making roles at any level except perhaps within their professional organization.

Conclusion

The foregoing review of the literature seems to indicate the existence of the problem of role autonomy and job satisfaction faced by emergent professions such as occupational and physical therapists in their attempt to move from the occupational end of the continuum to the professional.

First, it was pointed out that the professionalization taking place in these professions has been characterized by a drive toward autonomy. In essence, it is a thrust toward a better status, a greater independence and authority over decisions which have to do with work and how it is done. Such a thrust relies essentially on the possession of expert knowledge and its scope refers to the amount of authority acquired or wrested by a group of professionals or a professional association over a range of decisions. The literature also identified the criteria of professionalism which were considered as germane in differentiating professions from occupations.

Secondly, the three different theories of job satisfaction: Maslow's (1943 Hierarchy of Needs, Schaffer's (1953) Fulfilment and Herzberg's (1959) Two-Factor which have been reviewed in this chapter seem applicable to this study. Because the job represents an important opportunity for self-actualization, by performing the task unencumbered, an occupational or physical therapist can achieve the rewards i.e. achievement, recognition, responsibility autonomy that reinforce self-actualization.

This study, therefore, attempted to find out whether the occupational and physical therapists in Nigeria agreed with the views expressed in the literature and research findings which link autonomy with job satisfaction.

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CHAPTER THREE

METHODOLOGY

Subjects

The subjects consist of all occupational and physical therapists who were registered and active members of the Nigerian Association of Occupational Therapists (NAOT) and the Nigeria Society of Physiotherapy (NSP). Because of the paucity of their respective populations, questionnaires were sent to ~~everyone~~ all members whose names and addresses were properly listed in the two associations' registers.

There were thirty-four registered members with the Nigerian Association of Occupational Therapists as at 1985. By March 1986, when the questionnaires were administered, the Association's Secretary disclosed that seven therapists had already left the service for reasons ranging from death, retirement to leaving for post-graduate studies.

As at June 1985, 245 physical therapists were registered with the society, but only 205 therapists had their addresses properly listed.

Instrumentation

Two different instruments were used in this study to measure the two variables - professional role autonomy and job satisfaction. The instruments were made up of questionnaire items employed by Herzberg, Mausner and Snyderman (1959), Lehmann (1973), Maxwell and Maxwell (1977) and Meltzer (1980) and modified to suit the Nigerian environmental context. The items on the instruments were grouped into two sections (B and C).

Section B sought the opinions of the respondents about the general conditions of their work while section C sought information on the concept of autonomy, and professionalism (See Appendix 1).

Apart from the variables covered in the instruments, biographic variables such as sex, age, marital status, present work position and academic qualifications were included under section A of the questionnaire (See Appendix 1).

The Job Satisfaction Instrument

This instrument contains twenty-three statements designed to measure the degree of satisfaction of occupational and physical therapists. This Likert type instrument has the responses ranging from very satisfied to very dissatisfied. The job satisfaction inventory was based on the instruments used by Herzberg et al (1959) in their study of 203 engineers and accountants.

They identified two levels of needs for their subjects - "hygiene" needs (which tended to focus on the dissatisfaction factors identified in their study) and "motivators" or satisfaction needs (which tended to focus on the satisfaction factors identified). They also perceived some factors as satisfiers when present but not dissatisfiers when absent. Other factors were dissatisfiers; but when eliminated as dissatisfiers did not result in positive motivation.

The respondents were required to indicate the degree to which they were satisfied or dissatisfied with such things as recognition on the job, advancement opportunities, interpersonal

relations, working conditions etc.

Professional Role Autonomy Instrument

This instrument contains fifty items which were designed specifically to measure role autonomy and professionalism i.e. knowledge and service. This was accomplished by employing a rating scale of five for strongly agree and one for strongly disagree, from which the respondents ticked the most appropriate one (See Appendix 1).

The items were patterned after the instruments used by Lehmann (1973) for his doctoral thesis on occupational therapists' attitudes toward role autonomy, and those employed by Maxwell and Maxwell (1977) in their Queen's University study on occupational therapy and from those utilized by Meltzer (1980) in his study of the job satisfaction of physiotherapists.

According to Freidson (1970), self-regulative autonomy was the only truly important and uniform criterion for distinguishing professions from other occupational groups. He identified this as involving autonomy to practise, control and organize professional activities. Pavalko (1971) and Goode (Etzioni, 1969) also identified the dimensions of professionalism as incorporating essentially intellectual knowledge and service ideal.

The respondents were required to indicate the degree to which they agree or disagreed with issues such as responsibility to develop their departmental budget, opportunity to provide their services to clients without the requirement of a physician's prescription, authority to make either initial

or further diagnosis etc. They were further asked whether they had enough professional preparation to cope with such issues.

Pilot Study

A pilot study was carried out to determine the reliability and validity of the questionnaire items. Even though most of the questionnaire items employed had been tested for reliability in other settings, they were subjected to reliability and validity tests before they were used in this study. Six occupational and physical therapists from the Military Hospital, Yaba, and the National Orthopaedic Hospital, Igbobi were involved in the pilot study.

Reliability: According to Kerlinger (1973), reliability is the accuracy or precision of a measuring instrument. The interpretation of a reliability coefficient depends on the method used to obtain it (Ferguson, 1976). In this study, the spilt-half method was utilised. The questionnaire items were divided into two halves and two scores obtained on the odd and even items. These scores were then correlated. The subjects for the pilot study consisted of four physical therapists and two occupational therapists. Using the odd-even method, a correlation coefficient of 0.74 was obtained. This result was corrected with the Spearman - Brown Prophecy Formula which provides an estimate of the reliability of the whole test. This yielded a correlation coefficient of 0.85 (See Appendix 2).

Validity: Validity tests, both content and face validity, were carried out initially to evaluate the degree to which

Job Satisfaction and Professional Role Autonomy questionnaire items measure what they were supposed to measure within the context of the present study. Later, the SPSS Factor Analysis PA2 was used to identify those items which are most efficient for tapping job satisfaction and role autonomy.

According to Treece and Treece (1977), content validity has been described as the extent to which the instrument samples the factors or situations under study. The content of the instrument must be closely related to that which is to be measured. Face validity on the other hand was described by the same authors as logical validity which involves an analysis of whether the instrument appears to be a valid scale. This procedure however, calls for a high degree of subjectivity.

Content Validity

This was ascertained by submitting the instrument to five experienced and professionally qualified heads of occupational and physical therapy departments of the Military Hospital, Yaba, National Orthopaedic Hospital, Igbobi and the Lagos University Teaching Hospital, Idiaraba. They assisted in determining that the items contained in the questionnaire fully represent all the relevant aspects of the two variables involved in the study - role autonomy and job satisfaction. There was a consensus about its validity among these judges.

Face Validity

This is sometimes called logical validity, it involved the writer's analysis of whether the instrument appeared to be a valid

scale. In carrying this out, the writer solicited the assistance of a senior lecturer in the department of educational administration who vetted the questionnaire items.

As a result of the feedback from the occupational and physical therapists and the senior lecturer, some of the concepts were restructured while some items that appeared ambiguous to them were either reframed or completely removed.

Empirical Findings of the Questionnaire Items

Factor Analysis: This was utilized to determine the degree to which a given variable or several variables are part of a common underlying phenomenon or characteristic (Nie, Hull, Jenkins, Steinbrenner, and Bent, 1975, p.10). Factor loadings greater than or equal to .254 $p \leq .01$ were considered significant thereby reducing the gradual intrusion of unique variance into later factors (Nie et al, 1975, pp. 473-475). The varimax rotated factor matrix identified twenty-seven factors in all but only sixteen of these had eigen values greater than one whole number, accounting for 82.1 per cent of the variance, and only forty-nine items loaded significantly on these sixteen factors. Out of these, factor number two accounted for five items representing biographic variables. Table 3.1 gives the break-down of the eigen values, the

TABLE 3.1

THE RELATIONSHIP BETWEEN THE ITEMS AND THE DERIVED FACTORS USING PA2 VARIMAX ROTATION TECHNIQUE

Factor No	Eigen Value	Percentage of Variance	Cumulative Percentage of Variance	No of Items Which Loaded Significantly on Factor
1	6.74299	13.9	13.9	4
2	5.50018	11.4	25.3	5*
3	4.38554	9.1	34.4	3
4	3.40987	7.0	41.4	4
5	2.63723	5.5	46.9	5
6	2.144454	4.4	51.3	4
7	2.00645	4.1	55.5	3
8	1.88129	3.9	59.3	2
9	1.68959	3.5	62.8	2
10	1.64093	3.4	66.2	1
11	1.52847	3.2	69.4	2
12	1.42096	2.9	72.3	1
13	1.25998	2.6	74.9	4
14	1.20041	2.5	77.4	3
15	1.19470	2.5	79.9	1
16	1.08944	2.3	82.1	5

* Items loading on Biographic Factor.

transfer to p 79 before Table 3.1

variance accounted for, and the numbers of items which loaded significantly on each factor. Tables 3.2, 3.3 and 3.4 give a break-down of questionnaire items which were considered significant in tapping role autonomy, job satisfaction and professionalism. Out of the forty-four questionnaire items, role autonomy scale accounted for twelve, job satisfaction scale, seventeen and professionalism scale fifteen items.

Intercorrelations Among Questionnaire Items: Pearson Product Moment Correlations were performed on all the questionnaire items that loaded significantly on each of the scales used in the study. This was found useful in making a comparison, in testing relationships and in finding the correlation coefficients between the variables in the data (Treece and Treece, 1977).

Table 3.5 shows that intercorrelations among role autonomy items for occupational therapists range from $r = .000$ to $r = .810$, $p \leq .001$. Occupational therapists recorded their highest correlation of $r = .810$, $p \leq .001$ between permission to terminate or continue the treatment of their patients as they deem fit and the responsibility to develop their departmental budgets. Conversely, no correlation ($r = .000$) was found to exist between therapists being given the opportunity to make further diagnosis and their involvement in determining programmes which will best meet patient care objectives.

Table 3.6 also shows that intercorrelations among job satisfaction items for occupational therapists range from

$r = -.006$ to $r = .842$, $p \leq .001$. The relatively high correlation coefficient of .842, $p \leq .001$ was found between the items which stated that the introduction of more men into the profession would increase the status of the profession in the eyes of the medical authorities and by the same token would improve the career structure. On the other hand, the lowest negative correlation coefficient $r = -.006$ existed between the variety of equipment in the department and the reasonableness of pay compared with that of others in similar professions. The same correlation coefficient was also found between the availability of space for treating patients in the department and the confidence which patients have in the therapists' professional ability.

TABLE 3.2

ROLE AUTONOMY INSTRUMENT ITEMS

Variable Number	Questionnaire Items	*Pearson r
Please indicate the extent to which you agree with each of the following statements:		
31	Therapists should be permitted to terminate or continue the treatment of their patients as they deem fit.	.394
33	Therapists should be responsible for developing the budget for the departments under them.	.682
34	Therapists should be responsible for developing staff projections in their departments.	.539
36	Therapists as members of a health care team should be allowed to function more independently.	.523
37	Therapists within medical settings should be allowed to provide their services to clients in need of those services without the requirement of a physician's prescription.	.301

TABLE 3.2 (Cont'd)

Variable Number	Questionnaire Items	*Pearson r
38	It should be permissible for the therapist to violate medical protocol if it is in the best interest of the patient.	.311
39	Therapists should be given the opportunity to make the initial diagnosis.	.358
40	Therapists should be given the opportunity to make further diagnosis.	.784
41	Therapists should be given the opportunity to make differential diagnosis if the first appears wrong.	.776
42	Heads of departments should take responsibility for the actions of other therapists working in their departments.	.295

TABLE 3.2 (Cont'd)

Variable Number	Questionnaire Items	*Pearson r
53	The best interests of therapists would be served by conforming to professional standards rather than the standards set by their employing institutions.	.688
59	Therapists should be involved in determining programmes which will best meet patient care objectives.	.297

*Factor Loadings greater than or equal to r = .254, $p \leq .01$

TABLE 3.3

JOB SATISFACTION INSTRUMENT ITEMS

Variable Number	Questionnaire Items	*Pearson r
Please indicate the extent to which you are satisfied with each of the following statements:		
08	The amount of equipment you have in the department.	.831
09	The variety of equipment you have in the department.	.793
10	The space available for treating patients in the department.	.619
12	The physical condition of the building.	.627
13	The pay is reasonable compared with that of others in similar professions.	.790
14	The pay has not kept up with the cost of living.	.697
15	The pay is reasonable for the type of work I do.	.733
16	The conditions under which you have to work (i.e. lighting, ventilation, etc.).	.685
19	The amount of job security you have in your position.	.672

TABLE 3.3 (Cont'd)

Variable Number	Questionnaire Items	*Pearson r
20	Your control over the quality of your work.	.576
21	The amount of decision-making demanded by your position.	.676
22	The amount of responsibility demanded by your position.	.748
29	The confidence which your patients have in your professional ability.	.636
30	The extent to which you are left relatively free of supervision by others.	.651
71	The introduction of more men into your profession would increase the status of the profession in the eyes of the medical authorities.	.848
72	The introduction of more men into your profession would improve the career structure.	.884

TABLE 3.3 (Cont'd)

Variable Number	Questionnaire Items	*Pearson r
74	The introduction of more men into your profession would improve the salary structure.	.701

* Factor loadings greater than or equal to $r = .254$, $p \leq .01$

TABLE 3.4

PROFESSIONALISM INSTRUMENT ITEMS

Variable Number	Questionnaire Items	*Pearson r
Please indicate the extent to which you agree with each of the following statement:		
28	The adequacy of your present professional qualifications.	.262
43	Membership in the state association should be a requirement to practise or hold a position.	.760
44	Membership in the national association should be a requirement to practise or hold a position.	.684
52	I feel the need for some other person with a higher level of expertise within the profession in my department.	.649
55	Your training has prepared you to conduct and report research.	.537
58	My professional education has prepared me adequately to carry out administrative/supervisory duties.	.271

