Achieving Our Potential

In 2003, when I decided to run for president of the American Occupational Therapy Association (AOTA), my colleague Charles Christiansen and I drew a picture to describe areas of concern we believed needed to be addressed to move the occupational therapy profession forward. In our view, the profession’s attention and efforts at the time were limited to the immediate issues of the day, and we were not sufficiently focused on building a future and developing relationships with those we serve. We then shared that diagram (see Figure 1) with the AOTA Board of Directors and senior staff. After lively discussion and debate we came to consensus, and the collective “we” set out on a journey to build the organizational infrastructure and establish the relationships that would make it possible to shape and build our future. We also asked AOTA members to help us set in place a vision that would guide the profession in becoming what it wants and needs to be to serve society’s needs in the years ahead.

What we envisioned, as depicted in this illustration, was an active role of the organization to unite our practitioners, educators, and scientists in pursuit of a single but important end—to develop the knowledge, systems, and resources needed to best serve occupational therapy’s consumers. Only by having strength in our practice, education, and science sectors can we enhance the health and well-being of those we serve. We also envisioned that, as this work becomes more visible, the organization can play a greater and greater role in public awareness and policy work. This drawing became the working model for our collective efforts.

Uniting the Profession

We discovered that there were some functional and structural issues that needed to be addressed to make it possible to have a strong, healthy profession. The American Occupational Therapy Foundation (AOTF)/AOTA relationship had been fractured, and the interagency relationship among AOTA, AOTF, and the National Board for Certification in Occupational Therapy (NBCOT) had been neglected. In fact, in 2004 these organizations, each representing occupational therapy to consumers, other professionals, and practitioners, had not met to discuss professional issues since 1996. At that time, the AOTA Representative Assembly (RA) and the Board of Directors were not communicating effectively, nor were they working well together. If this were
not enough, as the rest of the world realized the reality of our global community, the association had limited visibility and little influence in the international community.

The first thing the Board and the staff did was to commit to relationship healing and building, and we joined with all of our partners to discuss how to move forward. Today we have in place the Occupational Therapy Organizational Partners (AOTA, AOTF, and NBCOT) that meets quarterly to address and cooperate on professional issues. We have a memorandum of understanding and a functional relationship with the Accreditation Council for Occupational Therapy Education (ACOTE®)—the profession’s only recognized accrediting body—and the chair of ACOTE is an organizational advisor to the AOTA Board of Directors and attends all meetings.

A helpful structural relationship has been established between the RA and the Board of Directors. The RA chair sits on the Board to foster communication and coordination between the two bodies. The AOTA/AOTF relationship has been restored, and we have a joint commitment to building the science of the profession. The AOTF president is an organizational advisor to the AOTA Board and, along with AOTF’s executive director, attends all meetings. AOTA and AOTF have established a new joint Research Advisory Panel that will make recommendations to both boards to further the research efforts of the profession and facilitate the translation of science to education and practice.

We have collaborative relationships with leaders from Canada, Great Britain, Mexico, Australia, and the World Federation of Occupational Therapists. There is ongoing discussion on common issues and a forum for international discussion at each of the nation’s conferences.

We have set in place the opportunity to talk to and be advised by members. The Centennial Vision (AOTA, 2007) process, led initially by Charles Christiansen and now by Florence Clark, involved nearly 2,000 AOTA members from across the United States. The approach to framing issues and reports or recommendations through the creation of the ad hoc committee format initiated by the Board has united practitioners, educators, and scientists in providing advice and guidance to address professional issues that require our attention.

There is a Centennial Vision Commission charged with fostering communication among all association bodies and tracking the activities that document the accomplishment of our strategic initiatives. The efforts put forth by leadership throughout the organization and with our AOTF and NBCOT partners has provided an infrastructure that enhances the capacity of our organizations to support excellence and innovation as we work collectively to achieve the goals of the Vision.

There also has been incredible growth in the National Office resources. We have a truly outstanding staff under the leadership of our executive director, Fred Somers. During the
past 3 years they have done outstanding work in partnership
with the Board of Directors, the RA, and other association
bodies to move the organization and profession forward. This
infrastructure is there to help you address the issues or put
you in touch with resources you can use to address the issues
that bring excellence to your activities.

