Colleagues and friends, old and new: It is an honor to address you today for a fourth and final time as president of your American Occupational Therapy Association (AOTA).

You know that I use the phrase *OT in HD*—occupational therapy in high definition—to describe how I see the profession of occupational therapy as we approach our *Centennial Vision* (AOTA, 2007) in 2017. Much as a high-definition video screen shows images made from millions of individual pixels, *OT in HD* is a metaphor for a picture of occupational therapy formed from thousands of vibrant individuals who coalesce into a crystal-clear image of our profession.

Greater Than the Sum of Its Parts

This pixel principle is not limited to digital screens. Consider this abstract form: simultaneously geometric and organic, a rough square rotated 45° with a bold border surrounding loosely concentric circles, set in a complementary color palette (Figure 1, next page). When enough of these shapes are arranged systematically, something new emerges. The details of the individual shapes fade away as our eyes zoom out to see a portrait, in profile, of a graceful woman, eyes gazing to the horizon (Figure 2, next page). In the same way that thousands of pixels make a digital image, the individual shapes form a unified whole greater than the sum of its parts.

The original portrait is painted on an oversized canvas nearly 10 feet tall. If you know modern art, you know this painting is by one of America’s renowned modern artists, Chuck Close. His work hangs in the world’s premier galleries and museums; he has been awarded the National Medal of Arts and has received dozens of honorary degrees. What’s especially ironic, given his obvious skill for portraits, is that Chuck Close has prosopagnosia, a condition that impairs his ability to recognize and remember human faces. Even more incredible is that he paints in a modified art studio, using adaptive equipment, from the seat of his wheelchair.

That’s because Chuck Close has incomplete tetraplegia, caused by what he calls his “Event,” with a capital E. At a 1988 gala honoring New York City artists, he experienced severe chest pains, so he walked across the street to Beth
Israel Medical Center, where he immediately went into seizure and within minutes was paralyzed from the neck down.

During the weeks that followed, his medical team traced the cause to a spontaneous obstruction of the spinal artery, essentially an incomplete C6 spinal cord injury. After several weeks of steroid-induced psychosis, his clarity of thought eventually returned. But when it did, he was racked with worries: How will I ever make a living as a productive member of society? How will my wife and children cope with my new condition? Will I ever again be considered an artist? Chuck Close’s place in the world shifted from that of a successful artist to that of a person with severe paralysis and a future filled with unknowns.

Those of you working in physical rehabilitation may already know the rest of his story. Once he was medically stable, Close began his rehab process, slowly regaining strength and motor control, yet all the while despairing over when, how, and whether he would ever paint again. But soon Close discovered something: Through the months of rehabilitation, occupational therapy was becoming more and more important to him. That was thanks in part to his occupational therapist, Phyllis Palsgrove, who recognized that art must be front and center in his occupational therapy.

As described in Close’s biography (Finch, 2010), “the first tentative steps towards a return to painting were taken in the occupational therapy room” (p. 187). That was where his occupational therapist, Phyllis, adapted a prefabricated splint to hold his paint brushes and customized an easel so he could paint directly from his wheelchair. Close’s wife brought canvases and art supplies into the hospital. Phyllis convinced hospital administrators that a corner atrium with natural light streaming from the windows made a better art studio than the windowless therapy room with its fluorescent lighting.

Although Close’s first attempts at painting were not exactly what might be called “art,” there is no doubt that these occupational therapy sessions allowed him to reclaim his Life, with a capital L. In Close’s words,

I told everyone that it was no good, I couldn’t do it, but the truth is I was looking for reassurance. I was actually thrilled to see that I was able to put paint onto cardboard, and I wanted people to tell me it was okay. (quoted in Finch, 2010, p. 187)

Within a few years of his Event, Close was painting proficiently once more and, soon, again experimenting with his evocative, trademark pixelated style. Close’s altered physical condition in no way compromised his occupational identity as an artist. His story testifies to the power of occupation to serve as both an anchor and a compass as we navigate the inevitable and unanticipated stormy seas of life, a power that we must continue to recognize in our profession.

