Beyond Our Clinics: A Vision for the Future

We live in an uncertain world. In January of this year, I was attending an Executive Board meeting of the American Occupational Therapy Association (AOTA) in Scottsdale, Arizona, when someone walked in to tell us that the United States had declared war on Iraq. Although we had known that the possibility of this occurrence was great, I do not really think that any of us were prepared for the impact of the announcement. We were stunned and frightened. Many of us had friends and relatives who were stationed in the Gulf or on alert to go there. Some of us had children who we feared would be drafted. Although we were split on our opinions about support for the war, all of us expressed strong and total support for our troops; few of us, however, seemed to really understand what was occurring and why. I certainly did not, and neither did my sons.

I have three sons, all of whom are of draft age. One is a new teacher and the other two are college students. They are happy, handsome, and well adjusted. I love them. I became physically ill as I tried to imagine what it would be like for my children to be called to serve in a war that they did not understand, in a place that they had until recently heard little about. I thought a great deal about my youngest son, David, who would bring home stray and hurt animals for us to nurture and care for. How would this gentle, loving child, now a young man, exist in a world where it was his job to learn the use of weapons of destruction and death? How could he and countless others survive the psychic and physical trauma of war and then, if they were lucky enough to return home, resume their youthful existence where they had left it? I thought that this could not be done, because the truth is that when we send our young to war, those who return have lost their youth forever.

I am thankful that for most of us in the United States, those situations have not had to be faced. The deaths were few (though in my opinion, even one was too many); the war is essentially over for us; and while other citizens of the world continue to face uncertainty, hunger, death, and a myriad of difficult and life-threatening conditions related to the war, in the United States we have essentially returned to business as usual. It is this state of affairs that I wish to discuss today—business as usual in the United States.

It is an interesting, diverse, and sometimes troubled world that is embodied in the clients who step into our clinics and agencies each day. As health care providers, we are constantly faced with problems and situations that are the result of broader social ills.

An estimated 12.6 million children live in poverty in the United States, and according to a report released on March 26, 1991, by the Food Research and Action Center, a nonprofit antihunger group, 5.5 million children may go to bed hungry on any given night (Pear, 1991). Tens of thousands of children and adults are essentially homeless and sleep on city streets, in cars, in abandoned houses, and in other undesirable places. I have watched with interest and compassion as American forces have moved in to provide food and clothing and other forms of assistance for those persons in Bangladesh who have been ravaged by the recent typhoon that killed more than 125,000 people and left countless others homeless. We all have been touched and saddened by the sight of Kurdish people struggling and fighting for food in what for many was a last attempt to avoid starvation for themselves and their families. I believe that it is our duty as American citizens, through our government, to address and assist in the effort to save these people. What I cannot understand is how, amidst our humanitarian efforts that reach around the globe, we can ignore the hills of Appalachia, the city streets, the shacks in the rural South, and all of the many places where our own hungry and hopeless exist on the edge of survival.

Education in the United States is in a state of crisis. Many children receive a less than adequate education, which may put them at risk for social dependency for their entire lives. Although a privileged few receive outstanding education at well-equipped and well-staffed institutions, most American children go
to mediocre schools. Children at or near the bottom of the socioeconomic ladder generally attend schools that are overcrowded and physically unsafe, without even basic equipment and resources. Most schools are staffed by overworked and underpaid teachers who often start out filled with idealism but quickly become mired in the bureaucracy of a nonworking system and a society that is reluctant to pay its teachers to teach and shape its future citizens and leaders but that gladly pays entertainers and sports figures exorbitant salaries for what I consider nonwork. We hear constantly that the products of our educational system are ill prepared to function in the world of the future (I always have to laugh when I hear the term products, as if the speaker cannot hear to admit that these are not products, but rather, our children). We hear and know that these children are unprepared to compete in tomorrow's world. Employers say that many high school graduates cannot adequately read or do simple math computations. How will these children ever be able to compete in the technological explosion that is in its infancy?

