Generalist Versus Specialist Occupational Therapists

The discussion as to whether occupational therapists should be general practitioners or specialists or whether our profession should be composed of both has a long history. Dunton (1952) stated:

Having developed special ability in imparting a knowledge of one craft and its curative value [occupational therapists] are limited by the director to practice in the metal shop or wood shop or loom room because they are specialists in that craft. (p. 215)

He goes on to state, “The writer has been of the opinion for a long time that training of occupational therapists should permit shorter courses of training with more emphasis on specialties for which pupils seem best adapted” (p. 215). Welles (1958) stated:

In the last half century organized knowledge has moved forward so rapidly that it is no longer possible for one individual to be fully competent in even one branch of it [i.e., occupational therapy]. There is widespread feeling that our present practice is no longer adequate. (p. 289)

A review of our literature indicates that the following positions have been taken and concerns expressed about whether occupational therapists should be trained and practice as specialists, and, if so, whether this means that we move from a bachelor’s degree to a master’s degree entry-level requirement.

Positions
• A holistic treatment approach is the historical foundation of our profession. Specialization will eliminate this approach and in so doing, change the purpose and focus of our profession.
• To assure the highest quality of care, we must become specialists.
• We treat a wide array of impairments across the entire age spectrum. Knowledge and skills specific to the individual populations we serve are required to appropriately serve them. It is impossible for one person to gain much knowledge and skills for all conditions and ages.
• Specialization is inherent in the development of any profession, and it should occur in ours as it has in others. However, a number of prerequisite professional development steps must occur: (a) We must develop a unifying purpose and philosophy; (b) we must establish occupational therapy as a specialty in health care before we create areas of specialty practice; (c) we must define what constitutes our fundamental knowledge and skills; (d) we must develop a basic educational curriculum that teaches our fundamental knowledge and skills; and (e) we must apply this curriculum in all training programs.

Concerns
• We are not able to meet the demands for our services. The training of specialists will slow down the entry of therapists into the workforce and may even reduce the overall number of therapists. If we are unable to meet the needs, another discipline will.
• Specialists will most likely practice in urban areas. This will further exacerbate the existing difficulty in serving the needs of rural areas. If we cannot meet these needs, another discipline will.
• Specialization will eliminate our career mobility.
• Specialization will change our entry-level degree requirement from a bachelor’s degree to a master’s degree and will thereby reduce the number of persons entering the field. It will reduce employability because we will be too expensive.
• It will cost too much to become a specialist. Cost will increase if a master’s degree is required. If specialization is to be obtained through education, there will be increased training, travel, and lodging costs.
• Continuing education will be more available in urban areas, and as a
consequence, there will be a bias toward developing specialists only in those areas.

The concept of specialization is not new. Literature in the American Journal of Occupational Therapy has, for many years, reflected specialized areas of practice.

More than 20 years ago, a group of hand therapists got together informally while attending a meeting for the American Society for Surgery of the Hand (ASSH). They had a common interest in hand rehabilitation and a desire to form a recognized professional organization that would complement ASSH. With encouragement and support from orthopedic surgeons, this initial interest eventually led to the formation of the American Society of Hand Therapists in 1977.

In the 1970s, as part of a plan to increase organizational responsiveness to member needs and interests, the American Occupational Therapy Association’s (AOTA’s) Commission on Practice established a task force to make recommendations regarding the development of specialty sections. In 1976, after a period of discussion, the Executive Board adopted a revised bylaw that provided for the establishment of specialty sections. In that same year, the Delegate Assembly adopted resolutions for the following five specialty sections to be established in 1977: mental health, developmental disabilities, physical disabilities, gerontology, and sensory integration.

