A Holistic Approach to Specialization

delivery of health care; specialization, occupational therapy

Jane Hoyt Slaymaker

There is a growing concern that extensive specialization in occupational therapy may so fragment the profession that it may be lost in the changes taking place in the delivery and payment of health care services. The early concepts of occupation and purposeful, developmentally appropriate activities are giving way in some settings to the use of highly specialized technologies. This article examines the trend of leaving occupational behaviors and adopting activity of a more technical nature and offers a conceptual model to preserve the traditional holistic approach to the practice of occupational therapy in today's climate of specialization. The approach is seen as important to the viability of the profession in a modern competitive health care market.

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ith prospective payment for acute-care Medicare patients and a subsequent movement of health care out of the hospital and into the community, there is a need to look at the practice of occupational therapy today to see if therapists are ready to meet the changing demands of the nation's health care delivery system. As a profession, occupational therapy has been moving toward a more positive view of specialization. The American Occupational Therapy Association (AOTA) is considering a proposal to recognize specialists through a form of advanced-level certification. Is this a wise direction to take, or is there an alternate route that can recognize and use occupational therapy's foundation in human occupation yet still allow practitioners to incorporate new ideas and methods of evaluation and treatment into practice? An excess of specialist practitioners may be detrimental to the profession in a health care climate demanding more versatile generalists. The issue bears examination now before future alterations in health care delivery overtake the profession's ability to adapt and change.

Health Care Today

The American health care system is in the state of a major transition. By the end of the 1970s, health care was the second largest industry in the country, consuming almost 9% of the US gross national product (1). Since then health care costs have continued to escalate at an appallingly rate. In 1982 the increase was 11.9%, triple the rise of the consumer price index (2). Health care costs were targeted for action by the Reagan Administration when it became apparent that because of skyrocketing hospital costs, the Medicare Hospital Insurance Trust Fund, which pays for Medicare Part A hospital services, would be exhausted by 1990 (2). No matter what Congress, state legislatures, or others do in response to the mandate to contain health costs, changes in the payment system for hospitals, physicians, rehabilitation, mental health, and home and skilled nursing care will have a direct impact on the field of occupational therapy (3).

Two aspects of the health care system are vying with each other. They are efficiency, the achieve-
ment of objectives that meet financial standards, and effectiveness, the use of resources to achieve desired program outcomes, which includes the processes by which health services are delivered and client satisfaction (4). To survive this dichotomy, occupational therapy must find a way "to develop and maintain the patient's capacity, throughout the life cycle, to perform with satisfaction to himself and others, those occupational tasks and roles essential to productive living and to the mastery of the self and the environment" (5, p 5) while making this whole process cost-effective. This is quite a challenge in a society that does not always value the commonplace, such as the activities of play, leisure, and self-maintenance (6, p 16).

Naisbitt (7) foresaw several trends that would affect health care. He predicted that planning would move from short-term goals to a greater emphasis on long-range planning. However, it appears that in this country health care is moving in the opposite direction. It is moving away from long-term patient management and institutional care toward short-term, competitive, cost-dominated care delivery (8). One example of this is the use of diagnostic-related groups (DRGs) on a predetermined rate basis for Medicare payment in some settings. Before this trend is over, most other third-party payers will also adopt a preset payment plan because it provides a simple way to contain costs. Cost containment and the effectiveness of all professional services will be examined very closely in this new, cost-driven system (9).

However, such short-term, efficiency-based service delivery will not always be to the advantage of the people served, nor will it necessarily be cost-effective in the long run. As California demonstrated in its Medi-Cal program, patients are being discharged from hospitals more quickly, but they also return more often because their problems have not been fully addressed. An example of this might be the stroke patient whose life was saved but who received neither physical nor occupational therapy before being sent home. As a result, the patient developed severe contractures, had to be rehospitalized, and ended up in a nursing home because he could no longer care for himself and the family could no longer care for him in the home. This illustrates that the profession must not lose sight of the fact that effectiveness, as well as efficiency, must be considered in health care. Until this is widely recognized, occupational therapy will have to find ways to work with and around the present system to offer total (and holistic) care.

