Geraldine Finn said, “For a profession to maintain relevancy, it must be aware of the times, interpreting its contribution to mankind in accordance with the needs of the time” (Finn, 1972, p. 59). This is the time for occupational therapists to come forward with their knowledge and skills to meet the needs of individuals, families, and communities and respond to society’s call to promote health and reduce barriers that limit people from doing what they need and want to do.

We are no longer going to wince when someone says, “Do you help people find jobs?” We are going to say, “Yes! We help people gain skills for the job of living.” Another person, then, will know more about occupational therapy.

When someone says, “Are you like physical therapy?” we say, “We’re both rehabilitation professionals. Their expertise is in movement and ours in performance. We work together to help people recovery from injury and illness. Our unique contribution, however, is to help people get back to their family roles, their jobs, and their community lives.”

If this sounds like an overwhelming task, it isn’t. We are going to do this together. Our biggest problem as a profession is not the work we do—it is that many people do not know what we do. Individuals do make a difference, and you will make a difference. Today we’re going to explore how we fit into a changing health system, why we are the profession to focus on participation, why society needs us, and what we need to do together.

So, how does a profession develop? You’ve all seen this picture; it’s of those who have formed our profession. What you might not know is that this group of people had to think occupation was important enough to form a society. In that group are a nurse, two architects, a physician, and a social worker. They formed a society for the promotion of occupational therapy. Our interdisciplinary roots remain evident today as we bridge between medicine and community to enable people to participate in society.

Let’s look at how our profession has responded to societal needs. World War I: Society had a need. The profession had a response. The reconstructive aids that worked with the war and those returning from the war were the beginning of our schools and the beginning of our educational programs. Out of that came the curative workshops, which was the beginning of the rehabilitation center.

I will discuss only a few key issues that I think shaped us. World War II yielded much of the leadership that formed a second generation of our profession, our standards of practice, and our position in health care. World War II brought forth much of the leadership that guided the profession from 1950 through the 1970s.

The next major event that greatly impacted us was the polio epidemic. Occupational therapists responded. There had been some work in pediatrics prior...
to that time, but the epidemic became a real force in establishing our role in working with children. I want to read something to you from Clare Spackman and Helen Willard’s introduction to the first edition of *Willard & Spackman* (1947). They wrote:

The value of occupational therapy was recognized in WWI when broadly diversified programs were established in the military hospitals. Great strides have been made...during WWII. The importance of its activities in the dynamic programs of rehabilitation established in the hospitals of the Army and the Navy, and now beginning to be organized in the veterans' hospitals, has been recognized. There is a strong tendency to use lessons learned in the military medicine for the betterment of medical care for civilians. There has been a woeful lack of adequate literature on occupational therapy...there is a greater need for education in the principles of the profession. This book has been prepared as a basic text for doctors, nurses, social workers and occupational therapists. (p. vii)

They used their knowledge and skills to educate others as to who they were and what they brought. The authors further stated, “...all of whom have produced their material under a severe limitation of heavy workloads, shortage of time and of personnel, deserve great credit for their efforts” (p. viii). See, life really never changes.

In 1961, Mary Reilly gave us the challenge that I don’t think we have yet fully managed. She said, “How free are we in these troubled times to reconstruct our thinking at this level? I do not know, but I do know that the crucial nature of our service cannot be spelled out in the loosely constructed way that it is today. Society requires of us a much sharper focus on its needs.” She further stated, “American society in general and medicine in particular has need of a profession which has, as its unique concern, the nurturing of the spirit in man for action” (Reilly, 1962, p. 2).

Another key point in our development came when clinician A. Jean Ayres felt she had to answer questions to understand how sensory systems impacted major performance. Her work was the beginning of OT clinical science. When I was in school I learned about Dr. Ayres’ work from mimeograph sheets of paper. I believe we’ve come a long way but still have questions the clinical scientists among us must be challenged to ask and to answer.

In 1969, Wilma West challenged us when she asked us to focus on creating healthy communities and workplaces as well as healthy individuals. We need to prevent problems that limit performance. If you read Wilma West’s writings of the late 1960s, you would swear they are the writings of today.

