Embracing Our Past, Informing Our Future: A Feminist Re-Vision of Health Care

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Using a feminist perspective, this paper explores the roots of the practice of healing and medicine. It traces the role of women in health care from prehistorical times, through the present, and into the future discussing the changing paradigms that the author identifies as (a) the Prototypic Paradigm: Mysticism and Healing; (b) the Scientific Paradigm: Curing; and (c) the Paradigm of Inclusion: Caring, Curing, and Healing. The role and status of women in society are reflected within these paradigms, and the changing status of the profession of occupational therapy is discussed within this framework. The unique skills and contributions of occupational therapy more closely fit within the Paradigm of Inclusion and can support us as health care leaders within the changing world of the 21st century.

As we stand on the threshold of the 21st century, poised to take our rightful place in the health care arena of the future, occupational therapists are evaluating and reevaluating the strengths and weaknesses of the profession. We see occupational therapy as a strong profession, both in numbers and in philosophy, with a dynamic and growing body of knowledge. Our research base as outlined by Yerxa (1991) has continued to grow, the number of educational programs is increasing, and clinical practice continues to expand into new and varied settings. We are responding to global changes by increasing our awareness of ethnic, multicultural, and international issues within the profession (Dyck, 1991; Gibbs, 1991; Lowery & Wright-Scott, 1991; Sayles-Folks & People, 1991; Wells, 1991).

Despite this obvious growth, the profession of occupational therapy still lacks recognition and public visibility. The number of educational programs is insufficient to produce the number of therapists necessary to fill all the job openings nationwide, and the number of men and ethnic minorities, although increasing, is still limited (American Occupational Therapy Association [AOTA], 1990). Occupational therapy remains primarily a white woman’s profession. Although AOTA has a strategic plan for addressing the issues of ethnicity and multiculturalism, the issue of gender has not yet been systematically studied. Rider & Brashear (1988) explored why occupational therapy does not attract more men, but as yet no solutions have been suggested. Perhaps the field of feminist inquiry can offer another perspective that will help to illuminate these challenging problems.

Since the modern women’s movement began in the late 1960s and early 1970s, numerous authors have researched and rewritten history from a woman’s perspective. Many of us, because of age or experience, were not introduced to the theories and philosophies of this new scholarship during our occupational therapy education, nor is it an integral part of most occupational therapy curricula today even though women make up 93% to 95% of our student body and membership. Articles written from a feminist perspective have proliferated in the nursing, psychology and social work literature, particularly in the past decade. However, few references in occupational therapy literature have focused on women’s or gender issues (Gilligan, 1976; Reese, 1987; Jantzen, 1972; Mathewson, 1975). I believe that by reexamining occupational therapy history, theory, and practice through the lens of a feminist perspective, we will gain much insight into its present status that will strengthen the profession as we prepare to enter the 21st century.

This paper explores some recent feminist works on the history of women in healing and the health professions to give the reader a new perspective on the roots of occupational therapy. The changing paradigms of medicine and healing are identified and discussed in relation to how they reflect women’s status in the society of the
time. This information is correlated with the current role of occupational therapy within the health care system. A paradigm that embraces both ancient and modern ideologies of health, healing, and wellness identifies the role of occupational therapists in the future.

The Prototypic Paradigm: Mysticism and Healing

Since the beginning of written history, the stories that were told were truly his-stories. They were stories and theories devised and defined by educated men, transcribed by male scribes who deleted and edited as they saw fit. Things women had "done and experienced have been left unrecorded, neglected and ignored in interpretation" (Lerner, 1986, p. 4). Generalizing a perspective that is shared by less than half of the world's population (upper and middle-class white men) to the total population (women, minorities, and other disenfranchised men) not only renders the perspective of the nondominant group invisible, it also tells only part of the story. Over the past two decades, feminist scholars have begun the task of recounting her-story in an effort to fully complete the history we have been taught. The following is an overview of the role of women who engaged in the healing arts as derived from those scholars.

