Maintaining Autonomy: 
The Struggle Between 
Occupational Therapy 
and Physical Medicine

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In 1948, several physiatrists, representing the emerging medical specialty of physical medicine, held a meeting at which they aggressively attempted to wrest control of occupational therapy's educational programs and national registry from the jurisdiction of the American Occupational Therapy Association. This paper offers one view of the events that led up to that meeting and the consequences of that struggle for occupational therapy autonomy. It focuses on several critical incidents in the struggle, the salient issues debated, and the strategies used by both physical medicine and occupational therapy to influence the outcome. The consequences of the confrontation as they affected occupational therapy education and practice are discussed.

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Throughout its history, occupational therapy has sought to maintain a balance of autonomy and cooperation in its relationship to medicine. That balance was severely stressed following World War II, with the development of physical medicine. As physiatrists organized and sought specialty status, they directly challenged occupational therapy's autonomy within the health care system. That challenge emerges as a pivotal event in the shaping of occupational therapy's education and practice.

This paper documents the development and implications of the relationship between occupational therapy and physical medicine in its formative years. Specifically, it focuses on the events surrounding the emergence of physical medicine as an obvious force influencing occupational therapy's education and practice between 1936 and 1954. Additionally, it explores the more subtle pressures imposed by physical medicine to shape occupational therapy throughout that era. The story, as told, is based on data gathered from both written and oral history sources. The oral histories were conducted with three occupational therapists, all now retired, who were active participants in the decision-making bodies of the American Occupational Therapy Association (AOTA) when physical medicine first sought to influence a variety of health care professions. Throughout this era, two of the occupational therapists were curriculum directors and one was an AOTA administrator.¹

Occupational Therapy and Physical Medicine
Prior to World War II

By the early 1930s, AOTA had established educational guidelines and accreditation procedures. In creating the guidelines, the Board of Managers of AOTA (Board) debated its vision for determining the qualified occupational therapist (Colman, 1984, 1990c), assessed the variety of practice settings, and evaluated the medical system within which its practitioners worked. Among other outcomes, the establishment of educational criteria led to a cooperative relationship between AOTA and the American Medical Association (AMA) (Colman, 1984, 1990c; Gritzer & Arluke, 1985).

In the mid-1930s, although the majority of occupational therapists were employed in mental health settings, a small but growing number of occupational therapists were working in rehabilitation programs. Gritzer and Arluke (1985) noted that as the rehabilitation movement emerged in this era, physical therapists and "physical therapy physicians" (p. 83) dominated the field. For these physicians to pursue specialty status within the

¹In accordance with the contract under which the original research for this paper was conducted, the identities of those providing oral histories were not to be revealed.
AMA, it became imperative for them to "stake[e] a claim to a unique territory" (p. 84). Thus, they sought control of occupational therapy and physical therapy departments and attempted to define occupational therapy as a physical therapy specialization. The AOTA Board resisted these efforts, seeking independence in administration and practice for occupational therapy (Colman, 1984). The Board focused its efforts on internal matters by increasing the effectiveness of AOTA, establishing control over professional activities, and developing internal certification procedures for regulating the quality of its therapists (Gritzer & Arluck, 1995).

As the United States began to mobilize for World War II, members of the Board debated ways of contributing to the war effort and increasing occupational therapy's recognition and position within the medical community. These debates centered on the status granted to occupational therapists by the U.S. Army. That status was negotiated through the introduction of a special training course designed to increase rapidly the number of qualified therapists working in army hospitals (Colman, 1984, 1990b). The focus of this work was in the area of physical medicine.

Concurrently, the physical therapy physicians (now called physiatrists) continued their attempt to incorporate occupational therapy into their territory. As part of this effort, they opened discussions on the possibility of merging occupational therapy and physical therapy education into one advisory council under their jurisdiction. The physiatrists assumed that such a council would facilitate a closer correlation between occupational therapy and physical therapy "with mutual improvement in therapeutic technique and more successful rehabilitation" (Watkins, 1942, p. 119).

