

Maturing of the Profession Task Group Report to Ad Hoc Committee for Future of Occupational Therapy Education

The *Maturing of the Profession Task Force* was comprised of Gail Jensen, PhD, PT, FAPTA; Christine Peters, PhD, OTR/L, FAOTA; Doris Pierce, PhD, OT, FAOTA, Kathlyn Reed, PhD, OT, FAOTA, MLIS; and S. Maggie Reitz, PhD, OTR/L, FAOTA. We met by conference call on five occasions to discuss the Ad Hoc Committee's request to provide responses to five questions. These questions included:

1. What makes us unique?
2. What is our signature educational strategy?
3. Does the profession have "autonomy" in decision-making in practice?
4. How does the profession accept "power" and make decisions to move forward?
5. How do we do this?

Our deliberations began with discussions regarding the questions from a historical lens, philosophical and theoretical perspectives, as well as current and future fiscal, social, and geopolitical contexts. Through these discussions literature was identified for the group to read and assignments were made to draft background statements based on individual members' expertise. Draft background statements were vetted and discussed further during subsequent conference calls. Draft recommendations were developed and presented at the Fall joint meeting of Program Directors and Fieldwork Administrators via PowerPoint slides. Feedback from this group was then discussed and considered in the deliberation and crafting of the final recommendations. Below you will see a summary of our recommendations for questions one through four. In addition, this set of 24 responses addresses question five. Attached to this summary are the background statements that were developed by task force members, upon which the recommendations were built. The background statements are organized by questions one through four with one joint reference list.

We thank you for the opportunity to address these questions and make recommendations.

1. What makes us unique?

Recommendation 1. Harvest the potentials of the discipline of occupational science for occupational therapy through: research on occupation in relation to health and practice; increased critical conversations regarding the interrelationships of basic and applied research on occupation through the widening of the scope of publication venues; and research on and enhancements to occupation-centered education.

Recommendation 2. The profession should prepare for 2050, through research and education that is responsive to projected changes to occupations, lifestyles, cultures, health conditions, economics, ecology, and systems of health care, education, and research.

Recommendation 3. Shift to doctoral entry level by 2017, is recommended that the AOTA Executive Board determine the appropriate process for a realistic and expedient shift in entry level occupational therapy education by 2017.

Recommendation 4. Make the understanding of how change typically works and is effectively facilitated a core knowledge and competency of occupational therapists through: research and theory development in regard to occupational change, and improvements within educational programs to students' understanding and competencies in facilitating change in clients' occupational patterns.

2. What is our signature educational strategy?

Recommendation 5. Identify occupational therapy's signature pedagogy through targeted educational research. Several professions have engaged in investigations exploring their identified signature pedagogies, that is, the characteristic forms for teaching and learning that are fundamental to professional preparation. These pedagogies are pervasive and routine as they cut across courses, programs, and institutions. The recent series of Carnegie studies provides three dimensions of preparation for professional work: surface level (concrete operational acts); deeper structural level (assumptions about how to impart the body of knowledge) and an implicit moral dimension revealing a set of beliefs about the profession. After the signature pedagogy has been identified, research then needs to be conducted to answer questions such as -- What is it about the signature pedagogy allows the professional to take these complex activities that are now routine (once learned) and internalize them?

Recommendation 6. Provide financial support to researchers to evaluate innovative models of education including workplace learning to identify what is effective and not effective in preparing students for future practice. Many professions are conceptualizing the workplace as a learning progression or curriculum that makes a transformative difference in the thinking and practice for both educators and students. Potential research questions include -- What dimensions optimize or inhibit workplace learning? What is unique about workplace learning in occupational therapy? What makes learning extraordinary?

Recommendation 7. Investigate the effectiveness and student outcomes of various teaching and learning strategies. Determine the right balance between more traditional teaching and learning, laboratory work and alternative methods of teaching and learning through distance education with pressures to educate more students and meeting workforce needs.

Recommendation 8. Engage in cross health professions investigations on education processes and outcomes centered on critical questions central to preparing and ensuring graduates are collaboration ready to provide competent, efficient care.

3. Does the profession have “autonomy” in decision-making in practice?

Recommendation 9. Professional autonomy is, and should be, an ongoing goal. As technical occupational therapy knowledge and skills and socioeconomic factors change, the need to re-examine the potential threats to professional autonomy arise and must be addressed to avoid deprofessionalization.

