Transition in Health Care—Critical Planning for the 1990s: Part One

Evelyn Jaffe

Evelyn Jaffe, vice-president of AOTA, calls on occupational therapists to accept the professional challenges of a future characterized by rapid growth and change. In Part One, she examines change: its implications in the larger societal context, and significance for occupational therapy and AOTA. In Part Two, to be published in next month’s AJOT, Jaffe continues with ways to cope with resistance to change, and she presents strategies for therapists to adapt to today’s fast pace of change.

“It must be considered that there is nothing more difficult to carry out, nor more dangerous to handle, than to initiate a new order of things.”—Niccolo Machiavelli, The Prince (1).

Mandate For Change

During the last five years of the 1980s we must prepare for the professional challenges of the future. In this era of rapid growth and change, there has never been a greater need for understanding the philosophy of growth, including the theoretical implications of change. Without this understanding and with only continued rhetoric, necessary professional changes will not be realized.

Recent leaders in our Association have been advocates for moving the profession beyond maintaining the status quo in health treatment to promoting quality care in all areas of the health delivery system. West (2) spoke eloquently about the need for occupational therapists to develop a professional consciousness and to respond to the trends of comprehensive health care to enlarge our concepts from that of therapist to health agent. Cromwell (3, 4) discussed the mandate for change in our educational system that would prepare occupational therapy students for the evolving patterns of health delivery. Johnson’s vision of a profession that could influence the tides of health care resulted in a major reorganization in the structure of the Association and the development of a Long-Range Plan, which identified the goals and objectives of the Association. Hightower-Vandam’s administration developed a strong financial base for the Association and saw the beginning of a system to identify issues in the health, social, political, and economic environment that directly affected both the profession of occupational therapy and AOTA.

Bain’s tenure supported the seeds of a strategic management system that could help bring about the influence on health care sought by the leaders of occupational therapy of the 1950s and 1960s. Bing’s administration has seen that this strategic integrated management system (SIMS) is used by the Association for planning activities and projects of both the voluntary sector and national office staff.

The use of AOTA’S Long Range Plan, the foundation of all Association planning, and the identification of strategic issues in health care for AOTA planning and management have already moved the Association into a leadership position among the allied health professions. Our system has served as a model for other associations.

Philosophy of Change

It is important that this method of planning be understood and adopted by the membership-at-large in order to move into the advocacy position of quality health care mandated by our leaders.

Planned change evolves over time. Until the twentieth century, the pace of change allowed people the opportunity to incorporate change while feeling a sense of stability. During this century, however, the scope, scale and, above all, pace of change have been accelerated to keep up with the rapidity with which our society is changing.

Social change before the 1900s
was so slow that it almost passed unnoticed in a person’s lifetime (5). The individual, and certainly a profession, could change gradually. New ideas and methods could replace old concepts and practices within the slow process of evolution (6). In today’s world, the demand to act is often present before we have had sufficient time to understand and assimilate its meaning and significance. In this era, professions are presented with a need and the pressure to respond to that need without the necessary time to reflect on the knowledge and skills required to respond effectively. Reality is continually outdistancing the preparation essential to respond to it.

Toffler’s warning from more than a decade ago has even greater significance today. He stated that it is no longer possible to ignore the roaring current of change; a current, he warns, that is so powerful that it can overturn institutions, shift our values, and shrivel our roots (7).

Organizations that continue to maintain a bureaucracy or formal organizational structure to deal with the routine, day-to-day business or to maintain ideas simply because they worked in the past will surely fall by the wayside (8, 9). These operate under a conventional, “safe” management system and thus lose the essence of the issue; the intuitive, creative, risk-taking side of progress. Gardner spoke of “organizational rot” when he described the usual organizational structure that is designed to solve problems that no longer exist. There is a need for “organizational fluidity”, a concept that addresses new issues and allows organizations to use communication strategies and decision-making techniques that result in quick action (10). This often involves taking risks and the juxtaposition of both rational safe reasoning with a creative, interactive philosophy.

**Challenge of the 1980s**

As an organization, AOTA must develop strategies to strengthen and enrich the profession of occupational therapy in the 1980s if it is to be successful in the context of societal change in the 1990s. The need for specific approaches to ensure a dynamic role in the health care system has never been as great; the current upheaval in health care is dramatic. An organization and a profession must be able to change its structure or focus in response to changes in the environment. This change may thus require the development of several different organizational characteristics and behavioral patterns, responsive to different external conditions (11). Toffler stated that the prevention of future shock demands the necessity for transitional models or “change-regulators” to act as buffers and balance wheels by which societal acceleration can be harnessed or channeled (7). Organizations and health systems therefore must reexamine priorities and develop new techniques for managing health services. Occupational therapy and AOTA must reconceptualize their roles in the health care system, examine their methods, and make the necessary changes. The alternative is that someone else will make the changes for us (12).

