Embracing Our Ethos, Reclaiming Our Heart

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A profession’s ethos is an interlacing of sentiment, value, and thought that describes its character, conveys its genius, and manifests its spirit. The ethos endures over time, serving as touchstone against which individuals may strike their actions to know their worth. As a profession’s inner voice, the ethos inspires individuals and calls them back if they stray too far.

This discussion of the occupational therapy profession’s ethos has two discernable parts. The first invites deliberation, given its historical ground. The second is a blend of ideas and images, a clutch of reflections inviting affect and will to join in thought. My hope is to illuminate the ethos of the profession in such a way that a new perspective on current challenges is possible. In the end, I will set before you this idea: To advance into the future with the ethos that has characterized occupational therapy since its inception is a reclamation of the profession’s heart.

I prepared for this day with a synthesis of my prior work, gathering new ideas to lift those thoughts to higher ground. In the process, an insight emerged. Over the years, many of you have told me that my work strikes a resonating chord, some of you naming that chord soulful, others philosophical, and still others poetic or lyrical. I believe that you discerned in my writing glints of an ethos that always has resonance, and your discernment sealed my choice of topic.

Any hope to cast light on an ethos is large enough to give one pause. This effort is but a start. I’ve read widely, thought deeply, and sifted many works for the beliefs that guide us. From dauntingly many iterations, I’ve culled themes well-worn and ethological. I’ve chosen words with care, seeking fidelity to our forebears and a quintessence that endures. The guiding beliefs that I propose are but my take on many other takes, here now for your taking, remaking, or leaving altogether.

The Meaning of a Professional Ethos

Dictionary definitions of the term ethos include these: a person’s character or disposition; an individual’s moral nature; the characteristic spirit or prevailing sentiment of a group; the genius—that extraordinary and distinctive capacity or aptitude—of a people or institution; the guiding beliefs, standards, or ideals that pervade and characterize a group; the spirit that motivates the ideas or practices of
a community; the complex of fundamental values that permeate or actuate major patterns of thought and behavior (Simpson & Weiner, 1989).

A profession’s ethos is thus an interlacing of sentiment, value, and thought that captures its character, conveys its genius, and manifests its spirit. An ethos carries beliefs so fundamental and sound that they endure, both transcending and supporting the particularities of shifting paradigms. The idea of a professional ethos kindles hope that one can apprehend and articulate a profession’s character. Physician Larry Churchill (1975) said that ethological beliefs are “often loosely identified, seldom find articulate form, and generally operate inconspicuously in the routines of a given community” (p. 31). Physical therapist Christine Stiller (2000) understood a professional ethos as core beliefs held in a dynamic that responds to change. Nurse Anthony Tuckett (1998) said that an ideal ethos has moral integrity in addressing both what one ought to do and how one ought to be. Each thought a profession’s ethos discoverable.

Metaphors reveal its functions. An ethos serves as touchstone against which individuals strike their actions to know their worth. As inner voice, an ethos inspires individuals and calls them back when they stray too far. An ethos sets a profession’s course in ever-changing times. It is bare-bones plot in a heroic tale. Bold standard raised in a milling crowd, an ethos leads those with diverse roles and views to say, “That’s right!” The pull of an ethos is unbroken, sometimes under- tow in currents less ideal. Its confluence of sentiment, value, and thought yields guiding beliefs, both vital and lasting.

It is important at the outset to distinguish our profession’s ethos from other more familiar of its characterizations. Intimations of the profession’s character, genius, and spirit nest in key documents of the American Occupational Therapy Association. The official definition, for example, describes occupational therapy’s unique purpose, focus, and populations (American Occupational Therapy Association [AOTA], 2004). The philosophical statement reveals our grasp of the nature of persons and of occupation (AOTA, 1979). The Code of Ethics sets guidelines for moral practice and relationships, linking them to cherished principles (AOTA, 1994). The core values and attitudes paper calls values from our documents and uses nursing’s language to cast them as commitments (AOTA, 1993). The Guide to Occupational Therapy Practice describes to a broad audience the scope and actions of our therapy (Moyers, 1999). The Occupational Therapy Practice Framework lays out the domain and process of our work (AOTA, 2002). Singly and collectively these documents draw from, organize, standardize, or recognize aspects of our ethos. They reflect its contours and honor its substance. Even together, however, they neither constitute nor state our ethos.

Also drawing from and leading back to our ethos is discourse about the profession’s paradigms, models, and legitimate tools—hallmarks of our knowledge and interventions. Especially close to the ethos are discussions of the art, science, and ethics of the profession and thoughts about our culture and integrative values (Hansen, 2003; Hasselkus, 2002; Hubbard, 1991; Kielhofner 1997; Mosey, 1981; Reed & Sanderson, 1999; Rogers, 1983; Shannon, 1977; West, 1984; Wilcock, 1998; Wood, 1995, 2004; Yerxa, 1967). Not yet within our literature, however, is there an exposition of the guiding beliefs that serve as ethos.

Absent from easy access, therefore, is the ground on which Robert K. Bing (1986) suggested we stand when he said this: “Where we will find comfort, safety, and stability is in those decades-old fundamentals and principles developed by our founders and practiced by our pioneers . . . our beliefs, our values—they form the rock upon which we must stand” (p. 670). The rock is there; we need only cast light on it.

The Ethos of Occupational Therapy

The early decades of the 20th century shaped the context from which our ethos emerged. Physician Sidney Licht (1967) shared a glimpse of those times from his lived experience. A loaf of bread cost a nickel, then. Eggs were 40 cents a dozen. A man who bought a 5 cent beer could eat all the hard-boiled eggs he wanted. There was neither radio nor television. Milk was brought to homes 7 days a week by horse-drawn wagons. Toast was made atop a gas range. Houses were heated with wood or coal, and neither electric refrigeration nor supermarkets existed. It cost a penny to send a postcard, a penny more to mail a letter. All telephones were black. Street lights were turned on by men called lamplighters; there were no traffic lights or parking meters. Ford’s touring car sold for $360.00.

A recently industrialized society rued the effects of machines that maimed bodies at an alarming rate. Arts and crafts societies emerged against the monotony and lost autonomy of factory work. Sanitation was poor. Social workers such as Jane Addams saw the ill effects of city life among poor immigrants and offered community activities in neighborhood settlement houses. Engineers such as the Gilbreths advanced techniques to make people and machines more efficient. War was in the news. The ways through which neighboring countries supported their soldiers prompted readiness to do the same here.

