Ten Milestone Issues in AOTA History

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This paper identifies 10 professional questions that the author has labeled milestone issues in the history of the American Occupational Therapy Association. Subjects encompassed by these issues are medical control, certified occupational therapy assistants, licensure, proficiency testing, entry-level degrees, treatment media, maintenance of competency, whether occupational therapists serve patients or clients, professional autonomy, and the status of occupational therapy as a profession. Although this paper is primarily a factual record of events and discussions referenced in official publications, the reader will recognize the insertion of author commentary and opinion in several of the issues discussed.

In our 75th Anniversary Year, it seems appropriate to reflect on selected issues that have faced the profession over its history to date. The definition of an issue most pertinent to this discussion is “a point, matter or question to be disputed or decided” (Guralnick & Friend, 1964). The literature citations that follow attest to disputes these issues have raised, some still controversial and under debate, others decided.

The first six issues discussed below, about which decisions have been made, I consider past or closed professional issues. The last four, which remain under debate, I consider ongoing issues in occupational therapy. Few of us, be we active practitioners, critical observers, or amateur historians, would find it difficult to list issues relevant to our profession. Selecting a few from many deemed important and labelling them milestone issues inevitably imply subjectivity and reveal bias. I freely admit to and am solely responsible for these aspects of the issues that compose the following list and this discussion of them.

Past or Closed Issues

Control by Physical Medicine

This is the first and, in my judgment, the most important milestone issue in the history of the American Occupational Therapy Association (AOTA). I also discuss it first because, with exceptions to be noted in relation to the ninth and tenth issues, it places first when the issues are listed in chronological order. However, this issue is also the most obscure in the literature and probably the least valued by contemporary practitioners. Its low value is understandable because it occurred nearly 50 years ago, before the birth of most occupational therapists active today, and it is thus overlooked by all but the few who, like me, were intimately involved with the issue at the time or who, also like me, are history buffs.

The aspect of obscurity in the literature needs more explication. It must be remembered, for example, that this confrontation with medicine was occupational therapy’s first and that it followed a history, from its beginning in 1917 until the early 1940s, of not only extremely close alliance with but also warmly sought guidance and direction by medicine. Because of occupational therapy’s origin in psychiatric institutions and tuberculosis sanatoria, we received the longtime support of physicians in those specialties. Nine of AOTA’s first 20 annual meetings convened in conjunction with the American Hospital Association (AOTA, 1924a, 1925, 1926, 1927, 1929a, 1929b, 1936) and the American Medical Association established the Essentials of an Acceptable School of Occupational Therapy (AMA, 1935) and inspected and accredited schools, in collaboration with AOTA, from 1935 to the present time (AOTA, 1991c). During the 1940s, largely because of wartime experiences with fractures, amputations, and both peripheral and central nervous system...
injuries, occupational therapy also enjoyed close and cordial relationships with the medical specialties of orthopedics and neurosurgery.

Why, then, in view of their pressure to make occupational therapy, along with physical therapy, a part of their specialty, did we reject the patronage of physical medicine? We did so because such an affiliation abrogated all our traditional bonds of collegial and collaborative relationships with medicine, first by psychiatrists’ implicit plans for control of our practice and later by explicit moves to control our education (Gritzer & Arluge, 1985) and publish our Registry. These intents were forestalled by AOTA’s publication of a key Statement of Policy (AOTA, 1950) in support of its earlier stand against control of occupational therapy practice and education by any one medical specialty.

That statement included a definition of occupational therapy, the requirement of a prescription by a patient’s physician (then a protective requirement), and the establishment of relationships with physicians in psychiatry, pediatrics, tuberculosis, and other medical specialties by the prescription and by continuing contact. The policy further stated that the education of occupational therapists balanced emphasis among the medical specialties; that occupational therapy curricula were most effectively directed by qualified occupational therapists with advisory committees including members of medical and allied professional fields; and that registration of qualified occupational therapists was established and maintained by AOTA. Although an organizational edict, that Statement of Policy was the result of serious study by its Education Committee and reflected the insight and influence of Beatrice D. Wade, who had earlier staved off physical medicine’s control of the curriculum she directed at the University of Illinois.