The traditional evaluation and treatment focus of occupational therapy has been on disability reduction. Occupational therapy’s focus on functional skills distinguishes us from other disciplines. However, where specialization has occurred, it has not been in relationship to the disability consequences of impairments, but rather in relation to impairment categories (e.g., hand, sensory integration, neurologic impairments, orthopedics, psychiatric), age (pediatrics vs. adults), and place of practice (e.g., hospitals, schools, private practice). In certain instances, specialization has occurred out of personal interest and choice (i.e., a preference to treat children in a school setting vs. a hospital environment, an interest in evaluation and treatment approaches unique to psychiatric impairments vs. neurologic impairments). In other instances, the movement toward specialization was created by external forces. For example, in medical rehabilitation facilities, patients are now managed within the framework of diagnostic groupings from both the service delivery and payment perspectives. Concurrently, staffing patterns changed. Occupational therapists are assigned to specific programs that provide services to a specific diagnostic group. Under these conditions, it was natural for therapists to develop specialized knowledge and skills simply by working with a circumscribed population. It is also natural for them to seek formal continuing education to increase their level of competency.

External Trends Related to the Issue

- Pressure for increased use of assistants (which is mirrored from within AOTA)
- A push from health care policy for multiskilled therapists
- Facility-based cross training
- Patient-focused care (one person responsible for multiple areas of patient care that previously were carried out by specialists)
- A shift to hands-on service provided by unlicensed or uncertified personnel who are supervised by licensed or certified therapists

Current Status of the Issue

Currently, the issue of generalist versus specialist is probably moot. Occupational therapy specialists are already real, which will continue unless there is a change in the health care delivery system that causes a change in our pattern of practice. Today, the issue is not simply defining advanced practice (i.e., a specialist), generalist versus specialist, or bachelor’s degree versus master’s degree. We must define who and what a specialist is as well as clarify how the knowledge and skills of the specialist, generalist, and certified occupational therapy assistant interact both with each other and with the wider system within which they practice. There is the need to differentiate professional work carried out by each type of therapist with respect to both range and depth. Within this context, specialists could be considered to be persons who possess a deeper understanding of

- Impairment conditions and their effect on performance
- Particular arenas of practice and the sociopolitical dynamics particular to an arena
- A particular aspect of the profession (i.e., clinical practice, management skills)

We all hold a perception and belief as to what deeper understanding means. Our task now is to develop a consensus around an objective, operational definition of this phrase. It is a good beginning point because we all have observed it in action in clinical practice. Now, we need to give size, shape, and texture to this understanding and to what it means in relation to identifying the distinguishing characteristics of the generalist and certified occupational therapy assistant.

Proposed Action Plan

A paradigm shift is required. To move forward, we must evaluate this issue from the perspective of the service delivery model that is required for practice within the broader health care delivery system. We must shift our perception, thinking, and discussion from an education and training perspective to that of a service delivery point of view. By differentiating our work, we will lay the groundwork to address the type, level, and amount of education and training required for our various types of work.

Proposed Action Steps

1. Define generalist, specialist, and assistant in relationship to their scope of work.
2. Define the product of their work.
3. Identify the process (i.e., categories
of work tasks) required to produce their product.
4. Establish the clinical competencies required for each category of work tasks.
5. Establish specialist, generalist, and assistant clinical utilization guidelines.

Define Generalist, Specialist, and Assistant

At a minimum, the following questions should be addressed:

1. Is a generalist one who is capable of evaluating and treating all impairment groups and all ages?

Or

2. Is a generalist one who is capable of evaluating and treating all impairment groups within certain age groups?

Or

3. Is a generalist one who is capable of evaluating and treating all conditions within an impairment group (e.g., neurology, orthopedics, psychiatry) and all ages within that group?

Or

4. Is a generalist one who is capable of evaluating and treating all conditions within an impairment group and within certain age groups?

5. Is a specialist one who specializes in all conditions within an impairment grouping (e.g., neurology specialist, orthopedics specialist, psychiatric specialist)?

6. Is a specialist one who specializes in a specific impairment group (e.g., neurology specialist, orthopedics specialist, psychiatric specialist)?

7. Is a specialist one who specializes in a certain age group within an impairment group (e.g., pediatric specialist, neurology specialist, adult orthopedics specialist)?

8. Is a specialist one who specializes in a particular impairment within an impairment group (e.g., hand specialist, stroke specialist, sensory integration specialist)?