**AOTA—The Reorganization and Move to Strategic Planning**

More than two decades ago, Mary Reilly stated quite cogently, “If we [occupational therapists] fail to serve society’s need for action, we will most assuredly die out as a health profession. It is also most assuredly true that if we did dissolve from the scene, in a decade or so, another group similarly purposed and similarly organized and prepared would have to be invented” (13).

Throughout this period other forward-thinking leaders in occupational therapy have reexamined our definitions and reevaluated the goals of the profession. One theory of innovation in organization implies adoption of goals, processes, policies, or theories that are departures from the organization’s traditions. The organization must pass through several stages to reach innovation: (a) knowledge, (b) dissemination, (c) persuasion, (d) decision (14).

Our profession is at the first stage, knowledge or awareness. As stated earlier, several recent leaders saw the need to assess the impact of changes in the social and health care systems as they relate to occupational therapy as a profession. Since the mid-1970s and the development of a long-range plan, the Association has continued to grow based on what has been learned about member needs; surveys from the National Office and state associations, and input provided by our members to the various components of the volunteer sector, including the Representative Assembly (RA), the Commission on Practice (COP), the Commission on Education (COE), the Commission of State Association Presidents (CSAP), and the Special Interest Sections (SISs).

The effects of the accelerated rate of change in society these last two decades on health services...
and health professions is evidenced by the number of public health laws enacted by Congress. Of the 35 major health laws passed in the last 200 years, 28 were enacted since 1960 (15). Health associations could not ignore the consequences of such legislation and the factors in society that demanded it.

AOTA has attempted to keep pace with these changes by using its Long Range Plan as a dynamic document, along with SIMS, to plan Association activities based on the forecasting of external issues that might have an impact on health services and occupational therapy. The Long Range Plan establishes the scope and major goals of Association activities, and SIMS allows the Association to identify those emerging issues crucial to the profession and aids in the development of measurable objectives to facilitate a quick response to current and predicted trends. SIMS includes trends analysis in the four major scanning categories of social, economic, technical and legislative/regulatory developments.

Barriers to Change

In the early 1970s the need for organizational and institutional change in occupational therapy to maintain the relevancy of our profession and Association was discussed (16). At this time there was concern that our Association was not completely in tune with the many changes occurring in health care. In the last ten years, AOTA has made considerable organizational changes that have resulted in a recognized leadership position among health organizations. Although AOTA is in the forefront of organizational leadership with the use of SIMS, members must also be interested in addressing external issues and become involved in planning for their own future and that of the profession.

As stated earlier, change usually requires a period of incubation to allow the process of recognition, internalization, and acceptance to occur. Often it is easier for those in leadership positions who continually confront the broad issues of the total health care delivery system to understand the changes demanded by the external environment on health than the general membership. The majority of occupational therapists, as with many other “educated and otherwise sophisticated people, find the idea of change so threatening that they attempt to deny its existence” (7). Despite the oratory, the mandate, even the awareness of crisis in the health field, there are too many of us whose intellectual understanding has not yet reached internalization. This critical facet of human nature may not have been taken into account in the planning and implementation of many professional activities. Individuals or groups may react in different ways when faced with the need for change, from passively resisting the thought of change, to actively attempting to undermine efforts to deal with change, to pursuing ways to cope with the change process. Even changes that appear to be positive and rational involve fear and uncertainty (17). Although many persons recognized that increased knowledge of the impact of external factors was essential to maintain viability as a profession, this caused not only concern, but confusion and fear. In the early 1970s we were warned that change processes at best are not pleasant, but in times of a rapidly accelerating society, change can produce shattering stress and disorientation (7). The four most common reasons people resist change include (a) a desire to prevent losing something deemed of value, (b) a misunderstanding of the meaning of the change and its implications, (c) a belief that the change is not appropriate, and (d) a personal frustration with and low tolerance for any changes (17).

Changing Models of Treatment—A Change in Values?

As the model of occupational therapy services began changing concordant with changes in medical practices in general, placing health on a life-span continuum from birth to death and encompassing concern for the pre-illness, health maintenance phase, many therapists wondered what would happen to the profession’s historical emphasis on restoration and rehabilitation. Would the profession lose status in the eyes of other health professions if there were a major change in the focus of occupational therapy services? Would this be a violation of the principles on which occupational therapy was founded?

