As I start my presidential address today, I want the AOTA [American Occupational Therapy Association]—which is you, the member—to hold your leadership to a high level of accountability. Last year I stated some goals. Today I want to highlight some of the accomplishments. I would like to attribute most of these accomplishments to our very, very talented staff. To begin, would all the National Office staff in attendance please stand and be recognized?

Report to the Members

You wanted us to promote greater public understanding of occupational therapy. We stepped up our media outreach to promote the profession’s public image. The staff is responding to over 20 media requests weekly, and the profession is being promoted in nationwide press conferences. I hope you have all noted the improved Web site and the related site, Promote OT.

We wanted to heighten the importance of occupational therapy with public and private sector policymakers. We hired a new staff member in reimbursement to increase our focus on working with local Medicare contractors and other state payers. The government relations staff increased visits to congressional offices. A special effort has been made to involve occupational therapy in the White House Conference on Aging, which will set the agenda for aging issues for the next decade. At least five occupational therapists have been chosen by governors or congressional representatives in their states to serve as elected and seated delegates at the conference, so we will be represented when future policies are being proposed. We hosted an officially designated World Health White House Conference on Aging event here at the AOTA Conference, which many of you attended. I was fortunate to attend a mini-conference in Washington to initiate policy for long-term care.

The AOTA has achieved a historical collaboration with the National Association of Home Care for our two organizations to work together to address regulatory issues around the broader use of occupational therapy by home health agencies.

The Occupational Therapy Organizational Partners (OTOP) was initiated. The American Occupational Therapy Foundation (AOTF), the National Board for Certification of Occupational Therapy (NBCOT), and the American Occupational Therapy Association are communicating regularly to address the issues of the profession and build for the future of the profession.

AOTA has agreed to work collaboratively with strategic partners and form coalitions on critical issues facing society. Many new collaborations have been formed that have a life span focus and will enhance our practice areas.

We wanted to recruit students to the profession. We have formed a very important relationship with the National Association of Advisors to the Health Professions, the group that steers students to medical and graduate schools. Last year several staff and I attended and presented at that meeting, and we are now being invited to be a part of their Advisory Council. Janice Burke
from Thomas Jefferson University will be serving in that role for us.

The staff has made a CD-ROM of student recruitment that will be made available to all programs for their recruitment activities. I want to announce that this has been cosponsored in part by NBCOT. Recruitment continues to be a major issue, as the Bureau of Labor Statistics projects employment to increase 21% to 35% for occupational therapists and 36% for occupational therapy assistants by 2010. We are going to have a labor shortage. In the past, when a manpower shortage occurred, others came in to fill the gaps, so we have to put a huge emphasis on recruitment. We sponsored a contest for OT and OTA programs to help us foster recruitment, and the winners of that contest will be announced at the business meeting.

You also have asked AOTA to promote the application of evidence-based knowledge in practice. We created a rich, evidence-based practice resource center on the Web. I hope you’ve seen it. If you haven’t, get to it, use it, and encourage all of your colleagues to use it.

AOTA and AOTF were also awarded a federal grant from Agency for Healthcare Research and Quality (AHRQ) to host an international evidence-based practice conference. Thirteen countries were represented, and a series of actions are forthcoming. Additionally, a new series of practice guidelines are being developed that will integrate evidence. Last year the Assembly requested a review of the evidence to support interventions with children, with special emphasis on problems associated with sensory integration and sensory processing.

We know we have to support you in these new initiatives, so AOTA is now conducting seven online workshops and three regional workshops covering issues of pediatrics, aging, and general practice.

We are also lobbying for congressional support of appropriations for Allied Health Training Grants for the preparation of both occupational therapy faculty and students. We are particularly targeting maternal and child health and school-based services. At the National Institutes of Health (NIH) we are working to establish more training monies for rehabilitation and occupational science.

I recently attended a rehabilitation summit where our colleague Ken Ottenbacher, from the University of Texas Medical Branch in Galveston, was one of the planners. As a result of this summit, we will be joining other rehabilitation professions and consumers to lobby for more money for training and research to meet the needs of those who will benefit from effective rehabilitation interventions. I have also been invited to participate in a meeting at the National Institutes of Health to make recommendations on how to recruit more scientists to the field of rehabilitation.