The principles that Beatrice Wade impressed upon AOTA’s Education Committee and Board of Management and that led to the Statement of Policy that preserved our professional independence deserve attention. First, she promoted the concept that occupational therapy, like nursing, should be a service available to all medical specialties, not just to one. For many years, that principle preserved our close ties with psychiatry, in which psychiatrists had little or no interest. Second, and consistent with the first principle, she defended the principle that occupational therapists were accountable to the physicians who referred patients for treatment. Stressing that logical fealty strengthened the traditional relationships with medical specialties that occupational therapists had enjoyed for more than 30 years before the newer specialty of physical medicine came into being. Third was the derivative and fundamental management principle that a basic service (e.g., occupational therapy) is accountable to any intermediate service (e.g., physical medicine) under which it is organized. All three of these principles, and particularly the last two, reaffirmed the appropriate lines of responsibility and accountability of therapist to physician, including those instances in which occupational therapy is a service organized within a physical medicine service or department.

Why was this milestone issue so obscure in our literature from 1950 until very recently? Because, at that time, reasons for the profession’s stand against control by physical medicine were not widely understood, internal professional agreement was less than 100%, and there was some reluctance to proclaim prematurely what might be a precarious independence. Fuller disclosure of several aspects of this early bid for autonomy may be noted in a book (Gritzer & Arluge, 1985) and a journal article (Colman, 1992).

**An Assistant Level of Personnel**

My second milestone issue in AOTA history is that of the creation of the certified occupational therapy assistant (COTA). Factors precipitating another level of practitioner included a shortage of personnel, increasing assumption of occupational therapy–related positions by activity therapists, and the then near-standard qualification for occupational therapists of a baccalaureate degree. In response to growing discussion and debate on both sides of the issue, the Assistants Committee, established in 1953, reported guidelines for training (AOTA, 1956) that resulted in the first 3-month educational program in psychiatry in 1958 and a second course of preparation for general practice in 1960 (AOTA, 1961).

By the following year, 5 more assistant programs, all hospital-based, had met AOTA approval and caused the national organization’s publication of the first directory of occupational therapy assistants (AOTA, 1961), which listed 555 names. Because 7 training programs of even such short duration could hardly produce that number of graduates in 3 years, grandfathering of assistants who were already working, on the basis of experience in lieu of education (AOTA, 1961), was a major factor in the initial growth of occupational therapy assistant numbers. Another development that was to expand the ranks of graduates and the number of educational programs was the 1963 piloting of 1- and 2-year occupational therapy assistant courses in community and junior colleges (AOTA, 1963b). Although certification in psychiatry based on experience was terminated in 1961 and in general practice in 1965 (AOTA, 1964), growth in the number of technical education programs has expanded to today’s total of 66 accredited by AOTA, 6 under probationary approval, and 8 developing programs as of December 1991 (AOTA, 1991b).

Role delineation of occupational therapy assistants vis-à-vis occupational therapists and career mobility from assistant to professional levels have been tangential but major points of difference within the total issue of occupational therapy assistants in AOTA history. Role delineation...
tion has too many parameters to be included in this discussion. It is also ongoing and, like its parent, still controversial in some quarters. Career mobility, on the other hand, has been an issue since the first occupational therapy assistant passed the Registration Exam and became an occupational therapist (AOTA, 1973b). In 1978, 41 others used the same route (AOTA, 1978a) and approximately 30 others have so qualified since establishment of the program in 1972 (AOTA, 1982). However, the Representative Assembly voted in 1982 (Resolution 580-82) to phase out the career mobility program in 1988 and that was effected as scheduled. Reasons cited included the small numbers involved and the costs of administering the program that could better be spent on programs and services beneficial to a larger number of the 5,000 occupational therapy assistants then certified. Recognizing some remaining aspects of debate surrounding occupational therapy assistants, such as role delineation and appropriate supervision, I have placed this issue in the past category in the belief that no future official action will reverse the status of a group now certified by and recognized as members of AOTA.

State Regulation of Practice and Licensure

The third milestone issue is state regulation of practice by licensure, trademark, or registration laws. For virtually half of its first 70 years, AOTA was apparently not concerned about licensure of occupational therapy personnel: I did not find the word in our literature until 1951. Rather, it was national registration that was sought, first on the basis of uniform standards of education and later also by means of a qualifying examination. Following is an outline of the sequence of events in establishing national registration that ultimately led to state regulation.