Misunderstanding of the Implications of New Models of Services

This fear led to a resistance to accept new models of service. There was misunderstanding that change would bring the demise of the treatment team and the arena of treatment in which therapists felt safe (3). There was considerable anxiety that such a change would cost more than would be gained.
Differing Analysis of Models of Practice

Some occupational therapists resisted a change in professional practices because they had embraced an early definition that described occupational therapy as any activity, mental or physical, definitely prescribed and guided for the distinct purpose of contributing to or hastening recovery from disease or injury. Operating under this philosophy and practicing the art of healing through guided prescription, the occupational therapist depended on identification with a hospital-based, treatment-oriented medical team. As the model of community-based, health-oriented occupational therapy began to emerge, the security of the traditional role of the occupational therapist was shaken. To some occupational therapists working in traditional settings, the new role of health promotion/disability prevention posed a threat and was viewed by some as being devised by "public health types" or "social action groups," and of no interest to them (18).

Lack of Tolerance for the Process of Change

This broader scope of services was not a part of former educational theory or practical experiences, therefore anxiety developed over the ability to cope with these new demands. Fear of a lack of skills produced resistance to change. Even though there may be an intellectual understanding of the need to make changes in modes of operation, some people are unable emotionally to make the transition (17). Often the major obstacle to organizational growth is the inability of its members to change their attitudes and behavior as rapidly as their organizations may require (19).

Other barriers to change in occupational therapy services include the lack of analytical data, the threat to the therapist's self-image, the communication gap, the narrow educational goals; and the shortage of specifically trained, identifiable leadership.

Lack of Analytical Data

Occupational therapy traditionally has not been a research-oriented profession. Most therapists devise their own evaluation forms and procedures pertinent to their individual programs, but seldom refine or replicate studies and publish results. Recently, AOTA and AOTF have supported endeavors to standardize evaluation procedures and to develop performance measurements as indicators of effectiveness. A larger percentage of therapists must adopt more analytical approaches to the techniques, procedures, and performance measurements of service to ensure efficacy in occupational therapy practices.

Threat to Self-image

Accountability to others often poses a personal threat to self-esteem. The development of criteria for evaluation of performance may create anxiety in those therapists who feel exposed when called upon to explain or evaluate program plans. Many therapists are unable to communicate the rationale for action when they operate under our traditional intuitive basis for program planning instead of a theoretical one. Fear adopting processes or theories that are departures from the profession's (or individual's) tradition is the real barrier to change in occupational therapy.

Communication Gap

Many members perceive a gap between Association activities and the views of the therapist in clinical practice. AOTA has attempted to diminish this communication gap by disseminating information such as Occupational Therapy News, with the "Member Hotline" column, "I'M Glad You Asked" column, and others; Special Interest Section newsletters; CSAP Exchange; ASCOTA newsletter; development of a liaison network; information packets available from the National Office; and, of course, The American Journal of Occupational Therapy. However, not all therapists always review this material; therefore, they may not have attained the high level of trust necessary to understand changes in the activities and structure of the Association (17).

Narrow Educational Goals

Practicing occupational therapists often look to the educators to develop new theories and methods of practice. Yet many schools of occupational therapy have continued a curriculum that has a rather traditional, conservative approach to education. In recent years, some schools have attempted to build the designs for learning that match theories for today's health needs, as mandated by Cromwell in 1970 (4). There are also some attempts to enrich our theory base through graduate study research. However, there is still too little evidence that occupational therapy schools have had the "courage to dump the old ways" (4). Most occupational therapy students are still being prepared for the same model of practice as those 5, 10, or even 20 years ago (3). Inflexibility in educational institutions imposes con-
constraints on the creativity of the present generation of students and does not encourage a sound climate for growth and adaptability (20).

Leadership Manpower Shortage

Many recent occupational therapy graduates aspire only to a level of clinical services that overlaps that of paraprofessionals or assistants. While in school, at the undergraduate level, students are seldom directed toward or trained for faculty positions in education or curriculum planning, toward careers as skilled research therapists, or toward leadership roles in administration, legislation, or local or national organization. Thus, the trained manpower for leadership roles in skilled research, administration, or education is limited (20). Rather than the result of specific training or experience in administrative leadership, promotion from staff therapist to supervisor to administrator is often the result of seniority. When institutions operate on this principle, with a hierarchical system of promotion based on rewards of longevity rather than competence, there results a tremendous barrier to change.

REFERENCES

4. Cromwell FS: Address given at conference on clinical affiliation in occupational therapy, University of Southern California. Los Angeles, Feb 1970