Building Our Future; Learning Lessons From the Past

As I prepared for my address, I asked the Association Fellows, the Roster of Honor recipients, and staff leadership from the AOTA and AOTF to share with me what they felt were the most important decisions that have shaped the profession. Many also shared their hopes for the future. I want to share their thoughts with you. The purpose of sharing these events is to remind us that being part of a profession requires that strategic decisions be made in order for change to occur that keeps the profession contemporary and meets the needs of society. These events and decisions have led to major successes for the profession. Other decisions, or lack of decisions, actually created barriers requiring actions that we were not able to take, resulting in consequences. I am going to visit these events to help us see how the profession is always facing challenges. I will also look forward to help each of us see what must be our focus in today’s environment that will secure our future as a profession and as a valuable service for people facing limitations that can be helped with our services.

What would we be doing if we had not changed with the needs of society? Figure 1 shows the reconstructive aides of the Division of General Hospital in 1918 with their basketry supplies, preparing to help soldiers who sustained injuries in World War I. They were brave women. They put their basketry supplies, preparing to help soldiers back to life and back to work. The newly developed professional association faced the challenge. Did we want to be vocational trainers or did we want to be occupational therapists? The leaders decided to position occupational therapy as a medical profession, working under physician prescription, and to establish occupational therapy services primarily within hospitals to disassociate themselves from vocational reeducation services. The leader felt that physician involvement would advance the prestige of the profession and also enhance the physicians’ knowledge of occupational therapy. They knew that medicine would protect occupational therapy from being subsumed by nonmedical specialists.

In 1935 our leaders approached the American Medical Association to build criteria that would bring consistency and quality to occupational therapy education. Medicine had just gone through a process of standards setting resulting from the Flexner Report. The quality of programs in our occupational therapy programs varied; some programs had 6 weeks of training, and there was not a core curriculum that would ensure consistency. I want you to know how forward thinking those leaders were, because occupational therapy was the first allied profession to establish standards. This effort was to become a very valuable strategy.

In 1944, after World War II, some major things happened, but first I want to take you to 1941 and the beginning of World War II. Eight qualified occupational therapists and four occupational therapy technicians were on duty in five Army hospitals. At the close of the war, their ranks had swelled to 899 occupational therapists and their assistants, working in 76 general convalescent regional and station hospitals in the United States. According to Wilma West, in 1944, the Army Surgeon General needed 1,000 occupational therapy personnel for civilian employment in the medical Department of the Army. This number was presented to the profession when there were only 1,300 occupational therapists in the
entire field. We were in demand. That created an interesting situation. At the same time as this huge demand, the medical specialty of physical medicine was developing and, after serving with the OTs in the war, the physicians in physical medicine saw our value. However, they wanted to bring occupational therapy under their control, not just to prescribe interventions, but to control our educational programs. Strong leaders—including Beatrice Wade, Winifred Kahmann, Helen Willard, and Henrietta McNary—worked diligently. Some of the records show they worked passionately with great difficulty over 3 years to assert the autonomy of the profession. The fact that they worked with the American Medical Association to set the standards for education in the field was central to warding off control by one medical group. This action preserved the right for occupational therapists to work with any group of physicians to address the needs of people with many different conditions that limited occupational performance, not restricting us to a medical model.

It is now the late 1940s and we are seeing medical advances. Occupational therapy had been known for its work with the mentally ill, war veterans, persons with tuberculosis, and general hospital work. Advances in medicine and societal changes were about to change our practice. Psychotropic drugs took mental health from being a problem of living to one that could be managed with drugs. This prompted deinstitutionalization that began in the late 1950s. The advances in managing infection and trauma led people to survive serious illnesses and injury, which required more focus to be placed on recovery and rehabilitation. All of you who are friends of the television show M*A*S*H know that immediate triage preserves lives. After the Korean War we saw the technology from war transferred to hospitals as they built trauma services. This meant that people with spinal cord injuries and head injuries were living because of good acute medical care, thus increasing the need for more occupational therapy.