What else has shaped us? Dr. Paul Brandt in North Carolina thought it was important to start working with individuals who had hand injuries. We now have a whole industry of professionals working in that arena. Children’s services emerged under public law 94–142 in 1975. Thirty percent of our members now work to respond to the needs of children who are guaranteed access to services to support them in a learning environment. In 1976 we saw the role of OTs to emerge in neonatology. Now we see a cycle of children at risk, children in the schools, and children needing to transition into adulthood. This has had a profound impact on our profession.

With regard to these few things, if we want to ask the question, “How does a profession develop?” We have to say, “Society has needs and members of the profession develop knowledge, share the knowledge, and develop programs to address the problems.” This requires a collaborative effort of scientists, educators, and practitioners.

Another question: How does occupational therapy fit into the changing health system? Probably one of the most important policy developments occurred in 1997 when the Institute of Medicine in its book, *Enabling America*, framed rehabilitation as an enabling process (Institutes of Medicine, 1997). Rather than focusing on functional restoration, the concept emerged that we all fit within our environments, but when something occurs such as an impairment or a chronic health condition and our environment no longer fits, we have to modify the environment. This enabling process happens through functional restoration, environmental modification, or a combination of both. This work provided the catalyst occupational therapy needed to implement occupational performance at the interaction of the person, environment, and the occupations that people want and need to have.

Following on that is the *International Classification of Functioning, Disability and Health (ICF)* (World Health Organization, 2001).
Organization [WHO], 2001). The ICF model includes concepts central to occupational performance such as body function and body systems, activities, participation, environmental factors, and personal factors. The ICF offers a language that is in concert with our language and values. It is also challenging us, however, to be part of a larger system because all health professions are being challenged to address function and participation. We do not own those concepts. We have to build our knowledge to enhance the understanding of those concepts, but we cannot prevent another profession from dealing with those issues.

Another change is that health is no longer defined as a physical state; it’s a state of complete physical, social, and mental well-being and not merely the absence of disease or infirmity (WHO, 1946). If you interpret this definition from the occupational therapists’ view of the world, and Betty Yerxa was one of the first to do this (Yerxa & Baum, 1986), health is a resource of everyday life, not the object of living.

Our unique contribution in health care is occupational performance. The term has been in our literature and definitions since 1976, even though it was grounded in the early philosophies of occupation. No one else—no other profession—focuses on the person–environment–occupational interaction, the interaction that supports occupational performance.

What is occupational therapy’s contribution to health? Our literature has been very clear for many, many years identifying our contribution. Adolph Meyer said in the “Philosophy of Occupational Therapy,” “Our concept of man is that of an organism that maintains and balances itself in the world of reality and actuality by being in active life and active use” (Meyer, 1922, p. 5). We all know the hypothesis proposed by Mary Reilly in 1962, “That man, through the use of his hands, as they are energized by mind and will, can influence the state of his own health” (Reilly, 1962, p. 2). Gary Kielhofner in 1992 told us that when participation is restricted, it causes physiological deterioration leading to the loss of ability to perform competently in daily life. People need to make use of their capacities through engagement in individually motivating and ongoing occupations. And if they pursue this need, they will enhance their health.

There is evidence in the literature today that occupation or engagement in activity reduces the risk for disabilities and protects against cognitive decline and depressive symptoms. From the seminal study, the Well Elderly Study from our colleagues at USC, we know it provides a protective response to both cognitive and physical performance (Clark et al., 1998).

The next question: Is there a need for occupational therapy services? Is there a need for more occupational therapists? Let’s explore what is happening in society that will require our attention.

What do we mean by aging? We are being challenged about the ideas of aging. At the turn of the last century, the life span was 40 years. It’s now approaching 80, and it’s actually going to 120 years (Walford, 1983).

When you think about this, if we keep traditional ideas of aging, people will retire halfway through their lives, so we have to shift our thoughts. Another thing I think about as an occupational therapist is that we see so many people at risk because they are aging with chronic conditions. We are not seeing the number of people who remain very active. We have a huge aging population; some will have chronic diseases, some will have disabilities, and many need our help. One in five Americans has some form of disability, and one in four has activity limitations. We see the number of people with chronic conditions moving from 100 million in the year 2000 to about 150 million by 2040. About 5% are under the age of 18, but almost 45% are 75 years and older (U.S. Census Bureau, 1996). There is a huge population of people whose activities are being limited.