In earlier times, women were worshipped for their ability to create life. Artifacts from the stone age include thousands of round female figures of goddesses that represented women as the embodiment of the beginning and continuance of life and the symbol of immortality (Gimbutas, 1989; Stone, 1976). The human female was regarded as a prodigious source of wisdom and power who "could bring life and save life, and therefore was the healer of sick bodies and wandering souls" (Achterberg, 1991, p. 9). Women who could bring forth life were closely connected with the earth and its life-giving forces, both of which were revered (Jayne, 1925; Kramer, 1981; Lerner, 1986; Stone, 1976). Goddess figures have been found in South America, within the ruins of the civilizations of ancient Crete and Eastern Europe, and in Sumer, the most prominent city-state in Mesopotamia, located approximately in the vicinity of modern Iraq (Achterberg, 1991; Kramer, 1981).

The art of healing in the beginning of time combined pharmacy (the knowledge of botany and plant lore and its therapeutic qualities), manipulation (bone setting, surgery, and blood letting), and ritual magical intervention and spiritual supplication. It was the women of ancient cultures (much as it is in tribal cultures in recent history) who possessed this knowledge and skill (Achterberg, 1991). From the earliest time, healing was closely correlated with spirituality, divinity, and the goddess. Therefore, the first, or prototypic, paradigm related to medicine was that of the woman healer who often used mystical practices to assist her healing powers.

From 7500 BC until approximately 2000 BC, women in the Sumerian culture participated fully in sacred activities, owned property and businesses, and, if unmarried, could serve as priestesses or physicians (Wolkstein & Kramer, 1983). In Sumer the revered goddess Isanna (Ishtar) embodied the trinity of love, healing, and birth (Ochshorn, 1983). The Sumerian legacy to the healing arts was profound and enduring and became the basis for western medicine long before the knowledge from the Greeks and Romans was available. What is generally referred to as the oldest medical text in history was found on two tablets from the Sumerian period. More than 800 prescriptions have been recovered from this area and time, as well as surgical tools made of flint and bronze (Achterberg, 1991). Often these artifacts were found in the graves of women.

Historians (Campbell, 1987; Landsberger, Benno, Reiner, & Civil, 1969; Stone, 1976; Wolkstein & Kramer, 1983) indicated that until about 2000 BC, women were allowed to practice healing with few or no restrictions. However, after that time the great Sumerian civilization became a constant and perpetual battlefield, and Ishtar was transformed into the goddess of war and destiny. Slowly the powers for which she was worshipped shifted from healing to sexuality. By the year 1000 BC, as the Sumerian civilization was in a state of decadence, women were excluded from formal education and their roles had been sharply limited. By 700 BC, the participation in the healing arts for women had been downgraded to one of service only, and included that of "entertainer, transvestite, midwife, nurse, sorceress, wet nurse and prostitute" (Achterberg, 1991, p. 18).

Remnants of Ishtar and other goddesses found their way to other ancient countries and civilizations. In ancient Denmark, the deity Nerthus was a healer who granted her skills to mortals formed in her image—women. Unearthed Danish grave sites from approximately 500 BC indicated that female deities dominated religious expression, and that women were the shamans, the most honored level of healer, with skills more advanced than those of the herbalist or housesetter (Davidson, 1964; Glob, 1969).

In ancient Greece, several healing goddesses were revered, including Athena and Hygeia. These deities were often depicted with snakes, whose image was eventually adapted and adopted by the American Medical Association. Although there is evidence that early Greek women were writing medical books at this time, these works were later attributed to men (Capra, 1982). By 1000 BC, the feminine deities of Greece were far less powerful than the masculine gods, and by the time of Aristotle (340 BC) and Hippocrates (460 BC), women had become little more than slaves (Eisler, 1987; Lerner, 1986; Stone, 1976).