In 1952 the World Federation of Occupational Therapists was constituted. Helen Willard and Clare Spackman took the leadership for the United States when 10 countries formed the organization. The World Federation of Occupational Therapy is the official international organization for the promotion of occupational therapists, and it serves to promote international cooperation among occupational therapy associations, therapists, and allied health professions. In addition to serving the immediate needs of communication of occupational therapy around the world, in 1959 the World Federation was admitted to official relations with the World Health Organization, and in 1963 it was recognized by the United Nations. Occupational therapy personnel are well represented in a much broader world.

From 1955 on, deinstitutionalization was fueled by public outcries about the deplorable conditions in mental institutions and the use of new classes of drugs. This concern led ultimately to the formation of the Joint Commission on Mental Illness and Health in 1955 and its recommendations for community alternatives to state hospitals.

Another significant federal development was passage of The Mental Retardation Facilities and Community Mental Health Centers Construction Act in 1965 to provide grants for the cost of staffing newly constructed centers. This legislation was a strong incentive to the development of community programs, with the potential to treat people whose main recourse previously had been state hospitals. It is important to note, however, that although rehabilitation services and pre-care and after-care services were among services available for funding, an agency did not have to offer them in order to qualify for funding.

Here’s where we made a mistake. We did not have the workforce to serve the needs of these developments, nor were we working locally to include occupational therapy services into these community mental health centers. We also did not have an advanced degree, so psychology, nursing, and social work became the primary mental health professions.

In 1958 the first Occupational Therapy Assistant Educational Programs were initiated, and their first classes graduated. The OT’s assistant, as a recognized provider, emerged to alleviate an acute shortage of occupational therapists in mental health. Eventually services were expanded to practice serving the growing population of those communities.
with disabilities who needed occupational therapy services. Occupational therapy assistants are playing, and will continue to play, a vital role in community health programs. As a profession we need to tend to the issues of the occupational therapy assistant. We need to explore how the OT assistant can partner in the future of occupational therapy. To help address this issue, I am going to establish an OTA Advisory Panel to advise the Board on policies that can be brought to the Representative Assembly with the aim of embracing the full potential of the occupational therapy assistant.

By now, it is 1961 and OTs are in great demand to deliver OT services, but we haven't been concentrating on building the future. Everyone remembers Mary Reilly because of her elegant hypothesis, “Man, through the use of his hands as they are energized by mind and will, can influence the state of his own health.” But she was also commenting on the times, that we were developing fast, without a focus on building knowledge to underpin our work. We were also working with physician prescription rather than generating our own approach to care. She felt that we should build to our uniqueness a profession dedicated to helping people be active. Dr. Reilly, a woman far ahead of her time, predicted 45 years ago what we are now required to do—focus our practice to meet the needs of society and show evidence for our practice.

Jean Ayres was our first well-known scientist. Her legacy is that if you recognize the problem and seek to understand and measure it, you can shape the direction of practice. She was another person who was ahead of her time. Her observations of children’s behavior led her to a life of science. Her work was just the beginning. When Medicare was enacted, occupational therapy coverage was limited to Part A, inpatient services. The first record of the discussion regarding the fate of occupational therapies amendment that would have allowed Part B outpatient coverage occurred in December 1974, but it would not have fully changed the limitations we continue to have in home health.

A report was discovered stating that the Senate Finance Committee is concerned that present law treats occupational therapy differently from physical or speech therapy. I asked the staff to research why we might have been treated differently from physical therapy. They found a paper that indicated that no state—Puerto Rico did, but no state—had licensure in 1971. The Association policy was also balanced about whether licensure was good or bad. We did not make a decision. It may be that the lack of licensure contributed to the failure to include occupational therapy as a qualifying service in the home health benefit. As you well know, we fought a long battle to get Part B services, and we still have work to do to get occupational therapy recognized as an independent service under home health. We are now 40 years past legislations that we didn’t prepare for.

What can we learn from this experience? We now have a substantial body of knowledge that contributes to our understanding of occupational performance. I know if she were alive today she would be very proud of the recognition of the need for children to have guided experience that fosters plasticity and contributes to the optimal occupational performance necessary for development.

The year 1964 was one of planning for medical coverage for the elderly. Actually, not many thought Medicare was going to happen, as a social system of care in Great Britain was very unappealing to many people. Occupational therapists were small in number. We did not have a lobbying presence in Washington, and the office was still in New York. National efforts had been focused on education and practice. In fact, we did not have a government affairs division or a lobbyist until the mid-1970s. When Medicare was enacted, occupational therapy coverage was limited to Part A, inpatient services. The first record of the discussion regarding the fate of occupational therapies amendment that would have allowed Part B outpatient coverage occurred in December 1974, but it would not have fully changed the limitations we continue to have in home health.