I tell Chuck Close’s story because I think it is a poignant synopsis of our efforts through AOTA during these past 3 years. Together we have painted a picture...
of occupational therapy that is comprehensive and unified when viewed from afar, but, when inspected up close, is equally colorful, distinctive, and bold. Together we have developed our own signature style to distinguish occupational therapy from other health professions in the eyes of the public. We understand that the events that bring us face to face with our clients—disability, disease, injury, and lifestyle interruptions—are tremendous turning points in their lives. Together we have proclaimed our fundamental belief that the activities that matter most to us are some of the most powerful means of restoring equilibrium and optimizing health, well-being, and quality of life.

**Achievements Toward the Centennial Vision**

In my Inaugural Presidential Address (Clark, 2010), I said that “the overarching goal of my presidency” would be “to put occupational therapy in HD” to broadcast a clear message of what occupational therapy is and why what we do matters so much (p. 848). In my 2011 Presidential Address, I explained how a healthy sense of competition and a constant drive for personal excellence will fuel us for a successful Centennial Vision journey (Clark, 2011). And last year I introduced OT in HD–3D, a metaphor for the authority and integrity that come from a solid grounding in scientific research and evidence (Clark, 2012).

When I introduced these concepts, I knew they could not stand alone. Instead, they had to be embedded within the AOTA Centennial Vision, our profession’s strategic initiative that transcends the term of any single elected officer. If you are new to AOTA, our Centennial Vision foresees occupational therapy in the year 2017 as “a powerful, widely recognized, science-driven, and evidence-based profession with a globally connected and diverse workforce meeting society’s occupational needs” (AOTA, 2007, p. 613).

And let me tell you, our journey to the Centennial Vision gets better with each passing year. Our recent victories include the following:

- In 2012, Leslie Davidson became the first occupational therapist ever appointed by the American Medical Association to the editorial panel of the *Current Procedural Terminology*™ (CPT) system. Occupational therapy literally has a seat at the table alongside the power brokers who define the all-powerful CPT codes.
- In a 2012 survey of thousands of parents who have children with autism, occupational therapy was the intervention they most frequently cited as best for their children (Peacock, 2012).
- The impact factor of the *American Journal of Occupational Therapy* has more than doubled in the past 5 years.
- Occupational therapy is listed as one of the essential rehabilitation and habilitation medical benefits in the Patient Protection and Affordable Care Act (2010; Pub. L. No. 111–148), ensuring that consumers nationwide will continue having access to our services.
- On the mental health practice front, legislation to include occupational therapy practitioners as behavioral and mental health providers in the National Health Services Corps has again been introduced in the U.S. House of Representatives (Occupational Therapy in Mental Health Act, H.R. 1037, 2013) and has a committed sponsor in the U.S. Senate. Earlier in April, the Senate passed an act that would provide occupational therapy practitioners with new mental health service opportunities in schools (Mental Health Awareness and Improvement Act of 2013, S. 689).
- I am also delighted to announce the establishment of the AOTA Division of Academic and Scientific Affairs. This new division will be responsible for coordinating all of our accreditation, education, and research operations, especially necessary in today’s complex research and higher education systems. Congratulations to Neil Harvison, the new AOTA Chief Academic and Scientific Affairs Officer.
- AOTA grew exponentially between 2003 and 2013: Membership is up 30%, from 36,000 members in 2003 to more than 47,000 members today; student membership is up 300%, from 5,700 members in 2003 to 17,500 members today; total contributions to the American Occupational Therapy Student Conclave is averaging well over 500 students annually; total contributions to the American Occupational Therapy Political Action Committee (AOTPAC) are up 278%; and AOTPAC contributions from program directors of accredited educational programs have increased an incredible 1,000%.

I cannot overstate the long-term implications of all these achievements. Everything you do on behalf of our profession makes us shine that much brighter, and I cannot say it enough—thank you, thank you, thank you! We are all vibrant pixels shimmering together in our wide-screen, high-definition picture of occupational therapy!
Building a Globally Connected and Diverse Workforce

But with 4 years remaining until 2017, we’re not finished yet. In my previous Presidential Addresses, I explored two components of the Centennial Vision—the first, power and recognition (Clark, 2011), and the second, evidence and research (Clark, 2012). There’s a third piece that has not yet received the attention it deserves—our “globally connected and diverse workforce” (AOTA, 2007). Because a globally connected and diverse workforce is absolutely essential to realizing the AOTA Centennial Vision, let’s explore what that looks like and what we are doing to make it a reality.