In October 1943, AOTA received a brief letter from Dr. Frank H. Krusen announcing the establishment of the Baruch Committee on Physical Medicine (Krusen, 1943). Krusen stated that the purpose of the committee was to "survey the fields of physical and occupational therapy" and "[to] be influential in assisting in the adequate development of occupational therapy." The Baruch Committee held its first meeting in December 1943, at which time Krusen asserted that "it [has become] obvious that there is a tremendous need for the development of certain educational programs in the field of physical and occupational therapy" (Baruch Committee, 1943, p. 3). Krusen continued, "Physical medicine includes the employment of physical procedures, not only for diagnosis, but also for occupational and physical therapy" (p. 6). He argued against the value of the "psychological benefit with which ... a large part of occupational therapy is concerned" (p. 7). Later in the meeting, Dr. Howard Rusk stated,

The trained occupational therapist ... has ... the skills and the basic physiological knowledge. ... But I think it is a matter of our getting together with them and getting our program ordered as we see it and as they are able to carry it out. (p. 21)

Throughout the remainder of the meeting, the discussion centered on redirecting occupational therapy in a variety of ways. The committee members discussed the changes occupational therapy education programs would need to make in order to emphasize physical medicine techniques more fully. They also considered the problem of reorganizing hospital departments in order to place occupational therapy under the direct supervision and jurisdiction of physiatrists. In addition, Krusen introduced the term "occupational therapy technician" (p. 30) at this time.

In March 1944, after reviewing the transcript of the meeting, the Board debated the idea of a joint educational advisory council with physical medicine. Although, as originally conceptualized, the purpose of this advisory council was vague, the Board discussed the possibility of participation and responded favorably to the idea (AOTA, 1944). However, by December 1944, the Baruch Committee had issued a bulletin announcing the establishment of physical medicine as a new branch of medicine. Noting that physical therapy was already fully incorporated into physical medicine through its education, clinical practice, and research, the bulletin indicated that physiatrists planned to unite occupational therapy "under the banner of physical medicine" as well (Baruch Committee, 1944, p. 4).

Postwar Developments

By the end of World War II, AOTA had made great strides in advancing its level of professionalism and effecting its autonomy from medicine. These efforts resulted in the upgrading of the status of occupational therapy in the army, the election of the first female registered occupational therapist as President of AOTA, and the initiation of an in-house edited and administered journal, the American Journal of Occupational Therapy.

At its 1946 annual meeting, the Board discussed the increasingly problematic relationship between occupational therapy and physical medicine. Board members reviewed a document from the U.S. Public Health Service requiring occupational therapy and physical therapy to function under one department in U.S. Marine hospitals (Federal Security Agency, 1946). The document was replete with definitions of occupational therapy, as if a great effort had been made to fit the profession into a particular physical medicine mold.

Gitting other evidence of the problem, Henrietta McNary (AOTA Educational Field Secretary and member of the Executive Committee) noted that physiatrists were being trained in what they considered to be occupational therapy, and she feared disintegration of the quality of that training (AOTA, 1946). McNary suggested that AOTA develop training materials for the physicians "to get more information on hand so we can make it available to Occupational Therapists and to those whose job it is in any
teaching center to back her up” (p. 37). McNary continued, “The American Medical Association and the Council on Physical Medicine . . . has an Advisory Committee on Occupational Therapy, which is a group that can be of keen help to us. A closer working relationship with that group, I believe, is essential” (p. 38). There was no voiced disagreement from other Board members.

Physiatrists Approach Occupational Therapy

Sometime between 1946 and 1947, several members of the Baruch Committee on Physical Medicine approached the University of Illinois Medical School in Chicago for the purpose of developing a physical medicine division. The board of trustees of the medical school encouraged both the head of orthopedics and Beatrice Wade, director of the occupational therapy department, to talk with the Baruch Committee representatives. Wade was informed that the physiatrists hoped to develop an arrangement with AOTA similar to the one they enjoyed with physical therapy: the control of their education and their registry of therapists. Some physical therapists had shared with Wade their grave concerns regarding that arrangement, noting that under similar conditions it had become impossible for them to raise educational standards and upgrade clinical practice.

The Baruch Committee representatives first offered the occupational therapy department a grant to support a clinical director and entreated Wade to serve as a liaison with AOTA. Wade referred these representatives to AOTA president Winifred Kahmann, then contacted Kahmann to apprise her of the situation. Initially, Kahmann expressed to Wade uncertainty regarding the physiatrists’ position; she was unsure of exactly what they sought or what limitations they might impose on occupational therapy education. Kahmann’s hesitation may have reflected the view of many occupational therapists who, because of their positive experience with the army programs during the war, approved of the relationship that had developed between themselves and the physiatrists. In addition, many of those therapists applauded the potential to legitimate occupational therapists’ relationship to physiatrists, as they assumed that would result in an equalization of the competition that had emerged between occupational therapy and physical therapy in rehabilitation departments.

