In support of the American Occupational Therapy Association's (AOTA's) commitment to the implementation of the Directions for the Future initiatives, I intended for this paper to reinforce a vision of the potential of occupational therapy in a changing world and to emphasize the practice-education-research linkage and its dynamic influence on professional growth. Part 2 of this paper will appear in the January 1990 "Nationally Speaking" column.

A Vision of Potential

The word vision expresses far more than its ethereal quality first implies. My vision of occupational therapy's potential embodies concepts and beliefs embraced by our founders that are as viable today as when they were proposed initially. The philosophical importance and practical value of these beliefs have enabled them to endure over the 70-plus years of our profession and far longer as an early treatment for physical and mental disabilities.

The clinical reasoning study conducted by Gillette and Mattingly (1987) yielded a list of beliefs held by today's occupational therapists that reaffirm many of the beliefs of our founders. In synthesizing my own professional beliefs, I developed a more generic list, but one which contains most of the same abiding principles of both early and modern practitioners. I precede this statement with a disclaimer to authorship: I am echoing that which I have heard, read, and thought.

As occupational therapists, we hold these truths to be the reason for our being:

1. The individual has an inherent and compelling need for activity.
2. Such activity must stimulate the individual's intellect and emotions as well as his or her sensory and motor systems.
3. Self-fulfillment is best realized through engagement in activity that meets the individual's inner drives and the requirements the outer world places on his or her behavior and performance.
4. When disease or disability interrupts either the will or the ability to engage in activity, the individual needs special help through the medium of restoration, adaptation, or, at a minimum, maintenance of independent function and performance.

These tenets of our profession originated in the writings of our founders, who conceived and promoted them as the fundamental bases of our calling. They have been preserved in our literature by our modern colleagues, who have perceptively and expressively elaborated their meaning. They have been instilled in our practitioners by educators, who have professed our heritage and shared its valued principles. They have been reconfirmed by our practice through demonstration of apparent improvement in patients of all ages and with a broad range of disabilities. They are now being validated through research to support our claim that there is a science as well as an art of therapy through occupation.

I have thus far expressed a collective vision of the potential of occupational therapy. I believe most of us would agree that sound concepts underlie our efforts—concepts that include the occupational nature of human beings; the role of activity in human development, adaptation, and self-actualization; and the worth of the goal of social reintegration of the individual for physical and psychosocial function. Thus, many of us see the effect of activity or its absence on health as the most easily identified, readily understood, and generally compelling concept that makes our service unique and distinguishable among the health professions.
Why, then, do society in general and medicine in particular not value our service? Reilly (1962) suggested, "The wide and gaping chasm which exists between the complexity of illness and the commonplaces of our tools is, and always will be, both the pride and the anguish of our profession" (p. 1). Our anguish stems from the lack of mystery and magic in what we do, the lack of scientifically enhanced equipment to aid our evaluation and treatment, and the absence of a laying on of hands or the administration of cures that, if not fully understood, appear to have ameliorating and positive effects. Conversely, we take pride in the commonsense principles of enlisting the patient's own effort in his or her recovery and of engaging the patient in everyday, interest motivating activities of play, work, leisure, and self-maintenance, which are essential to a healthy and satisfying life. Because I cannot accept that these principles are flawed and that our mode of intervention is therefore inappropriate; because I have neither heard nor read a serious challenge to either; and because we have not only continued to exist but also have grown and developed on an upward curve over the past 70 years, I can only reaffirm my vision of our potential.

**Potential in a Changing World**

To consider the potential of occupational therapy in a changing world, we must first look back at some early changes.

We are told that a new generation is born about every 30 years. Using that measure against our organized origins, I count the first generation of occupational therapists in the years 1917 to 1947 and the second in the years 1947 to 1977. Because the next 30-year period takes us to 2007, a date not clearly visible to a person of my age, I have opted to think of our third generation therapists as approaching, in 1992, the midpoint of their time span.