Understanding the Importance of
Our Work

Although they are helpful, having an effective organizational
structure or even a really talented staff will not be sufficient
to meet the goals we have set out in our Centennial Vision.
Achieving the Vision will happen because each of us will use
our knowledge and skills to deliver excellent services to our
clients, students, and institutions. Our efforts will help others
realize what we and many others already know: Occupational
therapy is an indispensable service for meeting the occupational
needs of individuals, organizations, communities, and society.

For years we have had people telling us how important
occupational therapy is. Adolf Meyer’s propositions in the
seminal address delivered at the Fifth Annual Meeting of the
National Society for the Promotion of Occupational Ther-
apy in 1921 and later published in Volume 1, Issue 1 (1922)
of the Archives of Occupational Therapy, say that “our [pro-
fession’s] concept of man is that of an organism that main-
tains and balances itself in the world of reality and actuality
by being in active life and active use” (p. 5); “there must be
opportunities to work, opportunities to do, and to plan and
create, and to learn to use materials” (p. 7). These proposi-
tions underlie occupational therapy practice.

Mary Reilly (1962) challenged us to place our focus on the
human need for action with her hypothesis that “man,
through the use of his hands as they are energized by mind
and will, can influence the state of his own health” (p. 2). Tris-
tam Engelhardt (1977), a philosopher, reminded us that
“occupational therapy . . . does not seem to be essentially
bound to concepts of disease. . . . It is, instead, focused on the
success of individuals in finding fulfillment through human
activity . . .” (p. 670). “[By] viewing humans as engaged in
activities, realizing themselves through their occupation, occupa-
tional therapy supports a view of the whole person in func-
tion and adaptation. . . .” (p. 672). Gary Kiellhofner (1992)
described the impact of being restricted from participation
in occupation as causing physiological deterioration, with the
restriction leading to a loss of ability to perform competently
in daily life. It is now more than a decade later, and we know
that restricted participation also relates to depression and cog-
nitive decline. Ann Wilcock (1993) stressed that people need
to make use of their capacities by engaging in motivating
occupations, because engagement will not only supply suste-
nance for survival and safety but also will enhance health.

Now we see the importance of occupational therapy work
integrated in national and international policy. The concept
of engagement or participation as central to health care deliv-
ery has taken hold only in the past decade. In its 1993 report
to the U.S. Congress, the National Center for Medical Reha-
bilitation Research at the National Institutes of Health intro-
duced the possibility that social limitation due to societal pol-
icy, attitudes, and actions, or lack thereof, creates physical,
social, or financial barriers to access health care, housing, and
vocational/avocational opportunities. The Institute of Med-
icine later developed the report Enabling America (Brandt &
Pope, 1997), which introduced the enabling–disabling pro-
cess to describe the outcome of rehabilitation as restoring the
individual’s function and using environmental strategies to
remove barriers that limit performance and participation.
More recently in 2001, the World Health Organization
released the International Classification of Functioning,
Disability, and Health, which shifts the view of the indicators
of health from one based on mortality rates of the populations
to one focused on how people live with health conditions and
how individuals can achieve a productive, fulfilling life. It en-
compasses personal independence, social integration, and
community integration.

These models embrace the core elements of occupational
therapy: They are offering us the opportunity to take our
knowledge, skills, and approaches to our health, educa-
tional, and community systems—knowing that what we do
is important—to make a contribution to health and to the
economy.

Defining the Occupational Therapy Role

Occupational therapy professionals have a civic responsibil-
ity to create, disseminate, and apply new knowledge for the
benefit of the people, organizations, and populations we
serve. This means that those of us in practice must seek evi-
dence to support our interventions; form relationships with
colleagues; and build bridges across the multiple challenges
of practice, from managing impairments to fostering activity
and participation of children, adults, and older adults. We
also must recognize that our students represent the future of
the profession. They must be educated with contemporary
strategies that are supported with evidence, and they must be
allowed to bring these strategies to the marketplace.