Fostering Global Connections

A globally connected workforce is one in which the international community of occupational therapy practitioners, educators, scientists, and students frequently interact in substantive ways. These interactions can be as simple as virtual connections on social media. Or they can be formally established by contractual agreements between educational institutions, academic fieldwork placements, or international student exchanges. But what matters more than the form these connections take is their value for improving practice, programs, and evidence. They cannot be merely superficial or symbolic connections but must provide utility. Think of global connections as the infrastructure—the highways—over which knowledge is traded back and forth across international lines. What we excel at here can be exported abroad. In turn, we can import what the world’s occupational therapy communities do better than us, learn from it, and adapt it to improve research, practice, education, and policy here at home.

Let me give you a personal example of this kind of knowledge exchange. In December 2012, I visited Gail Mountain, professor of health services research at the University of Sheffield in England. Dr. Mountain is currently the principal investigator on Lifestyle Matters, a multimillion-pounds-sterling research study funded by Britain’s Medical Research Council. She and her team have been investigating the impact of the Lifestyle Matters occupational therapy intervention on the mental well-being of people aged 65 and older. This study, as well as Dr. Mountain’s previous research, was inspired by the Lifestyle Redesign® research funded by the National Institutes of Health (NIH), which my colleagues and I have been conducting at the University of Southern California (USC) for the past two decades.

Dr. Mountain’s work is legitimizing lifestyle-based occupational therapy in the eyes of Britain’s National Health Service, which includes the Lifestyle Matters program in its guidance (Mountain & Craig, 2011). That is a tremendous victory for our profession, not just in the United Kingdom, but also in the United States when policymakers comparatively examine other nations’ health systems. Reciprocally, Dr. Mountain’s work will influence the next iteration of Lifestyle Redesign research back at USC to improve the lives of people living in Los Angeles.

We have plenty more international successes that inform our domestic research and strengthen the evidence base of occupational therapy practice. Examples of these successes include Philippa Logan and her colleagues’ research on community-based fall prevention in the United Kingdom (Logan et al., 2010); Takashi Yamada and his colleagues’ research on the Model of Human Occupation’s impact on well-being among Japanese older adults (Yamada, Kawamata, Kobayashi, Kielhofner, & Taylor, 2010); Lindy Clemson, Anita Bundy, and their colleagues’ functional exercise research in Australia (Clemson et al., 2012); Marko Ka-leung Chan and his colleagues’ randomized controlled trial (RCT) on bilateral task training for upper limb rehabilitation in Hong Kong (Chan, Tong, & Chung, 2009); and Jeanette Christensen and her colleagues’ RCT on the effects of a lifestyle intervention on weight and other health outcomes of people living in Denmark (Christensen et al., 2011).

Evidence generated beyond our borders can help guide research within them and vice versa. And the advantages of global connections are not exclusive to research. For example, Carolyn Baum and her colleagues are investigating stroke interventions informed by Helene Polatajko’s Canadian studies (Henshaw, Polatajko, McEwen, Ryan, & Baum, 2011). These approaches can be readily implemented in our rehabilitation settings. Other evidence-based intervention models developed abroad can also be adapted for use in the United States.

Like so many things in life, overcoming inertia is the biggest obstacle to action. But you don’t have to board an international flight to spread your global wings. Every year at this conference, AOTA hosts an International Breakfast followed by a poster session on topics of international interest. This year, the 2013 International Breakfast welcomed Sue Baptiste, vice president of the World Federation of Occupational Therapy and president of the Canadian Association of Occupational Therapists, for her lecture entitled “A Global Narrative of Appreciating Health” (Baptiste, 2013). Your own global connectivity can be kick-started right here at the annual AOTA Conference!
AOTA is fostering other international collaborations to help you become a globally connected professional. I mentioned the World Federation of Occupational Therapy: AOTA supports its World Occupational Therapy Day and the 24-Hour OT Virtual Exchange, and on the association’s Web site we keep members informed of upcoming events and multimedia resources around the globe. The AOTA Commission on Education has appointed a task group to develop international fieldwork resource materials. And last year, in a long-awaited global partnership, AOTA, the British College of Occupational Therapists, and the Canadian Association of Occupational Therapists agreed to open access to our respective research journals to members of all three organizations. AOTA members, you now have access to full articles from the British Journal of Occupational Therapy and the Canadian Journal of Occupational Therapy online today at AOTA.org! In short, global connections bring the world’s occupational therapy to our doorstep and provide tangible benefits to the work we do every day. The benefits ripple out to the care, research, and policies that directly affect our clients’ lives.

