We Cannot Hang Our Hat on Occupation Alone

The Guide to Occupational Therapy Practice by Moyers (AJOT, 53[3], 247–322) is an attempt to define the general scope of occupational therapy for practitioners, health care professionals, teachers, reimbursement organizations, and policymakers. The document, however, raises a major concern about what truly is our profession’s scope of practice. There is an overriding emphasis placed on occupations throughout the document that seriously limits our profession’s domain of concern, body of knowledge, and tools for practice.

Though occupation is a cornerstone of our practice, there are many other aspects of our profession that were not clearly identified in the document. Narrowing the scope of practice to occupations alone may have a significant impact on the way in which outside audiences understand, interpret, and pay for our services.

First, occupations is the label predominantly used to identify and describe many different concepts throughout the document. Outside of occupations, other key concepts such as performance areas, performance components, and therapeutic activities are not adequately identified or defined. In general, the conceptual level and the essential characteristics of each concept are not identified, which makes it difficult to distinguish between concepts. Additionally, concept labels are, at times, used interchangeably, making it difficult to determine the full meaning of each concept in different contexts. For example, occupations are defined as the everyday things that people do. Occupations are also identified as being a part of a performance area. And still, occupations are used synonymously with therapeutic activities, indicating their potential use as a tool of practice. By not clearly identifying and defining key concepts critical to occupational therapy, the document sends the message that the scope of practice is limited primarily to occupations.

“Occupations,” in the areas of activities of daily living, work, and leisure, are emphasized as the profession’s domain of concern. The document does not adequately identify or define performance areas or performance components (American Occupational Therapy Association [AOTA], 1994) as areas of human experience with which occupational therapists have expertise and offer assistance. By narrowing the profession’s domain of concern to occupations alone, the profession runs the risk of losing key areas of expertise in practice and gives other professions the opportunity to take on traditional areas of our domain of concern as their own.

In addition, the document does not clearly describe the process of problem identification. According to the document, the primary mode of evaluation is that of a person’s occupations and occupational performance through interview and observation. There is little mention of the way in which an occupational therapist assesses abilities in one of the performance areas (AOTA, 1994) or the way in which an occupational therapist assesses the performance components (AOTA, 1994) or environmental influences that may affect a person’s performance. The document merely states that an occupational therapist develops “hypotheses” (p. 265) about the person’s performance in any of these areas. It is not clear from the document how an occupational therapist develops these hypotheses. By not clearly identifying ways in which an occupational therapist assesses a person’s abilities and limitations, and by focusing primarily on occupations in the problem identification phase of treatment, specialized areas of evaluation seem to be nonexistent. In turn, outside audiences, such as reimbursement organizations, may not recognize our skills in assessing areas other than occupations and, thus, may stop reimbursement for such services.

According to the document, the practice of occupational therapy is based on nine principles of occupations. There is no mention of the frames of reference that have been developed and are used by occupational therapists to identify and remediate problems. Many of our frames of reference are based not on the principles of occupation, but on biological and behavioral sciences such as neurology, physiology, psychology, and sociology (Levy, 1993b). For example, an occupational therapist working with a person with a physical illness or injury may use a biomechanical frame of reference (Dutton, 1993a), which is based on the principles of increasing joint range of motion, strength, and endurance, to assist in problem identification and remediation. Additionally, an occupational therapist working with children may use the sensory integration (Simon, 1993) or neurodevelopmental (Dutton, 1993b) frames of reference, which focus on underlying neurological and sensorimotor issues. Further, an occupational therapist working with a person with a mental illness may use a behavioral frame of reference (Levy, 1993a), which focuses on learning new, or adaptive, behaviors that promote independence for the person. By not mentioning the frames of reference used in occupational therapy, key areas of our expertise are eliminated. As a result, outside audiences, such as our referral mechanisms, may not recognize interventions that are based on frames of reference, other than the nine principles of occupations, as being part of our repertoire and may begin referring traditional occupational therapy clients elsewhere.