In 1917, our profession’s founding year, Binet proposed the IQ test; Dewey endorsed learning by doing. Many condemned the failure of hospitals to ready patients for return to society. Inhumane conditions for mental illness earned public exposure, and the National Committee for Mental
Hygiene, launched by former patient Clifford Beers, sought better treatment. Human behavior was examined in the lights of inner purpose and environmental cause. Philosophers spoke of holism, common sense, and practical consequences (Peters, 1953; Roback, 1952). I’ve but skimmed the wellspring from which our ethos emerged.

Early supporters of the use of occupation, the founders of the Society for the Promotion of Occupational Therapy, and early occupational workers drew from this context and their experiences a common understanding: Occupation could help. In discussing the power of occupation and a therapy built around it, they reiterated central themes with visionary zeal. From their discussions, five beliefs emerged with guiding potential, each a confluence of sentiment, value, and thought. Each had the capacity to shape character, establish reputation, and carry the profession’s spirit across changing times. Each became part of our ethos.

Because each ethological belief captures a distinct and equally important dimension of occupation or occupational therapy, each relates to the others existentially rather than sequentially or hierarchically. The end result is a complex of guiding beliefs, an ethos. It is this: (1) time, place, and circumstance open paths to occupation; (2) occupation fosters dignity, competence, and health; (3) occupational therapy is a personal engagement; (4) caring and helping are vital to the work; and (5) effective practice is artistry and science. Taken together, these beliefs capture that which we profess—declare and affirm—in the world.

I offer a sampling of each of these early beliefs and, on this golden anniversary of the first Eleanor Clarke Slagle Lecture in 1955, follow each sampling with thoughts from Slagle lecturers who extended them across time. These thoughts complement kindred ideas taken from all such lectures and showcased during today’s prelecture time. If they evoke others from your memory, I am pleased.

Time, Place, and Circumstance Open Paths to Occupation

One guiding belief is that time, place, and circumstance open paths to occupation, challenges notwithstanding. Situated in life circumstances of all kinds, persons occupy time and place (Reed & Sanderson, 1999). Adolf Meyer (1922), a neuropathologist and champion of the profession, saw time’s path to occupation. Sharing his philosophy of occupational therapy when professor of psychiatry at Johns Hopkins University, he said: “Man learns to organize time and he does it in terms of doing things . . . and one of the things he does we call work and occupation—we might call it the ingestion and proper use . . . of time with its successes of opportunities” (pp. 9–10).

Meyer (1922) cited philosopher Pierre Janet, noting that proper use of time is “the realization of reality, bringing the very soul of man out of dreams of eternity to the full sense and appreciation of actuality.” Our role as occupation workers, Meyer said, consists of “giving opportunities rather than prescriptions” (p. 7). If a person’s use of time was a doing, it was also and more essentially a becoming, a realization of the soul (Peloquin, 1990, 1997a; Wilcock, 1998). Meyer continued, “The awakening to a full meaning of time as the biggest wonder and asset of our lives and the valuation of opportunity and performance as the greatest measure of time; those are the beacon lights of the philosophy of the occupation worker” (p. 9).

Watching groups of mentally ill patients engaged in handwork, Meyer (1922) saw “a pleasure in achievement, a real pleasure in the use and activity of [one’s] hands and muscles and a happy appreciation of time” (pp. 3–4). He said that valuing time led to a “conception of mental illness as problems of living” rather than as only problems with thinking, or diseases, or disorders of constitution (p. 4).

Taking a complementary if pragmatic view, Allan Cullimore (1921), chief of Educational Service in Letterman Hospital in San Francisco, spoke of time’s worth. He applauded occupational therapy’s real work as therapeutic agent, cautioning against busy work. “Occupational therapy planned to kill time,” he said, “stands in the same relation to the real occupational therapy as that of first aid to medical treatment based on examination and careful diagnosis” (p. 537). “Occupations must lead somewhere,” Cullimore said, “and the patient must want to follow” (p. 538). Time and circumstance, we note, open paths to occupation. Place and circumstance do so as well.

Many places of the time called for occupations: hospitals for the insane; wards in general hospitals, from pediatric to psychopathic to orthopedic; hospital workshops; sanitarium for the treatment of tuberculosis; tents and army barracks; schools for defectives; institutions for the blind; convalescent homes; and private dwellings. Meyer’s (1922) philosophy included harmonic engagement with place: “Our conception 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 . . . and acting its time in harmony with its own nature and the nature about it” (p. 5). He supported an “orderly rhythm in the atmosphere” of mental hospitals, using among disturbed patients the habit training approach to life tasks—dressing, eating, working, playing—developed by Eleanor Clarke Slagle (Meyer).

Other early practitioners saw occupation at the interface of place and circumstance. Susan Tracy (1913), nurse and early practitioner, wrote, “The occupation room provides a new environment. It takes the patient away from his...
individual apartment and from the living rooms of the institution which may be filled with the suggestion of invalidism. It presents a cheerful atmosphere of quiet activity and a satisfying sense of something worthwhile being accomplished” (p. 4).

Discussions of helpful atmospheres led to the making of places that grew them. Thomas Kidner (1923), Canadian architect and founder, published designs for recreation halls, workshops, and theaters to accommodate occupations. A few years later, Louis Haas (1927), director of Men’s Therapeutic Occupations at Bloomingdale Hospital in White Plains, New York, published more designs, noting reciprocal ties between occupation and place. “In occupational therapy,” he said, “any corner that would hold a couple of chairs was at first considered a place in which this treatment could be given. . . . The treatment itself was used as a means of transforming, not only the patient, but the very inadequate floor spaces and unsightly walls, into more inspiring surroundings” (p. 285). Many instances of environmental transformations appear in our literature (Carlova & Ruggles, 1946; Slagle, 1938).

Thoughts about occupation’s emergence from time, place, and circumstance have endured. In her Slagle lecture, Anne Fisher (1998) made the connection succinctly and well. She said: “The term occupation conveys the powerful essence of our profession—enabling people to seize, take possession of, or occupy the spaces, time, and roles of their lives” (p. 511). Some 30 years earlier, Gail Fidler (1966) had said in her lecture, “Man’s innate drive to fulfill his needs for self-identity and realization through productive transactions with his object and interpersonal world is and has been the cornerstone of occupational therapy” (p. 8). Our ethos, in part, is this: Time, place, and circumstance open paths to occupation. Guided by this belief, occupational therapy practitioners are pathfinders.