Those of us who educate future practitioners must recog-
nize that we are in the business of leveraging talent. We are
producing our future clinicians, educators, scientists, and
administrators, all of whom may ask different questions and
want to take a different focus on their graduate work. I want
their activities for the and AOTA staff to ask them to address the issues related to

Each team has answered these questions in a positive, state affiliate presidents, the RA, the Special Interest Sections, and many that can be done by each of us in our daily lives

The reports generated by these teams are being sent to the state affiliate presidents, the RA, the Special Interest Sections, and AOTA staff to ask them to address the issues related to their activities for the Centennial Vision. Actually, some of the recommendations already have gone to the RA and have been acted on. You can obtain these reports from the AOTA Web site at www.aota.org and use them to foster discussion with your colleagues in your clinic or among your faculty, in your planning for continuing education opportunities, and especially when working with students who need topics for their master’s or doctoral projects.

As we move forward to accomplish our Centennial Vision, this goal will require the collective effort of each of us in this room and our colleagues at home. We must recognize that we are providing vitally important services for our clients, our health systems, our schools, our organizations, and our universities. We also must recognize that there are aspects of our practice, education, and research we can improve. As professionals we are obligated to dedicate our efforts toward such improvements.

Occupational therapy is a profession with many blessings. We have immense talent and creativity among our practitioners, our educators, and our scientists. We have begun to break down the barriers that divide these groups. Now we must demonstrate that the collaborative effort of all three groups working together will become more than the sum of the parts. The added value of collaboration of practice, education, and research provides the necessary foundation for strong educational preparation, answers the policy questions that justify our reimbursement, creates opportunities for awareness, and fuels the questions that our scientists address. We cannot stand with strength without standing as collaborators. We are all members of AOTA, and AOTA must meet all of our needs.

On the Internet, I recently found a document, World Citizens Guide (Business for Diplomatic Action, 2004), which gave practical advice for Americans traveling abroad. Seeking to find similar guidance for our association’s journey, I wondered what practical advice can help us travel to our 2017 goal. As I thought about what would constitute such advice, I remembered that in 1993 the Pew Commission offered several recommendations that would better prepare health care professionals for the new health system. When I searched for the Pew report I found Twenty-One Competencies for the Twenty-First Century. I would encourage all of us to review the report Recreating Health Professional Practice for the New Century (Pew Health Professions Commission, 1998).

In reviewing this list, it seems to me that the competencies they are proposing fit nicely with the values we hold as occupational therapy practitioners. The Pew Commission tells us that health professionals must incorporate the multiple determinants of health in their clinical care; apply knowledge of the new sciences in their intervention; demonstrate critical thinking, reflection, and problem-solving skills; and demonstrate that they understand the role of primary care by
rigorously practicing preventive health care. Furthermore, they suggest that practitioners integrate population-based care and services into their practice and improve access to health care for those with unmet health needs. Practitioners are being asked to embrace a personal ethic of social responsibility and service; provide evidence-based, clinically competent care; and practice relationship-centered care with individuals and families. Practitioners also are being asked to provide culturally sensitive care to a diverse society and use communication and information technology effectively and appropriately. We are being asked to work in interdisciplinary teams and ensure care that balances individual, professional, system, and societal needs while we focus efforts to promote continuous improvement of the health care system and take responsibility for quality of care and health outcomes at all levels. Twenty-first-century practitioners also are being asked to practice leadership and to partner with communities in health care decisions, as well as advocate for public policy that promotes and protects the health of the public. Most of all, practitioners are being asked to continue to learn and to help others learn.

Most of these competencies do not represent stretch goals for occupational therapy. They are inherent in the practice of client-centered care. Their long-standing presence reflects the leading values of those who have gone before us. We can take pride in the fact that we have been prepared for practice in the 21st century and that we are using the competencies in our practice. We also need to be sure to continue our learning.