Finally, the document seriously narrows the scope of practice by limiting the tools of practice to the use of occupations. Outside of the use of occupations, there is little or no mention of tools of practice, such as therapeutic use of self, activity groups, assistive technology, and physical agents, all of which are a part of occupational therapy (Mosey, 1996). By limiting the tools of practice to the use of occupations, the value and use of other tools may be lost. Additionally, outside audiences may have difficulty viewing the use of such tools as a part of our practice.
tice of occupational therapy. By not emphasizing other aspects of our practice, the profession runs the risk of losing key areas of expertise, losing referrals, and losing reimbursement for services, which poses a great concern to the future of occupational therapy as we now know it.

References

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Author’s Response
As the author of The Guide to Occupational Therapy Practice (AJOT, 53, 247–322), I am excited by the opportunity to begin a much-needed dialogue. Because this practice guide outlines the scope of practice for occupational therapy, we should consider this document to be a work in progress, one that must reflect the latest thinking, practice innovations, and research developments. In recognizing the importance of further refining the guide, the American Occupational Therapy Association (AOTA) Executive Board passed a motion (EB Charge 1/99) to form an evidenced-based panel for the purpose of reviewing and evaluating research that supports or refutes claims made in the document so that it may be revised accordingly. I highly encourage those with concerns and suggestions to become involved in the ongoing revision process.

I would like to respond to Pelczarski’s concern that the guide is overly focused on occupations to the extent that there is danger in narrowing our scope of practice. In my view, the guide actually broadens our previously narrowed scope by its description of the role of occupational therapy in disability prevention and health promotion. The guide discusses population-based services, thereby supporting occupational therapy practitioners in their work as consultants to organizations or communities in helping groups of people resolve problems of living. Additionally, the guide expands outcomes of intervention from a limiting focus on function to life satisfaction, wellbeing, and quality of life related to role performance. The definition of function has been overly restricted by insurance programs and by the disease emphasis of the medical model. In the past, enhanced function has been synonymous with improvements only in performance components or in activities of daily living performance to the exclusion of achieving comparable goals in the areas of leisure or work and other productive activities.

In my role as a consultant to a health insurance company, I am constantly challenged to justify why occupational therapy practitioners are addressing goals other than those considered to be typical of “medical occupational therapy” (i.e., range of motion, strength, coordination). Even many performance components are excluded from this definition of occupational therapy, such as cognitive and psychological components. It is time to educate third-party payers regarding the importance of occupational therapy tackling not only the broader questions of health and disability prevention, but also the importance of formulating holistic interventions that address psychosocial impairments existing in concert with other sensorimotor impairments. The guide provides consultants like me with the information necessary to support decisions regarding the appropriateness of occupational therapy services received by insurance beneficiaries. If we allow insurance programs to dictate our services, it is only natural that these services will shrink due to the current cost-cutting emphasis in today’s health care system. Therefore, reliance on third-party payment and government sanctioning of the value of occupational therapy is no longer a viable way to ensure that our services are used by those in need of improving their occupational performance.

Additionally, as a practitioner who works with clients needing rehabilitation for upper-extremity conditions, I have long been frustrated by the overemphasis on such performance components as range of motion, strength, coordination, and so forth. The clients with whom I worked improved in these components as the result of my intervention, but often these gains were short-lived unless the client was also helped to make life design changes. These changes in lifestyle address such problems as the client’s susceptibility to reinjury or tendency when in pain to withdraw from valued occupations instead of reinventing them to correspond with activity limitations. Occupational therapy practitioners can assist clients in overcoming difficulty in sustaining employment because of poor task or task object design and improper environmental support for developing less harmful methods of completing job functions. The important question is how should occupational therapy practitioners work with corporations to prevent these damaging effects of cumulative trauma from occurring in the first place?

As can be seen by my ergonomics example, this focus on occupations does not denigrate our knowledge of the underlying factors that contribute to or inhibit occupational performance. Our strength is the ability to analyze occupations according to the skills and performance components required within a specific environmental setting. This means that we select a variety of therapeutic methods, including enabling activities, sensorimotor techniques, graded exercises, physical agent modalities, or manual techniques because of the potential to improve the performance components and thereby enhance occupational performance. The guide clearly states, however, that although occupational therapy practitioners may use these techniques, the ultimate goal is occupational performance. This goal necessitates that the client practice occupations in relevant