During the past ten years, the profession has been moving toward more specialization. The fact that specialists are often hired before generalists and are frequently paid more than generalists has reinforced this trend. Specialization is a natural outcome of the medical and reductionist models (3) and fol-

![Figure 1](An occupational therapy student's holistic view of the patient at entry level into the profession)
In a special issue of the *American Journal of Occupational Therapy*, in which contributors discussed in depth the issue of specialization, West (14) wrote, “all occupational therapists should be both generalists and specialists” (p 46). In the same issue, Welles (15) wrote that there is *too much* knowledge today for any therapist to be fully competent in even one branch of the field (p 287); hence it is a logical and necessary step to narrow practice areas to areas of special expertise. Specialization can lead to a higher and broader level of professional development and also aid therapists in offering better service to the consumers of health care. However, occupational therapists must also use their flexible generalist background to maintain a total perspective on each patient (16).

**A Holistic Approach to Specialization**

I propose the concept of holistic specialization, based on the functional model of occupational performance, as a way of combining the best of both approaches—specialization and generalism. Figure 1 shows the areas of knowledge that a typical occupational therapy student would have at graduation. In looking at a patient, the new practitioner would be aware of the patient's functional abilities in the areas of self-care, work, education, and play/leisure by seeing what the patient's developmental activities and roles were at a particular time. The practitioner would then look at the patient's functional level in the areas of neurosensory, physical-motor, cognitive, social, and psychological performance. Since health consumers cannot be separated from the environment in which they function, or hope to function, it would also be necessary to consider the patient's physical environment and how it relates to their performance.

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therapy may have relinquished the broad approach taken at graduation. This therapist uses few developmentally appropriate activities, emphasizing instead techniques like hydrotherapy, exercise, and splinting. West (6) questions this approach: "Why the denial of traditional media, and their replacement with modalities more closely identified with the knowledge base of other disciplines and the practice of their professions?" (p 16).

The areas of neurosensory and physical-motor performance are emphasized while the others are neglected. Only the physical environment and family support are attended to in the patient's day-to-day environment. Such a separation can occur in almost any area of practice.

Figure 3 provides an example of holistic specialization—therapists who specialize yet remain true to their holistic training. For example, a therapist functioning in the field of mental health has developed an area of specialization that requires a great deal of experience and training in psychological, social, and neurosensory function, but has not divorced him- or herself from the total configuration of occupational performance. The therapist is still examining all of the areas, including physical-motor and cognitive function, the central core of developmentally appropriate activities, and all of the environmental factors that affect his or her patients. This holistic approach requires a variety of continuing education activities and reading to keep current, but it reflects and uses the basic concepts of occupational therapy.

Conclusion

How specialization is used by occupational therapy personnel may be aware of the patient's physical environment, community expectations, and support systems and to consider socioeconomic factors, culture and religion, and the type of personal support system the person has via family and friends. All of this would be viewed in relation to the sex and age of the patient as this total “balance or configuration of self-care, work, and leisure activities changes as each individual matures from infancy through adulthood and senescence” (17, p 47). An awareness of all these factors and how they interact with each other is basic to the occupational therapy process. The smaller areas outside the circle in the figure are the Fieldwork Level I and Level II experiences that a new graduate has in the subcomponents of occupational performance at the time of graduation. The fieldwork experiences are depicted as equal although in reality they vary from graduate to graduate because everyone does not have the same interests or receive the same type, or quality, of instruction.

Figure 2 shows what often happens when someone separates from the holistic model and specializes in a particular area to the exclusion of the other areas. For example, a person who has specialized in hand
have an impact on our profession. Keen competition for limited health care dollars means "we are going to have to aggressively prove we can function on many levels and in many settings, not just in the hospital. We need to look outward toward community-based care centers, home health, out-patient clinics, health maintenance organizations and wellness centers, because hospitals are finding that many services are better provided on an outpatient basis (2). By using the holistic approach to specialization for practice, therapists can meet this challenge. The process involves the evaluation and treatment of the whole person. This is occupational therapy at its very best. As John Gardner said, "What could be more satisfying than to be engaged in work in which every capacity or talent that one has is needed, every lesson one may have learned is used, and every value one cares about is furthered" (18, p 32).

REFERENCES