Cognizant of both sides of the debate, Kahmann, along with two other occupational therapists, Helen Willard and Henrietta McNary, agreed to meet with the physical medicine representatives in Chicago. During that meeting, the physiatrists announced their plan to assume control of the occupational therapy registry and the profession’s entry-level education programs. Kahmann, Willard, and McNary rejected the plan.

Having failed to influence activities at the national level with AOTA, several physiatrists attempted to gain control of the occupational therapy department at the University of Illinois. Through petitions and contact with administrators, the physiatrists pressured the university and the occupational therapy department to institute a plan for departmental restructuring that placed occupational therapy under their jurisdiction. They neglected to include Wade in their planned deliberations. According to Wade, several administrators learned of Wade’s incognizance of the proceedings and of her opposition to the plan and, without hearing arguments, denied the petitions.

Physical Medicine Continues Its Pursuit for Control

Despite these setbacks, physiatrists continued to pursue their mission to control occupational therapy education and practice, banking on support from the growing numbers of occupational therapists now working in rehabilitation. Along with an increased military status won during the institution of the special war courses that focused on rehabilitation (Colman, 1990b), physical medicine was able to offer occupational therapy a certain level of clinical status it had not previously known. In another attempt to sway opinion in favor of physical medicine’s control of occupational therapy, Dr. A. William Reggio (1947), director of Physical Medicine for the U.S. Public Health Service, published an article in the American Journal of Occupational Therapy outlining and discussing his definition of rehabilitation. He noted that a team approach was the best way to provide patient care. Several times throughout the article, in which he compared the rehabilitation team to a football team, he warned,

There is no place for individuals ... the physician [is] in charge as Quarterback. He should know all the “plays” and be able to call the signals ... [There should be] good team-work and no broken-field running attempts by any one self-appointed star player. This must include the quarterback! (pp. 149–150)

Here it appears that Reggio is criticizing what he perceives as occupational therapists’ independence in their approach to patient care. Unlike other physiatrists, Reggio stressed the importance of the psychological factors involved in physical injury and he invoked the philosophy of treating “the whole human being” (p. 149). He defined occupational therapy as “aimed to accomplish what the physician desires in such a way that the patient will cooperate to the fullest” (p. 151). Concerned with this continuing pressure, the Board again debated how to handle physical medicine’s demands. In a short, impromptu, and impassioned speech, Wade implored,

Frankly, I don’t think there is another time in the history of our organization that we don’t need to strengthen everyone’s think-

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The First Educational Conference

Although physiatry continued to gain influence clinically, the Congress of Physical Medicine remained unsuccessful in its attempt to gain control of occupational therapy’s registry and entry-level education. However, it persevered and called a meeting of the combined educational committees of the occupational therapy and physical therapy national organizations (Minutes of the Combined Meeting, 1948). This conference was designed to sway the occupational therapy decision makers in favor of a physical medicine–controlled education and registration program. One focus of the meeting was to establish physiatrists as directors of occupational therapy educational programs. The physiatrists argued that these programs needed to be run by medical directors, preferably physiatrists. During the discussion, Wilma West called for the establishment of a committee of occupational therapists, physical therapists, and physiatrists. The purpose of the committee would be “to review and evaluate the basic curriculum of both technical professions with the view toward possible revision of the curriculum to make it more adequate to the determined practical needs” (p. 7).

This appears to be the first indication that some members of the AOTA Board were willing to relinquish some autonomy regarding education and practice and adopt the term technician. Helen Willard (1979) noted, “Occupational therapy was commonly used much more by physiatrists than by physiatrists” (p. 9), and she continued to argue for the necessity of diversity in occupational therapy. However, a motion was passed recommending that a physiatrist or other physician with special qualifications in physical medicine serve as the medical director of occupational therapy and physical therapy schools. As the group continued with a discussion of curriculum, Willard again argued for a balance between psychiatry and physiatry in training. She also requested a discussion of the terminology used to refer to occupational therapists. Her request was denied and the meeting was adjourned.