We also have a major role to play in work. News reports indicate that many people over the age of 65 are seeking employment. They want to continue to work. They have back disorders, heart disease, arthritis, and respiratory diseases. Some people have mental disorders and, of course, there’s a population of people with diabetes. The link between chronic conditions to work performance must be further explored. People are protected under the law to have work modified to maintain a job situation, and occupational therapists have the skills to help both the employee and the employer.

If we look at the conditions of childhood, more than 1 in 10 children have conditions that limit their occupational performance (U.S. Census Bureau, 1996). These conditions impact children in school and in life. Occupational therapists have to think about the roles of transition and aspects of a child’s development that do not occur in the school but may occur in families and community.

To give you two other examples of why we’re going to be needed: More than 400,000 children and adults have autism (Autism Society of America, n.d.) and 4 1/2 million persons live with the consequences of stroke (Centers for Disease Control and Prevention, National Center for Health Statistics, 2002). The question is, “Is there a need for more occupational therapy practitioners?” The answer is, “Yes.” We also have communities with violence, chronic disease, joblessness, limited productivity, homelessness, poor
access to services, abuse, and poor lifestyle choices. With our focus on occupational performance, there are many societal needs that occupational therapists can address.

We know of our importance, but do others? Do payers realize that providing coverage for occupational therapy services can translate into a cost-benefit and prevent secondary conditions? Do school administrators realize that occupational therapists can address a range of issues that support children’s learning and help them gain skills to transition into productive adulthood? Do physicians understand the potential of occupational therapy to help their patients with chronic disease lead meaningful and productive lives? Do health system executives know how occupational therapists can support their mission to build healthy communities? And lastly, do businesses know how we can help foster productivity in employees with both ergonomic and behavior management strategies? We have to tell them. We have to be visible with our efforts to ensure those who provide and support services understand occupational therapy.

When I knew I was going to become president of the American Occupational Therapy Association, I felt it was very important to reach out to the members to identify their issues. I posed a number of questions that were sent out over listservs and received responses from educators, scientists, practitioners, and students. Rather than me telling you their issues and hopes for the future, I thought it would be best for our members to demonstrate our strength for the future. I want you to join with me in imagining what can happen when we use our collective strength to take our profession forward.

Representing the Profession—Practitioners, Scientists, and Educators

Dr. Schell
My name is Dr. Barbara Schell, and I’m a professor and chair of occupational therapy at Brenau University in Gainesville, Georgia. I serve the profession as an educator and a scholar, and I focus on clinical reasoning and trying to figure out ways to make a connection between the newer ideas of occupation-based practice and our existing intervention strategies. My hope for the future is that managers and advanced practitioners will join with educators and scholars to help us create the kind of practice environments so that we can actually maximize practicing what we preach!

Jean Polichino
I’m Jean Polichino from Houston, Texas. I’m an occupational therapist and I provide occupational therapy services to children with disabilities in the public schools. I’m a practitioner, an administrator, a regulator, but primarily an educator and advocate for school-based occupational therapists. My hope is that the scope of occupational therapy in schools will broaden so that all children needing assistance will have access to occupational therapy services.

Dr. Cohen
My name is Dr. Helen Cohen. I’m an associate professor in the Department of Otorhinolaryngology and Communicative Sciences at Baylor College of Medicine in Houston. I do research on vestibular disorders, vestibular rehabilitation, and sensory-motor adaptation. My hope is that by increasing our understanding of neuroscience and motor control, we will improve the quality of care for all of our patients through evidence-based practice.

Christina Metzler
My name is Christina Metzler. I’m director of Federal Affairs for you at AOTA. I advocate using my knowledge and skills to promote you and your profession in public policy. My hope is that you use the incredible skills you have to give others power over their destinies, to empower yourselves to take control over your destiny in public policy.

Kristi Voelkerding
My name is Kristi Voelkerding. I’m an occupational therapy assistant. I practice as an assistive technology specialist for Easter Seals in Massachusetts. My hope is that through deep listening and deep questioning, we shine a light on bright ideas and bold initiatives and that our practice comes to life at the intersection of academic excellence and contemplative practice.

