Farewell Presidential Address, 2007

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’s 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
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 Therapy in 1921 and later published in Volume 1, Issue 1 (1922) of the Archives of Occupational Therapy, say that “our [profession’s] concept of man is that of an organism that maintains and balances itself in the world of reality and actuality by being in active life and active use” (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 propositions 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, occupational therapy supports a view of the whole person in function 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 cognitive 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 sustenance 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 delivery has taken hold only in the past decade. In its 1993 report to the U.S. Congress, the National Center for Medical Rehabilitation Research at the National Institutes of Health introduced the possibility that social limitation due to societal policy, attitudes, and actions, or lack thereof, creates physical, social, or financial barriers to access health care, housing, and vocational/avocational opportunities. The Institute of Medicine later developed the report Enabling America (Brandt & Pope, 1997), which introduced the enabling–disabling process 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 encompasses 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, educational, 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 responsibility 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 evidence 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 recognize 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...
our educational programs to incorporate but move beyond our standards (which are minimal standards) and design educational experiences for our students that prepare them for the changing health system and the emerging needs of society. Only with this approach can the student be a resource to the economy.

What should the nature and scope of our practice be? Is it based on scientific knowledge? Are we relating to other professionals in the health care workforce with whom we could effectively partner to provide better services to our clients? These are questions that must be asked and answered as our role, as well as the role of all health professionals, is evolving in the new millennium.

This year, the AOTA Board of Directors did something it has not done before: We asked clinicians, educators, and scientists to join hands and explore some of the important questions that will help us all understand what we can do to achieve our potential.

Dr. Penelope Moyers, our incoming AOTA president, and I asked members of six teams serving our practice areas (Children and Youth; Productive Aging; Mental Health; Health and Wellness; Work and Industry; and Rehabilitation, Disability, and Participation) to address the following questions:

- Which external partners will ensure that clients have access to occupational therapy services?
- What critical educational issues support occupational therapy practice (e.g., foundational knowledge, specific occupational therapy knowledge, practice skills)?
- What occupational therapy issues should be addressed in acute care, rehabilitation, schools and organizations, and communities?
- What occupational therapy outcomes relate to participation? How do they relate to the outcomes valued by consumers? How do they relate to the outcomes valued by payers?
- What research is needed to inform occupational therapy practice?

Each team has answered these questions in a positive, forward-looking way that lays out the actions that can and must be taken to put the occupational therapy profession in the position I know we all want it to achieve. They have given us strategies that can be carried out by AOTA and its partners, our state associations, and our educational programs, and many that can be done by each of us in our daily lives as practitioners, educators, and scientists.

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 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 Dr. Reilly to see what she would want to say to us today, 46

What We Need to Do

Not all of us aspire to public recognition; we entered the occupational therapy field because we wanted to make a difference in people’s lives. There are many ways that we can do that. Society is facing a large population of elderly people who want to remain independent as they age, more and more children with special needs, many workers who have been injured, and even more older workers who want to stay active and productive. There are more than 50 million people with disabilities and millions of individuals with persistent mental illness—all who want quality in their lives and the opportunity to participate in their families, communities, and society. We each have the knowledge and skills to make a difference in their lives.

Everyone you will serve is counting on you to help them do what they want and need to do. Helping others achieve their goals is the greatest contribution you can make.

As I look out at you today I see colleagues who are leaders in pediatrics. You provide culturally competent services for infants at risk, provide children with experiences to foster their development, and build better models of practice in the schools and in our health systems. I see consultants who are building new systems of care that will preserve worker roles for adults and provide opportunities for older adults to age in place. I see practitioners who are contributing evidence to the field and scientists who are generating knowledge that provides strategies to improve people’s lives.

Some of you are doing very innovative programs that introduce technology, recreation, and fitness to your clients and to communities. Some of you are being recognized for removing barriers that limit community participation. I see all of you with successful lives making contributions to your families, your communities, and your profession.

Every day, thousands of people benefit from the services that you provide, thousands of students have the opportunity to learn what is known to be effective, and hundreds of participants are engaged in our research to contribute knowledge that will improve the human condition. As you make these contributions, you are doing your part to achieve what our founders had in mind when they gathered in Clifton Springs, New York, on that March day in 1917. The common thread that connected them was that each believed in the power of human occupation to influence health. This is the same thread that connects us today and will help us achieve what we know society is asking from us.

Each of you will be given a template [at the meeting] that you can use to work out a plan for what you hope to accomplish by 2017. Consider your goals in stages, identify mentors who can help you identify additional schooling or training that you will need, and think about what kind of a position you need to consider to get there. Also identify the enablers that will help you achieve your goal and the barriers that will need to be overcome. This is a very important process, because we must be able to imagine possibilities if we are to create them. The future is constructed by people who know what they want to do and then roll up their sleeves to do it.
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


New Resource From AOTA Press

Culture and Occupation
A Model of Empowerment in Occupational Therapy

By Roxie M. Black, PhD, OTR/L, FAOTA, and Shirley A. Wells, MPH, OTR, FAOTA

This follow-up to the best-seller Cultural Competency for Health Professionals emphasizes the role that culture and cultural competence play in occupational therapy. The Cultural Competency Model introduced in this book helps practitioners, educators, researchers, and students develop self-awareness and the concept of power, attain cultural knowledge, and improve cross-cultural skills. Two chapters detail the use of this model in working with an ethnic population and community, and evidence is featured throughout the discussion.

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