Great changes were occurring in the earth's geology during this period. The land temperature dropped, Scandinavian glaciers began their descent, and groundwater...
began to rise, eliminating fertile soil. The frightened populace prayed to the Great Mother and Healer for intercession. When conditions did not change and the upheaval of the earth created fewer resources, leading to war, the people lost faith in the Earth Goddess and she was given warlike characteristics to intercede in battle. Ultimately she was replaced by angry, warlike male gods and finally by a single male God (Achterberg, 1991; Hurd-Mead, 1938). During this process, any magical art practiced by women, including healing, became less valued and was eventually banned.

During the first few centuries following the birth of Christ, women regained some of their power and respectability. Early Christians respected women for their intellect, their healing abilities, and their contributions to the religious movement (Pagels, 1981). Jesus himself held women in high esteem as seen in their description in each of the four Gospels of the New Testament. During the early years of Christianity, God was described in androgynous terms and was given both masculine and feminine qualities (Pagels, 1987). Gospels were written on Christian women and on God as mother, further strengthening the full expression of woman as healer and divinity (Christ & Plaskow, 1979; Stone, 1976). However, these Gospels (Gospel of Mary, Wisdom of Earth, and Gospel of Phillip, among others) and other aspects of the written work were deliberately omitted from the New Testament in a systematic selection process that ended in about 200 AD (Christ & Plaskow, 1979; Eisler, 1987; Pagels, 1981). By the year 284 AD, the numbers and fame of Christian men and women healers had grown to such an extent that the leaders of the increasingly patriarchal Christian church began to feel threatened. They ordered the murders of several healers, who are now known as saints (Achterberg, 1991).

Still, the first half of the first millennium after the birth of Christ was relatively calm. Despite obstacles, women, many of whom came from the lower classes, continued to nurse the sick. During the Dark Ages and Early Middle Ages (476 AD to 1000 AD) peasant women were often called in to heal the women and children who were suffering from the bubonic plague and other diseases. These women, functioning mainly as caretakers and herbalists, treated the sick with their healing potions, but imbued their skill with a mixture of pagan and Christian ritual.

The High Middle Ages (1000 to 1300 AD) were times of excitement and diversity for women healers. Women of the landed gentry were exceptionally literate and well educated. Daughters and wives of craftsmen were taught the family trades and their value was recognized in the prevailing society. Though not considered equal to that of men, the status of women was higher than it had been or would be for centuries. Many continued as healers, caregivers, and midwives, carrying on the traditions of their mothers. However, the only physicians who were recognized as qualified were men who, unlike the women healers, limited their services to paying clients (Achterberg, 1991).

Scholarly interest in the field of medicine was high and institutions for training medical practitioners were founded. Around the year 1000 AD, the most famous of these developed in Salerno, Italy; its most distinguished teacher was a woman named Trotula, a skilled diagnostician who made outstanding contributions toward managing the health of women (Gies & Gies, 1978). She wrote about the need for hygiene and used a “knowledge of science, attention to the magic embedded in the mind, a mission of service, awareness of suffering and the gift of compassion” (Achterberg, 1991, p. 50). Until the end of the Middle Ages, an awareness of the mind-body-spirit connection, the use of natural herbs and plants (gifts from the earth), and the view of a caring attitude as important were the hallmarks of the woman healer.

As hundreds of women joined the new medical orders of the Christian church during the Crusades of the Middle Ages, they continued to practice their healing art. Many became well known for their skill and knowledge. Hildegard of Bingen (1098-1179 AD), one of the most accomplished, was considered one of the greatest mystics of all time, and her medical writings are considered some of the most important scientific contributions of the period (Flanagan, 1989; Gies & Gies, 1978).

However, except within the confines of the large abbeys, women who were practicing the healing arts at the end of the Middle Ages were falling under the suspicion of Christian leaders. Women had begun to lose the importance they had formerly enjoyed, and many were subjected to endless drudgery and constant childbearing. Except for the heirs they could produce, women were devalued in the eyes of society. This lack of respect for women, coupled with the increasing fanaticism of the church in its search for heretics, provided the framework within which the following centuries of terrorism toward women healers could occur.