These same questions must also be posed in relation to the certified occupational therapy assistant, recognizing that he or she does not evaluate.

Define the Product

Historically, we have confused our treatment approaches with our product. For example, we have taken the position that we provide a holistic approach to the treatment, or we say that we provide sensorimotor integration therapy. Thus, when asked what we do (i.e., What do we produce?), we often respond, “We provide a holistic treatment approach” or “We provide sensorimotor integration therapy.” In this way, we confuse product with process. The holistic approach and sensorimotor integration therapy is our service delivery process, not a product. The product is the outcome the consumer can expect from participating in our process.

What is our product? What do we produce for patients regardless of their diagnostic category? For example, medicine produces physical health; physical therapists produce products such as mobility and endurance; speech-language pathologists produce improved ability to communicate and think; and psychologists produce emotional health.

What do we produce? What is the outcome of our therapy process that is not directly produced by another discipline? Do we have types of products—a product that is the same across all impairment groupings and different products for each impairment grouping?

Identify the Process

• What are the generic work tasks carried out by the generalist, specialist, and assistant regardless of impairment grouping or group?

• What are the generic work tasks carried out by the generalist and assistant regardless of impairment grouping or group?

• What are the work tasks carried out by the generalist, specialist, and assistant that are unique to each impairment grouping?

• What work tasks can only be carried out by a specialist?

• What work tasks should only be carried out by an assistant?

To discuss these questions, the National Commission on Medical Rehabilitation and Research (NCMRR, 1992) may be a useful framework:

• Pathophysiology: The impairment grouping or group

• Impairment: The loss or abnormality of cognitive, physical, emotional, physiological, or anatomical structure or function

• Functional limitation: Any restriction or lack of ability to perform an action

• Disability: An inability or limitation in performing tasks, activities, and roles

• Societal limitations: Restrictions caused by structural or attitudinal barriers that limit fulfillment of roles or deny access to services and opportunities

Given a particular grouping or group, what work tasks are required for each of these levels of rehabilitation or habilitation, and who is the most appropriate person to carry them out?

Establish Clinical Competencies

Most of the information related to these questions already exists. Therefore, as such, the task here may be to agree on the appropriate allocation of work tasks. That which would be considered the advanced competencies for various work tasks may require further discussion within the specialty sections. For example, both the specialist and the generalist would perform patient evaluations. Will the specialist have a higher evaluation skill level than the generalist, or will the specialist possess certain evaluation skills for a specific impairment grouping or group that the generalist does not have? Both the generalist and the assistant might be assigned some similar work tasks. Would the generalist possess a
higher skill level than the assistant in carrying out these tasks and turning treatment over to the assistant when the higher skill level is no longer required to assure a quality outcome, but the skills of the assistant are required to assure a quality outcome? Again, the NCMRR model could be used as a framework within which to discuss these questions.

Establish Utilization Guidelines
As discussed earlier, the use of these three types of personnel is not an either-or question, but rather a question of when? The service delivery model within which all three types of personnel function must be based on a design that fits within the constraints of today’s health care delivery system. To this end, our service delivery model must address the following questions:

- Will a specialist be required for all impairment groupings?
- Will a specialist be required for each impairment group within an impairment grouping?
- Under what conditions or at what point will the knowledge, skills, and judgment of a specialist be required?
- Under what conditions or at what point will the knowledge, skills, and judgment of a generalist be required?
- Under what conditions or at what point will the knowledge, skills, and judgment of an assistant be required?
- What is the least expensive way of delivering these services relative to clinical criteria for their use and distribution across time?

Summary
The issue is not generalist versus specialist, bachelor’s degree versus master’s degree, or even registered occupational therapist versus certified occupational therapy assistant. The issue is: What is each professional’s product? What is the process by which each produces it? What knowledge, skills, and judgment do each need to competently produce the product? And, under what circumstances and conditions and at what point are each required to assure a quality product? The delineation of the requisite knowledge and skills as well as the delineation of generalist and specialist will flow from the answer to these questions.

References