Notice what the Centennial Vision ingeniously does using the phrase “a globally connected and diverse workforce”: It recognizes that global connectivity goes hand in hand with diversity. The value of global connectivity lies in the fact that different parts of the world do things, see things, and understand things quite differently. In the process of learning about others’ beliefs, attitudes, and motivations, we gain new perspectives that can lead us to reflect on our own biases, norms, and customs.

Appreciating Diversity

Over the course of our careers as occupational therapy practitioners, researchers, and educators, one source of professional power is our capacity to create bonds with people with whom we may not appear to have much in common. In fact, I would argue that it is nearly impossible to be an effective practitioner, researcher, or educator without this personal capacity to build bridges between ourselves and those who may look, think, and act differently. Recognize that diversity is not simply a function of comparing countries and cultures but rather is so wide ranging that it exists between every single person, every mind, and every heart. In our increasingly multicultural world, an appreciation for diversity opens opportunities for reflection, inspiration, and growth, not just across international boundaries but across interpersonal boundaries here at home.

So what does the Centennial Vision mean by the words diverse workforce? How can we measure progress toward realizing it? What value does it promise for strengthening our profession? And in what ways will a diverse workforce ultimately benefit the people with whom we work?

First, let’s define diversity. The etymology of the word diversity is the Latin word diversus, meaning “various” or “different.” But that variety or difference can be segmented two ways. The first way, demographic diversity, is composed of the categories that people use to self-identify: age, gender, ethnicity, disability status, sexual orientation, religious affiliation, military status, and so on. Demographic diversity is quantifiable. Think of, for example, the questions on the U.S. Census or the different categories you display on your Facebook profile. The second type of diversity is what I call embodied diversity: This type of diversity encompasses the different feelings, perspectives, and interpretations guiding our thought processes and everyday actions. Embodied diversity is qualitative. It’s the unfolding product of a lifetime of experiences, interactions, relationships, and sometimes shocking transformations.

But these two types of diversity, demographic and embodied, are not mutually exclusive; rather, they are two sides of the same coin. Demographic diversity, on one side, recognizes that members of a demographic group typically share some beliefs, attitudes, and norms. Embodied diversity, on the other side, recognizes that each of us has a unique fingerprint. We are not carbon copies preprogrammed by demographics but individuals expressing ourselves and realizing new possibilities through an unfolding confluence of biology and circumstance, training and temperament, talent and conviction. Arguably, when we cross the most daunting borders, we experience the most profound epiphanies.

Throughout our lives, the encounters we have with people from different demographic groups and our own internal struggles to figure out who we really are will profoundly alter our embodied diversity. This principle is powerfully illustrated in the 2011 French motion picture Intouchables (Duval-Adassovsky, Zeitoun, Zenou, Nakache, & Toledano, 2011). The film is based on the true story of two starkly different men, Philippe and Driss, who differ both in their demographics and in their embodiment.

Philippe is an aristocratic, millionaire nobleman who has a physical disability: He was paralyzed from the neck down by a spinal cord injury from a paragliding accident. At his Parisian manor, he is interviewing candidates to be his personal caretaker, when into the
office barges a brash, young Senegalese man named Driss, who demands a signature as proof to the French authorities that he is indeed searching for work and therefore can continue collecting unemployment benefits. To the shock of the household, Philippe hires Driss, the street-smart, womanizing hothead, and both men will be forever changed.