The Scientific Paradigm: Curing

At the beginning of the 14th century, as the Middle Ages were beginning to wane, the Christian Church had hardened its attitude toward women as healers. It began to educate scientific theorists (all men, as women were denied access to education) who defined medicine wholly within the framework of astrology and alchemy. As these scientific areas of study developed, other areas, including botanic therapies, ritiistic preparation, magic, and sorcery, were determined to be not of God and science and were therefore heretical. Anyone practicing healing in these ways was condemned. Because women were not allowed to study medicine at the educational institutions, they often practiced their healing skills in the manner of
their mothers, from whom they derived their information. Unfortunately, the position of the Church was “that if a woman dare to cure without having studied, she is a witch and must die” (Achterberg, 1991, p. 81). Some have felt that “witch hunting [was] women hunting or at least . . . the hunting of women who did not fulfill the male view of how women ought to conduct themselves” (Lerner, 1986, p. 100).

Witch-burning fires flamed throughout Europe from the 14th through the 17th centuries as the Christian church sought out and destroyed anyone who they believed practiced or acted in a heretical manner. Although some men were tried and burned, 85% of those destroyed as witches were women (Ehrenreich & English, 1973). Witch-hunting campaigns were well organized, initiated, financed, and executed by the church and state. Laws on witch-hunting were written into the Malleus Maleficarum (Hammer of Witches) written in 1484 by Pope Innocent VIII. The Papal Inquisition publicly acknowledged burning 30,000 witches over a period of 150 years (Robbins, 1959). Some estimates of the total number of women burned fall in the millions (Ehrenreich & English, 1973; Robbins, 1959). Small towns were left with no women at all, with the worst devastation taking place in Germany where large towns, similar to those built during the Holocaust, were made for the mass murders (Achterberg, 1991). The witch-burning craze finally ended around the mid-1700s. The madness diminished as Christianity lost its stronghold on the governments of Europe, although the attitude toward women had not greatly changed.

These centuries of terrorism against women healers occurred during a time in history known as the Renaissance, when remarkable discoveries were made in the arts, humanities, and sciences. However, this period of cultural growth certainly did not reflect the status of women at that time. The Scientific Revolution, which began around the early 16th century, saw the proliferation of male physicians trained at universities. One of the most renowned, René Descartes, developed the theory of separation of mind and body, and he likened the human body to a machine that could be taken apart, examined, and repaired. Although Starr (1982) stated that “modern science has succeeded in liberating humanity from much of the burden of disease” (pp. 3–4), Descartes’ theories also resulted in the separation of caring and curing in the healing arts. His philosophy of rational objectivity in scientific medicine had a profound effect on western thought and it prevailed until the past decade. The separation of mind, body, and spirit tore at the fabric of women’s art in healing, which had holistically incorporated intuition and mysticism with the knowledge of the therapeutic qualities of plants and other natural cures. Any value that women healers had held up to this point in history was further diminished. Whereas women were formerly forbidden to act as independent healers on religious grounds, after the Scientific Revolution the objection to women as healers was related to their supposedly deficient ability to act as rational beings.

By the mid-1700s, women in America were even discouraged from practicing midwifery, their most rightfully owned area of knowledge and medical or healing practice. Midwifery became dominated by male obstetricians who gave strong testimony to their own training and superiority in matters of medicine, and to the midwives’ inferiority in matters of birthing (Scholten, 1985; Ulrich, 1990).

Women’s role as healers had finally been relegated to that of the passive assistant or handmaiden to the male doctor. Muff (1982) stated that physicians’ sexist attitudes and paternalistic tactics have encouraged nurses (and, one might add, other women health professionals) to internalize a subservient, inferior status. A few strong, wealthy, and bright women, encouraged by the women’s rights movement, dared to challenge the oppressive role assigned to them within the medical field and entered medical schools in the mid-1800s. However, most physicians were opposed to women entering the profession and the policy of the medical societies of the time was strict ostracism (Starr, 1982).