From that time until the next education conference 6 months later, the AOTA Board debated the increasing pressure from physiatrists to assume responsibility for occupational therapy education and registration. According to the three oral histories, the AOTA Education Committee announced that it was giving careful consideration to the relationship between occupational therapy and physical medicine. Committee members debated the idea that the profession should remain available to all areas of medicine in order to best serve its patient population, work most effectively within the health care system, and maintain its autonomy and control of its entry-level education and professional standards. They argued over continuing to work with the AMA and resisting closer involvement with any one particular medical specialty.

The Second Educational Conference

This conference was also organized by the Council on Physical Medicine. The physical medicine representatives opened the discussions by proposing that they control the occupational therapy registry (American Congress of Physical Medicine, 1948). They argued for educational control, citing the need to increase rapidly the number of qualified occupational therapists in light of the projected continuing demand for personnel. Their plan for accomplishing this included (a) increasing the number of schools, (b) altering the entry-level education program to be more accessible to a greater variety and number of students, and (c) revising the curriculum to accommodate more technical and less theoretical material. They proposed again that a physiatrist head each occupational therapy entry-level education program and that the programs be housed primarily in medical schools and hospitals. The physiatrists concluded, “The very best type of training... that can be found [is that] which is supervised by a physiatri[st]” (p. 12).

As evidenced in the conference transcript, the occupational therapy representatives apparently prepared well for this conference (American Congress of Physical Medicine, 1948). They conducted themselves with discipline, appearing clear-minded and well-directed toward a goal of maintaining educational and registry autonomy. Their arguments were pithy and carefully placed, focusing on only two points. First, they noted that occupational therapy entry-level education programs were currently located in universities under academic rather than medical jurisdiction. This created a semantic rather than a contextual dispute of the proposals. For example, the physiatrists’ proposal referred to entry-level education as “training,” a term wholly unacceptable to the occupational therapy representatives who supported the academic viewpoint expressed by the phrase “professional education” (p. 97). Such arguments served to displace cleverly the covert intention of the debate while maintaining the occupational therapy view of the importance of an academic setting for entry-level education. Second, the occupational therapists argued that occupational therapy education was already supported by medical supervisory committees that included physicians from every relevant medical specialty, with particular preference toward none.

Some physiatrists countered with their intent to block the further development of occupational therapy entry-level education programs under the present system. They suggested that occupational therapy education would benefit from the “better medical direction and closer medical direction” (American Congress of Physical Medicine, 1948).
Medicine, 1948, p. 101) that physiatry would provide. Those physical therapists in attendance supported the physical medicine position, suggesting that such an association could only serve to strengthen occupational therapy. As the transcript indicates, the occupational therapists firmly stood their ground and suggested that such a policy demanded further discussion. They requested that the AMA become involved. Additionally, Helen Willard reiterated the view that the AOTA discouraged the development of any new schools following the tremendous growth of programs experienced during World War II.

Other physicians on the council did support the occupational therapy position. The oral histories revealed that during a recess in the proceedings, two physicians approached the occupational therapists and privately suggested that they not give in on any of the points being argued. These physicians, citing the issue of control, suggested that the AOTA would be foolish to give up its jurisdiction to physical medicine. At the time, the Council on Physical Medicine had no jurisdiction over occupational therapy education; the AOTA and the AMA jointly administered that system.

After vehemently pursuing the position that occupational therapy both clinically and academically belonged under physical medicine's jurisdiction, Dr. Sidney Licht, a physiatrist, challenged the group to determine whether occupational therapy was a part of physical medicine. He argued that if it was, then physical medicine had the responsibility to direct occupational therapy schools. That challenge served to disrupt the flow of the meeting. No one at the conference responded to it, and discussion continued in a disjointed way, devoid of much of the earlier passion. The other physiatrists finally agreed to retract the proposals and suggested that their concerns be taken only as the "recommendation of a group of people interested in physical medicine and interested in its future development, not as something to criticize or consolidate the present situation, but entirely toward future development" (American Congress of Physical Medicine, 1948, p. 103). The physiatrists then decided to send their recommendations to an intermediate committee and not directly to the AMA.

While the conference was underway, the AOTA Board held its semiannual meeting, at which the Education Committee presented a revised version of the Essentials of an Acceptable School of Occupational Therapy (Essentials, 1949) and a statement of policy regarding the relationship between occupational therapy and physical medicine. According to the minutes of the meeting, which did not detail either document, both received the Board's approval (AOTA, 1948b).

