environments in order to ensure that strength, for example, can be sustained throughout the 8-hour day for the job tasks assigned. The guide, thus, is intended to convey a balanced view in terms of our knowledge of occupations and their therapeutic use, methods of improving performance components, and ways in which modifications are made to tasks, objects, and environments when progress in performance components is limited. Procedural language is provided in the guide that enables occupational therapy practitioners to communicate strategies.

I do agree, however, with some of the points Pelczarski raises, especially with regard to the language issues. Because the guide is based on the third edition of the Uniform Terminology for Occupational Therapy (AOTA, 1994), it is difficult to incorporate more recent terms, such as occupations and occupational performance. As a profession, we have not determined or agreed on a usable hierarchy for the relationship among the terms occupations, tasks, and activities. I indicated that occupations are classified into performance areas. I also implied that occupations are broken down into tasks and activities. This was not made clearer in the guide, as I did not think one author, although operating from diverse input, should make these taxonomic decisions for the entire profession. In fact, the Commission on Practice (COP) has begun the arduous task of revising Uniform Terminology for these reasons. Further questions are being raised regarding how our language should interface with the revisions currently under way to the World Health Organization’s (1997) International Classification of Impairments, Disabilities, and Handicaps (ICIDH-2). The guide did illustrate how Uniform Terminology relates to the ICIDH-2 language of impairments, activity limitations, and participation restrictions. Many believe that the ICIDH-2 language can be used to articulate the role of occupational therapy as being primarily to enhance participation in social roles through maximizing occupational performance and the environmental support needed for this performance. Postponing the publication of the guide in anticipation of these discussions about our language was not possible because of the importance of communicating our scope immediately and as clearly as possible to external audiences. Again, I would encourage those with specific suggestions about our language to participate with the COP in its examination of the term occupation and its fit with Uniform Terminology.

I would like to remind all readers that The Guide to Occupational Therapy Practice was meant to communicate the scope of practice to primarily external audiences. The guide was never planned to be all inclusive of every aspect of our practice. Practice guidelines by their very nature are not intended to be a “cookbook” approach and in fact are designed to offer flexibility related to the unique situation of the client and the professional judgment of the occupational therapist. More detail focusing on interventions for persons with specific conditions is provided in the other AOTA practice guidelines. Conscious decisions were made regarding what could not be included in the guide because of the importance of describing our practice in a way that persons outside of the field could understand.

Consequently, terms such as frames of reference were deliberately excluded. I disagree that this exclusion leads one to conclude that occupational therapy practitioners choose their interventions without the use of sound clinical reasoning. Clinical reasoning tools of task and activity analyses are described in the guide along with our use of evidenced-based practice. In a similar vein, it was not possible to list all the evaluation instruments used by occupational therapists. Instead, the general types of tools (e.g., interviews, standardized and nonstandardized tests), were listed along with the type of data typically obtained (e.g., abilities and limitations in occupational performance). The list included all types of tools without placing undue emphasis on interviews and observations as claimed by Pelczarski. Further, Pelczarski’s assertion that the only way evaluation was described was through the statement that occupational therapists develop hypotheses about the way in which performance components contribute to occupational performance is in error.

I thank Pelczarski for her comments and for her willingness to raise issues that must be addressed before a revision of the guide. The current guide was certainly a first attempt to tackle the monumental task of describing our scope of practice to outside audiences. This charge was undertaken originally with the idea that such a document could be based on previous work of the COP and other AOTA bodies. This was not entirely feasible because of the transitions currently under way within our field. In many instances, the guide was a journey into uncharted territory and, thus, now requires broad review, critique, and systematic evaluation in terms of the impact on practice. The field of occupational therapy and its consumers benefit from this collaborative effort to improve how we communicate what we do to external audiences.

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References

Case Management Practice
I found Helene Lohman’s essay on case management as a career alternative for occupational therapy practitioners (AJOT, January/February 1999, 111–113) to be a good addition to the slowly increasing literature on the subject. I thought that her suggestion that the American Occupational Therapy Association (AOTA) publish a list of practitioners practicing as case managers who are willing to mentor other practitioners is an excellent one. Whether or how AOTA takes her up on her suggestion, a network already exists for occupational therapy practitioners practicing, or interested in practicing, as case managers. I founded it in late 1997: Membership is currently free and has been growing slowly, but recently, it has picked up speed with the Balance Budget Act axes falling throughout the country. AOTA membership is not required for network membership; there are members from the United States, Canada, Australia, Sweden, and South Africa who provide a broader perspective of what occupational therapy case management (OTCM) practice is or can be.
All members receive a copy of the membership list to establish independent communication, networking, and mentoring relationships as they choose. Members also receive an occasional newsletter.