In 1923, to unify education, AOTA established Minimum Standards of Training (AOTA, 1924b), believing that such was a requisite first step toward a national register or directory of qualified occupational therapists. A vote of the Board of Management and the membership at the 1930 annual meeting approved establishment of the National Registry of Qualified Occupational Therapists. When effected in 1931, education and experience were alternate forms of qualification for the Main Register, but the experience basis for admission was terminated in 1933. No new applicants were admitted to the Secondary Register after 1937 and its publication ceased in 1965 when only 4 names were included. The purpose of the Registry, published as the Directory and Yearbook in subsequent years, was the “protection of hospitals and institutions from unqualified persons posing as Occupational Therapists” (AOTA, 1952, p. 7). This purpose was to become a major objective in subsequent licensure laws.

For 25 years after 1951, when licensure was first mentioned in its official publications, AOTA assumed first a negative, then a neutral, and ultimately a positive stand on state regulation of occupational therapy practice. A major reason for its negative stand was the belief that registration of qualified occupational therapists on national standards was the best protection of both providers and consumers. Other objections were to the establishment of state barriers to recruitment; expenses for legal counsel, lobbying, and the required fees; and the difficulties and expenses of establishing separate state regulations. A final and important factor was the perceived threat to the national Registry when all states had regulatory legislation (AOTA, 1951).

AOTA’s neutral position on licensure, adopted by a resolution of the Delegate Assembly (AOTA, 1974), was precipitated by several events: collective bargaining (AOTA, 1967b) and unionization pressures (AOTA, 1960) visible in nursing, social work, and teaching; the 1967 reincorporation of AOTA as a business league, which freed it to engage in lobbying and other legislative activities formerly prohibited by its tax-exempt status; the Legislative Committee’s recommendation that AOTA employ a Washington-based legislative representative (AOTA, 1967a); the implementation of that recommendation (AOTA, 1968); and, in 1968, Puerto Rico’s enactment of a licensure law (AOTA, 1969b). Then, 6 months after adoption of the neutral stand on licensure, a Special Session of the Delegate Assembly rescinded that resolution, adopted a positive position and assigned it top priority (AOTA, 1975b). The rest, as they say, is history. As of March 1992, 47 of our 52 political jurisdictions had enacted regulation of practice (AOTA, Legislative and Political Relations Department, personal communication, 1992). This milestone issue therefore rests in the closed category, although its ramifications, primarily in the form of declining support of AOTA through membership, may be felt for years to come.

Professional Entry by Proficiency Testing

The fourth milestone issue is proficiency testing, also frequently referred to as competency-based qualification. This item first emerged in 1971 in the form of a government contract (AOTA, 1972) and it was, I believe, the first and last time to date that money was awarded to AOTA for purposes that may not have been in the best interests of the profession.

Phase I of the Proficiency Testing Project, to provide for entry into occupational therapy without traditional academic credentials, was completed in 1973 (AOTA, 1973a). Two years later, field testing of the proficiency exam was completed (AOTA, 1975a) and tests for validity and reliability were begun (AOTA, 1975c). In the following year, AOTA accepted another HEW contract for final development of what had come to be called a competency-based criterion-referenced examination (AOTA, 1977).
Then, in what I shall dare to call a truly shining moment, the Representative Assembly took two key actions. First, it ruled that proficiency testing was an unacceptable method of entry into the profession (AOTA, 1979b). Second, it adopted a motion in tandem with that action, stating that "any grants or contracts applied for and awarded would not obligate the Association to use or accept resulting products, methods or objectives inconsistent with existing policies and procedures" (AOTA, 1978b, p. 659).

A subsequent review of the Proficiency Testing Project revealed that $1.6 million in government contracts had been spent on that effort (Shapiro, 1978). For those who asked why it was aborted, a 1985 "The Issue Is" article in the American Journal of Occupational Therapy discussed implications for occupational therapy of competency-based education and concluded that, although such "meets the needs of a profession regarding accountability and mastery of methodological techniques . . . it does not adequately address a profession's philosophical base, theoretical concerns, ethical issues and affective functions" (Hinojosa, 1985, p. 541).

