Dreams, Dilemmas, and Decisions for Occupational Therapy Practice in a New Millennium: A Canadian Perspective

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This article presents the hope that, in the 21st century and the millennium it ushers in, the world will eliminate the concept of handicap by creating an environment where persons with different abilities can live with dignity. In this world, the focus of occupational therapy will shift from reducing impairment through purposeful activity to preventing handicap through enablement. Basic assumptions about occupational therapy and its values are provided, including that the ultimate goal of practice is the enablement of occupational competence.

My dreams for occupational therapy in the new millennium are predicated on what I imagine the world will be like in that millennium. Although I would like to believe that the world will be free of war, disease, illness, indeed all sources of human misery, I do not believe that to be the destiny of humanity. Rather, I believe that there will always be some phenomena that will result in less-than-ideal situations for human-kind. Whether these phenomena will result in disability or handicap, however, is another issue.

I Dream of a World Free of Handicap

In my dream, the world will be free of handicap in the new millennium. Free not because we have learned to rehabilitate those with disabilities but because we have learned to create an environment that allows those with different abilities to live with dignity. Free not because we have allowed those with disabilities to end their lives but because we have enabled all those with different abilities to have meaningful lives. Free not because we have learned to prevent disability but because we have learned to eliminate handicap. In other words, I dream of a world that honors, respects, and values differences, a world that enables living with different abilities.

Before I go on describing my dream and its implications for occupational therapy, let me clarify how I am using the terms disability and handicap and how they relate to each other. In attempting to establish an international classification for the long-term functional and social consequences of disease, the World Health Organization (WHO) identified three distinct and independent classifications: impairment, disability, and handicap. Impairment is defined as "any loss of psychological, physiological, or anatomical structure or function resulting from any cause" (1980, p. 27). Disability is defined as "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being" (p. 28). Handicap is "a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual" (p. 29). In the vernacular of occupational therapy, handicap is a disadvantage that limits or prevents occupational role performance. Although WHO considers these classifications to be independent, there is, as apparent from the WHO definitions, a causal relationship between them (see Figure 1). It should be noted, however, that not all impairment leads to disability, nor does all disability lead to handicap. Indeed, because handicap is viewed as a disadvantage, and disadvantage is a social construct, disability must be seen as neither a necessary nor a sufficient condition for the creation of a handicap. In my dream this will happen because of occupational therapy—not the occupational therapy we know now, but the occupational...
therapy that surely must evolve because occupation is a powerful idea. To quote Thomas Jefferson, “It is neither wealth nor splendour, but tranquility and occupation, which give happiness” (cited in Foley, 1967, p. 399).

The great psychologist Hebb (1966) noted long ago that “living things must be active” (p. 248); that the need for activity and the avoidance of boredom, the result of inactivity, are important determinants of human behavior. Recently, two courageous young persons, one Canadian and one American, provided dramatic personal testimony of the vital importance that activity, or the lack of it, has in determining human behavior.

In Canada, a 25-year-old woman caught national media attention when she fought the legal system for the right to refuse life-sustaining treatment. Having spent 2½ years in a hospital bed because of a disease that resulted in the permanent loss of all her independent function, including respiration, Nancy B. pleaded for the right to die. She told the judge that a life without the ability to do is not worth living (“Woman makes plea,” 1991). She won her case. On February 13, 1992, Nancy B. died.

In the United States, 29-year-old Larry McAfee had a motorcycle accident that left him unable to walk, eat, or even breathe independently. After a year of intensive rehabilitation, out of finances, Larry was also doomed to a life in a hospital bed where, he said, “I used to just lie there on my back, being just so bored” (Schindehette & Wescott, 1993, p. 85). Two years later, “broken in spirit after being warehoused in a series of institutions, McAfee fought for the legal right to shut off his life-sustaining respirator” (Schindehette & Wescott, 1993, p. 85). Larry McAfee won his case. However, he is alive and well and living in the first independent-care home in the state of Georgia. While engaged in his fight to die, he discovered that he had options other than boredom, that in an environment that enabled occupation he could have an active, meaningful life. But Larry McAfee warned, “If ever I have to return to an institution, then I prefer death” (Schindehette & Wescott, p. 86).