Occupation Fosters Dignity, Competence, and Health

Another guiding belief is that occupation fosters dignity, competence, and health. Founder William Rush Dunton, Jr. (1919) conveyed his belief in the healing role of occupation in a creed that prefaced a book on wartime work, known as reconstruction therapy. He wrote:

That occupation is as necessary to life as food and drink. That every human being should have both physical and mental occupation. That all should have occupations which they enjoy. . . . That sick minds, sick bodies, sick souls, may be healed through occupation. (p. 17)

Almost 10 years earlier, Robert Carroll (1910), a physician in Asheville, North Carolina, had noted the worth of occupation in terms of dignity and competence, confidently proposing a “Law of Work” and asserting that “work truly is life.” He said:

The greatest influence, the true and lasting benefit in work as a therapeutic agent, rests in the moral uplift, the great mastering of self which comes when one is taught to work right, when one knows the joy and forgets the burden of doing, when self-mastery displaces indulgence, when doubt of one’s strength is replaced by faith. (p. 2034)

Whether endorsed as moral creed or scientific law, the belief was this: Occupation fosters dignity, competence, and health. Meta Anderson (1920) thus said that occupational therapy “should inspire the feeling of pleasure and self-respect which comes from being useful, and the feeling of power which comes from progressive daily achievement” (p. 326). Most poignant is her story, told in the language of the day:

An official was visiting the work of the feebleminded in a certain school. The teacher reported the good work done by the various schoolchildren. When she had finished, a low grade girl member of the class tugged at her sleeve and said, “Tell him that I cleaned the garbage can.” She had cleaned the garbage can and had done it very well. She beamed over the praise given to her after she had called attention to her accomplishment. She had been useful and her joy was unbounded. (p. 326)

One soldier gave this testimonial to occupation: “I got a new vision of life. . . . [I] saw the dignity of labor made new and interesting, and even more powerful because of the handicap” (Cooper, 1918, pp. 24–25).

Belief in the healing power of occupation—in its capacity to help individuals become hale and whole—has endured. What bolder affirmation than that in the Slagle lecture of Mary Reilly (1962): “The hypothesis that I presented for evidence of proof was that man, through the use of his hands, as they are energized by mind and will, can influence the state of his own health. I asked if this were a kind of idea that America could subscribe to and to that I replied with a resounding yes” (p. 8). Our ethos, in part, is this: Occupation fosters dignity, competence, and health. Guided by this belief, occupational therapy practitioners enable occupations that heal.

Occupational Therapy Is a Personal Engagement

A third guiding belief holds that occupational therapy is a personal engagement. Engagement—the commitment to
involve and occupy oneself and be bound by mutual promise—was thought necessary for patient and therapist alike. George Barton (1920), an architect and founder informed by nursing courses and his own disability, clarified the aim of occupational work:

Not in the making of a product, but in the making of a MAN, of a man stronger physically, mentally, and spiritually than he was before, for just as his body can be strengthened by carefully graded exercise from week to week, as his mind can be strengthened and improved in the same way, so also may his spirit be reborn in greater strength and purity by the effort for, and the realization of his triumph over disability and despair. (p. 308)

Such engagement and cocreation were essentially and deeply personal.

Also personal were responses among patients such as those ill from tuberculosis. These touched Bayard Crane (1919), a physician in Rutland, Massachusetts. He said, “In them pain will create outcry or fright. Monotony will produce depression, discouragement, or desperation. Uselessness will break down initiative and ambition.” (p. 63). Crane sought occupational workers who could “help meet the individual patient more on his own terms. . . . I am pleading” he said, “for a method which aims to further individualize with the temperament of each patient. . . . It is an attempt to instill in the treatment inspiring [sic] influences created by diversion, by occupation of mind, by stimulation of flagging interests, and by reeducation of faith and self-confidence” (p. 64). The need for occupational workers to engage as and with persons was clear.

Charlotte Moodie (1919), nurse and director of Social Service at Grace Hospital in Detroit, described patients who were engaged:

Here, in his wheelchair we find Joe, recovering from a fractured thigh, busily engaged in carving a breadboard or bookrack. Close by, lying flat on his back is Max, a bright cheery young chap . . . tuberculosis of the spine . . . ties him to his bed. He is now making a wool sweater by means of which Miss Tracy calls “rake knitting.” In the women’s ward is Mrs. Schuster making a basket, something she has always wanted to do. (p. 314)

This scene of patients much engaged evokes the image of a practitioner who had explored capacity, interest, and meaning, inspired confidence and courage, and personally engaged.

Years earlier, Tracy (1913) had described the requisite engagement, noting that occupational nurses “are constantly being impressed with the fact that the technical and mechanical part of their work is but one aspect of their professional duty, that a broader conception must be attained—a sense of obligation to minister to the individual as well as to the disease” (p. 9) and to be “thoughtful of the deeper needs of her patient” (p. 11). Therapeutic obligation included deep consideration.

Meyer (1922) spoke of the integrity implicit in such engagement: “It takes rare gifts and talents and rare personalities to be real pathfinders in this work. There are no royal roads; it is all a problem of being true to one’s nature and opportunities and of teaching others to do the same with themselves” (p. 7). Being true and real were important. Equally vital to the engagement were other ways of being endorsed by Kidner (1929) in an address to graduating students:

May you realize in increasing measure the value of certain spiritual things which are the real making of life, but which we call by many common names. Kindness, humanity, decency, honor, and good faith—to give these up under any circumstances whatever, would be a loss greater than any defeat, or even death itself. (p. 385)

Perceptions of occupational therapy as a personal engagement have endured. Elizabeth Yerxa (1967) spoke eloquently of this view in her Slagle lecture:

We cannot really help clients unless we are there; that is we feel, we encounter, we take time, we listen and we are ourselves. . . . Personal authenticity as an occupational therapist means that the therapist allows himself to feel real emotion as he enters into mutual relation with the client. . . . Philosophically, we do not see man as a “thing” but as a being whose choices allow him to discover and determine his own Being. Our media, our emphasis upon the client’s potentials, the necessity for him to act and the mutuality of our relationship with him provide a milieu in which his suffering can be translated into the resolve to become his true self. (p. 8)

Our ethos, in part, is this: Occupational therapy is a personal engagement—a mutual commitment to involve and occupy the self and be bound by promise. Guided by this belief, occupational therapy practitioners cocreate daily lives.