Any occupational therapy practitioner interested in joining the OTCM Network can do so by completing a questionnaire and returning it to me, preferably by e-mail (i.e., to help keep membership free). The membership questionnaire is on http://members.xoom.com/vlink/memform.htm or available from me at PO Box 356, Prior Lake, Minnesota 55372-0356, 612-440-6846 (fax), or vitlink@tc.umn.edu. Any efforts AOTA puts forth in increasing the ability for interested occupational therapy practitioners to communicate with each other would be a welcome addition to the existing OTCM Network.

I would like to mention a serious concern I have about the issue of occupational therapy practitioners as case managers: AOTA’s Commission on Practice (COP) considers case management to be a role rather than an area of practice. Because of this position, the COP rescinded, rather than updated, the 1991 Statement, The Occupational Therapist as Case Manager, which was cited by Lohman. The COP’s position (or decision) is in direct contradiction of a case manager–certifying body’s philosophy of case management, which states: “Case Management is not a profession in itself, but an area of practice within one’s own profession” (Certification of Insurance Rehabilitation Specialist Commission, 1992)

As long as AOTA does not include any official statements about the legitimacy of occupational therapy practitioners among the ranks of case managers, individual practitioners will be left unaided in the challenges to overcome the nursing profession’s supremacy in case management, as alluded to by Lohman. Further, as long as AOTA maintains its position of benign neglect, there will be few, if any, opportunities for occupational therapy case managers to find continuing education and professional development within occupational therapy frames of reference that are also relevant to their case management practices. Being forced by institutional silence to seek professional development from other disciplines will only separate occupational therapy case managers from their occupational therapy identities, isolate them from occupational therapy peer communication (and mentoring opportunities), and rob AOTA of valuable resources for improving the future of occupational therapy practice in the United States.

With our profession past the cusp of radical changes in how we can enable occupations and enhance quality of life, the “official” leadership of our profession that is embodied in AOTA cannot, and should not, dismiss practice options that do not fit the models of occupational therapy practice “known” to date, especially when a core principle of our profession is adaptation to change. One of the many things that sets occupational therapy apart from other disciplines is the fact that occupation and the challenges of achieving satisfying occupational performance are infused in all aspects of human life, not just the lives embroiled in the “medical model” of professional human services. By the very nature of our profession, we have what I consider to be the most flexible career anyone could have: There is a nearly infinite variety of “job” options for practitioners who can think in terms of core occupational therapy philosophies and principles.

A thorough analysis of a published standards of practice for case managers (one is available from the Case Management Society of America, 8201 Cantrell, Suite 230, Little Rock, Arkansas 72227-2448, 501-225-2229, 501-221-9068 [fax]; cmas@csma.org; www.cmsa.org) should make it clear how an occupational therapy practitioner practicing as a case manager can, indeed, still be practicing occupational therapy, as long as the reader has not lost touch with what occupation is and the many ways occupation can be enabled. As a profession, we cannot afford to label something “not occupational therapy practice” just because some “leaders” do not have the same visions for our collective future as other visionary occupational therapy practitioners do.

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References


AOTA’s Response
I would like to begin by setting the record straight in reference to the 1991 Statement, The Occupational Therapist as Case Manager. This document was not rescinded by the 1998 Representative Assembly. The action item from the Commission on Practice (COP) report recommending rescission was withdrawn from the agenda, and the Statement remains as an active document.

Initially, the COP’s recommendation to rescind the Statement was based on the idea that although occupational therapy training, education, and experience help to prepare one to assume case manager roles, case management is a role or competency that may be filled by many different professionals. The initial Statement was written to support and justify the ability of an occupational therapy practitioner to assume the case manager role—and to support our efforts to enter into this arena. Since that time, occupational therapy practitioners have established themselves as effective external case managers, and the COP believed that a Statement was no longer needed to support entry into this area. Future directions for this Statement are still under active consideration by the Commission. To continue to support the role of occupational therapy in case management, the COP has decided to include internal case management as a key performance area in the occupational therapist role outlined in the revision of the Occupational Therapy Roles document (AOTA, 1993) currently being reviewed.

The COP continues to discuss the best ways to address the issue of how to support the expansion of practice into new arenas. Occupational therapy’s holistic perspective and understanding of persons as occupational beings permits us to make unique and important contributions in a broad range of areas. Being clear about the difference in “practicing” occupational therapy (i.e., providing occupational therapy services to individu-