I Dream of a World Where Occupation is a Powerful Idea

My dream for occupational therapy in the 21st century is that we will not only know unequivocally that occupation is a powerful idea but also choose to act on that idea, for “any powerful idea is absolutely fascinating and absolutely useless until we choose to use it” (Bach, 1988, p. 119).

Occupational therapy is in an exciting, transitional phase—a paradigm shift, as Kielhofner has described it (1992). If we make the right decisions now, if we frame the emerging paradigm well, I believe that the occupational therapy of the future will be quite different from the one we know today.

The occupational therapy we know now fails to realize the full potential of occupation. As Kielhofner (1992) and numerous others have pointed out, practice today is heavily influenced by the medical model. Practice is focused, primarily, on reducing impairment through the therapeutic use of purposeful activity. To quote Henderson et al. (1991), “the use of purposeful activity is the core of occupational therapy” (p. 370). In Canada, a similar emphasis on the therapeutic use of activity prevails. The definition of occupational therapy adopted by our national association begins with “Occupational therapy is the art and science which utilizes the analysis and application of activities” (Canadian Association of Occupational Therapists [CAOT], 1991, p. 140).

I Dream of a Discipline Focused on Occupation

In my dream, the occupational therapy of the future will realize the full potential of occupation. Practice will be grounded firmly in an occupational model. The focus of practice will shift from reducing impairment through purposeful activity to preventing handicap through occupational enablement.

My dream is predicated on two developments in our discipline, both called for by Ann Grady in her presidential address at the 72nd Annual Conference of the American Occupational Therapy Association. Grady asked occupational therapists to revisit and reaffirm the concepts and visions held by the founders of the discipline, to “reaffirm the idea that being meaningfully occupied provides direction for individuals and that successful engagement in the activity leads to individual satisfaction and promotes health and well-being (1992, p. 1062), and to “provide the leadership needed to continue developing knowledge based on our founders’ vision and to find a myriad of ways to apply that knowledge to the challenges of practice in the 21st century” (p. 1065).

For my dream to come true, we, as occupational therapists must
- affirm that occupation is a powerful idea
- adopt occupation as the core concept
- entrench occupation in our value system
- become experts in enabling occupation.

My dream is that our continued study of occupation will make it possible, in the new millennium, for us to move beyond the rhetoric of the day and translate our values into action.
In my 1992 Muriel Driver Lecture, I articulated what I and a group of colleagues believe to be the core values of occupational therapy (see Appendix). I elaborate on these briefly below and describe what I think it means to translate these into action as we embrace occupation as the core concept of our discipline. (For a more extensive discussion, see Polatajko, 1992.)

The values statement concerns itself with the core elements of this discipline. The first two, the individual and human life, are shared with all health care disciplines. The third, occupation, distinguishes occupational therapy from the rest. Occupational therapists view humans as occupational beings with a basic need to do.

Translating the Rhetoric into Action

Translating these values into action means, first of all, acknowledging some basic assumptions about occupation.

Occupation is a basic survival need. Occupation is essential to the well-being of every person much in the same way that sleep and food are: occupational deprivation, like sleep deprivation or food deprivation, results in serious mental and physical deterioration of the person and may even result in death—often at the individual's own hand.

Occupation is an extremely complex, multilevel, multifaceted construct. Occupation has cognitive, affective, physical, and environmental attributes and is individually determined; therefore, the study of occupation requires the investigation of the occupation, the person performing that occupation, the environmental context, and their interaction.