Caring and Helping Are Vital to the Work

A fourth guiding belief within our ethos is that caring and helping are vital to the work. Herbert Hall (Hall & Buck, 1915), physician and early practitioner, spoke with deep feeling of any individual left idle or bereft. He said, “Put yourself in that man’s place—imagine the despair and the final degeneration that must sap at last all that is brave and good in life” (p. viii).

Ora Ruggles (Carlova & Ruggles, 1946), reconstruction aide during World War I, enacted the empathy
endorsed by Hall. She explained the caring effects of such empathy: “I don’t see what’s missing, I see what’s there. I see real manhood. I see great courage. I see tremendous strength. I see true spirit. That’s what gives me courage, strength, and spirit. I gain as much or more as the men I try to help” (p. 76). She said that she had made a great discovery, simple, yet so effective: “It is not enough to give a patient something to do with his hands,” she said. “You must reach for the heart as well as the hands. It’s the heart that really does the healing” (p. 69). Early practitioners sought to develop traits that shaped such caring. Moodie (1919) valued, “above all, infinite patience, the ability to teach and to criticize without causing offense or discouragement, the power of inspiring confidence in others, and last but not least an optimistic temperament and a sense of humor” (p. 314).

Hall (1922a) described the nature of our helping: “Occupational therapy . . . attempts to restore the general effectiveness of people who have become incapacitated through illness and who are not able to make satisfactory progress by their own unguided efforts” (p. 163). Respect for personal dignity was central to such helping. Susan Wilson (1929), chief occupational therapist at Brooklyn State Hospital, said that “the patient’s every moment is carefully supervised,” but “the treatment must not become too paternal, killing the patient’s sense of responsibility for his own person” (p. 191). Similarly, Crane (1919) characterized our therapy as one which “makes the patient a creator, a doer” (p. 64).

Affirmations of our caring have endured. In her 1980 Slagle lecture, Carolyn Baum called us back to this belief at a time when health delivery systems had turned less caring. She said:

Occupational therapy harnesses will and gives the individual control through activity. That is human, that is care. We are respected by physicians and the health care system for that caring . . . through our professional relationships we reach out and with empathy to show that we care, hoping that from this caring the person will find his own strength. (p. 515)

And exhortations to help have endured, as June Sokolov (1957) reminded us in her lecture:

In this role of helping people to achieve commonly held objectives, nothing is more rewarding than our deepening awareness of human strength and frailty. One learns to hold aloft the ideal, to expect from people the most and the best of which they are capable yet to respect human frailty and hence to treasure the least of the offerings. (pp. 18–19)

Affirming respect for dignity in our helping, Jerry Johnson (1973) said in her Slagle, “The client and the therapist participate in a collaborative process . . . whereby the therapist provides an experiential learning environment in which the client can initiate or participate in occupational performance meaningful to him” (p. 3). Our ethos, in part, is this: Caring and helping are vital to our work. Guided by this belief, occupational therapy practitioners reach for hearts as well as hands (Peloquin, 2002a).

Effective Practice Is Artistry and Science

A fifth guiding belief is that effective occupational therapy is at once artistry and science. The interpersonal art is part of our ethos. A patient told Ruggles (Carlova & Ruggles, 1946), “You’re an artist in the greatest medium of all. You’re an artist in people” (p. 92). Slagle (1927), in her management roles, saw art’s necessity among occupational workers. She said:

For, if lacking in this—in understanding, in give and take, in spiritual vision of the “end problem” of all too many cases, the craftsman may make some initial showing, but the work will eventually flag and be largely a failure. (p. 126)

Supporting such artistry and vision, physician Addison Thayer (1908) of Portland, Maine, told a colleague using occupation, “It is not so much the work as the way you inspire the person to take it up” (p. 1486).

Artistry of the apt intervention is also part of the ethos. As an example, an anonymous piece in The Modern Hospital read in 1922, “Every OT worker of experience has seen hard, rebellious men and women soften and become teachable under the influence of quiet work . . . which may carry over into the machine life a new sense of humanity, a growing love of creative accomplishment” (p. 374). When Tracy (1921) personified occupational therapy as a wise woman walking swiftly through hallways to her patients, she included artful interventions:

A young house painter who has fallen hurt from a staging and is pretty badly hurt. . . . Next, a psychopathic patient in a bed held in a restraining jacket. . . . Third, a man who repairs furniture. Only one of his hands are [sic] available at present. Then a three-year-old baby with a new arm in place of one crushed by an automobile. Occupational Therapy sets down her basket—There is something interesting for each person. (Tracy, 1921, p. 398)

Belief in the value of our art, in its interpersonal and interventional aspects, has endured. Geraldine Finn (1972) argued for both in her Slagle lecture, saying,

It is this process of creative thinking which is required of us, as occupational therapists, in order to interpret our knowledge about human performance . . . and human relations . . . in the service of maintaining the health of a community. It is necessary for us to begin to think creatively about our particular understanding of man’s needs and to start to build new images around this knowledge. (p. 63)
Science has been of equal value. Hall (1922b) called occupational therapy “the science of prescribed work” (p. 245). Elizabeth Upham (1918), director of the art department at Milwaukee Downer College, framed it more deeply as “the science of healing by occupation” (p. 13). Calling for records and statistics in occupational therapy, Horatio Pollock (1929), director of the Statistical Bureau of the New York Department of Mental Hygiene, regarded occupational therapy “as a scientific effort for the restoration to health of the mentally and physically ill” (p. 416).

Barton’s (1915) scientific hypotheses, thought extreme, included one that any medicine of the day listed in materia medica books had an occupational equivalent. If doctors prescribed benzol as a leucotoxin, he said, occupational therapists could engage the same patient in canning work so that benzine fumes could yield the same effect (Barton, 1915). Signs of scientific pursuit were everywhere. Harry Mock (1919), a lieutenant colonel, supported the Walter Reed way of noting motion gained. He included a photograph of a soldier flexing to view his measurements. The caption read, “Visualizing results encourages the patient” (p. 13).

Belief in science as part of our ethos has endured. In the first Slagle lecture, Florence Stattel (1956) said this: “We have been given a wonderful professional heritage of courage and wisdom and as we continue to extend our hand to benefit mankind, may we continue to believe and search for further knowledge” (p. 194). Our long-standing belief in science has grown to recognize a discipline of occupational science well-represented by the Slagle lectures of Florence Clark (1993) and Ruth Zemke (2004).