Dr. Rogers
My name is Dr. Joan Rogers, and I’m professor and chair of occupational therapy at the University of Pittsburgh. I investigate practice and I contribute clinical research to our profession. My hope is that an evidence-based approach to practice will become an activity of daily living for each and every practitioner. By generating or applying the evidence in practice, the science of occupational therapy will catch up with its art and its ethics, and its clients will be better served.

Dr. Amaker
My name is Dr. Bobbi Amaker. I am an American soldier occupational therapist. I represent your neighbors, your family, your friends. My comrades have suffered physical disabilities from amputee to radial nerve palsy, and it is my hope to return them to active duty. Occupational ther-
apy helps them achieve this goal. I am truly proud to serve this profession.

**Nancy Dinsmore**
My name is Nancy Dinsmore. I’m a certified occupational therapy assistant. I’m an educator in an OTA program. I’m a program coordinator for Welfare-to-Work recipients. I also work with individuals with hand injuries. I’m president of the Washington State Occupational Therapy Association, and my hope is that all occupational therapists and all occupational therapy assistants continue to build teams in order to provide quality care for our patients.

**Bill Butler**
I’m Bill Butler. I’m an occupational therapy manager and clinician at the National Rehabilitation Hospital in Washington, DC. I feel that I bring an eclectic mix of leadership, enthusiasm, humor, and education to our profession. My aspiration is the worldwide recognition of occupational therapy as the leading health care profession in the provision of recovery from illness and the promotion of wellness for the enhancement of one’s quality of life.

**Dr. Haertl**
I’m Dr. Kristine Haertl. I’m representing occupational scientists and I am an associate professor in the department of Occupational Science and Occupational Therapy at the College of St. Catherine. I contribute education, I study, I practice, and I contribute energy, enthusiasm, and passion to the profession. My hope for the future of occupational therapy is that we will continue to emphasize evidence-based practice in the community and health prevention and promotion and in the study of occupation in life satisfaction and in personal and in societal well-being.

**Dr. Sabata**
My name is Dr. Dory Sabata. I’m an occupational therapist and program specialist at the National Resource Center on Supportive Housing and Home Modification at the University of Southern California’s Andrus Gerontology Center. I educate others about the ever-changing demographics, policies, technologies, and practices that affect aging in place. My hope is that all occupational therapy practitioners value the work they do and continue to learn, share, and implement effective practices for enabling occupational performance throughout the life span.

**Dr. Parker**
I am Dr. Judy Parker. I’m the director of the Occupational Therapy Assistant Program at Mercy College in Dobbs Ferry, New York, and chair of the Occupational Therapy Assistant Program Director’s Council. I contribute leadership, mentorship, and unflagging belief in the meaning of doing. My hope is that each of us can identify the strengths and potential in ourselves, our peers, and our profession.

**Elizabeth Moore**
My name is Elizabeth Moore from St. Paul, Minnesota. Part of my family is with me today: my son, Matt, and my daughter, Ellen. My daughter Katie cannot be with us as she is on vacation in Italy. Occupational therapy has helped two members of our family, Matt and Katie, in two very different ways. It has helped Katie to regain her health after a horrible accident. It has enhanced Matt’s life and increased the possibilities of what he can do.

**Representing Our Future—Students Studying Occupational Therapy**

**Hosia Towery**
My name is Hosia Towery. I am a graduate of Santa Anna College. I am currently an MOT student at St. Ambrose University, and I’m a licensed occupational therapy assistant. I advocate and contribute to our profession by communicating the importance of making the most of each and every interaction with others. I use my skills and experiences to make a difference in my community. I hope to enhance individuality and treatment interventions, focus on reinforcing my clients’ abilities, not disabilities, and strive to continue flexibility of knowledge and practice for the benefit of my clients and our profession.

**Kristen Lindeman**
My name is Kristen Lindeman. I’m a OTD student at Washington University in St. Louis, Missouri. I plan to practice and research in the area of home modifications. My hope is for each occupational therapist to promote and advocate our profession so that everyone will realize how valuable occupational therapists are to the medical field.