This year we join the celebration of the 40th anniversary of the American Occupational Therapy Foundation. The Foundation’s fellowship, scholarship, and research funding has built much of the infrastructure that underpins our profession. The Foundation was initiated because the leadership in our profession in the 1960s realized we needed to build the science that would create our future. Their efforts continue today and will get even stronger in the future. This past year the AOTA and the AOTF have reaffirmed a partnership that during the last decade had become strained. The partnership of practice, education, and science requires the leadership talent of both organizations.

Wilma West was the force behind the development of the Foundation. Wilma West was also a leader ahead of her time. If you read Wilma West’s writing from the late 1960s, you will see that she was pleading for occupational therapy to take its role in health promotion and community health. Luckily she was a strong woman and handpicked members and, I must say, I was blessed to be one of them. She was relentless in asking us to think of the relationship of occupation and health. She is smiling at us as occupational therapy is taking an important role in promoting health and participation by its work in the home, community, and workplace, where we can help people learn how to manage chronic or disabling conditions and where we are working to remove barriers for all Americans.

In the 1960s the attention devoted to exploring outer space also spawned assistive technology. Velcro®, pressure pads, and augmentative communication are just a few of the spin-offs of technology developed for
astronauts and space exploration. Occupational therapists have a crucial role in matching technology to people's needs, to foster participation in homes, school, work, and community environments.

Several of the Fellows told me how critical it was to have recognized Lela Llorens as a leader of the profession. She broke the color barrier when, in 1969, she delivered a groundbreaking Eleanor Clarke Slagle Lecture concerning developmental theory and adaptation over the life span. Gail Fidler was another leader ahead of her time. Gail Fidler was unrelenting in demanding that we use occupation as our intervention, since "doing" is at the center of mental and physical health. She was really the first in our profession to effectively use the phrase "use it or lose it," and we can all hear her saying that, can't we? This principle has been established and substantiated in physiological health for years, but only recently have we learned how critical "use it or lose it" is to stay active to preserve cognitive function and performance.

I thought it was telling that Gail Fidler told us those things in 1972, because she knew what was coming. In 1976 the first meeting of neuroscience was held with 1,500 people in attendance. The neuroscience conference today attracts 40,000 scientists. The explosion of knowledge in neuroscience has forced us to revise our educational standards and modify our practice. The new motor learning strategies incorporate the importance of activity, as does constraint-induced movement, and new cognitive theories require a performance-based approach to ensure individuals receive strategies to support their occupations in home, work, and community life. Just as we wouldn't want to go to a physician who was not practicing up-to-date medicine, our clients expect us to use new knowledge to enhance their opportunities for recovery or to use compensatory methods that allow them to live their lives. I recently heard an 81-year-old doctor say, "It is really an effort to stay current, but my approach is to treat my patients like I would like someone else to treat my mother. You find the time to keep up if you want to do your best for those that are counting on you."

It is now the mid-1970s, and the law requiring related services in the public schools is an important piece of legislation. It not only gives opportunities to children, but Public Law 94-142, later to be called IDEA [Individuals with Disabilities Education Act], also fueled jobs for nearly 30% of all of our occupational therapists and occupational therapy assistants. With the latest legislation, Congress is setting out to include language in IDEA about the need for teachers and other school personnel—which includes us—to be knowledgeable about and be able to use effective instructional practices supported by the research. Both of the laws surrounding this issue use the term scientifically based. This expectation is embedded throughout the statute and includes provisions related to early intervention services, development, revision of the IEP [individualized education programs] and family plan, and the professional development and research program.

Your Association has worked with Congress to get "to the extent practicable" inserted as a way of urging caution to schools, and we addressed it in our recent comments to the Department of Education in anticipation of the proposed regulations. We should interpret this as the writing on the wall. When federal legislation involves reimbursement for services, we will have to show the effectiveness of our interventions in order to have significant influence and perhaps even be included.