Recommendation 11. Vigilance is required at the local, state, national and international levels. Develop a monitoring system as occupational therapy is not immune to any of the technical practice) and socioeconomic factors that threaten professional autonomy.

Recommendation 12. Monitor major sources of threats such as changes in state and federal legislation (e.g., licensure laws and rules, trends in educational funding, state and federal regulations related to health insurance reimbursement); actions of other professions to change their scope of practice (e.g., medicine, physical therapy, speech language pathology, psychology, recreation, music, athletics, kinesiology, orthotics and prosthetics, and others); changes in organizational management of hospitals, clinics, and other organizations; changes in accreditation processes, credentialing mechanisms, and educational trends; changes and innovation in technology; changes in societal views regarding health and wellness; and social changes regarding the role and function of professions in society.

4. How does the profession accept “power” and make decisions to move forward?

Recommendation 13. Continue to evolve the profession in order to ethically take power versus waiting to accept power; this can be facilitated through AOTA increasing leadership development projects, enhancing curriculum content and developing mentorship strategies so that occupational therapy practitioners increasingly accept the positive influence and benefits of power.

Recommendation 14. Define and determine the type, scope, and focus for power in occupational therapy that is consistent with the philosophical and values bases of the profession.

Recommendation 15. Increase grass roots opportunities and avenues for diversity in race/ethnicity, culture, and gender for leadership laddering that are not limited to the few. Apply these models to educational, practice, organizational, and global settings.

Recommendation 16. Re-evaluate innovative models from other professions and semi professions in healthcare, and other industries to see how successful hyperchange has occurred.

Recommendation 17. Address internal professional confusions and identify roles for the greater good of occupational therapy and occupational science, without drawing rigid boundaries. Internal unbalance creates an external chaos that makes a profession more vulnerable to infringement.

Recommendation 18. Identify gaining power as a foothold to the academic and service delivery market place in the strategic plan.

Recommendation 19. Seek non- traditional arenas to forge new opportunities for occupational therapy.

Recommendation 20. Expand autonomy through increased education. Conduct a feasibility by 2017 to study the ramifications and positive impacts of moving OTA education to bachelor's degree entry. Also see Recommendation # 3.

Recommendation 21. Increase breadth and depth of doctorate education and funding to include research scientific tracks, practice evidence tracks, and expand post doctorate opportunities and internal professional funding for occupational therapists and occupational scientists.

Recommendation 22. Increase political and jurisdictional power by mentoring occupational therapy practitioners into running for local, state, and federal elected positions.

Recommendation 23. Increase occupational therapy's presence in business, including Fortune 500 companies.

Recommendation 24. Develop strategies to use power effectively to benefit clients of all socioeconomic, cultural, and diverse backgrounds.

Respectfully submitted,

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Appendix A

Question 1: What makes occupational therapy unique?

Background and Literature Review by Doris Pierce, PhD, OTR/L, FAOTA

Occupation Makes Occupational Therapy Unique

Occupation is the Profession's Defining Focus

What makes occupational therapy unique is its focus on occupation. That is, occupational therapy is named for, defined by, educated to understand, and professionally equipped to apply and remediate, human occupation. As a unique perspective on human life, development, health, and healing, occupation is occupational therapy's unquestioned core. Again and again over its history, occupational therapy has experimented with new perspectives, differentiated its special contribution from that of other professions through collaborative service, incorporated additional perspectives, and extended itself into opportunities for practice within novel settings and populations. Always, this process has been demanding, even concerning, as the field's focus on occupation is tested by exciting external trends, adaptation to new values and expectations for service, and expansion of its knowledge base. Always, occupational therapy returns to its core focus on occupation, further refined by its extensions into new applications (Kielhofner & Burke, 1977). Always, the view of the client is a perspective on occupational lives, losses, and goals, despite the therapist's understanding of the pathologies with which the person is challenged (Pierce, in press).

Emergence of a Discipline

As occupational therapy has developed as a profession, it has searched for basic knowledge descriptive of occupation with which to inform practice. Some professions have found highly beneficial knowledge base matches in outside disciplines: engineering is well supported by physics, physical therapy by anatomy and kinesiology. Some disciplines have offered occupational therapy useful islands of knowledge that provide significant insights (i.e., neurology, anthropology). Unlike the close match that other professions have found with the knowledge bases of outside disciplines, occupational therapy has not found a discipline that is sufficiently focused on occupation or a closely related construct that can be counted on to strengthen knowledge-based practice to the degree that is found in the discipline/profession match of other health professions.

