LETTERS TO THE EDITOR

Occupational Therapy Students Need Good Anatomy Courses

I heartily agree with Caryl E. Peterson, author of “The Issue Is—Austerity and the Cadaver” (January 1994, pp. 87-88), that occupational therapy students need to know their anatomy and learn it properly in labs with human cadavers. As she stated, “charts and models can never take the place of the cadaver in developing a true understanding of the intricacies of human systems and a deep respect for the uniqueness of life” (p. 87).

In 1975, as an occupational therapy student at Downstate Medical Center in Brooklyn, New York, I took an anatomy course that consisted of full cadaver dissection, not only of the musculoskeletal system but of the internal organs as well. I will never forget the brachial plexus, flexor tendons, or the 32 feet of small intestine that I worked hard to find and identify. This learn-by-doing approach was most consistent with the philosophy of occupational therapy. I am most grateful to our anatomist, Jacqueline Jakeway, and the occupational therapy faculty members who designed our excellent curriculum, which also included separate neuroanatomy, histology, and kinesiology courses.

Over the past 17 years, I have worked in pediatrics and all the areas of physical dysfunction, currently specializing in the hand and upper extremity. My knowledge of the cardiovascular and gastrointestinal systems enabled me to understand medical reports of acutely ill patients and converse intelligently with their physicians. Knowledge of neuroanatomy helped me correlate patients’ behaviors and function deficits with brain lesions. Currently, as an occupational therapist specializing in hand therapy, I use my knowledge of upper extremity anatomy constantly in evaluation, treatment, and patient education.

As occupational therapists, particularly those of us practicing in physical dysfunction, we must strengthen, not weaken, our knowledge of basic human sciences. We must command the respect of referring physicians, other allied health professionals, and our patients, to compete in the current health care arena. Our educational programs must therefore not exclude human cadaver labs from their anatomy courses.

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The Extinction of Mental Health Practice?

In response to the article “The Issue Is—Are Some Occupational Therapists in Physical Disability Practice Settings Hastening the Extinction of Mental Health Practice?” by Karen Sladyk (February 1994, pp. 174-175), I am one therapist who moved from physical disabilities practice to mental health practice and think that both are vital. When I rotated to a permanent position on the 26-bed inpatient mental health unit in the regional hospital where I began my professional career, the other hospital staff members, surgical nurses, physical therapists, doctors, and even occupational therapists, asked “What are you going to do up there?” Our rehabilitation department secretary said, “You’re going to lose all of your skills.” And what was this recent graduate, who had been working mostly with traumatic hand injuries and orthopedic conditions, doing moving to a psychiatry position that had been vacant for more than 2 years?

It is now 18 months later and I am getting ready to move on to pursue my master’s degree and guess what? My skills have never been better. I have raised the profile of occupational therapy in mental health in our regional hospital, becoming an essential member of the organization. I have more respect than I ever had in physical medicine and surgery, and I will have no problem recruiting another therapist away from the main physical medicine department to fill my position when I leave.

The main reason for all of these developments is that the goals with this population meet the same functional needs inherent to human occupation. Our occupational therapy approach is refined—attending to the subtleties of the client’s state of mind; our approach is delicate—assessing a suicidal client as I would assess the most fragile of tendon repairs; our approach is interdisciplinary—with lots of role blurring, and not sweating a minute of it; finally, our approach is eclectic—our practice is not limited to a specific device, a specific locale, or a specific procedure. Recipe book intervention is something that I began to see in my work, in the area of physical dysfunction, and I did not like it.

The challenges in mental health practice allowed me to hone my interpersonal skills to facilitate my private consultations in areas of interest, such as ergonomics and cognitive behavioral-based interventions with return-to-work clients. These skills were a help, not a hindrance.

Mental health practice has given me a level of satisfaction, profile, and financial remuneration that would not have been feasible in my previous position. I am confident that this message has been instilled in my students. Most therapists enjoy the “in your face” challenge of physical dysfunction, but they should never underestimate the challenge and rewards of being toe-to-toe with a client who is depressed, manic, delusional, or whatever else a new admission from emergency may bring.

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