TABLE 3.4 (Cont'd)

Variable Number	Questionnaire Items	*Pearson r
60	Your profession may be threatened by the growth and development of other occupations or professions.	.668
61	From my experience, I know that doctors have sufficient knowledge of the role of my profession.	.675
63	I feel my profession is less stimulating intellectually than I anticipated.	.311
64	In my opinion, therapists rely more on technique than theory.	.658
66	In my opinion, the present knowledge of medical subjects of the therapists is just about the same as that of the nurses.	.523
67	I feel that graduate education will provide a foundation for scholarly contributions in my profession.	.328

TABLE 3.4 (Cont'd)

Variable Number	Questionnaire Items	*Pearson r
69	In my experience, I agree that some doctors use my department as a dumping ground for chronic patients.	.594
78	Do you agree that the lack of a clearly defined area of competence in relation to other health professions account for some of the problems in the profession?	.259
79	Do you agree that the lack of training of the therapists in dealing with government and other professions account for some of the problems in the profession?	.334

* Factor loadings greater than or equal to r = .254, $p \leq .01$

TABLE 3.5

INTERCORRELATION MATRIX OF ITEMS ON THE ROLE AUTONOMY INSTRUMENT

Occupational Therapists (N = 22)

	Abbreviated Items											
	31	33	34	36	37	38	39	40	41	42	53	59
Variables Items	Pearson r											
31		.810***	.729***	-.004	.338	.226	.150	.123	.198	.188	.052	.423*
33			.690***	.132	.256	.135	.000	.000	.212	.098	.127	.463*
34				.081	.464*	-.031	.247	.301	.096	.038	.184	.261
36					.412*	.289	.150	.102	.285	-.188	.097	.038
37						.556**	.583**	.629***	.462*	.088	-.273	-.136
38							.409*	.271	.444*	.087	-.444	-.216
39								.658***	.403*	-.070	-.227	-.092
40									.735***	-.019	.074	.000
41										.163	.018	.064
42											-.031	.289
53												.575**
59												—

* Significant at better than .05 level

TABLE 3.6

INTERCORRELATION MATRIX OF ITEMS ON THE JOB SATISFACTION INSTRUMENT

Occupational Therapists (N = 22)

Variables Items	08	09	10	12	13	14	15	16	19	20	21	22	29	30	71	72	74
08		.758**	.123	.199	.027	.362*	.242	.189	-.090	.408*	-.050	.355*	.074	-.048	.205	.282	-.094
09			.421*	.398*	-.066	.065	.087	.117	.057	.315	-.216	.511**	.022	-.252	.384*	.383*	.141
10				.400*	.129	.039	.017	.430*	.088	.040	-.374*	.067	-.056	-.249	.019	.078	.132
12					.253	-.269	.161	.514**	.271	.330	.010	.549**	.414*	.026	.191	.175	-.218
13						.303	.686***	.196	.250	.030	-.070	-.095	.148	.041	-.084	-.070	-.147
14							.508**	.128	.184	.138	-.214	-.098	-.240	-.135	-.174	-.024	-.266
15								.261	.300	.139	.017	-.099	-.057	-.121	-.114	-.117	-.348
16									.188	.141	-.134	-.016	.285	-.128	.119	.046	-.206
19										.529	.215	-.120	-.120	-.044	-.145	-.279	-.085
20											.504**	.214	.208	.323	-.202	-.108	-.081
21												.130	.364*	.673***	.057	.099	.126
22														.626	.295	.290	.173
29															.112	.299	.369*
30																.522***	.412*
71																	.495**
72																	--
74																	

* Significant at better than .05 level

Table 3.7 shows that intercorrelations among professionalism items for occupational therapists range from r = -.002 to r = .544, $p \leq .01$. The lowest negative correlation coefficient of -.002 existed between two pairs of variable items. The first was found between membership of a state association as a requirement to practise or hold a position and the threat posed to the occupational therapy profession by the growth and development of other occupations or professions. The second negative correlation coefficient of -.002 existed between the threat to the profession by the growth and development of other occupations or professions and the therapists' agreement that some doctors use their departments as dumping ground for chronic patients. The highest correlation coefficient of .544, $p \leq .01$ revealed positive relationship between the fact that doctors have sufficient knowledge of the role of the profession and that in the therapists' opinion, the present knowledge of medical subjects is just about the same as that of the nurses.

TABLE 3.7

INTERCORRELATION MATRIX OF ITEMS ON THE PROFESSIONALISM INSTRUMENT

Occupational Therapists(N = 22)

	Abbreviated Items														
	28	43	44	52	55	58	60	61	63	64	66	67	69	78	79
Variable Items	Pearson r														
28		.401*	.291	.151	.111	.162	.198	.199	-.415*	-.314	.163	.511**	-.499**	-.165	.153
43			.388*	-.059	-.366*	.109	-.002	.202	-.049	.125	-.057	.465*	-.314	-.118	.145
44				.192	.073	.462*	.458*	.202	-.115	.179	.162	.476**	-.173	.127	.304
52					.342	.414*	.144	.360*	-.061	.130	.310	.285	.146	.205	.511**
55						.231	.374*	.116	.127	.236	-.011	.216	.090	.266	.090
58							.253	.066	.093	.095	-.121	.315	-.047	.117	.148
60								.146	.231	.248	.426*	.429*	-.002	.452*	.148
61									-.409*	.261	.544**	.196	.332	.190	.227
63										.081	-.337	-.177	-.030	.049	-.016
64											.320	-.034	.399*	.443*	-.150
66												.019	-.206	.167	-.032
67													-.331	.003	.465*
69														.380*	.043
78															.034
79															--

*Significant at better than .05 level.

Table 3.8 shows that intercorrelations among role autonomy scale items for physical therapists range from $r = .010$ to $r = .536$, $p \leq .001$. The highest correlation coefficient of .536, $p \leq .001$ was found between therapists being given the opportunity to make further diagnosis and the opportunity to make different diagnosis if the first appears wrong. The lowest correlation coefficient of .010, however, existed between permission for the therapist to violate medical protocol if it is in the best interest of the patient and the heads of the departments taking responsibility for the actions of other therapists working in their departments.

Table 3.9 also shows the intercorrelations among job satisfaction items for physical therapists. Many of these intercorrelations show highly statistically significant relationships very much like those found among the role autonomy items.

TABLE 3.8

INTERCORRELATION MATRIX OF ITEMS ON THE ROLE AUTONOMY INSTRUMENT

Physical Therapists (N = 144)

	Abbreviated Items											
	31	33	34	36	37	38	39	40	41	42	53	59
Variable Items	Pearson r											
31		.379***	.135*	.300**	.158*	.312***	.032	.139*	.175*	-.011	.373***	.087
33			.386***	.180*	.166*	.142*	.084	.192**	.198**	.080	.263***	.241**
34				.208**	.187**	.044	.082	.171*	.073	.118	.315***	.276***
36					.272***	.233**	.119	.251***	.173*	-.020	.190**	.052
37						.235**	.274***	.154*	.126	.025	.276***	.024
38							.084	.115	.181*	.010	.247***	.021
39								.329***	.201**	-.063	.063	.071
40									.535***	-.012	.252***	.117
41										-.078	.137*	.074
42											.123	-.034
53												.356***
59												--

* Significant at better than .05 level.

TABLE 3.9

INTERCORRELATION MATRIX OF ITEMS ON THE JOB SATISFACTION INSTRUMENT

Physical Therapists (N = 144)

	Pearson r																
	08	09	10	12	13	14	15	16	19	20	21	22	29	30	71	72	74
Variable Items																	
08		.757***	.286***	.041	.272***	.153*	.247***	.260***	.120	.138*	.133	.176*	.046	-.024	.016	.033	.147*
09			.297***	.137*	.382***	.204**	.319***	.210**	.025	.177*	.170*	.167**	.032	-.021	-.069	-.039	-.011
10				.386***	.141*	.153*	.152*	.407***	.092	.106	.098	.086	.028	.142*	-.029	-.018	.024
12					.227**	.242**	.193**	.454***	.161*	.104	.033	.003	-.023	-.051	.000	.056	-.058
13						.553***	.641***	.174*	.111	.170*	.285***	.209**	.004	.037	.019	.010	-.035
14							.570***	.195**	.229**	.171*	.245**	.171*	-.002	.009	-.005	.062	.024
15								.226**	.114	.136*	.238**	.158*	-.024	-.024	-.015	.004	.017
16									.116	.202**	.180*	.210**	.071	.107	-.056	-.029	-.023
19										.357***	.431***	.385***	.203**	.168*	.062	.067	.057
20																	
21											.609***	.587***	.369***	.417***	.047	-.019	-.057
22												.761***	.352***	.399***	.032	.045	.016
29													.466***	.504***	.066	.016	-.003
30														.438***	.045	-.045	-.049
71															.154*	.127	-.014
72																.814***	.623***
74																	.615***

The highest correlation coefficient of $r = .814$, $p \leq .001$ was found between two closely related items, that is, the introduction of more men into the physical therapy profession would increase the status of the profession in the eyes of the medical authorities and would also improve the career structure.

Table 3.10 shows the intercorrelations among professionalism scale items for physical therapists. The Pearson Product Moment correlation performed on these items show very low correlations, as they range between $r = .001$ to $r = .523$, $p \leq .001$. The highest correlation of .523, $p \leq .001$ was found between two similar variable items, that is, memberships in both state and national associations be made requirements to practise or hold positions. The lowest correlation of $r = .001$ however, was found between membership in the national association as a requirement to practise or hold a position and that in the therapists' opinion, their present knowledge of medical subjects is just about the same as that of the nurses.

TABLE 3.10

INTERCORRELATION MATRIX OF ITEMS ON THE PROFESSIONALISM INSTRUMENT

Physical Therapists (N = 144)

Variable Items	Abbreviated Items														
	28	43	44	52	55	58	60	61	63	64	66	67	69	78	79
	Pearson r														
28		-.061	-.056	-.208	.249***	.036	.042	.043	-.191	-.211	-.245	.029	-.071	-.277***	-.177*
43			.523***	.070	-.009	.016	-.040	-.045	-.015	.122	.073	.033	.059	-.154*	.011
44				.098	.044	.036	.012	.008	-.100	.120	.001	.080	.138*	-.122	.003
52					-.085	-.109	-.009	-.041	.161	.134	.069	.088	.032	.033	-.087
55						.221	-.004	-.016	-.040	.020	-.125	.128	.063	-.064	-.198**
58							.059	.082	-.051	-.080	-.202	.010	.057	-.174	-.109
60								.029	-.020	-.015	-.173*	.062	.099	.209**	.153*
61									-.079	-.071	.038	-.214**	-.099	-.093	.111
63										.248***	.332***	.014	.108	.125	-.011
64											.351**	.026	.092	.177*	-.003
66												.003	-.016	.142*	.092
67													.157*	-.092	-.014
69														.123	.085
78															.401***
79															--

Data Collection

Considering the small numerical strength of the population of the occupational and physical therapists in Nigeria, the questionnaires were sent to all active and registered occupational and physical therapists who numbered twenty-seven and two hundred and five respectively.

Administration of Instruments

By the beginning of March 1986, the questionnaires were dispatched to all the therapists. Along with a guide for the administration and completion of the questionnaire, each was accompanied by a letter indicating the purpose and the importance of the study. Also included was a stamped, self-addresed envelope for the return of the completed questionnaires. However, the researcher found it expedient to personally administer by hand, questionnaires to those therapists residing in Oyo, Ogun and Lagos States. This is because these states constitute the highest concentration of occupational and physical therapists working in the Federation, and they are relatively close to the researcher's home base.

Towards the end of April 1986, a follow-up letter was sent to remind all the subjects of the importance of having a high percentage return (See Appendix 3).

As at June 30, 1986, a total of 147 completed questionnaires were returned by the physical therapists and twenty-two by occupational therapists accounting for 71.7 per cent and

81.5 per cent returns for physical and occupational therapists respectively. Out of this number, 144 completed questionnaires from the physical therapists representing 70.2 per cent and the twenty-two questionnaires received from the occupational therapists were found usable.

In order to ensure anonymity, the respondents were not required to sign their names. A space was also provided in the questionnaire to express further comments if they so wished.

Subjects

The twenty-two occupational therapists and 144 physical therapists who participated in this study are described in Tables 3.11 (a) & (b) and 3.12 (a) & (b).

TABLE 3.11(a)

ACADEMIC QUALIFICATIONS, SEX AND MARITAL STATUS OF OCCUPATIONAL THERAPISTS

N = 22.