The audacious logic of Elizabeth Yerxa (1981, 1991a, 1991b, 1992, 1993, 1998, 2000a, 2000b; Yerxa et al., 1989) was this: if occupational therapy were to become a mature and independent profession, it must produce its own unique knowledge base. She then required faculty at the University of Southern California to begin that effort through the establishment of occupational science, beginning with the launch of a Ph.D. in Occupational Science in 1989 (Yerxa et al.). Since that time, occupational science has grown rapidly, as evidenced by the expanding numbers of occupational science articles, journals, books, societies, and Ph.D., Sc.D., and B.S. graduates (Glover, 2009; Molke, Laliberte-Rudman, & Polatajko, 2004; Pierce, in press). In occupational science, occupational therapy has undertaken the development of the knowledge base necessary to inform practice in regard to understanding occupation in human lives, relating occupation to constructs of other disciplines predicting typical occupational

patterns across development and populations, and insuring holistic occupation-based practice (Clark et al., 1991). The discipline demonstrates most of the hallmarks of a maturing discipline, although the final milestone of fully staffing academic departments with academics with terminal degrees in the discipline may not be reached for many years (Abbott, 1998, 2001, 2004). Not only is occupational science a unique disciplinary science, but the emergence of a new science from a predominantly female allied health profession is certainly an unusual development within the history of academic disciplines and professions. Even occupational therapy seems, at times, rather taken aback at this new science as a resource to practice, as accustomed as the profession has become to practicing from a patchwork and intuitive understanding of occupation in combination with a palette of models, standard approaches, techniques, and common sense. How to best infuse the early research products of occupational science into the education of practitioners is still a question very much under consideration.

Occupational Therapy, Past and Future

A Unique History

Another way of answering the question of what is unique about occupational therapy is to describe its distinctive history. Especially pertinent to the expansion of its knowledge base and practice capacities is the fact that the profession evolved in its earliest years within a bridging between the perspectives of mental health practice and physical rehabilitation practice. The stretching of the field's approach to practice so that it effectively encompassed such diverse philosophies as are found in these differing settings has pulled occupational therapy toward more broad and holistic

conceptualizations of practice. In the 1980s, the addition of a large proportion of school-based practice had a similar effect of widening the approaches of therapists to include a more significant emphasis on learning and development.

Occupational therapy in the United States has developed in a way that is reflective of its context. Many factors have had positive influences: Army occupational therapy training programs created in response to the two World Wars, the disability rights movement, the Individuals with Disabilities Education Acts, and others. In some areas, such as mental health, occupational therapy has not developed extensive services, possibly due in part to the stigmatization of the mental health population in the U.S. Competition for vocation-focused services in the early period of the field may have resulted in limited involvement in that area as well. These client population gaps are not necessarily the case for occupational therapy in other countries. Certainly, the for-profit health care system of the U.S. has exerted such a powerful shaping influence on the field that we are challenged even to discern it. Comparisons of the historical development of occupational therapy in different nations would be likely to identify further distinguishing characteristics of occupational therapy as it is practiced in the U.S. Similarly, it would be useful to do a comparative history of the development of occupational therapy and other similarly-situated health professions in the U.S., such as social work or nursing.

Lastly, in terms of the unique history of occupational therapy, we would be remiss if we did not state the obvious: occupational therapy is a predominantly female profession. Why this is, or how it shapes us, we prefer not to delve further or speculate. It is included here only for completeness and the reader is referred to the extensive

literature in this area for a potentially fruitful set of insights into the uniqueness of occupational therapy that may be due to its deep connection to women's values, customary occupations, and use or non-use of power in this culture.

Preparing for the Future Beyond 2017

The uniqueness of occupational therapy is shaped, not only by its past and present unfolding, but also by how it will engage the challenges and opportunities of the future. The American Occupational Therapy Association (AOTA) has completed commendable work to prepare for the future, using the vision statement for the 2017 anniversary of the profession to guide initiatives and decisions.