It is 1990 and the Americans with Disabilities Act (ADA) is signed by President George Bush. The Americans with Disabilities Act states its purpose as providing a clear and comprehensive national mandate for elimination of discrimination against individuals with disabilities. The ADA legislation guarantees persons with disability access to employment, public accommodations, transportation, public services, and telecommunications. I don't know about you, but I think this is the only law I can think of in the history of our country that doesn't have ramifications if it isn't obeyed. Think about it. Why are people fighting so hard for their rights? It is a law, but we don't have regulations that make it enforceable.

This piece of legislation, however, has given occupational therapists work, and as more and more older workers want to retain their positions, even more opportunities for occupational therapists will evolve. We have seen positions open up, not only at consultation level. In several cities (St. Louis and Denver), occupational therapists are running the transportation access centers to determine eligibility for accommodating transportation. The law has also brought occupational therapists closer to the disability community because we share their goals to fully participate in society.

An international effort, the World Health Organization, International Classification of Function (ICF), endorses the very concepts central to occupational performance and uses concepts and terminology in concert with our language and values. Our practice must go beyond impairments to address issues that are producing activity limitations and restrictions in social participation. Occupational therapists all over the world, but particularly Tora Dahl in Norway, Deb Stewart in Canada, and Susy Stark in the United States, have been central in the development of this model. You can see the work of occupational therapists in the ICF. This model also gives us a common context through which we can better communicate with our occupational therapy colleagues around the world. The ICF gives us words that we can all relate to.

Our Keynote speaker, Dr. Bill Rowley from the Institute of Alternative Futures, gave us some important information to begin to shape our thinking, and I want to call our attention to some of the issues that he told us will be central in the future thinking in health delivery. I do this because I believe occupational therapy is well on its way to having the values, attitudes, and skills to not only function in the future, but to help build it. I am not going to discuss all of his issues, but I want to discuss six of them.

First, he talked about the concept of prospective prevention. We all know how important prospective memory is, to be able to remember what we are going to do. Prospective prevention requires us to help people get the knowledge and skills to manage their health so they can retain their independence. I am not trying to represent all the approaches we use that focus on prospective prevention, but I could easily think of a few; and clearly this topic would provide the basis for useful discussion at
faculty or clinical inservices. What do we do that can be considered prospective prevention? I was thinking of children’s transitional skills in preparation for life and jobs, early identification of children needing services, use of technology, aging in place, lifestyle issues with chronic disease, work prevention, job modification. Now, for a minute, think with me where our profession would be ranked today if we were to grade our efforts in prospective prevention. We are gaining strength in this area; however, there are national priorities on issues such as obesity, mental health, and violence that require our attention.

Dr. Rowley also said that we would have cooperative teams of providers. I always find it interesting that policy leaders consider working as a team member a strategy. We have grown up as members of teams. I do, however, think our teams are changing. In traditional rehab, our team members are physicians, PTs [physical therapists], psychologists, nurses, and speech pathologists, among others. In the schools, our teams include teachers, administrators, and school staff in addition to our PT and speech colleagues. In industry, our team shifts to management, specialists, employee assistance managers, and supervisors. And in communities, we are teaming with contractors, architects, and engineers. Playing a much greater role are social workers and public health nurses as members of our team. So what about our position? I think for the most part we are really strong, and we know how to do it and we will work to do it.

Dr. Rowley also told us that there would be an emphasis on education and coaching. I want to ask a question, “What is the basis of occupational therapy intervention?” It is education and learning. People with whom we interact have to learn new skills; they must have new knowledge to manage their problems. What does the occupational therapist do? The OT is a coach, coaching clients to gain the knowledge and skills to accomplish the goals that are important and meaningful to them. The only reason I think we have work to do is that I am not sure that we are up-to-date on health education theories and learning strategy. I am hopeful that we will see much more emphasis on understanding the new cognitive approaches that support learning and strategies to support behavioral change in our basic professional and continuing education programs.