The idea of an integrated practice based on art and science permeates cases published in our early years. One is representative:

Private J. was studying law when he was drafted. . . . He was wounded by shrapnel in his left arm and a stiff, flexed elbow had resulted. Reading law books would hardly benefit his condition but J. was interested also in making mission furniture out of old boxes and lumber. . . . Using his left hand chiefly, he soon became adept at hammering, sawing, planing, and other movements which necessitated a certain amount of flexion and extension of the elbow joint. Every week the amount of motion in the joint was measured and a careful record made. When J. saw by actual measurement that his range of motion in this joint was increasing, he was indeed happy and redoubled his efforts. Practically full joint movement had been restored when he was finally discharged. (Mock, 1919, p. 14)

Beliefs about practice as artistry and science have endured. Joan Rogers’ (1983) Slagle lecture discussed our reasoning as a confluence of science, art, and ethics. In the very next lecture, Elnora Gilfoyle (1984) noted kinship in art and science: “Imagination,” she said, “is the common quality in both science and art” (p. 578). She elaborated:

In science, imagination organizes experiences into concepts, and in art imagination allows us to enter into the human experiences. Science offers explanations and rational knowledge, whereas art carries an awareness of intuitive knowledge. Science of therapy is a creation to explain, and the art of therapy is a creation to relate. (p. 578)

Our ethos, in part, is this: Effective practice is artistry and science. Guided by this belief, occupational therapy practitioners are distinctly artists and distinctly scientists, both at the same time, all the time (Collins & Porras, 1994).

The Guiding Power of Our Ethos

Consider the guiding potential of our ethos: (1) time, place, and circumstance open paths to occupation; (2) occupation fosters dignity, competence, and health; (3) occupational therapy is a personal engagement; (4) caring and helping are vital to the work; and (5) effective practice is artistry and science. Each belief is expressive, persuasive, and thoughtful. Each evokes the best of who we are; each plumbs the depth of what we do. Together they afford us this view: We are pathfinders. We enable occupations that heal. We cocreate daily lives. We reach for hearts as well as hands. We are artists and scientists at once. This is our character; this is our genius; this is our spirit.

Ours is an ethos of engagement—a commitment to involve and occupy ourselves and be bound by mutual promise. Were we to distill the complex of our guiding beliefs into one brief account, our ethos might be this: Engagement for the sake of persons and their occupational natures. We engage so that others may also engage (Moyers, 1999).

Formed in the youth of our profession, our ethos calls to mind a clear-sighted youth from The Little Prince. Antoine de Saint-Exupéry (1943) there argued that as many individuals mature, they lose their capacity to imagine, discern deeply, and thus understand. Remembering a childhood drawing, he said:

I showed my masterpiece to the grown-ups, and asked them whether the drawing frightened them. But they answered “Frighten? Why should anyone be frightened by a hat?” My drawing was not a picture of a hat. It was a boa constrictor digesting an elephant. But since the grown-ups were not able to understand it, I made another drawing: I drew the inside of the boa constrictor, so that the grown-ups could see it clearly. . . . The grown-ups’ response, this time, was to advise me to lay aside my drawings of boa constrictors from the inside or the outside, and devote myself instead to geography, history, arithmetic and grammar. That is why, at the age of six, I gave up what might have been a magnificent career as a painter. (p. 4)
Similar experiences pull many from their imaginative capacities. Devoting themselves to routine matters, they weaken their powers of discernment. But when the 6-year-old in this story matured, he used his childhood drawing to predict the quality of understanding that he might expect from others. He explained:

I have lived a great deal among grown-ups. I have seen them intimately, close at hand. . . . Whenever I met one of them who seemed to me at all clear-sighted, I tried the experiment of showing him my Drawing Number One, which I have always kept. I would try to find out, so, if this was a person of true understanding. But whoever it was, he, or she, would always say: “That is a hat.” Then I would never talk to that person about boa constrictors, or primeval forests, or stars. . . . I would talk to him about bridge, and golf, and politics, and neckties. And the grown-up would be pleased to have met such a sensible man. (de Saint Exupéry, 1943, p. 5)

De Saint Exupéry clung to the clear-sightedness of his youth. He preserved his imaginative capacities while considering grown-up matters. Similarly, we might hold close the clarity, imagination, and perspective of our ethos as we consider matters grown up in our profession.

Challenges to the Integrative Ethos

We mostly agree that in spite of rich contributions to our development, views from medical and business models can wither our health care, educational, and scholarly aims. Among those views are an emphasis on rational fixing, a reliance on method and protocol, a drive for efficiency and profit (Peloquin, 1993a). Embrace of such views could lead to these beliefs, each true in its way but stark in its omission: Time, place, and circumstance produce profit margins. Performance fixes dysfunction. Therapy is a detached transaction. Problem solving is essentially the work. Effective practice is best-researched protocol.

Complaints from many sectors of our profession discern in such beliefs a disregard (Peloquin, 1993a). Consider this: If time, place, and circumstance produce profit margins, paths to occupation can get blocked. If performance fixes dysfunction, quests for dignity, competence, and health can be thwarted. If occupational therapy is a transaction, personal engagement can get lost. If problem solving is key, caring can matter less. If effective practice is best-researched protocol, artistry can seem esoteric. In this way, one might mistakenly think organizational profit opposed to professed aims, therapeutic purpose at odds with personal meaning, technical efficiency preempting human presence, competent solutions more prized than caring actions, and scientific reasoning sounder than artful intuition. Such polarized thought is not surprising in view of Churchill’s (1975) argument that ethological norms, typically integrative and complex, are vulnerable to dualisms. Polarized thought can temporarily disintegrate an ethos.

A practitioner’s felt-experience of a disintegrating trend is a sense of juggling, a struggle to stand in place with some views held but briefly, a stretch to keep tossed items safe but still within reach. Pressed to disregard functions that they deem valuable, practitioners feel deep consequences in every realm of practice. We’ve named one depersonalization.

Depersonalization evokes a radical image in its removal of persons. When personal care is hollowed from health delivery, practitioners feel the assault, and those seeking care are devastated (Peloquin, 1993b). René Magritte rendered the angst well in a work called The Therapist. A seated and caped figure sits squarely under a slivered moon and flattened hat. Face and chest are gone, replaced by emptiness. Doubtful that this therapist could find paths to occupation. The promise of engagement is slim. Caring expressions seem improbable, helping unlikely. Depersonalization muted our call to engage for the sake of persons and their occupational natures. It spawns disheartening times, places, and circumstances. The realities and dangers of depersonalization permeate cultural images. As forms of art, they help us discern de Saint-Exupéry’s boa consuming the elephant. And we should be frightened by this hat.