In 1873, the professionalization of nursing began with the establishment of three training schools (Starr, 1982). Before that time, nursing was a menial occupation, held predominantly by women of the lower classes. Upper-class women, with support from their wealthy spouses and friends, sought to improve the conditions of the sick, and of those who cared for them, through education. From its inception, the nursing profession attracted mostly women and has remained 95% to 98% female. Women were viewed as natural nurses for the same reasons they were seen as unnatural physicians: They were believed to have inherent caretaking abilities, but were thought to be incapable of the higher responsibility of curing. The innate nurturing and caring traits of women were disputed as mythic by Muff (1982), who believes that caring is an active skill that must be learned. But in the mid-1800s, the profession of nursing was seen as merely supportive to the male-dominated medical profession. "At the turn of the century, American medicine was well on its way to becoming the most male-dominated system of health care in the industrialized world. Not a single health or allied health profession composed primarily of women was able to practice independently of the medical profession” (Achterberg, 1991, p. 171). The medical profession was better organized, better financed, and better educated than these fledgling allied health professions. This higher status of physicians contributed to the young professions’ acceptance of their lower status roles within the system. Actually, many of these newcomers to the health care field were initially sponsored by members of the medical profession.

It was on this legacy that the profession of occupational therapy was founded. A few physicians who recog-
nized the importance of the mind-body connection believed that science alone did not provide the complete answer to illness (Levine, 1987). They collaborated with women from the nursing and social work fields to develop a theory and practice of goal-directed activities to improve health (Levine, 1987; Schwartz, 1992). This new approach to maintaining and reclaiming one’s health through occupation became known as the field of occupational therapy. By 1918, occupational therapy education programs began, with an emphasis on training only selected genteile young women (Litterst, 1992). These programs often were guided by all-male advisory and executive boards (Litterst, 1992). In 1922, graduating occupational therapists pledged, “I will walk in upright faithfulness and obedience to those under whose guidance I am to work” (Rider & Brashear, 1988, p. 232). As occupational therapists we had joined nurses and other developing allied health professionals who were somewhat autonomous, maintained a research base and clinical practice, but had to work under the orders of physicians who had less knowledge of our field than we did.

Occupational therapy was founded to help people find balance in their lives through productive activity (Levine, 1987). This balance was accomplished through the belief in a holistic approach to therapy, reminiscent of the mind-body connection observed by the early healers. At the profession’s inception, practitioners used arts and crafts and other daily tasks, activities that were stereotypically believed to be especially suited for women. As a time when the scientific paradigm guided the medical field and was valued above all else, the nonscientific therapeutics used in occupational therapy, activities that fell within the traditional realm of women, did not raise the esteem of our practitioners in the eyes of many in power.

The founders of occupational therapy recruited only upper- and middle-class, educated young women who would be willing to endure conflict and hardship and to work long hours. They had to be “nurturing” and “motherly” (Litterst, 1992), unmarried, “resourceful, unfailingly patient, enthusiastic, thoughtful, versatile, and adaptable” (Tracy, 1913, p. 18). In other words, they had to be willing to give themselves wholeheartedly to their chosen profession.