The increase in drug use in all factions of society has left me feeling frightened and sometimes hopeless. In our practice, we routinely see wealthy, middle-class, and poor children and adults all caught in the same web of substance abuse. The seduction of illicit drugs is a threat to the future of those who are involved in drug activity, and we know that the fallout from drug use reaches each of us in terms of the social problems it creates in our families. Crime increases as those with minimal resources seek to feed an insatiable habit. We lose the much-needed creative, well-balanced, and contributing members of our society. Additionally, we are just starting to understand and grasp the meaning of our newest loss, that is, the loss of the right to life and any hope for a meaningful future for a generation of children born to drug-dependent parents. These newborns, scarred in utero by parents addicted to cocaine, heroin, and other illicit drugs, enter our world with a greatly decreased chance for a meaningful and productive life and are often raised by parents who are unable to break the bonds of drug dependency and who seem to have lost the will and the ability to dream that the opportunity for a drug-free life is possible.

With the aging of American citizens, we will face a new challenge—to provide a meaningful existence for elderly persons in what should be their golden years. I was at a conference recently at which Dr. John Henry Clarke, an 82-year-old black philosopher and scholar, discussed the development and evolution of culture and societies. He discussed the factors that exist in an organized society and the ways in which culture changes in a given society. He spoke on the issue of evaluating societies and cultures, and one of the things he said that captured my interest was that, in his opinion, the most important method for judging the strength and worth of a society is by looking closely at how it treats and values its children and its elders, that is, how it treats and values those who represent its future and those who are a repository for its past.

I have been privileged recently to work in an unusual program in Chicago called "Adopt a Building." This program is a joint effort of the Chicago Housing Authority, residents who live in public housing, area businesses, and social and health care agencies, including Mercy Medical Center, where I am employed. The goal of the program is to look at how all of these factions might join forces to effect permanent change for the residents. In the initial stages of the program, a public housing building is identified as a participant in the program. A sweep is performed in which police and security personnel search the building, apartment by apartment, for drugs and other illicit activity. Negative elements are removed from the building and the building is secured, with each resident given an identification card that must be shown for entrance to the building. Any visitors must be signed in by a resident or they are not granted entry. Although there are certainly some drawbacks in living in what one might call a police state, in talking with residents of the building, I found that those whom I spoke with see it as a trade-off. They generally feel safer and more secure.

As a major health care provider in the neighborhood that surrounds the building that we adopted, Mercy Medical Center has begun to provide a number of health services to the residents, including physical examinations, health screenings, and a variety of programs for children and teenagers in the building. I still remember the first day I walked into the building, signed in, and looked at the blight of the living conditions. No person in the United States should be forced to live in such conditions. I remember, too, my first interaction with the children who lived in the building. We provided inoculations, which were required for the children to enter or return to school. Many parents brought their children down; many of the children were beginning kindergarten. I sat with them, talked with them, and looked at their bright, hopeful faces. One 5-year-old talked with me about being a "big girl now," and she said, "I'm going to learn to read." We began a vocational program for teenagers. As I began to work regularly with these teenagers, I was pleased to learn that they dream, as all teenagers do, of a life of comfort and happiness. I felt a magnetic attraction to these children and an overwhelming compulsion to use my personal and professional resources to influence existing systems for these kids. Others who worked in area agencies and facilities and who had joined me in this project began to express the same feelings. It was almost magic—a zeal left over from the 1960s, only to be serendipitously rediscovered in the early 1990s in the social room of a public housing building. Though it was clear to each of us that we probably cannot save all of these children, we each talked about trying in a personal way, with personal responsibility, to bring about the opportunities that would enable some of them to save themselves. Perhaps that is the key for each of us—for you and for me—to commit to helping to provide the resources to help effect change in the lives of one or two people.