Is the world faced by this generation the only one characterized by change? Far from it! Our founders and their early successors contended with the dramatic challenges of the Great Depression and two world wars, yet they expanded practice from the single specialty of psychiatry to a broad range of disabilities and increased the profession's course of study from a mere few weeks to 4 or more years. Some of the accomplishments of the first generation of our profession include: (a) the accreditation of schools, (b) the national registration examination, (c) the first master's degree program, (d) the first textbook by and for occupational therapists, and (e) our own journal.

One of the earliest and most threatening challenges for the second generation of occupational therapists was the near loss of control of our practice and education to physical medicine and rehabilitation. Only by the wise counsel of a leading educator and the strong support of our other medical friends did we win the case for the availability of our clinical services to all medical specialties and the self-direction of our educational programs (AOTA, 1960; Kahmann, 1950). Willard, 1950). Another controversial and potentially divisive issue was the education, certification, and recognition of the occupational therapy assistant. Only recently has that development been credited as a partial solution to the personnel shortage, thereby freeing registered occupational therapists for more professional roles and furthering the professional educational ladder. The deinstitutionalization of mentally disabled patients, the mainstreaming of disabled children, and the emerging health mode of practice required new roles in health promotion and disability prevention; new, nonhospital community-based settings; and diversification in practice, for which this generation had not been prepared. These changes, plus the chronic problems of personnel shortages, recognition for reimbursement, and galloping health legislation in which we were not initially represented, pervaded the years 1947 to 1977 and, to some extent, persist today. This period also saw the profession's move from a long-standing negative stance, through a brief neutrality, and then to a positive stance on the state regulation of practice. Therapists nationwide paid a high price to secure the enactment of laws that would prohibit practice by unqualified personnel, to say nothing of the cost to the national association for legislative and legal staff. A later development experienced by second-generation therapists was the government's effort to impose regulations on education, certification, and practice. The most visible and near-tragic effect of this trend was the proposed substitution of competency-based education and proficiency testing as alternative methods of professional entry that would have bypassed our long-standing educational standards and requirements. Finally, our interprofessional debate about specialization and appropriate media and intervention strategies has threatened the cohesion and unity so needed in a group's movement toward mutual goals.

Not all changes are negative, however. In fact, the changes that have confronted third-generation therapists over their tenure to date may be grouped into three major categories: (a) benefits, (b) pressures, and (c) conflicts. Among benefits, there might be listed the broadened definition of the Developmental Disabilities Amendments of 1984 (Public Law 98–527), which makes many more diagnostic groupings than mental retardation eligible for health services; the Education of the Handicapped Act Amendments of 1986 (Public Law 99–457), which created two new programs for children from birth to age 5, enactment of the Medicare Part B Amendments ( Omnibus Budget Reconciliation Act of 1986), which cover occupational therapy services in skilled nursing facilities, rehabilitation agencies, clinics, and independent practice; and lastly, new roles in hospice care and the treatment of patients with AIDS or Alzheimer disease. These new frontiers required adaptation to new patient populations in diverse new settings, plus new applications of basic principles in treatment. Perhaps the ultimate challenge has been in meeting all of the needs brought about by these changes in the face of the profession's chronic personnel shortage.

The pressures on individual therapists include the emphasis on continued competence to practice and increased participation in research. The pressure on occupational therapy pro-
grams and departments includes quality assurance and program evaluation, the reduced length of hospital stays, and the expanding use of computer technology in both program administration and patient treatment.

The conflicts within the profession include the continuing debate about media and the appropriate form of intervention strategies, problems in the use of sensory integration techniques in the schools and in teachers' versus therapists' use of computers as educational tools or as treatment tools; the emerging patient-client issue; and the prospective payment system (PPS) and the diagnosis-related groups (DRGs), which replaced retrospective reimbursement based on treatment costs. The PPS–DRG model resulted in shorter hospital stays and treatment of more acutely ill patients, for whom occupational therapists were expected to increase productivity, facilitate early discharge, and maintain quality of care—certainly competing if not conflicting goals. For educators, who are already struggling with the most functional mix of courses to prepare therapists for changes in practice, there is the ultimate conflict of making the field an academic discipline to counter the mounting threat to the survival of professional schools at the university undergraduate level.