**A Graduate Degree for Entry Level?**

The fifth milestone issue is the requirement that entry-level occupational therapists must have a master’s degree. Although it sometimes seems that this question has been discussed forever, the first mention of it that I found in AOTA publications was in discussions of the Education Committee (AOTA, 1953). At that time, it was reported that attaining a master’s degree in occupational therapy was discouraged by deans of graduate schools, who instead recommended graduate study in anatomy, physiology, human development, and similarly related fields. That advice notwithstanding, the AOTA Board of Management approved Essentials of an Acceptable Course Leading to a Master’s Degree in Occupational Therapy, which had been developed by the Graduate Study Committee of the Council on Education (AOTA, 1955). Twenty-four years later, the Representative Assembly moved to publish the Guide for Graduate Education in OT Leading to the Master’s Degree (AOTA, 1979a).

Discussions of this issue continued over the years, inside and outside the Entry Level Study Committee’s January 1985 to July 1986 deliberations, and also of those issues surrounding the survival of professional education at the undergraduate level (Tanguay, 1985) and whether occupational therapy is an academic discipline (Yerxa, 1987). It seems obvious, then, that AOTA has considered such a mandate inadvisable. It also seems implicit that a mandate is considered unnecessary because, as of October 1991, one could obtain either an entry-level or post-baccalaureate master’s degree at 36 of the 74 accredited educational programs (AOTA, 1991a). Because the other 38 colleges and universities that offer accredited occupational therapy curricula award only the baccalaureate degree, the issue of an entry-level master’s degree remains a voluntary and optional decision for both beginning students and occupational therapy educational programs. It is, therefore, at least as of this 75th anniversary year, a closed issue in AOTA’s history.

**Range and Appropriateness of Treatment Media**

The sixth and final milestone in the closed category was invisible for nearly half of AOTA’s history; not until 1955 do we see what may be the first evidence of its origin in exclusion from the Registration Exam of questions about treatment media (AOTA, 1954). I believe this action reflected the problem of examining fairly the graduates of schools that, in the aggregate, were teaching treatment media in 331 courses (AOTA, 1963c), rather than any question about the appropriateness of treatment media used.

A different national dialogue on treatment media erupted 30 years later through an article (English, Kasch, Silverman, & Walker, 1982) and a series of letters to the editor (Clopton, 1981; Courtsunis et al., 1982; Leffler, 1978; Stevens, 1981; Trombly, 1982; Walker et al., 1982) published in the American Journal of Occupational Therapy. The message throughout was a protest against the use of only crafts and purposeful activity versus pleas for "pure exercise" and passive methods of facilitating, enabling, and preparing the patient for active engagement in occupations. The potent factor of reimbursement for seemingly more objective and measurable methods of treatment than activity or occupation funnelled debate and, with publication of the Task Force Report on Physical Agent Modalities (AOTA, 1991e), propelled the Representative Assembly to adopt an official statement on that subject (AOTA, 1991d).

My personal and professional stand that of Ruth Brunynate Wiemer, in dissenting but loyal opposition to occupational therapists’ use of physical agent modalities, has been thoroughly stated (West & Wiemer, 1991). In that article, we proposed one resolution to rescind the 1991 Representative Assembly action and another to adopt a resolution reaffirming occupations as the modalities that are singularly distinguishing and unique to occupational therapy.

A Draft Position Paper written by the Chair of the Task Force on Physical Agent Modalities and published concurrently with ours (McGuire, 1991) is, in our opinion, a much stronger and more approvable statement on
the subject than was the statement adopted by the 1991 Representative Assembly. We were therefore pleased that the 1992 Representative Assembly adopted that paper, although disappointed that our own resolutions failed. With that action, the final chapter on physical agent modalities seems to have been written, placing this aspect of treatment media in the closed category of issues in AOTA history.

Ongoing Issues

Continuing Education and Specialty Certification: Maintenance of Competency?

The seventh milestone issue but first in the category of issues still debated today is whether continuing education and specialty certification ensure maintenance of competency. These issues are not only more recent in professional debate, they are decidedly ongoing and, if truly professional goals are realized, they will neither fade nor disappear from our agenda - ever.