The state of health care, especially health care for the poor, is an important topic. All of us have begun to encounter increasing numbers of people who arrive at our doors with few or no resources for care. A recent article in U.S. News and World Report (Dentzer, 1990) stated that 31 million poor or working poor people lack medical coverage that would enable them to receive much-needed health care services. In addition, an estimated 28 million people have inadequate insurance that will not
cover the expenses of a devastating illness. We see increasingly that many services are limited to those who are able to pay through personal resources or medical insurance coverage. Those who lack health insurance or who are members of the working poor, if they are given health care services at all, may be treated in understaffed and ill-equipped facilities. As medical technology advances, we may have to deal with increasingly disturbing ethical issues, such as who will live and who will die and who will receive organ transplants and technologically advanced but expensive procedures such as kidney dialysis. In a recent study reported in a January issue of the Journal of the American Medical Association (Hadley, 1991) that involved 592,598 patient discharges, it was found that those persons with medical insurance received a different kind of care than did those persons without insurance. Although the uninsured had a significantly higher risk-adjusted mortality index, which is an indicator of more serious or acute illness, and they had a probability of a normal tissue biopsy that was less than half that of the insured patient and should therefore require more aggressive health care, the hospital stay for the uninsured persons was 7% shorter, and they received 7% fewer procedures. They had a much lower possibility of undergoing five high-cost or high-discretion procedures, such as coronary artery bypass graft and total knee replacement. They had a higher probability of suffering an in-hospital death. The article concluded (and I think this is extremely important) that insurance coverage should be a variable in predicting the outcome and cost of medical care in the United States.

In occupational therapy, a discipline whose effect is felt primarily in the realm of quality of life, as opposed to the sustaining or prolonging of life, we may have difficulty existing in the new health care world in which only the most privileged may have the luxury of considering and paying for quality-of-life treatment. But if we believe, as many of our clients do, that quality of life is as important as or, for some, more important than sustaining life, then we must continue to look at issues that relate to quality and to support our clients in the realization of a meaningful life.

I do not believe that it is enough to treat our patients in the confines of our clinics and hospitals without regard to factors outside of that realm that influence their right to life and happiness. Our intervention in their acute and sustaining care is vital but not enough. In moving beyond our clinics, we must identify those social and economic factors and causes that have a direct effect on their daily lives and that directly or indirectly affect our own. How powerful we can be, individually and collectively, if we choose to use our skills as organizers, planners, and evaluators to tackle the problems that confront our society. If each of us chooses even one of the causes I have discussed or one of the many others not discussed here and commits personal energy, skills, and resources to making positive changes in the lives of our patients and in the greater society, I really believe that there is nothing we could not accomplish. As we look beyond our clinics out into the larger world and make our presence felt in a broad and meaningful way, we become instruments of change for our patients and the greater society. Occupational therapy is grounded in the respect for, search for, and achievement of maximal human potential for all of those we serve. We have long stepped beyond our workplace to seek resources to enable success in our patients and clients and to assist them in living successful and meaningful lives. I believe we must widen our scope to include and seek solutions to local, state, national, and international issues that are vital to the successful existence of today's world and to future generations.

Who better than each of us to face this challenge? We have all seen and been involved in successes that many thought impossible. In our role as occupational therapists, we have forged bonds with patients to help them develop the courage to go on and the will to say “Yes, I can” in the face of seemingly insurmountable odds. Johnny Wilder, Jr., who performed at the opening ceremonies for AOTA's Annual Conference, is a perfect example.

So I challenge each of us who has not done so to move our skills and values to the larger arena: to join, participate in, and lead those efforts that will provide a better life for those we serve. Challenge the system, lead the movement, frame the vision. For it is our world we seek to change—our clients', yours, and mine. We are all children of the universe, connected inextricably to one another by the ties of human existence. Let us reach out in hope and caring to those around us to help them move to a life of maximal independence and to help all of us move to a future that is bright in promise, rich in human love, and filled with the light of hope.

References