I am going to build on a few of these competencies and add a few of my own:

- Health care is changing. For a decade we have seen and been a part of that change. We have seen the focus change from illness to wellness. The acute care focus now considers the importance of well-being and function. It has changed from one of survival to one that considers capability. Patients are being asked to take personal responsibility for chronic health problems, and we have seen prevention become central to health care delivery. It would be naïve of me to tell you these changes are prompted by a shift in health beliefs; they are prompted by economic changes. People who take personal responsibility for their health and health professionals who focus on prevention and self-management will save money, but these also happen to be good ideas and place occupational therapy’s contribution at the center of cost-effective care.

- Our administrators and leaders in our institutions must know that we have and use these competencies to support the missions of our organizations.

- We also must provide services that address public health problems. Fifty-four million Americans (1 in 7) have a physical or mental impairment that interferes with daily activities, yet only 33% are so severe that they cannot work or participate in community life (Brandt & Pope, 1997). Society is facing the consequences of increases in disability, chronic disease, the diseases of meaning (e.g., depression, suicide, self-inflicted injury, substance abuse), and stress-related disorders. Occupational therapists and occupational therapy assistants have the skills to help with these problems.

- We also must use evidence-based, client-centered care and assume leadership roles in our work, our communities, and our profession.

- We must accept the responsibility to advocate for those we serve. We must regularly and repeatedly attend town hall meetings of our senators, representatives, or state legislators. Stand up and say you are an occupational therapist or occupational therapy assistant. You can mention an important issue or just thank the official for his or her service and mention what occupational therapy is doing for the people in your district or state.

- When you see an article in the newspaper or on the Internet or hear a news story on television or radio that applies to occupational therapy, write a letter telling what you as a occupational therapy practitioner do that relates to the issue.

- Meet with a representative from an insurance company, the Medicaid program, a Head Start program, or a local parent group to tell him or her what occupational therapy is doing for those they serve—before you get a denial for your services!

Occupational therapy is at another crossroad. The profession has important decisions to make. Yet I want to invite your recollection of a time just like this, that occurred nearly 50 years ago. Come back with me to the year 1961, when occupational therapy was a small profession; there were fewer than 12,000 of us. We did not have reimbursement by third parties. Medicare was not yet a reality but was about to become so. AOTA was still located in New York, and the organization did not have government affairs staff. An occupational therapist who was a clinician in World War II became an educator, a scholar, and a woman who was mentoring today’s leaders by example. She was telling us of changing times and was asking us to consider what we needed to do to position ourselves for the enormous growth that was about to occur in medicine.
Mary Reilly (1962) said to us,

How free we are 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. (p. 4)

Society requires of us a much sharper focus on its needs. . . .

(p. 4)

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. (p. 3)

Our profession emerged from a common belief held by a small group of people. . . . (p. 1)

It was, and indeed still is, one of the truly great and even magnificent hypothesis of medicine today. That man, through the use of his hands as they are energized by mind and will, can influence the state of his own health. (pp. 1–2)

This hypothesis . . . sets few limits to [a profession’s] growth. It . . . endows [us] with the obligation to acquire reliable knowledge leading to a competency to serve the belief. (p. 2)

[We must] identify the vital needs of [human]kind that we serve . . . if we fail to serve society’s need for action, we will most assuredly die out as a health profession. It is also most assuredly true that if we did dissolve, another group . . . would have to be invented. (p. 3)

As I was revisiting these critical thoughts, I decided to call Dr. Reilly to see what she would want to say to us today, 46 years after her powerful Eleanor Clarke Slagle address. She said “make sure you tell them we have to have a change in years after her powerful Eleanor Clarke Slagle address. She said “make sure you tell them we have to have a change in . . . .

November/December 2007, Volume 61, Number 6
Those who have come before us laid the groundwork for what we do. Let us leave a legacy for those who will follow. In 2117, when our successors are preparing to celebrate the 200th anniversary of the profession, we want them to say that those visionary and dedicated professionals who recognized the urgent need to improve the health and well-being of the citizens of the world at the turn of the previous century did a fine job linking occupation and health, that there were fine scientists who taught us what factors influenced occupational performance, and that just as in the past there were students who left the classroom prepared and eager to meet important societal needs. They will say that at its 100th anniversary, occupational therapy was a very important part of 21st-century medicine and health care!

We are those people they will be talking about.

Thank you so much for the privilege of serving as your president!

References