Beginning movement toward continuing education seems to have started with appointment of a committee then called Upgrading Clinical Performance but subsequently renamed Continuing Education (AOTA, 1962). The charge to that committee was to replace the annual reregistration fee, which had long been thought unfair to inactive therapists and nonfunctional for those in active practice, with a method for documenting maintenance of competency beyond initial qualification to practice. After long and serious study, the committee devised a system for accruing points to qualify for annual reregistration, now called certification - through publications, conferences, institutes, workshops, seminars, and similar measures for staying abreast of new knowledge and its application in practice. The only problem was that the officers and Board members on whom it was piloted could not qualify. Obviously, the effort was less than successful, but it may be thought of as an early, if quaint, forerunner of more effective continuing education units.

Today, the continuing education issue also includes graduate degrees in our own and related fields, specialization, and specialty certification by other agencies and organizations such as Sensory Integration International and the American Society of Hand Therapists. Furthermore, as of the current decade, AOTA now offers specialty certification in pediatric occupational therapy through nationally administered examinations (Javernick, 1992; Joe, 1990). If specialty certification in pediatrics is just the first to be made available in occupational therapy, what specialties will be next and how many will there be? Will there be specialty certification in psychosocial dysfunction, our first, long our largest, but now distressingly diminishing specialty? Will specialty certification fragment the field, even as it strengthens it, and lead to disunity? Answers to these questions will have to await future developments.

Patient Versus Client as Descriptors of Our Caseloads

The eighth milestone issue is whether persons served by occupational therapy are most appropriately called patients, clients, or the occasionally seen combining form patients/clients. The origin of this terminology question is more difficult to place in time, has fewer references in the literature, and is not only the subject of ongoing debate but may have increasing importance in the future.

As long ago as the 1930s, community and sheltered workshops and some rehabilitation centers referred to those they served as clients, perhaps because they were neither ill nor under medical care. More current connotations of the term client have quickened debate in the literature of the mid-1980s. From two of our most respected colleagues (Reilly, 1984; Sharrott & Yerxa, 1985) have come thought-provoking articles strongly advocating use of the traditional term patient and citing legal, moral, and ethical reasons for their stand against the term client. Their cogent arguments are commended to study by all; it is also interesting to note that Yerxa says she first used the term client in her Eleanor Clarke Slagle Lecture (Yerxa, 1967).

My preference for the term client, when more appropriate, was formed during recent decades by the increased numbers of our personnel moving out of hospital and medical care models. Prime examples of these settings include the school system, where a significant percentage of children are seen for learning disorders but are neither sick, disabled, nor under medical treatment as patients; and long-term rehabilitation after treatment for acute phases of illness or disability, where restoration of maximum functional capacity succeeds the initial and primary goal of recovery from physical or psychosocial dysfunction. Finally, we must consider implications of practice trends in maintenance and promotion of health, prevention of illness and disability, and especially the most recent entry of our profession into the wellness arena (Johnson, 1986; MacDonald, 1992; Pizzi, 1992; Schallert & Burton, 1992). All these may be taken as concerns in occupational therapy for those who cannot be called patients in the purest sense of the word. For these reasons I place patient versus client terminology in the category of ongoing milestone issues that may be prominent in our internal discussions well into the future.

Autonomy in Education and Practice

The ninth milestone issue is the question of autonomy in education and practice. My need to establish a sequence of issues in a time frame compels me to remind readers that autonomy in education was originally established in 1923 when AOTA initiated Minimum Standards of Training (AOTA, 1924b). Autonomy was not complete, however, because long after that, we pursued the respect and support of medicine and welcomed the American Medical
Association's publication of the *Essentials of an Acceptable School of Occupational Therapy* (AMA, 1935). By the end of 1991, the *Essentials* had been revised 6 times and the process of accreditation of schools progressed from an AMA responsibility to joint inspection of schools by AMA and AOTA teams (AOTA, 1957) to the current system of certification by AMA’s Committee on Allied Health Education and Accreditation (CAHEA) on recommendation of AOTA’s Accreditation Committee (AOTA, 1991c).

Signposts of autonomy in practice started, I believe, in the 1940s with our first stand against control of practice by any one medical specialty. At that time, it was physical medicine, which I discussed as the first milestone issue. There followed, first, elimination from AOTA’s *Fact Sheet* of the requirement of a prescription, implying necessary authorization (AOTA, 1963a); second, replacement of the physician’s prescription by referral from a number of different professions, including medicine, in AMA’s 1965 *Essentials* (Presseller, 1984); and finally, self-entry into the health care system (AOTA, 1969a), reflecting new roles in prevention and other out-of-hospital community settings beyond the medical model.