ACADEMIC QUALIFICATIONS		SEX				TOTAL
		MALE		FEMALE		
		MARRIED	UNMARRIED	MARRIED	UNMARRIED	
Diploma	N	(7)	-	(8)	(1)	(16)
	%	31.8	-	36.4	4.5	72.7
Bachelors	N	(1)	-	(1)	-	(2)
Degree	%	4.5	-	4.5	-	9.1
Master's	N	(1)	-	(3)	-	(4)
Degree	%	4.5	-	13.6	-	18.2
TOTAL	N	(9)	-	(12)	(1)	(22)
	%	40.9	-	54.5	4.5	100

TABLE 3.11(b)

PRESENT EMPLOYMENT, AGE AND SEX OF OCCUPATIONAL THERAPISTS

N = 22

PRESENT EMPLOYMENT		AGE						
		MALE			FEMALE			
		31-40,	41-50,	50 & Older	31-40,	41-50,	50 & Older	TOTAL
Chief	N	-	-	(1)	-	(1)	(1)	(3)
	%	-	-	4.5	-	4.5	4.5	13.6
Asst. Chief	N	-	-	(1)	(1)	(2)	-	(4)
	%	-	-	4.5	4.5	9.1	-	18.1
Principal Therapist	N	(2)	(2)	(1)	(2)	(3)	-	(10)
	%	9.1	9.1	4.5	9.1	13.6	-	45.4
Senior Therapist	N	(1)	-	-	(1)	(1)	-	(3)
	%	4.5	-	-	4.5	4.5	-	13.6
Therapist I	N	(1)	-	-	(1)	-	-	(2)
	%	4.5	-	-	4.5	-	-	9.1
TOTAL	N	(4)	(2)	(3)	(5)	(7)	(1)	(22)
	%	18.1	9.1	13.6	22.6	31.7	4.5	100

TABLE 3.12(a)

ACADEMIC QUALIFICATIONS, SEX AND MARITAL STATUS OF PHYSICAL THERAPISTS

N = 144

ACADEMIC QUALIFICATIONS		SEX				
		MALE		FEMALE		
		MARRIED	UNMARRIED	MARRIED	UNMARRIED	TOTAL
Diploma	N	(20)	(1)	(11)	(7)	(39)
	%	13.8	0.7	7.6	4.8	27.1
Bachelor's	N	(42)	(13)	(26)	(16)	(97)
Degree	%	29	9	18	11	67.3
Master's	N	(2)	(1)	(2)	(2)	(7)
Degree	%	1.4	0.7	1.4	1.4	4.9
Doctoral	N	(1)	-	-	-	(1)
Degree	%	0.7	-	-	-	0.7
TOTAL	N	(65)	(15)	(39)	(25)	(144)
	%	45.1	10.4	27.1	17.4	100

TABLE 3.12(b)

PRESENT EMPLOYMENT, AGE AND SEX OF PHYSICAL THERAPISTS

N = 144

PRESENT EMPLOYMENT		AGE								TOTAL
		MALE				FEMALE				
		20-30	31-40	41-50	50 and Older	20-30	31-40	41-50	50 and Older	
Chief	N	-	-	(4)	(2)	-	-	(2)	-	(8)
	%	-	-	2.8	1.4	-	-	1.4	-	5.6
Asst. Chief	N	-	(2)	(1)	(1)	-	(2)	(2)	(1)	(9)
	%	-	1.4	0.7	0.7	-	1.4	1.4	0.7	6.3
Principal I	N	-	(4)	(2)	-	-	(4)	(2)	(1)	(13)
	%		2.8	1.4	-	-	2.8	1.4	0.7	9.1
Principal II	N	(1)	(10)	(4)	-	-	(10)	-	-	(25)
	%	0.7	6.9	2.8	-	-	6.9	-	-	17.3
Senior I	N	-	(9)	(1)	-	(6)	(6)	-	-	(22)
	%		6.3	0.7	-	4.2	4.2	-	-	15.4
Senior II	N	(5)	(4)	-	-	(8)	(1)	-	-	(18)
	%	3.5	2.8	-	-	5.6	0.7	-	-	12.6
Therapist II	N	(10)	(5)	-	-	(7)	(4)	-	-	(26)
	%	6.9	3.5	-	-	4.9	2.8	-	-	18.1

F.T.O.

TABLE 3.12(b) (Cont'd)

		AGE								
		MALE				FEMALE				
		20-30	31-40	41-50	50 & Older	20-30	31-40	41-50	50 & Older	TOTAL
Private Practitioner	N	-	(4)	-	-	-	-	(1)	-	(5)
	%	-	2.8	-	-	-	-	0.7	-	3.5
Others	N	(6)	(6)	(1)	(1)	(3)	-	(1)	-	(18)
	%	4.2	4.2	0.7	0.7	2.1	-	0.7	-	12.6
TOTAL	N	(22)	(44)	(13)	(4)	(24)	(27)	(8)	(2)	(144)
	%	15.3	30.6	9.0	2.8	16.7	18.8	5.5	1.4	100

Table 3.11 (a) & (b) show that thirteen or 59.1 per cent of the occupational therapists were female. Nine or 41 per cent were aged between thirty-one and forty and the same number and percentage were in the forty-one to fifty year age group. Only four or 18.2 per cent belong to the fifty and above age group. Twenty-one or 95.5 per cent were married. Ten or 45.5 per cent were principal therapists while seven or 32 per cent were in their highest positions (i.e. Chief and Assistant Chief Occupational therapists). On academic qualifications, sixteen or 73 per cent were diploma holders while only six or 27 per cent had bachelor's degrees or better.

Tables 3.12 (a) & (b) give the relevant background information of the 144 physical therapists. In constrast to the occupational therapists, eighty or 55.5 per cent were male. One hundred and seventeen or 81 per cent cluster around twenty to thirty and thirty-one to forty age groups. One hundred and four or 72.2 per cent are married.
Of their present employment, sixty-six or 46.1 per cent represented the lower cadre of the profession while fifty-five or 38.3 per cent belonged to the upper echelons. With regard to their academic qualifications, 105 or 72.9 per cent possessed bachelor's degree and above while thirty-nine or 27.1 per cent were diploma holders.

Scoring

Questionnaires were hand scored. The scores were then transfered to coding sheets for key punching.

The analysis of the data was performed by the utilization of programs and sub-programs contained in the Statistical Package for the Social Sciences. The facilities of the Computing Science Department, University of Lagos, were employed for processing the data.

Conceptualization of Further Research Hypotheses

Given the results of the factor analyses which revealed the multi-dimensional nature of the scale items used in this study, the operational hypotheses were expanded to explore the relationships between job satisfaction and professionalism of the occupational and physical therapists. For easy reference, numbers eight and nine denote these new hypotheses.

Operational Hypotheses

From the conceptual hypothesis, the following operational hypotheses were derived.

H_1 There is a preference for role autonomy in areas of organization, practice and control by registered occupational therapists in Nigeria.

H_2 There is a preference for role autonomy in areas of organization, practice and control by registered physical therapists in Nigeria.

H_3 Occupational therapists and physical therapists do not differ in their preference for role autonomy.

H_4 Occupational therapists' orientation with respect to role autonomy is positively related to their job satisfaction.

H_5 Physical therapists' orientation with respect to role autonomy is positively related to their job satisfaction.

H_6 There is a positive relationship between the orientation of occupational therapists toward role autonomy and their orientation toward professionalism i.e. knowledge and service.

H_7 There is a positive relationship between the orientation of physical therapists toward role autonomy and their orientation toward professionalism i.e knowledge and service.

H_8 There is no relationship between the orientation of occupational therapists toward job satisfaction and their orientation toward professionalism i.e. knowledge and service.

H_9 There is no relationship between the orientation of physical therapists toward job satisfaction and their orientation toward professionalism i.e. knowledge and service.

Summary

In this chapter, the instruments used in the study were described. The items relate to job satisfaction aspects of the therapists' work and working conditions, and concepts of professional role autonomy and professionalism.
Data from the pilot study were analysed using the odd-even method. The correlation coefficient obtained was corrected with the Spearman-Brown Prophesy Formula, yielding a correlation coefficient of 0.85. For further empirical validation of the questionnaire items, they were further subjected to factor analysis of the SPSS Program. The result obtained showed that forty-four questionnaire items were effective in tapping role autonomy, job satisfaction and professionalism. The mode of data collection, administration of instruments and scoring were exhaustively discussed. The operational hypotheses were also stated.

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CHAPTER FOUR

DATA ANALYSES AND RESULTS

In this chapter, data are presented in respect of the three variables of the study - professional role autonomy, job satisfaction and professionalism. To test the hypotheses stated in chapter three, SPSS sub-programs - Pearson's Product Moment Correlation, Multiple Linear Regression, Chi-Square and T-test were utilized. This chapter therefore presents the results of these analyses.

Role Autonomy of Occupational Therapists

Hypothesis One: There is a preference for role autonomy in areas of organization, practice and control by registered occupational therapists in Nigeria.

The observed results in Table 4.1 confirm this hypothesis. The chi-square analysis of the frequencies indicated a chi-square value of 113.68 (55 df), significant at better than the .001 level. There is therefore, a strong preference for role autonomy by occupational therapists in Nigeria. Appendixes 4 and 5 provide further details on this hypothesis.

Bring Appendices 4 & 5 to this page

TABLE 4.1

CHI SQUARE ANALYSIS OF ROLE AUTONOMY INSTRUMENT ITEMS

OCCUPATIONAL THERAPISTS (N = 22)

Response Categories		Items												Marginals
		31	33	34	36	37	38	39	40	41	42	53	59	
SD	N	-	-	-	(1)	(6)	(6)	(9)	(5)	(4)	(3)	-	-	34
	%				2.83	2.83	2.83	2.83	2.83	2.83	2.83			
D	N	(1)	-	-	(2)	(2)	(2)	(6)	(2)	(3)	(3)	-	-	21
	%	1.75			1.75	1.75	1.75	1.75	1.75	1.75	1.75			
UND VD	N	-	(1)	-	(2)	(2)	(6)	(2)	(3)	(1)	(3)	(4)	-	24
	%		2		2	2	2	2	2	2	2	2		
A	N	(5)	-	(2)	(6)	(5)	(5)	(3)	(7)	(7)	(2)	(4)	(4)	50
	%	4.17		4.17	4.17	4.17	4.17	4.17	4.17	4.17	4.17	4.17	4.17	
SA	N	(16)	(21)	(20)	(10)	(6)	(3)	(1)	(4)	(7)	(11)	(14)	(18)	131
	%	10.92	10.92	10.92	10.92	10.92	10.92	10.92	10.92	10.92	10.92	10.92	10.92	
NR	N	-	-	-	(1)	(1)	-	(1)	(1)	-	-	-	-	4
	%				.33	.33		.33	.33					
Marginals	N	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	
	%	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	264

* Chi Square value = 113.68 significant at better than the .001 level (55 df.).

Role Autonomy of Physical Therapists

Hypothesis Two: There is a preference for role autonomy in areas of organization, practice and control by registered physical therapists in Nigeria.

Table 4.2 shows that there is a significant preference for role autonomy among the physical therapists studied. Like the occupational therapists, the chi-square analysis of the frequencies shows a value of 469.52 (55 df), significant at better than the .001 level.

The hypothesis is thus upheld.

Appendixes 6 and 7 provide further details on this hypothesis.

Bring appendices 6 & 7 to this page.

TABLE 4.2

CHI SQUARE ANALYSIS OF ROLE AUTONOMY INSTRUMENT ITEMS

PHYSICAL THERAPISTS (N = 144)

Response Categories		Items												
		31	33	34	36	37	38	39	40	41	42	53	59	Marginals
SD	N	(1)	(2)	-	(	(5)	(9)	(35)	(6)	(5)	(14)	(1)	(9)	
	%	7.42	7.42		7.	7.42	7.42	7.42	7.42	7.42	7.42	7.42	7.42	89
D	N	(1)	(1)	-	(. ,	(12)	(13)	(30)	(12)	(9)	(15)	(1)	(11)	
	%	9.08	9.08		9.08	9.08	9.08	9.08	9.08	9.08	9.08	9.08	9.08	109
UND	N	(3)	(5)	(3)	(16)	(17)	(27)	(34)	(25)	(17)	(19)	(8)	(30)	
	%	17	17	17	17	17	17	17	17	17	17	17	17	204
A	N	(27)	(19)	(16)	(28)	(38)	(27)	(20)	(51)	(39)	(35)	(45)	(46)	
	%	32.58	32.58	32.58	32.58	32.58	32.58	32.58	32.58	32.58	32.58	32.58	32.58	391
SA	N	(112)	(117)	(125)	(93)	(72)	(67)	(23)	(49)	(73)	(61)	(88)	(46)	
	%	77.16	77.16	77.16	77.16	77.16	77.16	77.16	77.16	77.16	77.16	77.16	77.16	926
NR	N	-	-	-	(1)	-	(1)	(2)	(1)	(1)	-	(1)	(2)	
	%				.75		.75	.75	.75	.75		.75	.75	9
Marginals	N	(144)	(144)	(144)	(144)	(144)	(144)	(144)	(144)	(144)	(144)	(144)	(144)	
	%	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	1728

* Chi Square value = 469.52 significant at better than the .001 level (55 df).

Comparison of Occupational and Physical Therapists' Responses on the Role Autonomy Instrument

Hypothesis Three: Occupational therapists and physical therapists do not differ in their preference for role autonomy.

Tables 4.1 and 4.2, show that both groups have indicated their strong preference for role autonomy. But the t-test analysis (Table 4.3) on their responses showed that they do differ in their preference for role autonomy ($t = -2.92$, $p \leq .01$).

Physical therapists indicated more preference for role autonomy than the occupational therapists. The hypothesis is thus not supported.

Role Autonomy and Job Satisfaction of Occupational Therapists

Hypothesis Four: Occupational therapists' orientation with respect to role autonomy is positively related to their job satisfaction.

Bring appendix 8 & 9 here

The Pearson Product Moment Correlation was utilized in analyzing the data on role autonomy and job satisfaction. Table 4.4 shows that there is a low positive correlation $r = .223$ which is insignificant at .05 level. The finding shows that the hypothesis was not supported

TABLE 4.3.

T-TEST ANALYSIS OF OCCUPATIONAL AND PHYSICAL THERAPISTS' RESPONSES TO THE ROLE AUTONOMY INSTRUMENT (N = 166)

Groups	No. of Cases	Mean	Std. Dev.	Pooled Variance Estimate t-Value	DF	2-Tail Prob.	Separate Variance Estimate t-Value	DF	2-Tail Prob.
O.T.s	22	45.59	1.55	-3.58	164	.000***	-2.92	24.81	.007**
P.T.s	144	50.32	0.46						

** $p \leq .01$

*** $p \leq .001$

TABLE 4.4

THE RELATIONSHIP BETWEEN ROLE AUTONOMY AND JOB SATISFACTION OF OCCUPATIONAL THERAPISTS (N = 22)

	Job Satisfaction
Role Autonomy	r = .223
	r^2 = .049
	Not significant at the .05 level.