Driss runs on machismo and self-sufficiency and refuses to show pity to Philippe or his disability. Rather than rolling Philippe’s wheelchair into the back of an adapted minivan, Driss insists on physically transferring him into the passenger seat of his Maserati sports car. Together they speed through the streets of Paris at midnight like giddy teenagers. Instead of demurely listening to a chamber orchestra during Philippe’s buttoned-up birthday party, Driss pulls out his iPod and plays “Boogie Wonderland” by Earth, Wind, & Fire (Willis & Lind, 1979), boogying across the dance floor and igniting a footloose party.

Weary of Philippe’s platonic relationship with a faraway woman, Driss secretly arranges a dinner date for her and Philippe with hopes of sparking their physical intimacy. Driss helps Philippe regain his sense of humor and find the desire to once again live life to its fullest. But it’s not just a one-way relationship. In turn, Philippe shows Driss a world beyond the housing projects he calls home. As Abdel Sellou (2012), on whom the character Driss is based, recalled in his memoir, “[Philippe was] the one who taught me humility . . . who opened my eyes to the middle and upper classes, an alien world where some of the inhabitants aren’t so bad after all” (p. 202).

Intouchables has become the highest grossing non-English-language film ever produced, partly because it speaks to something fundamental about human relationships. As Philippe’s and Driss’s friendship blossoms, their respective worlds move from contrast to convergence. And the message is clear: that it is not our similarities, but our differences that offer the greatest opportunities for learning, connection, and understanding. It strengthens the next generation with connections, will broaden the scope and influence of our occupational therapy research agenda. And educators, you know that a more diverse student body is a precious resource in the classroom, deepening all students’ understanding of themselves and of the people they will meet in practice. It strengthens the next generation with the sensitivity and awareness necessary to deliver culturally competent occupational therapy services in a health care landscape that will only become more multicultural and more populated with all kinds of difference.

So what is AOTA actively doing to build a more diverse workforce and demonstrate our commitment to inclusivity? We recently renovated our headquarters in Bethesda, Maryland, to improve physical accessibility. AOTA’s executive team meets annually with the leaders of the occupational therapy Multicultural, Diversity, and Inclusion (MDI) Network and facilitates their gatherings every year at our annual conference. Congratulations, leaders of our MDI Network, and thank you for all your efforts and advocacy! Because building a diverse profession truly begins with student recruitment, the
Prospective Students page on the AOTA Web site now includes a section on diversity in occupational therapy featuring videos of practitioners who explain why they chose occupational therapy as their profession (Abraham, Dusenbery, Fabicon, Fraguela, & Herrera, n.d.). At our annual conference, we dedicate a workshop venue specifically to diversity and inclusion topics. AOTA also provides financial support to students from diverse backgrounds through the E. K. Wise Scholarship program. In addition, we recently submitted comments to the NIH National Institute of Neurological Disorders and Stroke’s (2011) request for information on enhancing diversity in academic research institutions.

Although we have made progress toward our goals, there is room to hone our strategies and ramp up our tactics. That’s why last year I called for the formation of a Diversity Ad Hoc Committee. Chaired by educator and research scientist Yolanda Suarez-Balcazar, our Diversity Ad Hoc Committee is charged with developing actionable, impactful, and measurable recommendations to increase workforce diversity and enhance the cultural competency of practitioners. This committee will be instrumental in shaping future diversity initiatives.

Beyond this, I urge all program directors to assess how your institution’s recruitment and admissions operations further diversity in its many forms. I urge practitioners to actively deepen your understanding of cultural and other nonmainstream perspectives so that you can be truly excellent at empathizing with and building rapport with your clients. Finally, I urge scientists to think about how diversity is represented on your investigative teams and to consider health disparities when you develop research questions. As the Institute of Medicine noted in its 2003 consensus report Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (Smedley, Stith, & Nelson, 2003), even when controlling for sociodemographics, insurance status, and clinical factors, health disparities “rarely disappear completely” (p. 77). That means we all—practitioners, researchers, educators, and students alike—have an obligation to better understand health care disparities and how cultural and social factors influence them and to build the knowledge, skills, attitudes, and communication strategies needed to become culturally competent. Reducing health disparities and truly crossing the quality chasm will not be possible any other way.