Luebben, Peters, Pierce, Price, and Royeen (2012) have proposed that occupational therapy should now begin planning for the year 2050. Changes to the earth, shifts in national and global demographics, increasing urbanization and poverty, globalization, and the emergence of new technologies will impact human occupations and, thus, occupational therapy and its clients (Luebke, 2009). The systems of science, health care, and education also will undergo dramatic changes that will also impact occupational therapy. The unique future of occupational therapy will be shaped by the degree to which it welcomes, plans for, adapts to, and takes advantage of opportunities presented by these projected changes.

The intent of this paper is not to detail the many ways in which everyday occupations will be shaped by the future, or the ways in which occupational therapy will need to respond. For now, let the following sketch of occupational therapy's future demonstrate the many possible ways that occupation focused services may be delivered in the future.

In the year 2050, occupational therapy will have retained its essential character through gradual and innovative change, co-evolving with a human culture that is diverse, elderly, urban, technological, globally-connected, ecologically-impacted, impoverished, and living collaboratively in non-kin groups. The mature discipline of occupational science will support practice that is focused on human flourishing, adaptable to all settings, and primarily serving elders. Presenting client issues will largely include chronic diseases, mental health needs and dementias, sleep disorders, ecological impacts on lifestyles, obesity, and failed adolescent transitions to adult work. Doctorate-prepared therapists will work globally and around the clock, communicate well across diversity, apply high and low tech technology, deliver services via tele-health, and frequently use group, population, and global approaches. Occupational therapy will apply a well-recognized philosophy of life in practice . . . blending an applied science with art of practice. (Luebben et al., 2012)

When Will Occupational Therapy Move to the Doctoral Entry Level?

At this point, it is clear that the move to a required doctoral entry level is in occupational therapy's future. Societal need for occupational therapists who are well prepared for the following competencies is driven by the increasing complexity of, and demands on, the systems within which they practice: completely self-directed practice, negotiation of rapid change, policy and advocacy work, research, and leadership. Pragmatic concerns and occupational therapy's tendency to cling to the status quo in all situations presently hold this key decision about the future of the profession in a state of limbo. Discussions of when to move forward are generally focused on detailing

impediments to that shift. The point usually missed in such considerations is that a slowed movement toward doctoral competencies has its costs in lost areas of service and decreased competitiveness, as the historical period of the profession's slow move to master's entry level clearly demonstrates in regard to the loss of mental health practice. Since it is clear that the future of occupational therapy will include doctoral entry, the remaining question becomes, simply, "When?"

Occupational Change: A Key Competency Awaiting Development

Current Understandings of Facilitating Change in Occupation

It is widely acknowledged that occupational therapists use occupation as their primary modality, or means of intervention, as well as their primary targeted outcome, or ends of intervention (Gray, 1998). To do so, therapists are centrally concerned with *facilitating, inducing, supporting, and creating change in occupation capacities and patterns*. That is, they support the increase in effective occupational functioning in everyday life. This therapist's art and the client's change in occupation have been referred to in many ways. Historically, it has most often been called adaptation. Taught strategies for facilitating a client's occupational change have been termed task analysis, grading, chaining, skill development, adjustment, problem solving, design, and many other descriptors.

Need for Theoretical and Empirical Development to Strengthen Change

Competencies

Although theorists have done important work within this conceptual area, the degree to which it has been developed is not reflective of the degree to which it is central to the field. Occupational therapists are expected, and somewhat prepared, to

enter chaotic and fluid life situations and make effective efforts to bring new patterns of organization and ability to the occupational lives of their clients. That is, they are expected to make occupational change. Not only are they expected to make change, but they are expected to do so in a manner led by the client. These are significant and highly valuable abilities of an occupational therapist, easily recognized in a master therapist. It is possible that the conceptual complexity of occupational change and the ways in which to effectively move a client from the initial to the desired occupational state has limited the degree to which this key area has been explicated. Despite these limitations, it is an essential skill which must be taught. Certainly, a wide variety of interdisciplinary theories and strategies are available to strengthen this area of occupational therapy education and practice (Gladwell, 2000; Rogers, 2003; Wheatley, 2006).

