On the Role of the Occupational Therapist in Physical Disabilities

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As a group of registered occupational therapists who specialize in physical restoration of upper extremity problems, we see our clinical role as that of maximizing physical restoration, analyzing functional elements, and retraining or adapting, where indicated. We believe that a strong functional orientation is critical to being an occupational therapist, and that use of purposeful activity is extremely important in our practice. However, we also believe that our skills—including range of motion, therapeutic exercise, muscle strengthening and splinting for corrective, preventive and functional purposes—in physical restoration are important adjuncts to reaching functional goals.

The American Occupational Therapy Association (AOTA) recently promoted the use of Purposeful Activity, which is used to denote the entire concept of exclusive use of purposeful, goal-oriented occupation in its many forms as the fundamental and unique base of occupational therapy. In doing so, the AOTA has increasingly denied the additional skills of the restorative areas of physical disabilities practice. Two articles in the September 1981 AJOT, written by Gail Fidler and Joy Huss, are examples of the promotion of purposeful activity. (1, 2) Other recent communications confirm this trend: For example, the letter dated August 20, 1981, from Mae Hightower-Vandamm, President of AOTA, to the AOTA membership affirms the prime and singular importance of Purposeful Activity in the practice of occupational therapy. She states that "...any public or professional confusion that arises over the difference between occupational and physical therapy, or any other health service, only hinders efforts to promote occupational therapy as a single viable service with a foundation rooted in the premise that purposeful, goal-directed activity has significant value in the rehabilitation or functional restoration of a bodily or mental condition." (3) Another example of this philosophical trend is the 1981 AOTA Entry Level Role Delineation, which describes program planning to restore performance as necessary, to minimize debilitation (as opposed to restoring or improving physical function), and to determine activities to attain these goals. It limits therapeutic methods to use only with purposeful activity (4). We submit that tying treatment methods directly to purposeful activity is not always appropriate nor effective.

In contrast, it should be noted that the (1978) AOTA Standards of Practice included more description of our restorative role. They described our role as "evaluative, preventive, restorative or corrective." (5) More specifically, they stated that re-education of motor skills could be done through active, passive, resistive, inhibition, or facilitation techniques.

The conjunctive use of purposeful activity was not stressed as it is in the 1981 Role Delineation. This new stress on Purposeful Activity seems to limit occupational therapy restoration to use of activities, excluding the use of exercises, other modalities, or corrective splinting to achieve the ultimate goal of maximum function.

Purposeful Activity is a vague term that will be interpreted in many ways both inside and outside the profession by those who wish to limit our practice of physical disability occupational therapy. For instance, a case could be made for the fact that any direction or assignment given to a patient by a therapist should have a purpose, whether or not it achieves an end product. Is Purposeful Activity distinguished by an end product? The mere use of an activity for the sake of producing an end product may actually have a more vague goal than an individually designed exercise. Thus, the distinction between Purposeful Activity and nonpurposeful activity appears ambiguous. Does this vague concept of Purposeful Activity best describe our role to each other, to our clients, to physicians, to government agencies, to insurance carriers, or to the public at large? It seems that such an ambiguous concept denies much of the knowledge and many of the restorative skills of the physical disability occupational therapist that are inadequately described by the term Purposeful Activity. Such restorative techniques might include biofeedback or active
range of motion exercises long before a physician prescribes purposeful activity with its implicit application of strength. These techniques might also include scar mobilization through exercise, or construction of splints that facilitate function, support weak structures, or increase range of motion by stretching tissue, scar, or joints.

We disagree with the AOTA's negative position on physical disability occupational therapists' providing restorative services. Physical disability occupational therapists have become recognized specialists in upper extremity treatment. Such recognition is due to our unique ability not only to evaluate and treat the physical components of the upper extremities, but also to develop splints, equipment, exercises, and retraining techniques including, but not limited to, purposeful activity. Since we also have the unique ability to look at the whole person and how he or she functions in the environment, we can integrate all the aspects of our treatment to restore maximum independence and function. However, we acknowledge that a degree of expertise is required to perform effectively, and that the foregoing comments are not as applicable to the entry-level therapist as they are to the therapists with a minimum of 1 to 3 years of full-time experience in physical disabilities. In fact, postgraduate training may be necessary for performing certain techniques. In AOTA's effort to conform to government guidelines and to speak to its membership, it has mistakenly geared standards to the least experienced and skilled members, while ignoring the level of excellence achieved by many of its more experienced and specialized members. With knowledge rapidly expanding, all professions are finding it necessary to develop, support, and reward its specialists. The profession of occupational therapy must do the same in order to hold onto its arenas of practice.

Occupational therapists who have specialized in upper extremity treatment are recognized by the current leaders in hand rehabilitation and surgery for their skills in physical restoration as well as in functional and adaptive rehabilitation. Writing in Rehabilitation of the Hand, Vernon Nickel, M.D., states that, "The occupational therapist traditionally is more extensively trained than the physical therapist in the psychosocial aspects of disability, but the occupational therapist is also very active in actual physical procedures such as strengthening, training, and so on." (6) Further, the fact that occupational therapists make up the highest percentage of authors in Rehabilitation of the Hand is testimony to the degree to which occupational therapists are contributing to the current body of knowledge in the treatment of the upper extremity (7). It should be noted that these authors have described many treatment techniques not easily included in the Purposeful Activity category, but that have become standard upper-extremity treatment. For example, sensory re-education, as described in Rehabilitation of the Hand, is no more purposeful than range of motion. Its only purpose is to restore normal physical function.