Role Autonomy and Job Satisfaction of Physical Therapists

Hypothesis Five: Physical therapists' orientation with respect to role autonomy is positively related to their job satisfaction.

The Pearson Product Moment correlation was utilized in analyzing the data on role autonomy and job satisfaction. Even though a low positive relationship (r = .118) is observable; the relationship is not significant (See Table 4.5).

TABLE 4.5

THE RELATIONSHIP BETWEEN ROLE AUTONOMY AND JOB SATISFACTION OF PHYSICAL THERAPISTS (N = 144)

	Job Satisfaction
Role Autonomy	
r =	.118
r^2 =	.014

Not significant at the .05 level

Role Autonomy and Professionalism of Occupational Therapists

Hypothesis Six: There is a positive relationship between the orientation of occupational therapists toward role autonomy and their orientation toward professionalism i.e. knowledge and service.

To test the above hypothesis, the Pearson Product Moment correlation was used.

Table 4.6 shows that there is a significant relationship ($r = .345$), at the .05 level. The hypothesis is therefore confirmed.

TABLE 4.6

THE RELATIONSHIP BETWEEN ROLE AUTONOMY AND PROFESSIONALISM OF OCCUPATIONAL THERAPISTS (N = 22)

	Professionalism
Role Autonomy	$r = .345$
	$r^2 = .119$
	$p \leq .05$

Role Autonomy and Professionalism of Physical Therapists

Hypothesis Seven: There is a positive relationship between the orientation of physical therapists toward role autonomy and their orientation toward professionalism i.e. knowledge and service.

By what analytical tool?

Table 4.7 indicates a correlation coefficient of r = .243 which is statistically significant at .01 level. Thus, it can therefore be inferred that there is a significant relationship between role autonomy and professionalism of the physical therapists.

Hypothesis is therefore confirmed.

TABLE 4.7

THE RELATIONSHIP BETWEEN ROLE AUTONOMY AND PROFESSIONALISM OF PHYSICAL THERAPISTS (N = 144)

	Professionalism
Role Autonomy	
r =	.243
r^2 =	.059

$p \leq .01$

Job Satisfaction and Professionalism of Occupational Therapists

Hypothesis Eight: There is no relationship between the orientation of occupational therapists toward job satisfaction and their orientation toward professionalism i.e. knowledge and service.

Bring appendices 10 & 11 here

Table 4.8 shows a relatively high positive correlation ($r = .697$, $p \leq .01$) between job satisfaction and professionalism.

By what means?

The hypothesis is thus not supported.

TABLE 4.8

THE RELATIONSHIP BETWEEN JOB SATISFACTION AND PROFESSIONALISM OF OCCUPATIONAL THERAPISTS (N = 22)

Job Satisfaction	r =	.697
	r^2 =	.485
	p	.01

Job Satisfaction and Professionalism of the Physical Therapists

Hypothesis Nine: There is no relationship between the orientation of physical therapists toward job satisfaction and their orientation toward professionalism i.e. knowledge and service.

Bring appendices 12 & 13 here

Table 4.9 shows a low but positive relationship (r = .110) between the two variables. The hypothesis is thus not supported.

By what analytical tool?

TABLE 4.9

THE RELATIONSHIP BETWEEN JOB SATISFACTION AND PROFESSIONALISM OF PHYSICAL THERAPISTS (N = 144)

	Professionalism
Job Satisfaction	r = .110
	r^2 = .012

Not significant at the .05 level

Biographic Variables, Role Autonomy, Job Satisfaction and Professionalism: Occupational Therapists (N = 22)

The variables of this study viz, role autonomy, job satisfaction and professionalism were examined as dependent variables with sex, age, marital status, present employment and academic qualifications as independent predictors.

Role Autonomy

Table 4.10 below shows that sex, age, marital status, present employment and academic qualifications are not significantly related to role autonomy in the case of occupational therapists.

by what means?

TABLE 4.10

THE RELATIONSHIPS BETWEEN ROLE AUTONOMY, SEX, AGE, MARITAL STATUS, PRESENT EMPLOYMENT AND ACADEMIC QUALIFICATIONS

OCCUPATIONAL THERAPISTS (N = 22)

Independent Predictors	Role Autonomy F Ratio
Sex	0.025+
Age	0.147+
Marital Status	1.126+
Present Employment	0.069+
Academic Qualifications	0.069+
Combined Predictors	0.3475+

+ Not significant at the .05 level 5/16 df.

Job Satisfaction

By what means?

Table 4.11 also shows that none of the independent predictors is significantly related to job satisfaction of occupational therapists.

Professionalism

By what analytical test(s)?

Table 4.12 shows also that none of the independent predictors is significantly related to professionalism of occupational therapists.

TABLE 4.11

THE RELATIONSHIPS BETWEEN JOB SATISFACTION, SEX, AGE, MARITAL STATUS, PRESENT EMPLOYMENT AND ACADEMIC QUALIFICATIONS:

OCCUPATIONAL THERAPISTS (N = 22)

Independent Predictors	Job Satisfaction F Ratio
Sex	1.321+
Age	1.243+
Marital Status	1.597+
Present Employment	1.062+
Academic Qualifications	1.391+
Combined Predictors	2.309+

\+ Not sugnificant at the .05 level 5/16 df.

TABLE 4.12

THE RELATIONSHIPS BETWEEN PROFESSIONALISM, SEX, AGE, MARITAL STATUS, PRESENT EMPLOYMENT AND ACADEMIC QUALIFICATIONS: OCCUPATIONAL THERAPISTS (N = 22)

Independent Predictors	Professionalism F Ratio
Sex	0.366+
Age	1.387+
Marital Status	0.079+
Present Employment	0.075+
Academic Qualifications	0.000+
Combined Predictors	.3688+

\+ Not significant at the .05 level 5/16 df.

In order to test the validity of the occupational therapists' explanations offered for the rather poor showing of independent predictors of professionalism, a restricted multiple linear regression analysis of the data was performed. Table 4.13 shows that sex, age and academic qualifications are not significantly related to professionalism.

Biographic Variables, Role Autonomy, Job Satisfaction and Professionalism: Physical Therapists (N = 144)

The variables of this study viz, role autonomy, job satisfaction and professionalism were also examined as dependent variables with sex, age, marital status, present employment and academic qualifications as independent predictors in the case of physical therapists.

Role Autonomy

Table 4.14 shows that out of all the independent predictors, only academic qualifications shows a significant relationship to role autonomy.

TABLE 4.13

THE RELATIONSHIPS BETWEEN PROFESSIONALISM, SEX, AGE, AND ACADEMIC QUALIFICATIONS

OCCUPATIONAL THERAPISTS (N = 22)

Independent Predictors	Professionalism F Ratio
Sex	0.300+
Age	1.789+
Academic Qualifications	0.000+
Combined Predictors	0.6439+

\+ Not significant at the .05 level 3/18 df.

TABLE 4.14

THE RELATIONSHIPS BETWEEN ROLE AUTONOMY SEX, AGE, MARITAL STATUS, PRESENT EMPLOYMENT AND ACADEMIC QUALIFICATIONS: PHYSICAL THERAPISTS (N = 144)

Independent Predictors	Role Autonomy F Ratio
Sex	0.963+
Age	0.870+
Marital Status	0.063+
Present Employment	3.253+
Academic Qualifications	16.220**
Combined Predictors	3.877**

** Significant at better than .01 level 5/138 df.

+ Not significant at the .05 level 5/138 df.

what results? by what means?

Job Satisfaction

The results on Table 4.15 show that only sex is significantly related to job satisfaction of the physical therapists.

Professionalism

how?

Table 4.16 shows that sex and academic qualifications are significantly related to professionalism.

To further test the validity of the physical therapists' explanations of the independent predictors of professionalism, a restricted multiple linear regression analysis was also performed. Table 4.17 again shows that sex and academic qualifications are significantly related to professionalism.

TABLE 4. 15

THE RELATIONSHIPS BETWEEN JOB SATISFACTION, SEX, AGE, MARITAL STATUS, PRESENT EMPLOYMENT AND ACADEMIC QUALIFICATIONS: PHYSICAL THERAPISTS (N = 144)

Independent Predictors	Job Satisfaction F Ratio
Sex	10.235**
Age	1.862+
Marital Status	3.096+
Present Employment	4.370+
Academic Qualifications	1.546+
Combined Predictors	4.919**

** Significant at better than .01 level 5/138 df.

+ Not significant at the .05 level 5/138 df.

TABLE 4.16

THE RELATIONSHIPS BETWEEN PROFESSIONALISM, SEX, AGE, MARITAL STATUS, PRESENT EMPLOYMENT AND ACADEMIC QUALIFICATIONS: PHYSICAL THERAPISTS (N = 144).

Independent Predictors	Professionalism F Ratio
Sex	3.318**
Age	0.432+
Marital Status	0.002+
Present Employment	0.436+
Academic Qualifications	4.673**
Combined Predictors	1.886+

** Significant at better than .01 level 5/138 df

\+ Not significant at the .05 level 5/138 df

TABLE 4.17

THE RELATIONSHIPS BETWEEN PROFESSIONALISM, SEX, AGE, AND ACADEMIC QUALIFICATIONS

PHYSICAL THERAPISTS (N = 144)

Independent Predictors	Professionalism F Ratio
Sex	3.151*
Age	0.285+
Academic Qualifications	4.337**
Combined Predictors	3.031*

** Significant at better than .01 level 3/140 df

* Significant at better than .05 level 3/140 df

+ Not significant at the .05 level 3/140 df

Summary of Findings

From the data analysis in this chapter, the following findings may be inferred.

1. There is a significant preference for role autonomy in areas of organization, practice and control by registered occupational therapists in Nigeria.

2. There is also a significant preference for role autonomy in areas of organization, practice and control by registered physical therapists in Nigeria.

3. Physical therapists differ significantly by indicating more preference for role autonomy than the occupational therapists.

poor construction
differ ... from

4. Occupational therapists' orientation with respect to role autonomy is not significantly related to their job satisfaction.

5. Physical therapists' orientation with respect to role autonomy is not significantly related to their job satisfaction.

6. There is a significant positive relationship between the orientation of occupational therapists toward role autonomy and their orientation toward professionalism i.e. knowledge and service.

7. There is a significant positive relationship between the orientation of physical therapists toward role autonomy and their orientation toward professionalism i.e. knowledge and service.

8. There is a significant positive relationship between the orientation of occupational therapists toward job satisfaction and their orientation toward professionalism i.e. knowledge and service.

9. There is no significant relationship between the orientation of physical therapists toward job satisfaction and their orientation toward professionalism i.e. knowledge and service.

10. There are no significant relationships between role autonomy, sex, age, marital status, present employment and academic qualifications of occupational therapists.

11. There are no significant relationships between job satisfaction, sex, age, marital status, present employment and academic qualifications of occupational therapists.

12. There are no significant relationships between professionalism, sex, age, marital status, present employment and academic qualifications of occupational therapists.

13. There is a significant relationship between role autonomy and academic qualifications of the physical therapists.

14. There is a significant relationship between job satisfaction and sex of the physical therapists.

15. There are significant relationships between professionalism, sex and academic qualifications of the physical therapists.

CHAPTER FIVE

DISCUSSION

This chapter discusses the significant findings presented in chapter four. These are: the preference for role autonomy expressed by occupational and physical therapists, the differences observed between the occupational and physical therapists on the role autonomy instrument; the seemingly low relationships on role autonomy and job satisfaction instruments; the significant relationships observed on role autonomy and professionalism instruments for both groups, and the relationships observed on role autonomy, job satisfaction, professionalism scales using such test factors as sex, age, marital status, present employment and academic qualifications.

Role Autonomy of Occupational and Physical Therapists

Table 4.1 shows that occupational therapists expressed preference for role autonomy. This does not appear surprising as the findings tally with the results of earlier studies carried out by Lehmann (1973) on the attitudes of occupational therapists toward role autonomy and Ogunleye (1980) on the attitudes of occupational and physical therapists toward their work. The quest for role

autonomy by occupational therapists started gathering momentum in the 1960's when Yerxa (1967, p.2) opined that too much reliance on physicians' prescription by occupational therapists would only reduce their potential to help clients.

Years later, occupational therapy was identified by Pavalko (1971) as one of the four occupations exhibiting characteristics of professional marginality. Pavalko determined their professional marginality by analysing the strengths of each profession on the occupation - profession continuum. He found that autonomy was the weakest factor in occupational therapy because of its dependence on physicians' referral or prescription before a therapist could see a patient.

In Nigeria, occupational therapists would seem to have a growing awareness of their need for autonomy in the practice of their profession. This is probably the reason for preference for role autonomy found in this study. A logical question that arises from this finding is whether occupational therapists can lay claim to role autonomy with all its attendant obligations when the majority of the practitioners are still diploma holders. This appears most unlikely in view of the findings by previous researchers cited in the review of the literature.

The Nigerian occupational therapists would need to take cognizance of Maas, Specht and Jacox (1975) observation that role autonomy is only possible when therapists show willingness to take positive action to define and control their practice and also demonstrate autonomy and accountability simultaneously. It would seem that occupational therapists' initial preparation would need to be improved before role autonomy becomes a reality.

Not unexpectedly, the physical therapists expressed a definite preference for role autonomy in this study (Table 4.2). Earlier studies on this subject have consistently supported this view. Prominent among the studies was the Pickering Report (Ontario Physiotherapy Association, 1979, p.42) which recommended that,

> without the need for physicians referral, patients could consult a physiotherapist as needed, either for a first incident of dysfunction or with recurring symptoms for the same problem. Physiotherapy would be an alternate entry into recognized health services.