When the above-mentioned characteristics of the ideal occupational therapist are compared with a list of stereotypical masculine and feminine traits (see Table 1), they seem to overlap greatly with the feminine list. Examination of these traits indicate that the systematic devaluation of women that occurred under an entrenched patriarchy during the mysticism and healing paradigm period has continued to the present time. When the two columns of traits are compared, it becomes clear that the characteristics in the masculine column are more highly valued in society and in many institutions (the academy being one, and the scientific world of medicine another) than those in the feminine column. If we agree that occupational therapists have tended and still tend to embrace more of the characteristics of the feminine column, it is easy to understand why the profession is not highly valued. Not only has occupational therapy been less scientific, it is basically feminine in nature. The traits of caring, cooperation, nurturing, and subjectivity are at the heart of occupational therapy. Gilfoyle (1980) defined caring as “the primary technique inherent in the art of occupational therapy” (p. 517). She wrote that it is not is not the science of therapy but the art of therapy, the ways in which we apply our scientific knowledge, that is the essence of our practice. King (1980) explored the concept of creative caring in occupational therapy. She stated that occupational therapy is a “helping profession” with the assumption that helping is an outgrowth of caring.

Although feminist authors such as Noddings (1984) and Gilligan (1982) have argued for the recognition of and increased valuing of the feminine trait of caring, such recognition has not fully happened in our society. Because caring has long been associated with unskilled women’s work, any profession that practices it is automatically devalued.

Caring becomes the category through which one sex is differentiated from the other. Caring is “given” to women. It becomes the defining characteristic of their self-identity and their life’s work. At the same time, caring is taken away from men. Not caring becomes a defining characteristic of manhood. Men are marked off as separate to and different from women because they are not

### Table 1

<table>
<thead>
<tr>
<th>Feminine</th>
<th>Masculine</th>
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<tr>
<td>Dependent</td>
<td>Independent</td>
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<tr>
<td>Weak</td>
<td>Powerful</td>
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<tr>
<td>Incompetent</td>
<td>Competent</td>
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<tr>
<td>Less important</td>
<td>More important</td>
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<tr>
<td>Emotional</td>
<td>Logical</td>
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<tr>
<td>Implementors</td>
<td>Decision makers</td>
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<td>Housekeepers</td>
<td>Breadwinners</td>
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<tr>
<td>Supporters</td>
<td>Leaders</td>
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<td>Fragile</td>
<td>Brave</td>
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<tr>
<td>Nice</td>
<td>Aggressive</td>
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<tr>
<td>Cautious</td>
<td>Adventurous</td>
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<tr>
<td>Flexible</td>
<td>Focused</td>
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<tr>
<td>Warm</td>
<td>Self-reliant</td>
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<tr>
<td>Passive</td>
<td>Active</td>
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<tr>
<td>Followers</td>
<td>Leaders</td>
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<td>Speculators</td>
<td>Doers</td>
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<td>Modest</td>
<td>Ambitious</td>
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<td>Subjective</td>
<td>Objective</td>
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<td>Suggestive</td>
<td>Outspoken</td>
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<tr>
<td>Secretaries</td>
<td>Bosses</td>
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<tr>
<td>Nurturing</td>
<td>Assertive</td>
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<td>Gentle</td>
<td>Strong</td>
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<td>Excitable</td>
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<td>Patient</td>
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<td>Cheerful</td>
<td>Forceful</td>
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<tr>
<td>Sensitive</td>
<td>Brave</td>
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<tr>
<td>Caretakers</td>
<td>Achievers</td>
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<td>Cooperative</td>
<td>Competitive</td>
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Is it any wonder that we are not attracting more males into the caring profession of occupational therapy given today’s social constraints against men acting too feminine?

Beginning in the 1950s and early 1960s, the leaders of the profession attempted to improve its status in the medical arena of the health sciences by encouraging more research and education in the so-called hard sciences. As a result, treatment approaches such as proprioceptive neuromuscular facilitation, neurodevelopmental treatment, and sensory integration began to flourish, while the use of arts and crafts began to wane. This tension between the art (of caring) and science of occupational therapy continues today, with examples that include the conflict between those who wish to emphasize the mechanistic physical agent modalities and those who wish to return to our historical connection to human occupation (Joe, 1991). Many want to continue to develop the profession based on the founding tenets of caring and maintaining balance in a person’s daily life. By doing so, however, we risk getting less respect than we deserve from those in power. As Noddings stated in strong terms, “to emphasize caring is to invite further oppression and exploitation” (1990, p. 404). The confusion regarding what we should value, and in which direction we should go, makes it difficult to frame the boundaries of our identity to the public, to the male-dominated American Medical Association, and to third-party payers. This lack of focus also continues to erode our status within the health care system.