Another issue raised by Dr. Rowley is the role that client-centered care will play in the future of health care. Client-centered care is central to our practice. Our evolving model in the field emphasizes the importance of asking the client, or his or her family, to set goals; and it is central to the way we think about care. I think some of us believe in client-centered approaches. We talk about being client centered, and yet we still follow institutional protocols that organized care at the expense of accommodating the patient’s goals. This is where each of us has to be brave. We need to advocate for our clients so they get what they want and need to contribute to their goals and care. We must never allow our practices or our principles to be defined by policymakers or bureaucrats who are solely driven by balance sheets and reimbursement rules. We must be aware of the influence of those who know the cost of everything and the value of nothing. Client-centered care is something we can all bring to the forefront of our practice, asking our patients and their families what they want to achieve in their occupational therapy sessions. This is central to our philosophy. We must also ensure that the family is central to the client’s care, as they need the skills necessary to have successful experiences with their loved ones.

Dr. Rowley also told us that care is going to be customized to needs and values. I think this is where occupational therapy shines, but I am going to put a caveat on it. Even when the client’s needs and values are similar to those we understand, I feel that we still have an increasing need to understand the cultures and needs among professionals that are addressing disparities in health and understand the cultures of the individuals we serve.

Dr. Rowley says we are going to do a lot in community. We are making progress. Six percent of our members are in community-based programs. Previously this was 1%. We still need to serve institutional programs. I am not saying “out of the hospital, into the community.” We just need the manpower to have a continuum of care. We have to serve institutional programs, but we must increase our community presence in the next decade to a level that at least equals school-based programs. This has to come from new additions to our workforce and also recognizing that those working in the community can call themselves occupational therapists and occupational therapy assistants, even though they are not being employed as direct providers.

Now let’s talk about evidence. Everyone is asking for evidence—payers, policy leaders, school administrators. Of course it is good to know that what you are doing is effective. Some zealous bureaucrats and insurance companies, however, are asking for evidence so that lack of evidence can be used as an excuse to deny payment for services. We cannot jeopardize closing off access to our service to those who need it because we have neglected our need to validate our practice through research. I am going to ask you to begin struggling with a new paradigm for both practice and education. We need to communicate with our colleagues, to share knowledge, to choose measures that will record the effectiveness of what we do. At this meeting of the Representative Assembly, they’ve asked the Special Interest Sections to take an active role in shaping practice using evidence in their practice arenas. I am also going to ask the educators to ensure that what they teach is supported with evidence. We are confusing students by telling them that they need to use evidence in practice while simultaneously teaching approaches where available evidence suggests that treatment is not effective. We will never move to a position of strength until we adopt a culture of evidence in our practice and in our teaching. This is where we need many more scientists to help us advance practice. We all have observations and questions generated by experience. We need to integrate our clinical experience with values and goals of our patients. Nobody is saying evidence is the only thing to underpin our practice. We are making progress—OT Search, OT Seeker, and PubMed all give us access to clinical trials and evidence. We just need to go after it. This is one area we cannot ignore and we have deliberate work to do.

Everyone thinks that we don’t have much evidence. I want to tell you that we are not without evidence, particularly evidence
about the role that activity plays in health. There is evidence at the personal level, family level, community level, and the society level—evidence for children, adults, and older adults and how important occupation and activity are to their health. Some studies—an example is the historic well-elderly study conducted by our colleagues at USC [the University of Southern California]—provide a great source for the importance of engagement and activity for our elderly. There is evidence, however, in gerontology, neuroscience, physiology, policy, psychology, sociology, anthropology, and other areas that should give us the base to have confidence in the fact that we are using occupation to enhance the health and lives of the people we serve.

My wonderful students (14 of them) just finished their contemporary practice models. As clinical doctoral students, they had to build a practice model based on occupational performance and the ICF. They have contributed their reference lists on the evidence they found to support occupation-based practice. The reference list is an appendix to this paper (see Appendix A). Please review these articles and talk with your colleagues in your practice and educational sites.

Bill Rowley told us it was time to come out of obscurity and into demand. Society is requiring from us—just like Mary Reilly told us in 1961—society demands us to present a much sharper focus. What can the occupational therapist do? We can reduce disability and improve function. We play a huge role in prevention and well being. We can design systems for functionality [and] peace of mind, and bring meaning to people's lives through occupation, and we can be leaders in shifting services to foster balance, emotional growth, and fulfillment.