The Struggle Continues

The Council on Physical Medicine eventually sent its recommendations for occupational therapy education to the AMA. However, the AMA shortly thereafter supported AOTA's revision of the Essentials of an Acceptable School of Occupational Therapy. The discussions of this revision reopened the dialogue regarding control and direction of occupational therapy entry-level education. AOTA officials reiterated their view that occupational therapy education must represent a variety of medical specialties (AMA, 1949). This position was supported by physicians who were not physiatrists. Dr. Winifred Overholser (1949), a member of the Physical Medicine Education Council and an occupational therapy supporter, threatened to resign from the physical medicine group "with appropriate publicity" (no page) if the physical medicine representatives did not begin to "act responsibly" (no page) toward occupational therapy. The two Curriculum Directors who provided oral histories indicated that Overholser was concerned about both the singular focus of occupational therapy treatment advanced by physiatrists and the AOTA's autonomy. One diary (Anonymous, 1949) indicated that many physicians recommended that occupational therapy drop its association with the AMA altogether.

It appears that only a handful of occupational therapists were aware of and involved in the ongoing conflict with physical medicine. These women, acknowledging the weight and future implications of the situation, planned strategies to maintain occupational therapy's educational integrity (Kahmann, no date). During this time, they chose not to publicize the conflict or its outcome. This small group planned strategies and made decisions regarding the profession's future and did not seek support from the AOTA membership. It is important to note that, at the time, AOTA was led by the Board, which served as its decision-making body, and many of the women involved in the physical medicine conflict held Board positions throughout this era. They were, therefore, officially empowered to make decisions.

Conversely, the physiatrists involved in the conflict aggressively gathered support for their position from within the occupational therapy membership at large. Dr. O. R. Yoder (1949) produced an emotional and persuasive argument in which he criticized those occupational therapists who resisted the ideals of physical medicine for their "almost fanatical attachment to the educational background as an index of a person's value" (p. 302). He stressed the increasing demand for qualified occupational therapists and suggested that the future of occupational therapy was secure only if a closer relationship with physicians were fostered. He argued that educational standards had become so elevated as to be "beyond the reach of the majority of the nation's youth" (p. 302). A few occupational therapy educators supported physical medicine's view that entry-level occupational therapy education should be shorter and more technically oriented than was then mandated (Anonymous, 1950).

One occupational therapist who opposed the phys-
of policy, who supported the shortened, more technically oriented ship between AOTA and physical medicine (Report From the aggressive action college graduates might take official approved developing groups Medicine Education Conference and noted that AOTA for occupational therapy's position in the conflict. The report also included a statement sanctioning the initiation of a policy specifying the boundaries of the relationship between AOTA and physical medicine (Report From the Education Office, 1951). The group in AOTA working to stop physical medicine from taking over its education subsequently wrote a policy that clarified occupational therapy's philosophy, its relationship with physicians, and the scope and nature of occupational therapy entry-level education and certification procedures (Statement of Policy, 1950). Throughout this one-page document, the authors stressed occupational therapy's position regarding the profession's autonomy and educational integrity. Diplomatically worded, the policy was presented to the Council on Physical Medicine. In part, the policy stated that occupational therapy is prescribed by the patient's physician and administered by the occupational therapist with consideration not only of the specific disability but also of the patient's physical, mental, emotional, social, and economic needs. (no page).

The document specified the various areas of medicine with which occupational therapists practiced. It noted that the education of the occupational therapist has been determined by the demand of the various fields of medicine in which this service is needed. Balance in emphasis on the medical specialties must be maintained. (no page)

Shortly thereafter, the Council on Physical Medicine convened another education meeting and capitulated. A review of the events of that final confrontation cited the physiatrists as saying, "[We were] in no way trying to control occupational therapy and particularly the registry" (Typewritten Note, 1950, no page). The author of this review noted that the physiatrists also agreed that medical supervision for occupational therapy students need not be conducted primarily by a physician. The physiatrists' continuing objection to the term therapist and their suggestion to substitute the label occupational therapy technician for occupational therapist was noted as well. The author recalled that physiatrists objected to the term therapist on the premise that it implied diagnosis. This account also reports that physical therapists recommended that a joint committee review this problem and make further recommendations. The occupational therapists, relying on the strength of their policy statement, objected to any further action on the subject. They withdrew from the proceedings, stating that the "American Occupational Therapy Association had already taken official action in the matter and it was [no longer] this committee's business" (no page).