We must ask: Is our ethos the problem? Is its interlacing of sentiment, value, and thought outdated fancy to be put aside? I think not. I propose instead a reframing of dishheartening contexts in the clear light of our ethos. Listen to the Parable of Two Frogs (author unknown, 1999):

A group of frogs were hopping contentedly through the woods, going about their froggy business, when two of them fell into a deep pit. All of the other frogs gathered around the pit to see what could be done to help their companions. When they saw how deep the pit was, they agreed that it was hopeless and told the two frogs that they should prepare themselves for their fate, because they were as good as dead. . . .

The two frogs continued jumping with all their might, and after several hours of this, were quite weary. Finally, one of the frogs took heed to the calls of his fellow frogs. Exhausted, he quietly resolved himself to his fate, lay down at the bottom of the pit, and died. The other frog continued to jump as hard as he could, although his body was wracked with pain and he was quite exhausted.

Once again, his companions began yelling for him to accept his fate, stop the pain and just die. The weary frog jumped harder and harder and, wonder of wonders, finally leaped so high that he sprang from the pit.

Amazed, the other frogs celebrated his freedom and then, gathering around him asked, “Why did you continue jumping when we told you it was impossible?” The
astonished frog explained to them that he was deaf, and as he saw their gestures and shouting, he thought they were cheering him on. What he had perceived as encouragement inspired him to try harder and to succeed against all odds. We too can reframe disheartening contexts. Our ability to do so rises from the capacity for resilience that Susan Fine (1990) described in her Slagle lecture. She asked, “Who rises above adversity?” (p. 493) I say that we do. We acknowledge an enormous cleft of land in Arizona, a dangerously deep pit and obstacle to circumvent, but reframe it positively as the Grand Canyon. Likewise, we can reframe challenges to our ethos as calls for its reclamation. The challenges can cheer us on.

A Fresh Perspective on Current Challenges

Five reflections follow, each framing a current challenge in light of a guiding belief. Together they suggest actions so grounded in our ethos that they promise reclamation of our heart. Let me explain. Dictionary definitions of the term heart yield a more fulsome meaning than we sometimes suppose. Heart is the seat of feeling but is also the seat of understanding and thought. It is the depths of soul or spirit. Heart is the source of life and its vital principle; heart is one’s disposition, temperament, and character; heart is courage; it is the source of human ardor, enthusiasm, or energy; heart is the innermost part of anything (Simpson & Weiner, 1989). Because the full-bodied meaning of heart is so like that of ethos connotationally and metaphorically, an embrace of the profession’s ethos seems an embrace of our heart.

We Are Artists and Scientists

Guided by the belief that effective practice is artistry and science, we are artists and scientists at once (Collins & Porras, 1994). Honoring our ethos, we strive toward integrative practices (Peloquin, 1994, 2002a). Gestalt visions grounded our ethos in it origins, images of whole persons possessed of mind, body, and spirit; hands and hearts; physical and mental health. How can we reclaim these? For one, we can prompt the imagination that drives our science and art. Consider a beach scene. Sand and water come together at seaside, quite distinct but dynamically related. Seaside is because of land and ocean. Grains of sand and waves of sea together make seaside. Seaside would not be if one were gone.


Add to such imagery the question asked by William James (1947) about whether we walk more essentially with the right or the left leg. Clearly we need both. And if we drift to polar thinking, we might consider ski poles, together lending support and balance. Can we not imagine cosupportive synergies drawn from science and art (Peloquin, 1994)? If so, we can see intervention, education, and inquiry as venues for the integration of competence and caring, professional purpose and personal choice, productivity and self-actualization, problem solving and collaboration, evidence and meaning. That perspective captures our ethos.

Even in the business world, James Collins and Jerry Porras (1994) endorsed the “genius of the and” noting that “a highly visionary group will aim to be distinctly yin and distinctly yang, both at the same time, all the time” (p. 45). When, in light of our ethos, we envision and enact our belief that effective practice is artistry and science, we realize a vital principle of our profession. And in doing so we reclaim our heart.

We Are Pathfinders

Guided by the belief that time, place, and circumstance open paths to occupation, we are pathfinders. But how can we find paths to occupation in managed care and other disintegrating environments? We must first see overly managed systems as polarized. Management—skillful handling and control—is a distinct part of good care, but even in the realm of horse training, where the term management originated, experts suggest this broader view:

We shall have to give up our inclination to control our horse by force. Instead we shall have to try to learn to respect the way that he wants to do things. . . . And, instead of trying to impose on our particular animal the idea of what he should be able to achieve, we must first seek to learn what his capabilities really are. . . . Without this, our relationship with our horse will be one of spiritual warfare instead of harmony and beauty. (Hassler, 1994, p. 16)

Strife occurs in health systems when control preempts care. Without harmonious relationships and respect for choice, management fails (Curtin, 2003). If we had galloping costs, unbridled excesses, and runaway procedures, these called for taming. But they did not warrant the split vision that
has made an oxymoron of managed care (Peloquin, 1996). To see the split is to discern the missing care. And that discernment opens paths for its return.

In his reflections about educational systems, Gordon Davies (1991) asked a hard question of those on governing boards with control: “Are we helping to create an environment” he asked, “in which teaching and learning are honored and can flourish?” (p. 58). He saw in governance a pathfinding role. He heard a call to engender restlessness throughout the system, disturb complacency, and insist that rules be broken for the sake of learning (Davies). Likewise we might ask, “Are we making environments in which occupation can flourish?” Our activists, theorists, and innovators have asked. They have seen their pathfinding roles. They cause restlessness and disturb complacency as they challenge oppressive policy, affirm occupation as central, and make new practice sites—in clubhouses, workplaces, and community centers—for the sake of occupation.

Others make paths in quiet ways. Practitioners nest kindness, choice, and respect in approved interventions, working within payment rules to enhance performance. They foster dignity. Practitioners working in cramped spaces share big and courageous ideas that help clients remake their lives. They foster competence. Practitioners with huge caseloads in rushed circumstances craft cogent letters that extend occupational therapy. They foster health. Blocked as some may be from real occupation, they feel its steady pull. They heed its innermost call for dignity, competence, and health. They shape circumstances that hasten its return. Their efforts call to mind the words of Nkosi Johnson health. They shape circumstances that hasten its return. They heed its innermost call for dignity, competence, and some may be from real occupation, they feel its steady pull.