Also, the findings on role autonomy confirm Ogunleye's (1980) research findings mentioned earlier in respect of physical therapists studied. Role autonomy, as earlier described in this study is one of the many characteristics that differentiate a profession from an occupation (Etzioni; 1969 and Freidson, 1970).

specify

With the present academic standard of the physical therapists, it seems they are set to seek and obtain role autonomy when the opportunity presents itself. This seems to have emanated from Porterfield's (1978) observation that only through increased standard of education will the physical therapists be able to obtain autonomy and sustain lines of communication with the physicians since, according to him, physicians themselves value and respect knowledge among themselves as well as among other professional groups.

A Comparison of Occupational and Physical Therapists Responses on Role Autonomy Instrument

Contrary to the hypothesis postulated, this finding shows that physical therapists were more desirous of role autonomy than occupational therapists (Table 4.3).

There are, of course, fewer occupational therapists than physical therapists (Table 3.11 and 3.12). According to Maxwell and Maxwell (1978), political effort demands more from each member in professions with fewer members than in those professions with larger memberships. Occupational therapists have been known to be diffident both individually and collectively in bringing their work to the attention of others (Cardwell, 1966).

Physical therapists on the other hand, because there are more of them, have been **very** vocal in their demand for role autonomy.

Earlier studies (Simpson and Simpson, 1969) have also shown that there is a predominance of women in most semi-professions such as occupational and physical therapy. This seems to account for the continuing semi-professional status and inability to attain role autonomy by occupational and physical therapists. The predominantly female composition of the semi-professions strengthens bureaucratic control in the organizations in which they work. The public is less willing to grant role autonomy to predominantly women groups. In this study, thirteen or 59 per cent of the occupational therapists were women while sixty-five or 45 per cent of the physical therapists were female. Consequently, more militancy is observable among physical therapists who have more males than females in their memberships.

Pavalko (1971) also affirmed that a firm core of theory and intellectual knowledge is crucial to the concept of role autonomy. In this study, sixteen or 73 per cent of the occupational therapists are diploma holders while 105 or 73 per cent of the physical therapists hold the

bachelor's degree or better. Therefore, the greater desire for role autonomy by physical therapists appears to confirm Pavalko's findings.

In sum, the preference shown by both groups seems to indicate that they are becoming more aware of their powerlessness in the health field and would want to participate more actively in health planning and administration at both the state and national levels.

Role Autonomy and Job Satisfaction: Occupational and Physical Therapists

In this study, no significant relationship was found between role autonomy and job satisfaction among occupational therapists. Although they expressed desire for role autonomy, such desire seems to have little relationship with their job satisfaction. This differs from the findings of earlier studies that have investigated the relationship between autonomy and job satisfaction (Maslow, 1943; Leavitt, 1951; Herzberg, 1966; Fagbamiye, 1981; and Checkland, 1984). In all these studies, there was ample evidence of linkage between role autonomy and job satisfaction of workers. Nevertheless, two other studies that seem to approximate the findings of this study are Lehmann (1973) and Maxwell and Maxwell, (1977).

A plausible explanation for the orientation of occupational therapists toward role autonomy and job satisfaction may be due to what Herzberg et al (1959) highlighted in their now-famous study of industrial employees' motivation to work, which they subsequently developed into the two-factor theory, or the motivator hygiene theory. According to them, the presence of certain factors in the work situation, acts to increase individual job satisfaction, but the absence of these factors may not necessarily give rise to job dissatisfaction.

It, therefore, seems reasonable to conclude in the light of the foregoing that because of the age-long subordinate status of occupational therapists, they are yet to feel in the same manner as those who have been deprived of role autonomy after having enjoyed it previously, so absence or lack of it may not evoke the same reaction in those who have never enjoyed it.

Table 4.5 shows an insignificant relationship between role autonomy and job satisfaction for physical therapists. The findings differ from the results of Barnes and Crutchfield (1977) on the job satisfaction of physical therapists. According to Lieberman (1970), the more educated one is, the more autonomy one would demand to carry out one's tasks. Therefore, since the majority of

physical therapists have superior academic qualifications compared with the occupational therapists, their desire for role autonomy was expected to be significantly correlated with job satisfaction. The findings in this study may thus be a reflection of the fact that physical therapists have never enjoyed role autonomy; so deprivation of what has never been enjoyed would probably have little or no influence on job satisfaction. Since they have never enjoyed role autonomy, the degree of job satisfaction has probably remained unchanged for some time.

When the orientation of occupational and physical therapists toward role autonomy and job satisfaction is viewed against the background of Maslow's (1943) hierarchy of needs Theory, one might conclude that both professions may still be grappling with "deficit needs" such as achievement, recognition, autonomy which Maslow stressed must be satisfied before any "growth need" (the desire to do work that is itself satisfying and rewarding) could be achieved.

Role Autonomy and Professionalism: Occupational and Physical Therapists

Table 4.6 shows that occupational therapists expressed a significant relationship between role autonomy and

professionalism. This is hardly surprising because according to Gross (1966), knowledge and service are the two main characteristics or criteria of professionalism. Nevertheless Table 3.11 shows that sixteen or 73 per cent of the occupational therapists, hold only diplomas, and so cannot be said to have sufficient education for them to be classified as professionals.

According to Tanguay (1985), inadequately qualified professionals risk relegation if they ignore higher academic attainments because other competing professions such as psychology, social work and physical therapy set their entry point at bachelor's level or higher. Tanguay intimated that occupational therapy must do what every other serious discipline has done, that is, hold itself academically accountable, ready to subject its assumptions, therapies and beliefs to test.

poor / confused construction

Even though, occupational therapists in this study saw a relationship between role autonomy and professionalism, the attainment of a separate and autonomous professional identity is likely to remain elusive until members are better qualified.

Table 4.7 also shows that role autonomy and profe-ssionalism are significantly related among the physical

therapists studied. Of the physical therapists, 105 or 73 per cent hold bachelor's degree or better. Education is frequently seen as the key to the attainment and maintenance of professional status. It is also necessary for role performance in modern society (Maxwell and Maxwell, 1977). The rapid development of professional education for the physical therapists in Nigeria, according to Oparinde (1985), has been facilitated by the establishment of departments of physical therapy at the universities in Ibadan, Lagos and Ife.

Is a Diploma not really some education al attainment? Compared this with teaching that has T.C II, holders & Assoc. Diploma, NCE etc.

Physical therapists in Nigeria, like their counterparts in the United States of America and Canada seem to have accepted the need for better education and preparation so that practitioners could acquire the knowledge, skills and attitudes to fortify them for complete acceptance of the responsibilities, rights and privileges of their profession (Lubkowsk, 1974; Pady, 1974; and Valentine, 1973)

<u>The Relationship Between Role Autonomy, Job Satisfaction, Professionalism, Sex, Age, Marital Status, Present Employment and Academic Qualifications: Occupational Therapists</u>

In this study, variables such as sex, age, marital status, present employment and academic qualifications were

round to be insignificantly related to role autonomy in the case of occupational therapists. This finding is totally not unexpected because most of the occupational therapists included in the study are too alike in most respects (Table 3.11 (1) & (b)).

According to Mathewson (1975), women's work in hospitals developed out of the need for house-keeping, motherly care and nursing of the sick. Decision-making was not included in their work. To lend further support to this view, Gilfoyle (1984) noted that medical societies have not respected women's contribution to science and technology. Rather, the norm in medicine seems to be that women provide the caring, not the knowledge to understand the cure or the process to heal. Since occupational therapists in Nigeria are predominantly married women, perhaps one should not be surprised by the seemingly lack of interest in role autonomy.

Interest in role autonomy may also signify radicalism - a trait that is more common among predominantly male rather than female groups - in other professions such as teaching, social work etc.

No significant relationships were found between such variables as sex, age, marital status, present employment,

academic qualifications and job satisfaction. According to Maxwell and Maxwell (1977), satisfaction is highly related to one's willingness to continue in an organization. The rate at which occupational therapists resign from their jobs leaves one in doubt as to whether they are really satisfied with their jobs. From about a population of forty occupational therapists a few years back, the present strength has dropped sharply to less than thirty with no new entrants into the field in the last five years. The reasons for this attrition rate are not far-fetched. First, there is no training institution of any kind in the country for occupational therapists. Secondly, both the Federal and State Governments have not sponsored students abroad in the last few years, perhaps as a result of the present state of the economy.

One would have expected that the older and more experienced therapists would have indicated higher job satisfaction, but this is not so. This finding seems to agree with Killian's (1971) and Fagbamiye's (1981) which found older and more experienced workers and teachers expressing more dissatisfaction than their younger counterparts. The present employment status of occupational therapists was also found to be a poor predictor of job satisfaction. Even though the majority of occupational therapists are holding top posts in their profession, they

are, nevertheless dissatisfied with their jobs. One would have expected that the more experienced occupational therapists who have now attained top positions would be more satisfied with their jobs. This finding also confirms Fagbamiye's (1981) findings in the study of university teachers in Nigeria.

Academic qualification was also found to be a not significant predictor of job satisfaction for occupational therapists in this study. This is undoubtedly due to the fact that most occupational therapists have about the same qualifications.

Occupational therapists have been perceived as ambivalent (Lehman, 1973). According to him, Lehman, until occupational therapists resolve their ambivalence, develop strong belief in their performance and initiate strategies for change, their professional growth would be restricted. Supporting the above view, a number of writers (Fidler, 1977; Maxwell and Maxwell, 1979; Silver, 1979; Grant, 1984; and Tanguay, 1985) have noted that, the lack of a body of theory and knowledge which seems to be linked to occupational therapy as in other health professions seems to provide an explanation for this state of affairs. In the Nigerian setting, there is no doubt that the small numbers involved would provide further adequate explanation for the findings.

The Relationship Between Role Autonomy, Job Satisfaction, Professionalism, Sex, Age, Marital Status, Present Employment and Academic Qualifications: Physical Therapists

Table 4.14 shows that of the test factors used in this study, only academic qualifications showed a significant relationship with role autonomy. The need for high academic qualification in the profession seems to have been buttressed by this finding. Furthermore, Reiss (1966) in his study of occupational mobility of professional workers noted that among professional statuses, the median years of school completed ranged from 16.4 years for workers in established professions to 10.5 years for the marginal professions. He therefore believed that a college and or professional school training was requisite for entry into the established professions and relatively lower academic qualification for those in the marginal professions.

Viewed from the foregoing, one could conclude that with the present level of academic qualification, the physical therapists seem to be on the threshold of becoming a full-fledged profession in the near future.

The Nigeria Society of Physiotherapy has also recently endorsed the post-graduate training of its practitioners (M. Sc. in Physiotherapy) which has since commenced at

Obafemi Awolowo University, Ile-Ife. This latest development appears to be in conformance with Helewa's (1979) view that a master of science as a basic educational requirement for physiotherapists would have the potential of upgrading clinical skills and academic knowledge in the field.

That sex, age, marital status and present employment are not significant predictors of role autonomy in this study may be due to the fact that the subjects are less differentiated on such variables compared with academic qualification which was found to be a significant predictor.

Table 4.15 shows that sex was the only predictive variable of job satisfaction among the physical therapists. This finding seems to suggest that males appear more satisfied than females in the field as seventy-nine or 55 per cent are male therapists. It also tends to support the observation of Maxwell and Maxwell (1977) which noted that men tend to be more satisfied in a profession where there are sufficient upwardly mobile positions to accommodate their career ambitions. Jantzen (1973) and Maxwell and Maxwell (1979) have intimated that if more men were recruited into physical therapy, the status and career structure of physical therapists would be enhanced. Nevertheless, Mathewson (1975) was quick to caution that when men had gone into female-dominated occupations, such as teaching,

social work and physical therapy, autonomy was usually handed to the men, who very often found themselves in positions of power by virtue of their sex rather than their own excellence and competence.

In this study, however, thirty-one or 21.6 per cent of the male physical therapists compared with twenty-four or 16.7 per cent female physical therapists were in top positions in their employment.

The finding therefore suggests that male physical therapists expressed more job satisfaction than their female counterparts, thus corroborating the influence of sex on job satisfaction found in the study.

Sex and academic qualifications were the two significant predictors of professionalism among the physical therapists.

Males generally are more career oriented than females in many professions, a fact vividly noted in various researches (Simpson and Simpson, 1969; Goode, 1969; and Etzioni, 1969). The fact that there are more male physical therapists than female in this study seems to confirm sex on professionalism.

It is also not surprising that academic qualification is a significant predictor of professionalism. Writing on the survival of physical therapy as a profession, Hislop (1975, p. 1079) warned that it is,

> by providing a unique and distinct service to the people - service not equalled in its excellence, breadth, or comprehensiveness by any other group.

This is meaningless!!

The import of the above statement confirms the general orientation that any profession that ignores professionalism risks relegation. An assumption that stems from this finding ~~seems to suggest~~ is that Nigerian physical therapists believe that more education would not only improve their effectiveness as therapists but enhance their future role and function in health care delivery.

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CHAPTER SIX

SUMMARY, IMPLICATIONS AND CONCLUSIONS

Summary

This study set out to investigate the extent to which occupational and physical therapists in Nigeria desire role autonomy and the extent to which role autonomy is related to job satisfaction.

The definition of role autonomy used in this study was given by Freidson (1970, p.53) as,

> the degree to which work can be carried on independently of organization or medical supervision, and the degree to which it can be sustained by attracting its own clientele independently of organizational referral or referral by other occupations including physicians.

Job satisfaction, on the other hand was given by Hoppock, (1935, p.47) as the totality of what a man expects and gets from his job, "a combination of psychological, physiological and environmental circumstances that cause" a person truthfully to say "I am satisfied with my job."