There is evidence that through 1954, physiatrists continued to pressure occupational therapy for educational and registration control (McNary, 1954; Report From the Education Office, 1951). The new AOTA president, Henrietta McNary, sent a letter to the American College of Orthopedic Surgeons, a group supportive of occupational therapy's position at the 1948 Education Conference, stating that (a) AOTA supported the concept of occupational therapy as a broad profession, as seen in its working relationship with various medical specialties over many years and that (b) AOTA opposed having occupational therapy educational programs under the direction of any one medical specialty (McNary, 1954). McNary asserted that occupational therapy's training must be balanced in psychological and kinetic areas of patient care and concluded that the "American Occupational Therapy Association does not wish to oppose physical medicine ... [but that they] do not wish to be absorbed by [it] or any other medical group" (p. 2).

Results and Implications

One major effect of the struggle with physical medicine appeared in the 1949 revision of the Essentials. Based on the content of the debate between occupational therapy and physical medicine, the revised Essentials included two compromises. First, the document contained a statement that occupational therapy schools were to be established in either accredited medical schools, colleges, or universities; the inclusion of medical schools constituted the compromise. Second, the guidelines established a requirement that the director of occupational therapy programs be a qualified occupational therapist and that the clinical training portion of the entry-level education program be directed by a physician or a committee of physicians (Essentials, 1949). In this way, occupational therapy maintained control over its entry-level education programs while responding to outside influences.

Another effect of the struggle may be seen in the strategies employed by each of the opposing forces to affect the future of occupational therapy. The physiatrists and the occupational therapists who supported them made their views known to the occupational therapy community and were thus able to influence the attitudes of the next generation of AOTA members (see Colman, 1984, 1990a, in press). One indication of the spread of their ideas is found in a student paper written in 1953 that
expounds the value of increasing the number of training centers for occupational therapists in medical institutions. The student described the expansion as a "healthy sign" for the profession (Wachter, 1953, pp. 20–21). This statement may suggest a spreading culture in occupational therapy regarding the profession's relationship to physiatry. As seen in subsequent literature that espouses physical medicine's view of occupational therapy (e.g., Locher, 1962; Murphy, 1958; Nationally Speaking, 1957; Robinson, 1961; Sokolov, 1957), the publicity promulgated by the supporters of physical medicine appeared to be effective in influencing the views of occupational therapists. The occupational therapists who directly engaged in the struggle with physical medicine did not publicize it until it was well underway. There is no evidence to indicate that they were able to gather support, even though they believed their actions were designed to protect the autonomy and integrity of the field, particularly with regard to subsequent generations. Thus, the group that so fiercely struggled to maintain occupational therapy autonomy may have done an injustice to their mission by remaining silent about their work. In addition to the educational policy changes that resulted from the struggle for autonomy, there were emotional effects of the conflict. As indicated in the oral histories, the women who pursued the situation to its conclusion believed that they carried the weight of the future of the profession. One of those interviewed perceived the situation as "harrowing and distasteful." In another account, an occupational therapist remarked that the group had been prepared to stand up even to the AMA if that's what it came to ... we had to take a stand because the future of the profession would have been terrible if we'd gotten under physical medicine. It would have been just dreadful... When one runs up against those kinds of things, one battles, not just for oneself or for one's position or for fun, if there is any in it, but because of a determination to maintain the standards of one's profession.

Despite the fact that such a posture was apparently a very difficult one for women in the 1940s, these women pursued their mission. They worried that should their demand for autonomy and educational control be publicized, it would jeopardize therapists and students in those programs and clinical departments supported through the auspices of physical medicine. It may follow that they therefore denied themselves the support of their colleagues and handled the conflict in isolation. The mission of maintaining professional standards through registration and education became the driving force for those occupational therapists who engaged in the struggle.

In the oral histories, two educators noted that they gained satisfaction from the immediate victory of maintaining control of the registry and the orientation of entry-level education programs. They defined victory as maintaining standards and autonomy with respect to (a) the registry, and (b) balancing the focus of entry-level education between psychosocial and physical dysfunction. However, both educators questioned the consequences and stability of that victory, providing an avenue for further research.

Summary

This paper documented a previously unrecorded conflict between AOTA and the emerging specialty of physical medicine as it related to occupational therapy's autonomy and professional standards. It outlined the development of the discussions and demands generated by physiatrists in their attempt to place occupational therapy under their jurisdiction within the health care system. AOTA's response to this force and the implications of the conflict were reviewed through a variety of written and oral history sources. ▲

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