All health professions are facing challenges, terrible challenges. We are not in this by ourselves. Payers are squeezing costs. With less money, there is more competition. We are all competing because services are similar, and we absolutely must identify our uniqueness. Consumers are expecting—actually demanding—quality and want to know what they can expect. There is a huge need for a strong advocacy base, a scientific base of evidence, and the need for political influence. These are not new issues. This is why our professional organization is so very important. It speaks for the collective us. It is the body that shapes policy, defends our positions with insurers, and makes our contributions public. Right now there are over 120,000 occupational therapists and occupational therapy assistants in the United States alone. Only 34,000 are supporting the work of the profession as members of AOTA. Just imagine if our lobbyist went to the Hill and said they were representing 100,000 professionals in the field of occupational therapy. Strength is in numbers, and I am personally asking you to ask your colleagues to join in our efforts to move the profession forward. OTs and OTAs cannot define themselves as professionals and fail to exercise their responsibility to advocate for those they serve. Membership in AOTA represents that advocacy. Our best defense is our knowledge, our skills, and our approach. We have a body of knowledge, and we must use it.

Occupational performance is our unique contribution, and only when we look at how the person or client factors intersect with the environment to support what the individual wants and needs to do will we be effective in our intervention. There is a place for all of us, but only if we are enabling occupational performance, as the outcome of our service is participation and well-being. We make a unique contribution to health care; we need to make that contribution visible. The following case study is presented to highlight our uniqueness.

Gail is a 34-year-old single parent of two girls, ages 5 and 7. They are from Vietnam. She and the girls do not live near her family. She works for a company that manufactures parts for heavy machinery. She barely makes ends meet. Her hand injury on her dominant hand.

Physically, she has tissue and tendon damage. From a sensory perspective, she has pain and certainly sensory loss that will take a long time to recover. From a sensorimotor standpoint, she is having weakness in her trunk that makes her back ache. Psychologically, she saw her hand injury and is having nightmares and isn’t sleeping. Cognitively, she is under so much stress she almost had an accident driving to her appointment.

From an environment standpoint you are asking her to wear splints and have given her a buttonhook, but she needs more tools to stay independent. From a social policy standpoint, she doesn't think her case manager is very effective and does not fully understand the problems she is facing trying to manage the girls at home, and she needs instrumental help. Culturally, her family thinks she doesn't need all this treatment, and her church is thinking all she needs is God's help.

You know all this. You are addressing her goal to be able to take care of her girls and get back to work. You are considering all the issues and treatment. You are answering her questions, giving her skills to do what she needs to do, and you are working with the case manager to get her help at home. You are an occupational therapist. Your work is directed at her occupational performance needs. This is how you are different from other health professions. You consider the impairment, environment, and activities that are central to her life. Occupational therapy is complex. We need to be very proud that we have this approach. We stand alone as practitioners who bridge the structures of function with the reality of everyday life. We do, however, have to measure our outcomes. Is she able to care for herself and her children? Is she back to work? And have your interventions improved her life? We have to create evidence. We have to use outcome measures, and we need to tell people our body of knowledge is around occupational performance because we are occupational therapists.

There are a lot of things we can accomplish together. We can promote greater public understanding, we can enlighten policymakers' understanding, we can form productive and collaborative relationships, we can recruit students to the profession, and we can apply evidence to our practice. These are all things that AOTA is doing, but just think how much we can do if everyone in our profession is integrating these activities into his or her daily lives. Put an article about what you are doing in the local newspaper or go on the noon news. Invite congressional representatives and candidates for elections to meet some of your clients. Look for opportunities to collaborate. Talk to people about what you do. You can help in
recruitment and start a discussion when you, with your colleagues, review literature in the area of practice. These are not difficult activities, and they really need to be done. What we are going to do is move forward with confidence, but we know we have work to do.

We are going to do what the professionals who went before us did, we are going to create the future so that people who want to live independent and meaningful lives have the services they need to do that. Our work today can build the profession for future practitioners, educators, and scientists.

As we go forward, we must be bold and strong and true to our heritage. What we do is needed by the people we serve and by society. Be proud of your status. You are a professional. I think it was very important for us to take a historical walk to see how critical it is for us to make important decisions at the right time, and this is the right time. Thank you very much. ▲

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Appendix A
Efficacy of Activity: The Relationship to Occupational Performance
Prepared by OTD Students at the Program in Occupational Therapy,
Washington University, St. Louis
Spring 2005

Importance of Activity in Children


Importance of Activity in Persons With Disabilities


Importance of Activity in the Elderly