The theoretical perspective arose out of studies which have investigated the relationship between autonomy and job

satisfaction. Argyris' (1973) predisposition model for motivation asserts that jobs that allow an individual to develop many abilities and to have increasing autonomy would allow for maximum satisfaction. Buttressing this view, Herzberg (1966) maintained that as well as economic needs, human beings have psychological needs for autonomy, responsibility, and development which have to be satisfied in work. In his own contribution, Fagbamiye (1981) had cause to condemn the gradual erosion of autonomy of the university councils by the erstwhile Federal Military Government of Nigeria when the latter took upon itself the responsibility of sacking university teachers without taking cognizance for statutory procedures for removing them. Checkland (1984), in reviewing several perspectives on organizational structure in the delivery of complex services, reiterated the notion that effective professional activity can occur only in conjuction with some degree of professional autonomy.

These studies among others seem to provide ample linkage between role autonomy and job satisfaction of workers. It is from this theoretical perspective that the occupational and physical therapists' desire for role autonomy and how the latter is related to their job satisfaction was viewed.

Two different instruments were used in the study to measure the two variables - role autonomy and job satisfaction. The role autonomy instrument contains fifty items which were designed specifically to measure it and its variant-professionalism i.e. knowledge and service. The items were patterned after the instruments used by Lehmann (1973), Maxwell and Maxwell (1977) and Meltzer (1980) in their various studies designed to explore the attitudes of occupational and physical therapists toward role autonomy. The job satisfaction instrument contains twenty-three items designed to measure the degree of satisfaction of occupational and physical therapists. The job satisfaction inventory was based on the items used by Herzberg et al (1959) in their study of engineers and accountants.

A pilot study was carried out to determine the reliability and validity of the questionnaire items. Even though most of the questionnaire items employed had been tested for reliability in other settings, they were still subjected to reliability and validity tests before they were used in this study. Apart from this, empirical findings of the questionnaire items was performed using factor analysis. The varimax rotated factor matrix identified twenty-seven factors in all but only sixteen of these had eigen values greater than one whole number, accounting for 82.1 per cent of the variance, and only forty-nine items loaded

how do you perform findings?

significantly on these sixteen factors. These forty-nine items subsequently constituted the valid instrument used for the study.

A total of twenty-two occupational therapists and 144 physical therapists took part in the study. The subjects consist of all occupational and physical therapists who were registered and active members of the Nigerian Association of Occupational Therapists and the Nigerian Society of Physiotherapy. Because of the small numerical strength of their respective populations, questionnaires were sent to everyone whose names and addresses were properly listed in the two associations' registers.

Questionnaires were despatched to all the subjects by March 1986. Along with a guide for the administration and completion of the questionnaires, each was accompanied by a letter indicating the purpose and the importance of the study. The researcher found it expedient to post some of the questionnaires and personally administer the rest by hand. After a follow-up letter to increase returns, the researcher finally cut off further returns of questionnaires by the end of June 1986.

Questionnaires were hand scored. The scores were then transferred to coding sheets for key punching. The analysis of the data was performed by the utilization of programs and

sub-programs contained in the Statistical Package for the Social Sciences.

From the conceptual hypothesis, nine operational hypotheses were derived. The findings from the study are as follows.

Majority of the occupational and physical therapists involved in this study desire role autonomy, but physical therapists have a stronger desire for role autonomy than occupational therapists.

Preference for role autonomy by occupational and physical therapists seem unrelated to job satisfaction. Both occupational and physical therapists feel that role autonomy is a sine qua non for professionalism. Job satisfaction and professionalism are significantly related in the case of occupational therapists but this was not the case for physical therapists.

Variables such as sex, age, marital status, present employment and academic qualifications did not sufficiently predict occupational therapists' desire for role autonomy, job satisfaction or professionalism.

However, in the case of physical therapists, academic qualifications significantly predicted their preference for role autonomy while sex predicted their preference for job satisfaction and sex and academic qualifications predicted their preference for professionalism.

Implications of the Findings for Practice

This study has shown that there is a clear indication that both the occupational and physical therapists desire role autonomy in order to organize, practice and control their professional activities. Generally, the central issue in the problem of autonomy at the level of the individual practitioner is the therapists' relationship to the physician. The point should be made that, the medical profession was instrumental to the development of occupational and physical therapy. The physician's prescription has thus remained, as a symbol of his control over treatment and is apparently a reminder of the therapists' subordinate status. Yet, occupational and physical therapists are now more desirous of role autonomy than ever before. The need to have control over their work is thus real. Sergiovanni and Starrat (1979) writing about the administration of school system noted that emphasis on hierarchy and formality may restrict access to administration and impede communication. Physicians may have to look beyond mere administrative adjustments in redefining their role to accommodate the therapists' increasing desire for role autonomy.

Since it is virtually impossible for physicians to keep abreast of all the developments in the therapists' area of

operation, there may be need for physicians to entrust to therapists, much of the responsibility for decisions concerning patients' treatment.

what type? how about nurses?

Therefore, autonomy based on a collegial decision making pattern wherein the therapists and the physicians could jointly reach agreement over decisions of a professional nature would seem more appropriate and more beneficial to the patient.

The early retirements among occupational therapists may be a sign of job dissatisfaction, arising out of their subservient status to the medical profession. Although Treslan and Ryan (1986) noted that within all organizations, the exercise of influence is essential for goal achievement, they also believed that such influence should be borne out of consideration of the perceptions of those involved. The average medical practitioner is not trained in the methods of occupational and physical therapy (Yerxa, 1967; Semple, 1974 and Ontario Physiotherapy Association, 1974). Yet, occupational and physical therapists are still to be accepted as professional colleagues by physicians. Physicians may therefore need to realise that their traditional domination of the medical profession may have to be altered to accommodate the new reality of other professionals within the medical field such as occupational and physical

therapists in the light of the study's findings. As earlier noted in chapter one, occupational therapy in particular is beset by three major problems: the small number of their members, the lack of training institutions in the country and perhaps most important, the general lack of knowledge of the therapists and the nature of their work by the Nigerian Society and even by some members of the medical staff. This study, therefore presents an avenue to briefly mention the historical perspective on occupational therapy, its aims and functions, the general areas of practice and the invaluable roles it played in concert with other professions during the world wars and the Nigerian Civil War.

According to Hopkins and Smith (1978), evidence was found that the healing qualities of work, exercise and play were recognized and utilized thousands of years ago. The Chinese around 2600 BC thought that disease was caused by organic inactivity and thus used physical training such as Cong Fu for the promotion of health. The ancient Persians realized the beneficial effects of physical training and about 1000 BC utilized it to fit their youth for military duty. Among the ancient Greeks, Socrates (400 BC) and Plato (347 BC) understood the relationship between physical and mental health. Hippocrates, the father of medicine (359 BC), and Galen, his successor (200 AD), recommended that their patients exercise in the gymnasiums as a means of recovering

from illness. Thus, the interrelatedness of work, exercise and play which were recognized 2000 years earlier thus inspired the pioneers of occupational therapy to affirm that the health of individuals was influenced by "the use of muscles and mind together in games, exercise and handicraft" as well as in work.

Occupational therapy developed into an identified profession during the years after World War I. The pioneers then developed the use of carefully planned methods for promoting health through the use of certain activities. These activities thus became the cardinal functions of occupational therapy in the treatment of patients.
At the first stage of treatment, activities carried out while the patient is still bedridden are designed to exercise fingers and hands and for this purpose handicrafts are commonly used. When patients can leave their beds, a much wider field of activities is available extending to those which exercise the limbs, legs, feet and body.
Once power has been regained, occupational therapy often leads to industrial and domestic rehabilitation. If such a degree of recovery is impossible, the occupational therapist is skilled in teaching the use of numerous ingenious devices which aid the daily life of the handicapped patient.

The general areas of occupational therapy practice in the medical field include restoration of functions in mentally disabled, functional restoration in physical disabilities, minimal brain dysfunction, peadiatrics, and disabilities arising from diseases in general medicine and surgery, gerontology and other special areas such as blindness and deafness, mental retardation; cerebral palsy; burns; hand rehabilitation; amputations; assessment and treatment in educational settings and community home health care.

As noted in the foregoing, the invaluable roles of occupational therapy came into prominence in the World War II when medical rehabilitation teams comprising of specialist doctors, nurses, physical therapists, occupational therapists, clinical psychologists, social welfare officers, speech therapists, remedial gymnasts and disablement resettlement officers were set up to cater for the rehabilitation and resettlement of the wounded soldiers.

The British Service Departments were among the first to appreciate the value of the progress made between the world wars in the sphere of medical rehabilitation and during the 1939-45 war, each initiated schemes for the rehabilitation of the sick or injured personnel, in addition to the normal medical services provided. According to the Standing Committee on the Rehabilitation and Resettlement of Disabled

Persons (1961), the Royal Air Force was first provided with rehabilitation units very early in the 1939-45 war when shortage of air crew and skilled tradesmen and the long training period, required for replacements made speedy return to duty an urgent necessity. The units were found to be so successful, that full-time treatment at them greatly minimized patients' incapacity. Consequently they were retained in peace time. Since the end of the 1939-45 war, the medical rehabilitation units have continued to prove of value both in reducing the time of incapacity and in maintaining a high standard of result following injury or illness.

It took the civil war of 1967-70 in Nigeria to sensitize the Federal Government into realising the essence of medical rehabilitation for the war victims. The writer as an occupational therapist was privileged at the out-break of the civil war to serve on a Federal Government sponsored medical Committee to tour some of the war affected areas under the Nigerian Army's first infantry division in order to appraize medical cover and map out strategies for the eventual rehabilitation of the war victims. The delegation which was consisted of six medical consultants in various specialties, a nursing superintendent and a physical therapist was led by the director general of the Armed Forces Medical Services. The Committee's report which made far reaching recommendations on the medical cover, also gave

comprehensive details on their medical rehabilitation and resettlement. It was rather sad to note that the committee's recommendations were haphazardly implemented.

As earlier noted in chapter one, all the trained Nigerian occupational therapists were educated abroad at one time or the other. With the present poor state of the economy, it appears that government can longer continue overseas training to meet the country's need in this field. There is therefore a pressing need to embark on the local training of occupational therapists in universities just like the physical therapists. A hopeful sign in this direction has just emanated from the Obafemi Awolowo University Ile-Ife where the head of the department of medical rehabilitation in the Faculty of Health Sciences, wrote to the Nigerian Association of Occupational Therapists in April 1987 to assist the university in providing an academically qualified therapist to start its school of occupational therapy which has been lying dormant since its approval by the Senate of that University in 1977. (See Appendix 16).

In the light of the foregoing, our policy makers should seriously reflect on the need for our institutions of higher learning, the health administrators and the therapists' associations to form a three-way partnership to meet the

challenges that the present demands of the occupational and physical therapists present to our health care delivery. In these difficult times, stronger leadership and more meaningful direction for our health care establishments are probably best developed by such a triumvirate.

Implications of the Findings For Research

Research in occupational and physical therapy is still in its infancy. Many leaders in the two fields emphasize that research should have the highest priority in order to develop the knowledge base of the professions (Yerxa and Gilfoyle, 1976 and Basmajian, 1977). Much of the research which has been done in occupational and physical therapy thus far, is mainly descriptive of the evaluation of the therapeutic modalities used. Research is therefore needed now as never before to ensure the professions' accountability to the public. In this connection, former patients who have benefited from their services need to be sought to determine the efficacy of their services and whether each of the professions could be regarded as an alternate entry into recognized health services.

Kuhn (1962) noted that the presence of competing theories in a field often leads to a scientific crisis which can result in a new paradigm.

Some authors hold that occupational therapy is at a stage of crisis (Diasio, 1979 and Gillete and Kielhofner, 1979). Research is therefore needed to develop and test the occupational therapy knowledge base in order to improve its professional competence among the therapists.

Further research similar to the one undertaken in the present study should be done in order to determine what medical administrators, patients and students think the autonomous areas of occupational and physical therapy should be.

As it has been noted in the literature review, some major studies that have investigated the relationship between autonomy and job satisfaction have found positive linkage between them, but this is not so in this study. As this study appears to be the first of its kind in the country, research may therefore be needed to replicate it in order to determine whether the study findings appear to be a definite trend or just a happenstance among the Nigerian trained occupational and physical therapists.

Significance of the Study

Occupational and physical therapy are yet to be known as professions in the real sense of the word within the

medical fold in Nigeria, when compared with their counterparts in the western world. After more than three decades of existence in the health care delivery system in Nigeria, their impact is yet to be felt by the public.

As it has been noted elsewhere in this study, occupational therapy in particular appears to stand in danger of completely disappearing as a serious discipline. Urgent measures are thus needed to enhance its status and image. The invaluable roles the profession plays in the amelioration and rehabilitation of incapacitated patients resulting from diseases or injuries have already been highlighted in this chapter. First, there is a need for an increase in the numerical strength of its population by putting emphasis on the establishment of training institutions in some of the country's universities. Second, the profession needs to be more vocal in bringing their work to the attention of others. Perhaps the political activity which Maxwell and Maxwell (1977) advocated to be a "necessary evil" in professional life might be a solution. Such effort may lead to the development of a definition of occupational therapy for the lay public which will make the services of occupational therapy understandable to more persons who need them.

Physical therapy on the other hand has comparatively made more advancement, first in the raising of the standard

of their academic and professional qualification and secondly in the effective services they are rendering in the country's health care system. As noted elsewhere in this study, three Nigerian universities are currently engaged in the training of qualified physical therapists and out of these, one has already commenced post-graduate degree programme in the field.

Research studies conducted up to date on occupational and physical therapists' orientation to role autonomy and job satisfaction have found positive relationship between them (Lehmann, 1973, Maxwell and Maxwell, 1977; Barnes and Crutchfield, 1977; and Meltzer, 1980). Their findings encouraged the researcher to undertake a similar study on the Nigerian trained occupational and physical therapists.

This study, although designed to investigate the extent to which occupational and physical therapists desire role autonomy and have job satisfaction, has also examined the need to reappraize the content of the therapists' training, its implications for practice and research in the light of its findings.