What can we do to decrease the conflict within our membership and to fully embrace our skills as caretakers as well as scientists? First, we must recognize that our inherent philosophy of caretaking (Gifford, 1986) puts us in conflict with the dominant scientific paradigm that focuses on curing. Much of the conflict is a result of societal demands on us as persons and as a profession. Despite progress in these areas made in part by the modern women’s movement of the 1960s and 1970s, societal attitudes remain that allow neither women nor men to be fully human, but expect us rather to fit into prescribed roles with prescribed behaviors reflecting the characteristics seen in Table 1. Until we can all comfortably embrace and value those misnamed masculine and feminine qualities within ourselves, and be comfortable exhibiting both tenderness and strength, we will continue to deal with these kinds of conflicts. As Muff (1982) stated, “when the concepts of femininity and masculinity cease to be value-weighted, and the constraints of gender eliminated, people will be free to be uniquely human, to develop their full capacities” (p. 17). The profession of occupational therapy, with its unique set of skills that encompass both science and art, both masculine and feminine qualities, represents a health care approach that can more easily fit within a new paradigm that is developing in our country, a paradigm of inclusion that incorporates caring, curing, and healing.

The Paradigm of Inclusion: Caring, Curing, and Healing

The 1990s and the 21st century will reflect a shift in health care philosophy and programming as we have known it in the recent past. According to Bezold (1989), the so-called soft technologies and alternative methods of health care will increase into the year 2010, and allied health fields should assume more change to meet future needs. The alternative methods include a variety of personal behaviors, attitudes, and techniques that allow control of autonomic function and self-enhancement of the immune system. Techniques include biofeedback, meditation, visualization, those techniques associated with health promotion and the holistic health movement. (Bezold, 1989, p. 450)

What Bezold described is a resurgence of the mind-body-spirit connection, an integration of the scientific and nonscientific. I describe this integration as the Paradigm of Inclusion: Caring, Curing, and Healing. Heide (1982) discriminated between medical care (curing) and health care (healing) in the following manner:

Medical care is not the same as health care and should not be used as a synonymous and/or interchangeable word meaning health care. Health care is basically an interrelational or social phenomenon. It may be augmented or aided by medical care, that is, by chemical or medical therapies or by instrumental technologies, procedures, or surgery. (p. 256)

In occupational therapy, we use the interrelational, therapeutic use of self as a major component in promoting the well-being of clients. Although it developed and grew under the medical model, this model has never fully defined the profession. I believe occupational therapy fits within the paradigm of inclusion. It has been a more integrated profession than many in its consideration of both the psyche and body of the client. The occupational therapist closely fits Bezold’s description of the health care worker of the future. It remains for us to continue to intentionally promote what has always been our focus, that of providing a caring, therapeutic application of scientific principles, while facilitating normal adaption of behaviors within the realms of work, play, and self-care.

The philosophy of occupational therapy encompasses and complements the tenets of today’s holistic health and wellness movement identified by Bezold (1989). Reitz (1992) provided a historical view of the profession’s role in wellness, the American Journal of Occupational Therapy devoted an entire issue to the topic of health promotion and wellness (White, 1986) and Johnson (1986) contributed a book on wellness for the current practice series in occupational therapy. AOTA continues to take a leadership role in the area of wellness, with the appointment of a Health Promotion/Wellness...
Program Manager to its staff and the recent revising of a position paper on preventative health and wellness (Reitz, 1992).