If health care environments seem disintegrative, they are not unique. Educators face a press for what Kerry Walters (1991) called a vulcanization of students, a Spock-like penchant for rational problem solving that stunts affective growth. Technologies proliferate, some putting interpersonal ken and harmony at risk. Through confluent models that foster learning with, about, and for whole persons, occupational therapy educators grow human potential and blaze trails to occupation (Peloquin, 2002b). Scholars face cut-throat trends to earn grant funds for institutional gain. Some are pushed toward discontinuous projects that neither flow from preferred inquiry nor grow the profession’s work (Mosey & Abreu, 1998). Through mindfulness, integrative methods, and a compass set on occupation, scholars make pathways back to our ethos (Abreu, Peloquin, & Ottenbacher, 1998).

Practitioners who honor occupation in disintegrating environments are pathfinders. When, challenges of all kinds notwithstanding, we affirm the belief that time, place, and circumstance open paths to occupation, we enact the courage of our profession. And we reclaim our heart.

We Reach for Hearts as Well as Hands

Guided by the belief that caring and helping are vital to our work, we reach for hearts as well as hands. Nine decades after he first said them, Hall and Buck’s (1915) words still ring clear: “Put yourself in that man’s place—imagine the despair” (p. viii). Depersonalized contexts in our times can fire such imagination and stoke our wills. Listen to Alfie Kohn (1990):

“No imported solution will dissolve our problems of dehumanization and coldness. No magical redemption from outside of human life will let us break through. The work that has to be done is work, but we are better equipped for it than we have been led to believe. To move ourselves beyond ourselves, we already have what is required. We are human and we have each other. (pp. 267–268)

How are we equipped to move ourselves beyond ourselves? Stories from the autobiography of Ora Ruggles point to our capacity for empathy (Peloquin, 1995). At its core a disposition toward fellowship, empathy is a turning toward another not just to solve a problem but to care and to help. Ora’s turning enabled her reaching, made clear in her work with a girl named Edith (Peloquin, 1995).

Ora launched a program at Olive View sanatorium, knowing that a board of directors would inspect her work before granting space or funds. She first intervened with Edith, a teen with spinal tuberculosis so severe that she lay arched and prone in a Bradford Frame. Ora found a mirror that let Edith see her hands; she built her a worktable. Noting Edith’s flair for style and skill at sewing, she nurtured her potential as a dress designer and suggested doll clothes as a start. Edith produced fine work.

When county board members visited Edith, Ora heard a woman nicknamed “Hawkeye” regret time spent on such a “hopeless case.” Ora said, “No one is hopeless who wants to be helped, and there’s nobody in this place who wants to be helped more than Edith does. That’s why I’m working with her and that’s why I’m going to continue working with her.” She smiled at Edith. “And that’s why she’s going to get well” (Carlova & Ruggles, 1946, p. 168). Hawkeye said that such sentiment was fine, but the board sought clear results.

Edith was to have shin bone segments grafted to her unstable spine. She yearned to pay for her surgery but doubted such income from doll clothes. Ora considered the situation. She made stylized figures from pipe cleaner and suggested that Edith clothe and group these to show rhythm and life. Edith caught on, creating ballets, skaters...
on a pond. Other patients joined in, making backgrounds and bases. The doll clothes sold readily in Los Angeles, and Edith’s share of the profits funded her surgery.

At the next visit of the board, a physician reviewed Ora’s work, and even Hawkeye was impressed. They approved a workshop that Ora helped design. Edith was discharged. She attended a fashion design school, became a well-known dress designer, supported her family, and funded patients at Olive View. The story is a tribute to Edith’s spirit. It tells of Ora’s empathy and good management sense.

John Gums (1994) would applaud the work of Ruggles, whose reaching for hearts and hands spread fellowship broadly. Gums said:

Every human being is born with the capacity to empathize. Most medical professionals, through their training, are taught to squeeze out that natural ability. Rediscovering it later in our professional life is a goal we should all have. Evidence suggests that to do so, emphasis must be placed on consideration of human life. (p. 251)

The rediscovery of empathy is not an add-on task to juggle alongside others, but more like the act of a cyclist turning the wheels of competence and caring at once. Elsewhere I’ve suggested that empathy is a considered way of being brought to our doing, no matter what that doing is (Peloquin, 1995). Being present to another in time is not the same as having lots of time. Consider interactions during checkout at a grocery store. In a few minutes, some cashiers forge real connections. We have much more time than most cashiers, and we connect well through our doing. And if being present admittedly takes energy, it paradoxically restores it, unlike the drain toward emptiness of depersonalization.

When, in light of our ethos, we affirm to ourselves and to others that caring and helping are vital to our work, when we empathically dispose ourselves toward that end, we share the ardor of the profession. In doing so, we reclaim the profession’s heart.

We Cocreate Daily Lives

Guided by the belief that occupational therapy is a personal engagement, we cocreate daily lives. But how can we engage in cocreation when so much pulls us elsewhere? Media messages say that a clock has filled our souls. We wear time-machines strapped to our bodies. We’re out of sorts without them. We tick with the many things that we must do. We stay wound up and out of touch with ourselves and others; we buzz within. We race with time, hoping to beat it. While seeking a control that eludes us, we turn from healthy rhythms of occupation and relationship. We loathe the idea of getting behind, or worse, of getting worn, ugly, and old.

We have nearly forgotten what it means to engage with the world and connect with others (Peloquin, 1990).

If we hope to engage—to involve and occupy ourselves and others and be bound by mutual promise—we must expand our views of time. Consider the book Cheaper by the Dozen, about Frank Gilbreth, honorary member of the Society for the Promotion of Occupational Therapy. Gilbreth’s son described his father’s passion for efficiency. Fully clothed and sitting on the carpet, Gilbreth taught his 12 children the most expedient way to bathe while extending the life of the soap. If we see time only as a commodity, we have split his larger vision. Gilbreth’s son, Frank Jr. (1948) shared what we have missed:

Someone once asked Dad: “But what do you want to save time for? What are you going to do with it?”

“For work, if you love that best,” said Dad. “For education, for beauty, for art, for pleasure.”

He looked over the top of his pince-nez. “For mumblety-peg if that’s where your heart lies.” (p. 237)

We mark time; we count units of productivity because we must. But only if we engage with the world will we find where our hearts lie. And only if we engage with others can we help them find what they love best.

Most media messages that commodify time differ from a sense of time’s wonder, like that of our forebears, found in the story of The Velveteen Rabbit (Williams, 1978). The Rabbit, new to a young boy’s nursery, asked the Skin Horse, a kindly older toy, a question that we too ask:

“What is REAL?” asked the Rabbit one day. . . . “Does it mean having things that buzz inside you and a stick-out handle?”