Conclusion

Even though, caution demands that no sweeping

generalization should be made beyond the study population, ample evidence both from the review of the literature and previous studies has shown that occupational and physical therapist have a strong preference for role autonomy so as to more effectively organize, control and practise their professional activities.

The signs of the present may point in the right direction as changes and developments in the educational preparation of occupational and physical therapists are necessary to facilitate better practice, enhance the status of occupational and physical therapy, and make them more effective.

Beyond the greater involvement in government and planning bodies, the Nigerian Association of Occupational Therapists and the Nigerian Society of Physiotherapists may need to encourage their members to take a more active and more visible interest in health care planning and administration at all levels than presently obtains.

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APPENDIX 1

17 February, 1986

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Dear Therapist,

The attached questionnaire is part of a study designed to investigate role autonomy and job satisfaction of practising occupational and physiotherapists in Nigeria.

The questions mainly ask for your opinions, there are no right or wrong answers. Please be frank. Some of the questions may appear personal, but be assured that your answers will be treated as confidential. It is important to the study that your questionnaire be returned within the next four weeks so that the investigation results can be accurate.

I am a qualified occupational therapist as well as an educational administrator. This study is a requirement of partial fulfilment of my Doctor of Philosophy degree in educational administration from the University of Lagos.

I wish to thank you in advance for your participation in this study and your co-operation in finding sometime to complete the questionnaire.

Yours sincerely,

Major P. A. OGUNLEYE, M.Ed. (Admin), B.Sc. (O.T.), Dip. C.O.T. (Lond.),
O. T. Dept.
Military Hospital M.N.A.O.T.
Yaba, Lagos.

HOW TO COMPLETE THE QUESTIONNAIRE

Please read each question carefully before giving your answer. To answer most of the questions, you will only need to put a tick (✓) by the appropriate answer. If anything else is needed; it will be clear from the question.

This is not a test of knowledge; there are no right or wrong answers. You need only about fifteen minutes to complete the whole questionnaire.

CC

SECTION A - GENERAL INFORMATION

1. SEX: ☐ Male ☐ Female 01

2. AGE: ☐ 20 - 30 ☐ 31 - 40 ☐ 41 - 50 ☐ 50 & Older 02

3. MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed 03

☐ Divorced/Separated

4(a) PRESENT EMPLOYMENT: (For Occupational Therapist only) 04

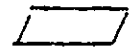
Chief ☐

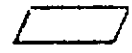
Assistant Chief ☐

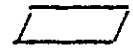
Principal Therapist ☐

Senior Therapist ☐

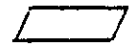
Therapist Grade I ☐

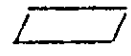
Therapist Grade II 

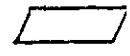
Private Practitioner 

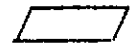
Other (specify) 

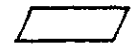
4(b) PRESENT EMPLOYMENT: (For Physiotherapists only) 05

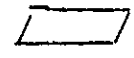
Chief 

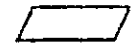
Assistant Chief 

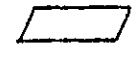
Principal Therapist I 

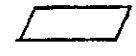
Principal Therapist II 

Senior Therapist I 

Senior Therapist II 

Therapist II 

Private Practitioner 

Other (specify) 

5. YOUR ACADEMIC QUALIFICATIONS: 06

Diploma ▱

Teaching Diploma ▱

Bachelor's Degree ▱

Master's Degree ▱

Doctoral Degree ▱

Other (specify) ▱

6. YOUR PROFESSION: 07

Occupational Therapy ▱

Physiotherapy ▱

SECTION B

Please indicate the extent to which you are satisfied with each of the following statements by putting a tick in the appropriate space numbered 1 - 5.

Very Dissatisfied 1 2 3 4 5 Very Satisfied.

	Very Dissatisfied				Very Satisfied	
	1	2	3	4	5	CC
1. The amount of equipment you have in the department.						08
2. The variety of equipment you have in the department						09
3. The space available for treating patients in the department						10
4. The position of the department in relation to the rest of the hospital.						11
5. The physical condition of the building.						12
6. The pay is reasonable compared with that of others in similar professions.						13

	Very Dissatisfied				Very Satisfied	
	1	2	3	4	5	CC
7. The pay has not kept up with the cost of living.						14
8. The pay is reasonable for the type of work I do.						15
9. The conditions under which you have to work (i.e. lighting, ventilation etc).						16
10. The recognition you get from your job.						17
11. The opportunities for advancement in your job.						18
12. The amount of job security you have in your position.						19
13. Your control over the quality of your work.						20
14. The amount of decision-making demanded by your position.						21

	Very Dissatisfied 1	2	3	4	Very Satisfied 5	CC
15. The amount of responsibility demanded by your position.						22
16. The extent to which you can use your skills.						23
17. The feeling of accomplishment from the work you are doing.						24
18. The opportunities to do the things you are really educated for (as opposed to those things that people with less training can do just as well).						25
19. The extent to which the medical doctors accept you as a colleague within the health care system						26
20. The co-operativeness you receive from other health care personnel in your institution.						27

	Very Dissatisfied				Very Satisfied	
	1	2	3	4	5	CC
21. The adequacy of your present professional qualifications.						28
22. The confidence which your patients have in your professional ability.						29
23. The extent to which you are left relatively free of supervision by others.						30

SECTION C

Please indicate the extent to which you agree with each of the following statements by putting a tick in the appropriate space numbered 1 - 5:

Strongly Disagree 1 2 3 4 5 Strongly Agree

	Strongly Disagree 1	2	3	4	Strongly Agree 5	CC
1. Therapists should be permitted to terminate or continue the treatment of their patients as they deem fit.						31
2. I feel more confident working with patients who have been referred to me by medical doctors.						32
3. Therapists should be responsible for developing the budget for the departments under them.						33
4. Therapists should be responsible for developing staff projections in their departments.						34

	Strongly Disagree 1	2	3	4	Strongly Agree 5	CC
5. Therapists should have final authority over their work.						35
6. Therapists as members of a health care team should be allowed to function more independently.						36
7. Therapists within medical settings should be allowed to provide their services to clients in need of those services without the requirement of a physician's prescription.						37
8. It should be permissible for the therapist to violate medical protocol if it is in the best interest of the patient.						38

	Strongly Disagree				Strongly Agree	
	1	2	3	4	5	CC
For questions 9, 10 and 11, please respond in relation to this question: Do you agree that therapists should be given the opportunity to make the following diagnosis?						
9. The initial diagnosis.						39
10. Further diagnosis.						40
11. Different diagnosis if first appears wrong.						41
12. Heads of departments should take responsibility for the actions of other therapists working in their departments.						42
13. Membership in the state association should be a requirement to practise or hold a position.						43

	Strongly Disagree				Strongly Agree	
	1	2	3	4	5	CC
14. Membership in the national association should be a requirement to practise or hold a position.						44
15. There should be a re-examination and re-registration for any therapist who wishes to re-enter practice after an absence of five years or more.						45
16. Your profession has a firm core of Theory and Knowledge that compares favourably with medicine or dentistry.						46
17. I sometimes have to do things that I do not have enough professional preparation for.						47
18. In-service education and refresher courses should be developed to update the training of the therapists						48

	Strongly Disagree 1	2	3	4	Strongly Agree 5	CC
19. Thinking of various jobs which the therapists may hold five to ten years from now, Nigeria would need a master's programme as entry qualification into my profession.						49
20. Do you agree that University education is adequate as a pre-requisite for entry into the profession?						50
21. Polytechnic education in a community college is adequate to meet the training needs of the profession.						51
22. I feel the need for some other person with a higher level of expertise within the profession in my department.						52

	Strongly Disagree 1	2	3	4	Strongly Agree 5	CC
23. The best interests of therapists would be served by conforming to professional standards rather than the standards set by their employing institutions.						53
24. Therapists should be made more accountable for the treatment activities of their patients.						54
25. Your training has prepared you to conduct and report research.						55
26. Therapists should be evaluated only by fellow therapists.						56
27. Because of what I am able to do for society, I would like to continue in my present profession even if I could earn more money elsewhere.						57
28. My professional education has prepared me adequately to carry out administrative/supervisory duties.						58

	Strongly Disagree				Strongly Agree	
	1	2	3	4	5	CC
29. Therapists should be involved in determining programmes which will best meet patient care objectives.						59
30. Your profession may be threatened by the growth and development of other occupations or professions.						60
31. From my experience, I know that doctors have sufficient knowledge of the role of my profession.						61
32. In order to gain more respectability as a profession, I feel that the knowledge of medical subjects by the therapists needs to be upgraded to the same level as for doctors.						62
33. I feel my profession is less stimulating intellectually than I anticipated.						63
34. In my opinion therapists rely more on technique than theory.						64

	Strongly Disagree 1	2	3	4	Strongly Agree 5	cc
35. I believe that graduate education will enhance the therapeutic effectiveness of the therapists.						65
36. In my opinion the present knowledge of medical subjects of the therapists is just about the same as that of the nurses.						66
37. I feel that graduate education will provide a foundation for scholarly contributions in my profession.						67
38. I think therapists should develop treatment plans based on an established frame of reference.						68
39. In my experience, I agree that some doctors use my department as a dumping ground for chronic patients.						69

	Strongly Disagree				Strongly Agree	
	1	2	3	4	5	CC
40. Your head of department can make an objective assessment of your work.						70
For questions 41 through 46, please respond in relation to this question: To what extent do you agree that the introduction of more men into your profession would:						
41. Increase the status of the profession in the eyes of the medical authorities?						71
42. Improve career structure?						72
43. Reduce the professional openings for women?						73
44. Improve the salary structure?						74
45. Reduce the amount of heavier work for female therapists?						75
46. Produce less wastage due to marriage and pregnancy.						76

	Strongly Disagree				Strongly Agree	
	1	2	3	4	5	CC
47. Do you agree that your training has provided you with the ability to cope with stressful work situation?						77
For questions 48, 49 and 50, please respond in relation to this statement: In many professions there are problems such as lack of power and influence, difficulty in relation to other professions etc. Thinking of your profession:						
48. Do you agree that the lack of a clearly defined area of competence in relation to other health professions account for some of the problems in the profession?						78
49. Do you agree that the lack of training of the therapists in dealing with government and other professions account for some of the problems in the profession?						79

	Strongly Disagree				Strongly Agree	
	1	2	3	4	5	CC
50. Do you agree that the fact that the majority of people in the profession are women account for some of the problems in the profession?						80

Comments (if any): .....

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If you would like a report of the findings of this study, please contact your Association's headquarters later.

Thank you.

APPENDIX 2

RELIABILITY COEFFICIENT OF PILOT STUDY

No. of Cases	X	Y	X^2	Y^2	XY
1	132	113	17424	12769	14916
2.	129	129	16641	16641	16641
3	121	119	14641	14161	14399
4	111	108	12321	11664	11988
5	142	136	20164	18496	19312
6	140	124	19600	15376	17360
Summation	775	729	100791	89107	94616

$$r = \frac{N\Sigma XY - \Sigma X \Sigma Y}{\sqrt{(N\Sigma X^2 - (\Sigma X)^2)\ (N\Sigma Y^2 - (\Sigma Y)^2)}}$$

$$r = \frac{6 \times 94616 - 775 \times 729}{\sqrt{(6 \times 100791 - 775^2)\ (6 \times 89107 - 729^2)}}$$

$$r = \frac{2721}{\sqrt{4121 \times 3201}} = \frac{2721}{3631.98}$$

$$r = 0.74$$

APPENDIX 2 Cont'd.

Formula for Spearman Brown for correction

$$r_{xx} = \frac{2rhh}{1 + rhh}$$

where rhh is reliability of a half test.

$$r_{xx} = \frac{2 \times 0.74}{1 + 0.74}$$

$$r_{xx} = \frac{1.48}{1.74}$$

$$r_{xx} = \underline{\underline{0.85}}$$

APPENDIX 3

April, 1986

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Dear Colleague,

FOLLOW UP LETTER

A few weeks ago, I mailed a questionnaire to you, attempting to investigate role autonomy and job satisfaction of practising occupational and physiotherapists in Nigeria. While the response has been most gratifying, I believe I should await the return of a few more completed questionnaires before beginning the analysis of the data.

Being fully aware of your rather tight schedule, I would request that you complete and return the questionnaire at your earliest convenience - preferably before the middle of June 1986. Because of the small numerical strength of the therapists, a high percentage of return is most important.

If your response is already in the mail, I extend my thanks, as well as my apologies for this reminder.

Thank you and compliments.

Yours sincerely,

Maj. P. A. Ogunleye
Occupational Therapy Dept.
Military Hospital
Yaba - Lagos.

APPENDIX L

FREQUENCY DISTRIBUTION OF THE OCCUPATIONAL THERAPISTS'

RESPONSE TO ROLE AUTONOMY (N = 22).