The use of Transcutaneous Electric Nerve Stimulator (TENS) to reduce pain in the patient with reflex dystrophy is significant but it is not a purposeful activity. Without the ability to use TENS, the therapist might be unable to achieve the end goal of purposeful activity and restoration of physical and functional use of the limb. It is therefore clear that some of the leading contributors in the field of upper-extremity rehabilitation, in order to achieve maximum functional results, advocate use of techniques that cannot be called Purposeful Activity.

Other professionals acknowledge occupational therapists' special skills in upper extremity restoration. Workman's compensation carriers are increasingly aware of the occupational therapists' special skills in treating hand and upper extremity injuries, and often insist that a trained occupational therapist handle their cases. In addition, many hand surgeons who work with therapists prefer occupational therapists for at least four reasons: first, their emphasis lies in relating treatment to function and job skills. Second, their extensive training in hand anatomy, kinesiology, splinting, and functional use of the hands is excellent. Third, they have a special respect for the delicate tissue of the hand. Fourth, they excel in treating the patient as a whole person, including psychosocial needs and complete ADL function. Finally, because of these factors, if physicians can only choose one therapist, they will often choose an occupational therapist. She or he is the professional capable of delivering the widest range of ser-
vices, including splinting, to give the patient improved function.

How will limiting our services to Purposeful Activity affect our referrals? We believe that limiting us to Purposeful Activity will cause us to fail to meet the goal of maximum function by not allowing the use of all available tools at the appropriate time. Thus referrals will reach us after the intervention stage when treatment might have been most effective. For example, a person with a Colles fracture may be referred for functional retraining only after receiving inadequate treatment or no treatment. In such a case, a contracture will often be present that might have been prevented by a combination of range of motion and splinting and/or modalities. Or, a Guillain Barre patient may finally come to occupational therapy for dexterity and functional training after months of overuse and stretching of the valuable intrinsic muscles from transfer training or ambulation in physical therapy. At that point, dexterity and functional training may be difficult or impossible. In cases such as these, where referrals reach us after harm has been done, the goal of maximum function cannot be reached. Even worse, in many cases we may not receive referrals for functional training at all since many patients and referring sources feel that function can be attained through “normal” daily activities without paying for occupational therapy services.

How will limiting our services to Purposeful Activity affect reimbursement? The problem of reimbursement for Purposeful Activity is a major one. Where such activities as Purposeful Activity, ADL, and vocational training are appropriate, efficient, and necessary to recovery, there is seldom any difficulty in settlement. However, for many types of patients being seen by contemporary physical disability occupational therapists, Purposeful Activity is not the quickest and most effective treatment technique. In these cases, justification and reimbursement are difficult, if not impossible. Where justification and reimbursement are difficult, the occupational therapist’s role will be diminished, and eventually the occupational therapy jobs will also diminish.

We are proud of our special ability to see and treat the whole person and to use Purposeful Activity skillfully and effectively, when appropriate. However, we must be able to use many different treatment techniques at various stages in each person’s recovery process in order to give quality care. In other words, in order not to fragment patient care, we must be involved throughout the entire recovery process, not just in some portions. For example, it is not logical, effective or cost efficient for a physical therapist to treat a patient until he or she has gained enough strength or skill to carry out Purposeful Activity and then have the occupational therapist integrate these skills at this late stage. Similarly, it is not useful at the early stage of recovery for an occupational therapist to make a splint to increase range of motion and then have the patient measured and followed by a physical therapist.

We feel that several questions must be addressed in discussing this issue: Must we give up certain skills just because another profession also uses these skills? Do physical therapists deny their ability to manipulate backs and peripheral joints just because chiropractors and physicians also do these activities? Will we have to give up splinting to physical therapists because many splints are made primarily to restore range of motion or strength?

In the 1981 Eleanor Clark Slagle Lecture, Robert Bing states, “The more we intermingle our fundamental philosophy and our treatment techniques with others, the more we intermarry, the more likely we will become enfeebled, the more likely we will degenerate, the more likely we will disappear.” (8) We strongly suggest that the opposite is true. The move to confine ourselves to Purposeful Activity destroys our role and does not clarify the problem. We firmly believe that official AOTA support for the restorative skills of the physical disability occupational therapists is necessary for the survival of the practice of physical disability occupational therapy. We submit that the Association is being influenced by pressures from outside our profession that may eventually destroy our profession from within. As we come under increasing attack from other pro-
essions, we must have support from within our profession. Since we do not promote fracturing the profession of occupational therapy, we believe it will be necessary to review and rethink this issue and survey the entire membership in order to avoid a breaking off of some of the physical disability membership. We urge that the AOTA Task Force on OT/PT Issues, headed by Joy Huss, be equally staffed by therapists representing all viewpoints on this issue. Later, after thorough study, we need an explicit definition of physical disability practice as it relates to Purposeful Activity with supporting data and practice examples for implementation in all types of physical disability settings.

REFERENCES
4. AOTA Entry Level Role Definition for OTRs and COTAs, Occup Ther Newspaper 35: 1-16, 1981 (insert, p 8)

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