Occupational competence is the result of a goodness of fit between the person, the occupation, and the environment. Competence is defined as adequacy or sufficiency, answering all the requirements of an environment (Pridham & Schutz, 1985). That is, the occupational competence of any given person is determined by the interaction between the skills necessary to perform the occupation, the abilities of the person, and the demands of the environment in which the occupation is to be performed (see Figure 2). Translating these values into action also means that

Practice is client driven. The client's right to autonomy is taken seriously, and the client is understood to be a prosumer (defined by Toffler [1981, p. 11] as a fusion of producer and consumer) of occupational therapy services, keenly interested in exercising choice over the services that she or he accepts and accepting only those services that can be tailored to meet his or her needs.

Practice is founded on an ideology of empowerment (as defined by Rappaport, 1981). The role of occupational therapist is understood to be one of enhancing possibilities for persons to control their own lives at both a personal and a social level.

The ultimate goal of practice is wholly and solely the enablement of occupational competence. The purpose of practice is to alter the person's ability, the occupation, or the environment so that the person can achieve the necessary balance between ability and the

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environmental demands to enable occupational competence (see Figure 3).

Practice is context focused. Given the ideology of empowerment and the nature of occupation, services must be oriented toward, if not provided in, the person’s context, that is, his or her physical, social, and cultural environment.

Practitioners take on many roles in enabling occupational competence. The traditional roles of hands-on clinician, administrator, researcher, and educator are not always adequate to enable occupational competence. Often, particularly when competence requires environmental changes, new forms of practice are necessary, such as a program designer, consultant, public educator, lobbyist, policy maker, and social critic.

Practitioners use many and any tools. Activity is only one of many tools used to enhance occupational competence. Practitioners use a variety of tools to enable clients; these may include technology, assistive devices, environmental adaptation, attitudinal shift, family education, social education, and policy change.

The domain of concern of the discipline is occupation. The body of knowledge of the discipline is centered on occupation. Scholarly inquiry is focused on understanding the phenomenon of occupation and the determinants of occupational competence. Given the complex nature of occupation, the study of occupation is multidisciplinary and multimethodological.

Occupational therapists are experts in occupation. As my dream comes true there will be a great deal of change for occupational therapy (see Figure 4). These changes will present all occupational therapists — present practitioners, administrators, researchers and educators alike — with dilemmas that each of us will have to resolve for ourselves and that the profession will have to resolve as a whole.

As my dream comes true there will be a great deal of change that will create dilemmas, not only for occupational therapists, but for the world in general. Once the central importance and power of occupation is realized, it will necessitate a shift in such basic notions as quality of life and human rights. This shift has already begun, as shown by the cases of Nancy B. and Larry McAfee.

I believe that mine is not an impossible dream. Rather, I believe that we, as a discipline, are uniquely poised to make this dream come true — to lead the way in health care. Steven Lewis, former Ambassador of Canada to the United Nations, speaking at the CAOT conference in June 1991, said:

“There is no other discipline that is so eclectic, so far ranging and whose core principles are at the very heart of where the health care system is going. You are the only health profession that has fully embraced the concepts of health promotion, prevention, community-based care and the individual as centre to the process. (“Perspectives ’91,” 1991, p. 11)

As with all change, this change will be experienced with some hesitation, discomfort, and, I hope, excitement. But when my dream comes true, I believe that occupational therapists will be instrumental in helping the world to enable all to achieve occupational competence and therefore eliminate handicap.
Figure 4. Changes for occupational therapy in the coming millennium.

Appendix

Occupational Therapy Values Statement

As Occupational Therapists,

We value

• the individual
• human life
• occupation

About the individual,
We believe that humans are occupational beings, that:
• every individual has intrinsic dignity and worth
• every individual has the right to autonomy
• each individual is a unique whole
• each individual has abilities and competencies
• each individual has the capacity for change
• individuals are social beings
• individuals shape and are shaped by their environment

About human life,
We believe that all human life has value, that:
• the value of human life is based on meaning, not perfection
• quality of life is as valued as quantity

About occupation,
We believe that occupation is a basic human need, that:
• occupation is an essential component of life
• occupation gives meaning to life
• occupation organizes behavior
• occupation has developmental and contextual dimensions
• occupation is socioculturally determined

(Conceptual Framework Think Tank, 1992)

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References