**Leah Lewis**
My name is Leah Lewis. I’m an entry-level OTD student at Creighton University in Omaha, Nebraska. I plan to work in a physical rehabilitation setting and train to become a certified hand therapist. My desire is to become an academic fieldwork coordinator. My hope for the future is that through the education of students like myself, I can help to increase the body of knowledge and introduce others to the profession of occupational therapy.
Lenna Aird
Hi, my name is Lenna Aird. I’m a recent graduate of the Occupational Therapy Assistant Program at Rhone State Community College in Oak Ridge, Tennessee. I’ve served AOTA as the OTA advice chair for ASD. I’m currently on the commission on practice as the student representative and have served as the student representative to this year’s RA. I’m beginning my career working in home health with older adults. My hope is to inspire and mentor students so that they realize the importance of contributing to and being active members of both our profession and our professional organization.

Tamara Mills
My name is Tamara Mills. I’m currently the chief postdoctoral fellow at Kessler Medical Rehabilitation Research and Education Corporation in West Orange, New Jersey. My research plans include further expansion of my interest that I began at the University of Pittsburgh where I focused on functional outcomes of wheelchair users and the impact on evidence-based practice. I hope to continually and aggressively contribute to the profession of occupational therapy for providers and consumers of our services.

Look what we can do together: Educators, practitioners, scientists, policy, students, and consumers. We have the resources today to do what we need to do.

We have some tasks to do. Your Association is going to help, but we are the Association. We are the members. We collectively have work to do. We must promote greater public understanding of occupational therapy. We can start with something really simple. I’m going to ask you to try to do this. We have such old habits. If we weren’t telling people we were hand therapists and peds therapists and NDT therapists and SI therapists, the public would know we are occupational therapists!

We need to heighten the importance of occupational therapy with public and private sector policymakers. This is a good time to engage in advocacy so that people understand and know that we’re working for our clients; we’re working for those we serve. The last time I can remember a national recruitment campaign for students was in the ’70s. We went through a period where OTs were losing jobs, and somehow the message got out that we didn’t need occupational therapists because jobs were limited. I can’t tell you the number of people that have come up to me at this Conference and told me that they know practitioners who are telling students not to go into occupational therapy. We must stop this! This profession needs energy; it needs growth. And we absolutely have to recruit the very best to this field where they’re going to have a career where everyday life brings joy and challenges, accomplishments and a feeling of pride. We are also going to form strong, productive relationships with our partners. We have three professions in separate corporate structures that serve this profession—of course, the American Occupational Therapy Association, the American Occupational Therapy Foundation, and the National Board for Certification in Occupational Therapy. It is time to work together—not duplicate.

We also need to promote the application of evidence-based practice for knowledge of practice. I would encourage everybody to pound on the doors of your local OT school and ask if you can either join in a class or have a class organized for your workplace. We all heard Gail Walensky say the two things that were absolutely critical. We cannot put blindfolds over our eyes and decide we’re not going to focus on evidence, and we also can’t put blindfolds over our eyes and decide that we’re not the best profession to deal with participation and wellness. It is going to happen, and we better be at the front of the line.

We are also going to need to support the development of knowledge to advance the profession. I don’t know how many of you have heard the business term that things are in silos. That means that people don’t communicate well; things goes up and down instead of across. We have to bring about a dialogue between our practice, our education, and our science because with that strength we will make our tapestry. It will be strong and colorful and visible, just like this beautiful piece of art that was constructed today.

Let’s use our partnerships to put our focus on strengthening and making visible our contribution to society as we enhance the capabilities of our citizens through occupation. I want to thank the incredible efforts of Sarah Ely and the creative staff at AOTA that helped make the tapestry a reality.

I also want to thank Dr. Andrea Lee, president of the College of St. Catherine, who is the creative spirit who used this concept in her own faculty training program last year at the College of St. Catherine, and my dear friend Dr. Julie Bass Haugen who said, “Carolyn, I think it would really work.” Thank you.

I want to thank all the members that responded to my surveys because I really feel like I have a sense of what people are thinking. And I want to thank all of you because you’re going away with a challenge to help make all this happen as we do become one of the most important health professions of the 21st century. Thank you very much.

References