Category Label	Role Autonomy Scale Items											
	31 %	33 %	34 %	36 %	37 %	38 %	39 %	40 %	41 %	42 %	53 %	59 %
1 (Strongly Disagree)	-	-	-	4.5	27.3	27.3	40.9	22.7	18.2	13.6	-	-
2	4.5	-	-	9.1	9.1	9.1	27.3	9.1	3.6	13.6	-	-
3	-	4.5	-	9.1	9.1	27.3	9.1	13.6	4.5	13.6	18.2	-
4	22.7	-	9.1	27.3	22.7	22.7	13.6	31.8	31.8	9.1	18.2	18.2
5 (Strongly Agree)	72.7	95.5	90.9	45.5	27.3	13.6	4.5	18.2	31.8	50.0	63.2	81.8
No Response	-	-	-	4.5	4.5	-	4.5	4.5	-	-	-	-
Mean	4.636	4.909	4.909	3.864	3.000	2.864	2.000	3.000	3.455	3.682	4.455	4.818
Mode	5.000	5.000	5.000	5.000	1.000	1.000	1.000	4.000	4.000	5.000	5.000	5.000
Std. Dev.	.727	.426	.294	1.457	1.746	1.424	1.309	1.604	1.535	1.555	.800	.395

APPENDIX 5

ROLE AUTONOMY OF OCCUPATIONAL THERAPISTS (N = 22)

PERCENTAGES OF RESPONSES

Response Categories	Percentage
Strongly Disagree	12.88
Disagree	7.12
Undecided	9.08
Agree	18.93
Strongly Agree	49.58
No Response	1.5.
Mean	45.59

APPENDIX 6

FREQUENCY DISTRIBUTION OF THE PHYSICAL THERAPISTS' RESPONSE TO ROLE AUTONOMY (N = 144)

	Role Autonomy Scale Items											
Category Label	31 %	33 %	34 %	36 %	37 %	38 %	39 %	40 %	41 %	42 %	53 %	59 %
1: (Strongly Disagree)	0.7	1.4	-	1.4	3.5	6.3	24.3	4.2	3.5	9.7	0.7	0.7
2	0.7	0.7	-	2.8	8.3	9.0	20.8	8.3	6.3	10.4	0.7	0.7
3	2.1	3.5	2.1	11.1	11.8	18.8	23.6	17.4	11.8	13.2	5.6	2.1
4	18.8	13.2	11.1	19.4	26.4	18.8	13.9	35.4	27.1	24.3	31.3	23.6
5 (Strongly Agree)	77.8	81.3	86.8	64.6	50.0	46.5	16.0	34.0	50.7	42.4	61.1	72.2
No Response	-	-	-	0.7	-	0.7	1.4	0.7	0.7	-	0.7	0.7
Mean	4.722	4.722	4.847	4.410	4.111	3.882	2.722	3.847	4.132	3.792	4.493	4.639
Mode	5.000	5.000	5.000	5.000	5.000	5.000	1.000	4.000	5.000	5.000	5.000	5.000
Std. Dev.	0.608	0.694	0.415	0.971	1.123	1.298	1.421	1.149	1.136	1.348	0.793	0.735

APPENDIX 7

ROLE AUTONOMY OF PHYSICAL THERAPISTS (N = 144)

PERCENTAGES OF RESPONSES

Response Categories	Percentage
Strongly Disagree	4.7
Disagree	5.7
Undecided	10.3
Agree	21.9
Strongly Agree	56.9
No Response	.5
Mean	50.31

APPENDIX 8

FREQUENCY DISTRIBUTION OF THE OCCUPATIONAL THERAPISTS' RESPONSE TO JOB SATISFACTION (N = 22)

	Job Satisfaction Scale Items									
Category Label	08 %	09 %	10 %	12 %	13 %	14 %	15 %	16 %	19 %	20 %
1 (Very Dissatisfied)	13.6	13.6	27.3	27.3	9.1	40.9	18.2	18.2	13.6	4.5
2	13.6	22.7	18.2	13.6	13.6	22.7	40.9	13.6	13.6	9.1
3	50.0	27.3	22.7	27.3	22.7	9.1	9.1	27.3	18.2	18.2
4	13.6	22.7	22.7	18.2	40.9	13.6	22.7	18.2	40.9	40.9
5 (Very Satisfied)	9.1	9.1	4.5	13.6	13.6	9.1	9.1	22.7	9.1	27.3
No Response	-	4.5	4.5	-	-	4.5	-	-	4.5	-
Mean	2.909	2.773	2.455	2.773	3.364	2.136	2.636	3.136	3.045	3.773
Mode	3.000	3.000	1.000	1.000	4.000	1.000	2.000	3.000	4.000	4.000
Std. Dev.	1.109	1.343	1.371	1.412	1.177	1.457	1.293	1.424	1.396	1.110

Cont'd.

APPENDIX 8 Cont'd.

FREQUENCY DISTRIBUTION OF THE OCCUPATIONAL THERAPISTS'

RESPONSE TO JOB SATISFACTION SCALE (N = 22)

	Job Satisfaction Scale Items						
	21	22	29	30	71	72	74
Category Label	%	%	%	%	%	%	%
1 (Very Dissatisfied)	-	4.5	4.5	-	4.5	4.5	13.6
2	-	4.5	-	4.5	18.2	27.3	31.8
3	27.3	18.2	4.5	18.2	22.7	9.1	18.2
4	40.9	27.3	40.9	36.4	9.1	13.6	9.1
5 (Very Satisfied)	31.8	36.4	50.0	40.9	45.5	45.5	22.7
No Response	-	9.1	-	-	-	-	4.5
Mean	4.045	3.591	4.318	4.136	3.727	3.682	2.818
Mode	4.000	5.000	5.000	5.000	5.000	5.000	2.000
Std. Dev.	0.785	1.593	0.945	0.889	1.352	1.427	1.532

APPENDIX 9

JOB SATISFACTION OF OCCUPATIONAL THERAPISTS (N = 22)

PERCENTAGES OF RESPONSES

Response Categories	Percentage
Very Dissatisfied	12.8
Dissatisfied	15.8
Undecided	20.6
Satisfied	25.4
Very Satisfied	23.5
No Response	1.9
Mean	55.3

APPENDIX 10

FREQUENCY DISTRIBUTION OF THE OCCUPATIONAL THERAPISTS' RESPONSE TO PROFESSIONALISM (N = 22)

	Professionalism Scale Items							
	28	43	44	52	55	58	60	61
Category Label	%	%	%	%	%	%	%	%
1 (Strongly Disagree)	4.5	18.2	4.5	36.4	4.5	-	36.4	54.5
2	9.1	4.5	4.5	13.6	27.3	-	18.2	31.8
3	18.2	9.1	13.6	18.2	18.2	4.5	4.5	9.1
4	36.4	13.6	13.6	22.7	18.2	36.4	18.2	-
5 (Strongly Agree)	31.8	54.5	63.6	9.1	27.3	59.1	22.7	4.5
No Response	-	-	-	-	4.5	-	-	-
Mean	3.818	3.818	4.273	2.545	3.227	4.545	2.727	1.682
Mode	4.000	5.000	5.000	1.000	2.000	5.000	1.000	1.000
Std. Dev.	1.140	1.593	1.162	1.438	1.478	0.596	1.667	0.995

Cont'd.

APPENDIX 10 (Cont'd.)

FREQUENCY DISTRIBUTION OF THE OCCUPATIONAL THERAPISTS' RESPONSE TO PROFESSIONALISM SCALE (N = 22)

	Professionalism Scale Items						
Category Label	63 %	64 %	66 %	67 %	69 %	78 %	79 %
1 (Strongly Disagree)	45.5	18.2	50.0	9.1	13.6	4.5	22.7
2	22.7	13.6	18.2	4.5	22.7	9.1	13.6
3	9.1	13.6	13.6	22.7	27.3	40.9	18.2
4	13.6	31.8	9.1	22.7	18.2	27.3	4.5
5 (Strongly Agree)	4.5	22.7	9.1	36.4	13.6	18.2	40.9
No Response	4.5	-	-	4.5	4.5	-	-
Mean	1.955	3.273	2.091	3.591	2.818	3.455	3.273
Mode	1.000	4.000	1.000	5.000	3.000	3.000	5.000
Std. Dev.	1.327	1.453	1.377	1.501	1.402	1.057	1.667

APPENDIX 11

PROFESSIONALISM OF OCCUPATIONAL THERAPISTS (N = 22)

PERCENTAGES OF RESPONSES

Response Categories	Percentage
Strongly Disagree	21.5
Disagree	14.2
Undecided	16.1
Agree	19.1
Strongly Agree	27.9
No Response	1.2
Mean	47.1

APPENDIX 12

FREQUENCY DISTRIBUTION OF THE PHYSICAL THERAPISTS' RESPONSE TO JOB SATISFACTION (N = 144)

Category Label	Job Satisfaction Scale Items							
	08 %	09 %	10 %	12 %	13 %	14 %	15 %	16 %
1 (Very Dissatisfied)	8.3	6.9	11.8	16.0	18.1	26.4	30.6	4.9
2	19.4	20.8	20.1	10.4	22.9	31.9	32.6	12.5
3	36.8	41.0	28.5	26.4	25.0	25.7	18.8	32.6
4	28.5	24.3	20.1	29.9	25.7	11.1	12.5	30.6
5 (Very Satisfied)	6.3	6.9	18.8	16.7	5.6	2.8	4.2	18.8
No Response	0.7	-	0.7	0.7	2.8	2.1	1.4	0.7
Mean	3.028	3.035	3.118	3.118	2.694	2.257	2.229	3.438
Mode	3.000	3.000	3.000	4.000	4.000	2.000	2.000	3.000
Std. Dev.	1.064	1.006	1.298	1.322	1.264	1.114	1.175	1.120

Cont'd.

APPENDIX 12 (Cont'd.)

FREQUENCY DISTRIBUTION OF THE PHYSICAL THERAPISTS' RESPONSE TO JOB SATISFACTION (N = 144)

Category Label	Job Satisfaction Scale Items								
	19 %	20 %	21 %	22 %	29 %	30 %	71 %	72 %	74 %
1 (Very Dissatisfied)	6.3	2.1	4.2	1.4	-	1.4	17.4	14.6	24.3
2	10.4	3.5	4.9	4.9	-	0.7	16.0	14.6	22.9
3	31.9	16.7	22.9	22.2	4.9	6.3	24.3	25.7	22.9
4	34.7	46.5	45.8	45.1	43.8	34.0	16.0	18.1	13.9
5 (Very Satisfied)	16.0	31.3	22.2	25.0	51.4	57.6	25.0	25.7	13.9
No Response	0.7	-	-	1.4	-	-	1.4	1.4	2.1
Mean	3.417	4.014	3.771	3.833	4.465	4.458	3.111	3.215	2.639
Mode	4.000	4.000	4.000	4.000	5.000	5.000	5.000	3.000	1.000
Std. Dev.	1.113	0.901	0.987	0.996	0.590	0.765	1.463	1.425	1.402

APPENDIX 13

JOB SATISFACTION OF PHYSICAL THERAPISTS (N = 144)

PERCENTAGES OF RESPONSES.

Response Categories	Percentage
Very Dissatisfied	11.5
Dissatisfied	14.6
Undecided	24.3
Satisfied	28.3
Very Satisfied	20.5
No Response	1.0
Mean	55.9

APPENDIX 14

FREQUENCY DISTRIBUTION OF THE PHYSICAL THERAPISTS'

RESPONSE TO PROFESSIONALISM (N = 144)

	Professionalism Scale Items							
	28	43	44	52	55	58	60	61
Category Label	%	%	%	%	%	%	%	%
1 (Strongly Disagree)	4.9	9.7	3.5	25.0	4.9	6.3	52.8	50.0
2	8.3	5.6	1.4	14.6	4.9	7.6	27.8	35.4
3	22.9	13.2	4.9	20.1	18.8	20.8	8.3	11.1
4	39.6	14.6	9.7	16.7	24.3	31.9	5.6	2.8
5 (Strongly Agree)	24.3	56.3	79.2	23.6	47.2	31.9	4.9	0.7
No Response	-	0.7	1.4	-	-	1.4	0.7	-
Mean	3.701	4.000	4.556	2.993	4.042	3.715	1.799	1.688
Mode	4.000	5.000	5.000	1.000	5.000	4.000	1.000	1.000
Std.Dev.	1.078	1.384	1.063	1.508	1.140	1.244	1.126	0.832

Cont'd.

APPENDIX 14 (Cont'd.)

FREQUENCY DISTRIBUTION OF THE PHYSICAL THERAPISTS' RESPONSE TO PROFESSIONALISM (N = 144)

Category Label	Professionalism Scale Items						
	63 %	64 %	66 %	67 %	69 %	78 %	79 %
1 (Strongly Disagree)	43.1	20.1	66.7	3.5	9.0	20.1	24.3
2	24.3	18.1	22.2	1.4	6.9	20.1	15.3
3	8.3	19.4	3.5	6.3	9.7	25.0	28.5
4	15.3	21.5	1.4	18.8	28.5	17.4	20.1
5 (Strongly Agree)	7.6	17.4	5.6	68.8	45.8	16.7	10.4
No Response	1.4	3.5	0.7	1.4	-	0.7	1.4
Mean	2.160	2.875	1.549	4.438	3.951	2.882	2.729
Mode	1.000	4.000	1.000	5.000	5.000	3.000	3.000
Std. Dev.	1.362	1.486	1.043	1.076	1.286	1.382	1.344

APPENDIX 15

PROFESSIONALISM OF PHYSICAL THERAPISTS (N = 144)

PERCENTAGES OF RESPONSES.

Response Categories	Percentage
Strongly Disagree	22.9
Disagree	14.3
Undecided	14.7
Agree	17.9
Strongly Agree	29.4
No Response	.9
Mean	47.1

APPENDIX 16

DEPARTMENT OF MEDICAL REHABILITATION
FACULTY OF HEALTH SCIENCES.
UNIVERSITY OF IFE
ILE—IFE, NIGERIA.

Our Reference....DMR/32.....
Your Reference.....

Telegrams: 'IFEVARSITY IFE'
Telephone Ife 2291
22nd April, 87

Secretary,
Nigeria Association of Occupational Therapy,
c/o Department of Occupational Therapy,
Psychiatric Hospital,
Yaba,
Lagos.

Dear Sir,

This brief correspondence is to initiate dialogue with your association with regards to starting a degree programme in Occupational Therapy in the University of Ife. We have been struggling to initiate a programme which was approved by Senate in 1977. The major reason why we have not taken off is because of lack of qualified staff. Essentially what we need is someone with a good master's degree (with publications) or a Ph.D. in the areas of occupational therapy. I wonder whether your association can help in this regard.

Cordially,

Prof. V.C.B. Nwuga
Head of Department.