It seems likely that the question of educational autonomy may see closure when the 1993 Representative Assembly acts on discontinuing relationships with AMA for accreditation of educational programs. That is the proposal made in a January 1992 letter from AOTA’s president to several hundred therapists involved in AOTA’s organizational structure. Noting that “AOTA’s accreditation process has reached a level of maturity that supports independence,” that letter scheduled sessions for discussion of the issue at the 1992 annual conference and urged debate and feedback from members throughout 1992 and 1993 in preparation for action by the 1993 Representative Assembly. It is also evident that the Task Force on Accreditation is studying the issue concurrently with member discussions (Kyler-Hutchinson, 1992). Predictions, anyone?

*Is Occupational Therapy a Profession?*

My tenth and final milestone issue is stated in the form of the question *Is occupational therapy a profession?* Almost from the formation of AOTA 75 years ago, we have so categorized the calling we follow. We are uniformly included among the so-called allied health professions. We consistently speak of our field as a profession and of ourselves as professionals. What are some of the reasons for this claim?

In education, we have seen advances from diplomas and certificates to bachelor’s degrees to master’s and doctoral degrees. In practice, there have also been developmental strides through at least 6 stages as we have embraced, first, the medical model of both acute and chronic care that still supports large numbers of our practitioners; second, the health model, with important and innovative penetrations increasingly evident in that area; third, the community model, where both our patients and clients live, work, and play; fourth, the health maintenance and promotion model; fifth, the prevention model, still in-bounds for occupational therapy if we remember that the highest goal of medicine has always been the prevention of disease and disability; and sixth, the wellness model (see Johnson, 1992; MacDonald, 1992; Pizzig, 1992; Schallert & Burton, 1992), which is also the epitome of prevention and strives for the goal of the World Health Organization’s definition of health as “a state of complete physical, mental or social well-being and not merely the absence of disease or infirmity” (Thomas, 1981, p. 625).

But does even this combination of achievements mean that we now merit the status of a profession? For the following reasons, I am not convinced that it does. First, not all occupational therapists have studied in a 4-year liberal arts program before undertaking professional education. Second, approximately half of our professional education curricula are offered at the undergraduate level, in contrast with the graduate degree requirement of the learned professions of medicine, law, the clergy, and others. Third, more than 40% of our accredited professional education programs are organized within schools or colleges of health-related professions, health-related sciences, health sciences, or allied health (AOTA, 1991a), several of whose associated curricula graduate technicians and technologists rather than professionals. Fourth, the skills, techniques, and modalities that we use as intervention strategies include many that are inconsistent with the central theme of our philosophy, that occupation (purposeful activity) is our unique and distinguishing means of influencing health. Fifth, we have only recently begun to document the efficacy of our service through research.

Finally, I do not believe that occupational therapy personnel uniformly demonstrate their professionalism: only 80% of registered, certified, or licensed occupational therapists and an even smaller percentage of certified or licensed occupational therapy assistants support their national professional organization, our collective agent of action, through AOTA membership (AOTA membership database, 1992). This final milestone question is therefore left in the category of ongoing issues in AOTA history for subsequent proof and final determination by future occupational therapists.

**Conclusion**

This discussion of milestone issues in AOTA history reflects one person’s thoughts about some key questions that have faced our profession over the years. This paper is, therefore, biased by my judgment in selection of content included and implied rejection of material that an-
other commentator might judge to be of equal or greater importance.

When I was contributing chapters for the Department of the Army’s volumes on Neuropsychiatry in World War II (Anderson, 1966) and Army Medical Specialist Corps (Lee & McDaniel, 1968), authors were cautioned that “history” should not be written until approximately 25 years after the events addressed. Against that criterion for objectivity, only the first two issues in the closed category so qualify. The remaining issues in that category, although in more recent debate, appear to have reached an improbable point of return and thus have also been so classified. Finally, the four issues in the ongoing category seemed to be of sufficiently crucial import to merit discussion as professional milestones if they are not yet properly considered objective history.

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tative Assembly have voted as it did, when it did, on occupational therapists' use of physical agent modalities? American Journal of Occupational Therapy, 45, 1143-1147.


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