Just like the other two arms of our Centennial Vision—(1) power and recognition and (2) evidence and research—a globally connected and diverse workforce is not an end but a means. It is a journey through which we are together positioning occupational therapy for success in its second century. It is a journey through which we are all empowered to make tangible differences for all people, populations, and societies.

I believe an all-important source of power in my career has been my exposure to diversity. You know that I have never been described as a person who is easily classified or thinks inside the box. Thank goodness! I believe that I am who I am today because I have had many intense and broadening experiences in diverse worlds. We all become what we have done. Without going into detail, I can recall many transformative experiences in my own life that required me to stretch beyond my comfort zone, learn from people unlike myself, and embrace the fundamental humanity of those of whom I previously had a stereotypical and shallow understanding. And I bet many of you sitting here today can reflect on similar experiences in your personal and professional lives. These are the experiences that make you grow, stretch, learn, and change.

Pushing Our Perspectives

I want to close today by describing a clinical encounter within a professional setting that demonstrates how preconceptions can lead to deep misunderstandings. This vignette comes from the Boundary Crossing research of Mary Lawlor and Cheryl Mattingly, a 15-yr longitudinal study funded by the NIH National Center for Medical Rehabilitation Research and the U.S. Department of Health and Human Services’ Maternal and Child Health Bureau (C. Mattingly, personal communication, March 30, 2013). Situated in an urban setting, Boundary Crossing qualitatively studied the health care trajectories of 30 African-American children with illnesses and disabilities and their families and the clinicians serving them.

When Andrena’s daughter, Belinda, was 4 years old, after a year of struggling to get an accurate diagnosis from a fragmented health care system, the doctors informed Andrena that Belinda had a brain tumor—as one doctor said, the “worst kind” of cancer. The following months were difficult for the little girl. Because of the cancer and the devastating side effects of treatment, her motor and cognitive functions became significantly impaired. Andrena struggled, too, an exhausted single parent thrust into a nearly unimaginable situation. Thankfully, occupational therapy became one of life’s few pleasures for Belinda. Therapy sessions offered a setting where she would laugh, play, and show glimpses of the vivacious, healthy little girl she once was.

Because Andrena was usually not present during therapy sessions, the clinicians assumed she did not feel that occupational therapy was important to her daughter’s
rehabilitation, and the clinicians assumed she was not bothering to do the prescribed home exercises either. But after interviews with Andrena, the research team realized that her absence from the occupational therapy sessions was actually a sign of her complete and total trust in the therapists—a remarkable sign from a mother who, after a year’s struggle to get an accurate diagnosis, was completely mistrustful of clinicians. It turned out that occupational therapy was the only time she felt safe to leave her daughter in others’ hands so that she could complete her essential errands. Even more remarkably, not only was Andrena doing the home exercises, she entirely rearranged their small city apartment to mimic Belinda’s therapy room.

Andrena and Belinda’s story shows how practitioners can easily miss their own good work or misinterpret the actions of others. In this case, the therapists assumed that because Andrena did not fit their idea of a “good” parent, she was not valuing occupational therapy. However, what the researchers discovered was just the opposite: The very effectiveness of occupational therapy not only gave Andrena time to deal with life’s everyday hassles but also had the profound outcome of providing hope for her sick daughter—a hope not necessarily of cure, but of care.

Just as occupational therapy helped Chuck Close remake himself into an artist, just as the lives of Philippe and Driss collided with mutually beneficial consequences, just as clinicians’ work can offer a misunderstood parent a sliver of hope, these rare encounters in life give us pause, challenge our preconceptions, and enable us to see in new ways. This is the inherent value of global connectivity and diversity: pushing us beyond our innately limited perspectives so that we start seeing ourselves as part of a bigger picture.

Like a bird that leaves its nest to soar the skies, the vision of global connectivity and diversity asks us to see ourselves and our profession with a macro view, elevated, as it were, from above. Climbing ever higher, the details in the landscape fade away, just as individual pixels dissolve into the greater whole. From above, we no longer see the differences between us but rather the threads uniting us, together moving occupational therapy toward our Centennial Vision destiny.

When I became AOTA president 3 years ago, I could not have imagined what we would accomplish together, and I am so excited about where we are headed. To serve as your president has truly been the honor of my career. Thank you, and farewell. ▲

References


