Does occupational therapy deserve to be called a profession? This question has concerned occupational therapy in the last decade as evidenced by the frequent discussion of this subject in the literature. In 1979, Fidler responded to this question by adopting the views of the sociologist Etzioni (1969) who outlined criteria that define professionals and professions. Among these criteria are "rigorous, prolonged education and apprenticeship" (Fidler, p. 32), an organized, refined, and specialized body of knowledge, an ability to win and hold society's trust, autonomy, a code of ethics, and the assumption of responsibility, accountability, and liability. After applying these criteria to "organized occupational therapy and its practitioners" (p. 31), Fidler concludes that occupational therapists must change if they intend to become professionals.

Mosey (1981) takes the position that occupational therapy is a profession and she adopts criteria similar to Etzioni's (1969) in defining occupational therapy's philosophical and theoretical parameters. She delineates a model for the profession, creates an ethical statement, defines a domain of concern, and identifies legitimate tools for the profession. These criteria may be noteworthy, but Fidler and Mosey accept them without referring to their conceptual origins.

A Historical Perspective

Starr's (1982) comprehensive history of American medicine contributes to an understanding of attitudes toward professionalism. He reports that early in this century, in response to concerns which, by varying accounts, were focused on public welfare or competitive economic interests, Flexner assessed the quality of medical colleges prevalent at the time. Flexner found that some of these schools were exemplary, representing the best of medical knowledge of that time, but that others were of questionable merit, founded on dubious concepts. Some schools were presumed to have been established to generate revenue for the faculty and not out of concern for the consumers of either health care or education. Economic competition was a factor in medical education.

During that period, a variety of health care practices prevailed. In addition to the more conventional and familiar forms of medicine, the practices of homeopathy, chiropractics, and midwifery existed. Although some of these practices remain evident in veterinary medicine, modern chiropractic medicine, and nursing, they have been dissociated from modern medicine as it is presently understood.

To assure the quality of medical education, Flexner (1910) established criteria by which medical colleges should be judged. These criteria include education based on philosophy and theory, evaluation of recognizable practices, and ethical conduct. Flexner’s criteria for medical education are remarkably like those Etzioni (1969), Fidler (1979), and Mosey (1981) proposed for professionals. It appears that these criteria for medical education have been generally accepted to date as those by which professionals are identified. Although they appear to have merit, they bear evaluation for their exclusionary implications.

Starr’s (1982) history reveals that in the nineteenth century a group of medical colleges had been established exclusively for the education of women. It was not uncommon during that period for women to be physicians. It is important to remember in this context that, since antiquity, health care has traditionally been a woman’s career and that elsewhere in the world, for example in the USSR and in other communist countries, physicians tend to be women. These women’s colleges had substantial endowments and competed successfully for student enrollment. Stimulated by economic competition, men’s medical colleges began to admit women. Starr interprets these events as follows: Once women were admitted to men’s colleges, women’s colleges were no longer needed because women could be educated along with men in equal opportunity. Women at that time competed openly for spaces in medical colleges. The situation changed when the number of medical
schools diminished with the closing of those that did not meet the criteria established by Flexner (1910). Starr reports that when the opportunities for student placement became fewer, discrimination in the selection of students ensued and it became difficult for women, Jews, Blacks, and other minorities to obtain a medical education. Criteria that were established to assure quality education and practice tended to reduce the number of educational opportunities for students, effectively excluding almost all but white men from the medical profession.

**Gender Issues**

By reading Fidler's (1979) article, one begins to understand what the acceptance of these attitudes toward professionalism meant. Differentiating between professional and semiprofessional behavior, Fidler adopts McClelland's views regarding male and female characteristics. Citing studies of women in business, Fidler characterizes typical male behavior as professional and typical female behavior as semiprofessional. Aggressiveness, competitive, and collaborative attitudes are seen as both professional and male characteristics. Submissiveness, the need for acceptance, flexibility (derogatorily called inconsistency) in practice dictated by family demands, and the need for personal fulfillment are characterized as semiprofessional and female. A result of these arbitrary distinctions between professional and semiprofessional behavior is that male characteristics are assumed to be superior and female characteristics are assumed to be inferior.

One could go beyond pointing out the inconsistencies in these characterizations and conjecture: Did these qualities come to be associated with professional behavior because male-governed interests dictated the characteristics of students and practitioners? Starr's (1982) report, along with the foregoing analysis, provides some indication that perceptions of what constitutes professionalism may be gender based. Nursing and medicine have drawn their differences on this line. Although earliest health care providers were as likely to be men as women and caretaking attitudes were then the primary dimensions of practice, it seems clear from Starr's analysis that the early twentieth century in this country brought considerable gender divisiveness to health care.

**New Perspectives on Professionalism**

Professionalism may need to be redefined. Theorists address this issue in different ways. Larson (1977) questions whether a profession can be defined on the basis of its adherence to specified criteria. She notes that other vocational groups commonly identified as professions, including medicine, do not fulfill the criteria set by the sociologists. Miller (1983) is concerned about women valuing themselves by male-oriented criteria and specifically raises this concern with regard to occupational therapists. Gilligan's (1982) perspective that men and women are apt to reflect different styles of conceptualization, attitude, and devotion has implications for occupational therapy. As Miller suggests, since most occupational therapists are women, it is disconcerting, and possibly damaging to the health of the profession, to regard qualities identified as male oriented to be good and wholesome and qualities identified as female oriented to be inadequate and inferior.

Therefore, to resolve some of these inadequacies, I suggest that the question of professionalism be readdressed. To perform as a professional a person needs to have qualities aside from those cited by Fidler (1979). For example, the caring attitude that Gilligan (1982) exposes as female in nature, that Huss (1977) espouses for occupational therapists, and that Sachs (personal communication, March 1986) examines in our profession, is a quality unaddressed by the Etzioni/Fidler criteria, yet it must be considered essential for health professionals. Additionally, continuing education throughout a lifetime of practice is also not mentioned as a criterion for professionalism. It is a mistake to assume that if one has once fulfilled a predetermined set of criteria, one is forever a professional. Ongoing knowledge acquisition should be a professional requirement, along with devotion to teaching others from the vantage point of clinical experience. In fact, in many professions, there is a general expectation that its members will continue to update their education even though continuing education is not officially a criterion for professionalism. Some responsibilities that come with professionalism have been emphasized: achieving specific levels of education and publishing research. I submit that a professional should be as concerned with disseminating education as with receiving it and that educating the next generation in clinical caring is not only meritorious but obligatory for a professional practitioner. Perhaps additional qualities, which would further characterize professionalism, could be identified.

The issue is not whether occupational therapy is a profession but whether practitioners exhibit the characteristics of professionals. To resolve this issue, we first must determine for ourselves which qualities and behaviors are important for occupational therapists. As a profession composed largely of women, we must consider the qualities of women and ennable these qualities rather than denigrate them. Then we must strive for the highest degree of professionalism as we have defined it, just as we strive for excellence in other ways. As Browning puts it, "... a man's reach must exceed his grasp or what's a heaven for?" (Andrea del Sarto [The Faultless Painter], line 97). In essence, one need not feel inadequate for not exhibiting every quality ascribed to professionalism that has been discussed in this paper. No professional does, and as Larson (1977) points out, many professions as a whole do not either. Members of our profession and other "women's professions" should not feel inadequate if they do not conform to a specified set of criteria established by individuals external to our professions. Rather, they should take pride in the qualities they demonstrate as caring practitioners and devote themselves to continuing education within and outside of formal institutions, both as educators and as students, with an on-
going sense of responsibility to their patients and their profession.

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References