A changing world? No doubt about it. But as Burke (1984) pointed out, "Occupational therapists are used to change. It is very much a part of our everyday practice when we work with people who are experiencing disruption and dysfunction in their lives" (p. 24). To the aspect of change that we have always faced, there must now be added the external forces that have caused multiple changes in the health care provision system of which we are a part. The form of change that challenges our third generation is admittedly different from the changes that confronted the earlier generations of therapists, and such changes will undoubtedly differ for those who follow. If we are not, as Burke said, used to change, we should think about becoming so, because as Heraclitus, a fifth century B.C. Greek philosopher noted, "There is nothing permanent except change" (Bartlett, 1955, p. 12a).

Even those who accept the inevitability and permanence of change, despite the opposing connotations of those words, may still find change uncomfortable—a natural reaction to the unfamiliar and unknown. If, however, we consider the alternatives to change—stagnation and obsolescence—we can see the logic of accommodation. Mindful that change is not a synonym for progress, we must expend extra effort to ensure that change will not pass us by.

This brief review of our history shows that we have, indeed, adapted to many changes over two and a half generations. I believe that the factor enabling us to adjust to those changes has been our allegiance to our basic beliefs in the interrelationships between occupation and health and our continuing application of those beliefs in the occupations we use to maintain or restore health and to prevent disability. I also believe that the vision we hold of our potential in a changing world will facilitate whatever other accommodations may be required of future generations.

The Practice–Education–Research Linkage

The interrelatedness of practice, education, and research—the three essentials of any enterprise—has been well established in the scientific literature and in our own literature as well. I did not feel it necessary to review the scientific literature for two reasons. First, in nearly all instances, our colleagues have used the scientific references in their respective reviews of the literature. Second, our colleagues have applied and related the rationale for linkages directly to our own field, thus sparing us the task of translations from the biological, behavioral, and social sciences.

I have therefore compiled the following brief statements on the subject of linkages and recommend that the reader review not only the statements but the total papers from which they were taken. With the exception of Flexner, all of the authors cited below are occupational therapists with both commitment to and expertise in research.

First, from Flexner (1910):

Professions are learned in nature and their members are constantly resorting to the laboratory and seminar for a fresh supply of facts. (p. 49)

And from our own ranks:

Yerxa (1964) said, "The development of the research attitude in every student and every clinician is the beginning of the development of professionalism in occupational therapy. Once critical thinking becomes a habit, research activity inevitably follows." (p. 22)

Ethridge and McSweeney (1971), authors of the first textbook on research in occupational therapy, noted that "through practice, questions are raised to be studied through research, the results of which . . . modify and improve practice." (p. 1)

Writing about education for research functions, Rogers (1982) said, "The proposed goals for professional education are to educate therapists who are inquisitive about their practice, use research findings to improve it, and participate in the conduct of research." (p. 16)

Gillette (1983), writing of Kielhofner's Health Through Occupation, said the book was devoted to "an examination of the full range of knowledge that has accrued through practice and research." (p. xii)

Reed (1984) stated that the purpose of her book was "to suggest some directions for research on theoretical and practice models in occupational therapy." (p. v)

Otenbacher, Barris, and Van Deusen (1980) advocated proceeding "from technical research literature to theory and from theory to practice to enhance the knowledge base of occupational therapy practice." (p. 111)

The American Occupational Therapy Foundation's (AOTF's) Research Advisory Council stated, "The national commitment to research that is related to occupational therapy theory, practice, education, and philosophy has been established." (Llorens & Snyder, 1987)

Research is probably the least accepted component of the practice-education-research linkage. Why, then, is research in occupational therapy so important to our future? Perhaps the most cogent reason is that the value of occupational therapy is more evident to ourselves than to others. The truth of this observation is best seen in our profession's belief that no age or disability is beyond the potential...
benefits of our services. Although we have always been motivated by these high ideals, and although many have realized them in resourceful ways, few among us would contest the need for greatly increased efforts to transform solid conviction and partial demonstration into the scientific documentation that is required to merit professionalism.

References