In addition to the mind-body-spirit connection of the holistic health and wellness movement, other trends and needs will affect occupational therapy. In a recent study involving seven health professional groups including allied health, one of the important changes in health and society was identified as “the broadening of the definition of health to transcend the traditional medical model” (O’Neill & Hare, 1990, p. 2). Other suggested changes made by the study were within institutions of higher learning, including “a broadening of the scientific core of the professions to include those components of the social sciences which will aid practitioners in addressing the psycho-social needs of patients and their problems” (O’Neill & Hare, 1990, p. 3). Because this component has always been part of the required curricula for occupational therapy students, our educational programs could easily become leaders in this area of change. That leadership role is supported as the PEW report also suggested that the allied health fields “reassert a proactive leadership role by redirecting educational programs to be consistent with the changing health care needs of the nation” (p. 3). These suggested changes will likely broaden the limited view of the hierarchical medical system to become more inclusive and integrative, and will challenge health care professions to alter the methods by which they provide services to society. I interpret these changes as a return to the caring, holistic, and more feminine aspect of health care; a health care system that empowers people to control their own health needs and provides support and facilitation as needed; a system that values body, mind, and spirit; a system that embraces healing and caring as well as curing; a return to the ancient values; in summary, the holistic, health promotion system that emphasizes health rather than treatment, wellness rather than illness. We are a profession whose values and philosophies complement society’s newly found allegiance to wellness, health promotion, self-care, performance and productivity. Our services address society’s social and economic needs . . . . Occupational therapy’s “strategic opportunism” is now; from our hillside we can say to ourselves, “We have seen the future and we are it.” (p. 487)

An understanding of the history (and herstory) of our gendered selves in the area of health and our role in the patriarchal medical system can be used to acknowledge our strength and wisdom. It may help us value the balance we have held for more than 75 years between the art and science of occupational therapy and may encourage us to claim recognition for our uniqueness as a health profession. Of all the exemplary leaders of occupational therapy, perhaps Gilfoyle (1988) understands this concept best, and stated it most eloquently when she said occupational therapy includes both health and human services that emphasize abilities rather than disabilities, health promotion rather than treatment, wellness rather than illness. We are a profession whose values and philosophies complement society’s newly found allegiance to wellness, health promotion, self-care, performance and productivity. Our services address society’s social and economic needs . . . . Occupational therapy’s “strategic opportunism” is now; from our hillside we can say to ourselves, “We have seen the future and we are it.” (p. 487)

The feminization of health care is also being recognized by futurists Naisbitt & Aburdene (1990) who predicted that the 1990s would be the decade of women in leadership. They believe that women may have an advantage over men in the business world because they need not unlearn the old authoritarian behaviors of their male colleagues. The authors discuss the strengths of women’s collaborative style in leadership and echo the recognition of the value of the feminine traits noted in Table 1. Occupational therapy has been privileged to have leaders who have used this style, who work collaboratively within our profession and with other professions, and who believe in the empowerment of others. Gilfoyle (1987a) referred to this approach as transformative leadership. “Transformative leaders empower others; they commit people to action, convert followers into leaders, and convert leaders into agents of change” (p. 283). With this leadership approach guiding the profession, occupational therapy can be the health leader of the future.

The predicted attitudinal change in society may result in increased recognition and support for the occupational therapy profession, a change that recognizes and values not only scientific knowledge, but also the caring, holistic healing contributions that the persons in our profession offer. This change encompasses both a new vision as seen by health futurists and a return to ancient values when women and men were each honored and empowered in the world, where the trait of caring is as important as the skill of curing for improving health.

To meet the challenges facing occupational therapy in the 21st century, we must build upon our strengths, recognize our limitations, and build them into strengths as well. Using the lens of a feminist perspective may assist us in this process.

To be fully human and humane all health care issues need the insights and alternative visions of feminist nurses, physicians and other health care providers. Feminism is a Gestalt, an all-encompassing view of human affairs; it makes the connections between the emotional and intellectual, the expressive and instrumental, the “feminine” and “masculine” in both sexes and between private and public affairs and policies. (Heide, 1982, p. 260)

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References