“Real is not how you are made,” said the Skin Horse. “It’s a thing that happens to you. When a child loves you, then you become Real.”

“Does it hurt?” asked the Rabbit.

“Sometimes,” said the Skin Horse, for he was always truthful. “When you are Real you don’t mind being hurt.”

“Does it happen all at once, like being wound up,” he asked, “or bit by bit?”

“It doesn’t happen all at once,” said the Skin Horse. “You become. It takes a long time. That’s why it doesn’t often happen to people who break easily, or have sharp edges, or who have to be carefully kept. Generally, by the time you are Real, most of your hair has been loved off, and your eyes drop out and you get loose joints and are very shabby. But these things don’t matter at all, because once you are Real you can’t be ugly, except to people who don’t understand. (pp. 16–17)

When engaged and real, Yerxa (1967) said that “we feel, we encounter, we take time, we listen and we are ourselves” (p. 8). A modern-day story reveals such engagement.

I sustained a severe, complicated injury to my right dominant hand. . . . I was prescribed occupational therapy.
We Enable Occupations That Heal

Guided by the belief that occupation fosters dignity, competence, and health, we enable occupations that heal. When asked to see what we do as performance that fixes dysfunction, we might recall Meyer’s (1922) vision of our dual beacon lights of performance and opportunity. Ours is a unique perspective. We see everyday activities as a making of lives and worlds, a broader and deeper view than that of mere performance or function, and one steeped in opportunity. Philosopher Elaine Scarry (1985) noted the world-making function of persons:

As one maneuvers each day through the realm of tablecloths, dishes, potted plants, ideological structures, automobiles, newspapers, ideas about families, streetlights, languages, city parks, one does not at each moment actively perceive the objects as humanly made; but if one for any reason stops and thinks about their origins, one can with varying degrees of ease recognize that they have human makers. (p. 312)

The image of someone in the act of making is one in which human being—its character, heart, and spirit—flows into personal doing. The difference between doing and making is one of substance and not semantic. Human making is a creation, our humane engagement a cocreation (Peloquin, 1997a).

Consider activities of daily living. We name hair care grooming, but we can see it as an act of making oneself presentable, attractive, or even likeable. What we call cooking we could easily call the making of a meal nestled within larger makings—of hearth, home, or tradition. What we call work is more deeply the making of a living, a family, a reputation, a community, a society. Wherever it falls in Abraham Maslow’s (1970) scheme of need, health, and hope, we see human making in daily tasks (Peloquin, 1997a). We see occupations as vital links to dignity, competence, and health. That perspective can lift our clever line, Occupational therapy, skills for the job of living, to higher and more healing ground where living is more than a job. And from there we might say, Occupational therapy, making daily lives (Peloquin, 2002a). That perspective captures our ethos.

In her poem, Janet Petersen (1976) casts even simple occupations as expressions of the human spirit:

There is a shouting SPIRIT deep inside me:
TAKE CLAY. It cries,
TAKE PEN AND INK,
TAKE FLOUR AND WATER,
TAKE A SCRUB BRUSH,
TAKE A YELLOW CRAYON
TAKE ANOTHER’S HAND
AND WITH ALL THESE SAY YOU,
SAY LOVING. (p. 61)

Through occupations such as these, the human spirit emerges, manifesting itself in small and large ways. Its emergence graces photographs of individuals seized by occupation (Menashe, 1980).

Practice stories revere this spirit. Therapist Betty Baer (2003) introduced us to a Vietnam veteran with a high-level spinal cord injury and from a remote part of Texas; he called himself a “Mountain Man.” Betty wrote:

J. was self-conscious about the hole left in his throat from the tracheotomy. He thought that an Indian choker necklace...
would be a good way to cover up the hole. Unfortunately, he was unable to make this himself, even with the best of OT compensatory techniques and gadgets. Since I had a little experience with beadwork, we decided that he would create the design and I would be his “hands”—following his directions to produce the choker necklace. We thought this would be a good experience. It was important for J. to direct his care—why not direct his creativity as well?

This was a big challenge for both of us. It was difficult for him to put into words the steps of the activity his hands knew how to do so well. It was challenging for me to follow his instructions, and not just improvise on the knowledge of beadwork that I already possessed.

To our mutual amazement, the choker . . . looked great. J. wore it with pride and received many compliments. This activity not only transformed a handful of beads into a necklace, but it also transformed J.’s role from a passive patient to active teacher. It was a truly wonderful OT/patient experience . . . one I will never forget. (p. 5)

When, in spite of constraints, practitioners make their interventions meaningful, lively, and even fun, they infuse therapy’s purposive aims with its capacity to encourage and inspire. Acting on the belief that occupation fosters dignity, competence, and health, we embrace the spirit of the profession. As we enable healing occupations, we reclaim our heart.

Conclusion

We can stand on the rock that is our ethos and from there proclaim our view: Time, place, and circumstance open paths to occupation. Occupation fosters dignity, competence, and health. Occupational therapy is a personal engagement. Caring and helping are vital to the work. Effective practice is artistry and science. Our profession takes this stand for the sake of persons and their occupational natures. We engage—we involve and occupy ourselves and commit to mutual promise—so that others may also engage. This is our character; this is our genius; this is our spirit.

Mihaly Csikszentmihalyi (1993), a modern-day friend of occupational therapy, offered thoughts to guide a profession through this millennium. His thoughts reverberate with our ethos. “You are a part of everything around you,” he said. “You shall not deny your uniqueness. You are responsible for your actions. You shall be more than what you are” (pp. 289–290).

The reflective part of this lecture began with de Saint-Exupéry’s story, to which I now return. Here, a wise fox shares goodbyes with the little prince:

“What is essential is invisible to the eye,” the little prince repeated, so that he would be sure to remember. (1947, p. 87)

The ethos of occupational therapy restores our clear-sightedness so that we see what is essential: We are pathfinders. We enable occupations that heal. We cocreate daily lives. We reach for hearts as well as hands. We are artists and scientists at once. If we discern this in ourselves, if we act on this understanding every day, we will advance into the future embracing our ethos of engagement. And we will have reclaimed a magnificent heart. ▲

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References


Anderson, M. L. (1920). Mental reconstruction through occupational therapy. Modern Hospital, 14, 326–327.

Hall, H. J. (1922b). “Science so-called.” Modern Hospital, 18, 558–559.


Wooten, J. (2004). We are all the same. New York: Penguin.