One Caveat

This response to the question of uniqueness, which has addressed occupation, occupational science, and occupational change, would not be complete without the following caveat. In recent years and in specific powerful influences, occupational therapy has narrowed its definition of desirable research to studies of clinical outcomes. The concern of this task group is that occupational therapy not be a “one trick pony,” abandoning its rich theoretical potential to ape medicine, secure grant dollars, and build university empires. Further, the level of cultural change faced with which the field and its clients will be faced in the near future calls for a broader response than can be provided by randomized controlled trials. Certainly evidence is needed, for better practice as well as to support the value of the profession in political domains.

Unfortunately, however, a single-minded valuing of this sole type of research can be expected to deter the development of descriptive, relational, and predictive research on occupation and its larger patterns, chill research that produces innovative practice, and deter historical research which is deeply informative to the profession. Although the current strong emphasis of evidence-based practice can be valuable in developing an understanding of occupation-based practice, it can also be detrimental, due to its tendency to reduce research questions to a focus on concepts more easily quantified than human occupation.

Appendix B

Question 2: What is our unique signature educational strategy?

Background and Literature Review by Gail Jensen, PhD, PT, FAPTA

Overview: Signature Pedagogy

What is a Signature Pedagogy?

Shulman (2005) argues if you want to understand a culture you study its nurseries. He makes a similar case for the professions. If you want to understand professional education and preparation you study the professional preparation environment. When you do this you uncover characteristic forms of teaching and learning that he calls - *signature pedagogies*. These signature pedagogies are pervasive and routine and cut across courses, programs, and institutions. Routine in this case means learning to do complex things in a routine manner (e.g., habits of mind focus in law, habits of heart focus in clergy); the signature pedagogy allows the professional to take these complex activities that are now routine (once learned) and internalize them.

The approaches or types of teaching done in professional education provide the organization for the fundamental ways that future practitioners are educated. Students (i.e., novices) are instructed in three core areas or dimensions of preparation for professional work: (a) to think;, (b) to perform, (c) to act with integrity. Professions vary in how much they emphasize these three dimensions. Law schools spend much more time on thinking and case law analysis and far less time on performance of activities or skills related to legal practice.

Key findings regarding signature pedagogies from the Carnegie Preparation for the Professions Studies, clergy,(Foster, Dahill, Goleman, & Tolentino, 2005), law

(Sullivan, Colby, Wegner, Bond, & Shulman, 2007), engineering (Sheppard, Macatangay, Colby, & Sullivan, 2008), nursing (Benner, Stuphen, Leonard, & Day, 2009), and medicine (Cooke, Irby, & O'Brien, 2010) follow:

- Shapes the character of future practice
- Symbolizes values and hopes of the professions
- Reveals the tensions that are part of professional preparation – demands of the academy vs demands of profession including multiple roles and expectations for professional practice
- Most fruitful to carefully observe the “pedagogies of the profession in action”

Three Dimensions of Signature Pedagogy Compared across Law and Occupational Therapy

Surface Structure Definition	Law	Occupational Therapy
Concrete, operational acts of teaching and learning; includes showing and demonstrating, questioning and answering; interacting and withholding; approaching and withdrawing	<p>Set of dialogues controlled by the teacher; authoritarian; most of exchanges go through the teacher; teacher controls pace, drives the questions, focuses on same student a number of times (Socratic method)</p> <p>Discussion centers on the law, texts used range from judicial opinions that provide precedent, contracts, settlements, testimonies and regulations</p>	Occupational therapy has used a modified apprenticeship or relational learning approach based on relative close teacher-student relationships and case based methodology (case studies, case examples, storytelling, narratives, chart reviews). Textbooks and lectures describe conditions that result in loss or risk of loss of occupation and occupational performance (occupational dysfunction, occupational deprivation) and give case examples

	<p>Legal principles provide organization and are exemplified by the text</p> <p>Expectations for students that they know the law, engage in intensive verbal dialogue with teacher as they uncover the facts of the case and the principles that are all part of the interpretation</p>	<p>and techniques of how to develop, restore, or maintain client as an occupational being who can perform occupational activities and tasks in everyday life. Problem solving to gain clinical reasoning skills, is often based on ill-structured case examples in which there is no absolute right answer but rather a better answer based on the client's situation and preferences. Laboratory classes stress active engagement through learning by doing. Laboratory tasks are designed 1) to provide opportunity to develop and practice skills demonstrated by the instructor, 2) experience and discuss affect and emotional reactions to task performance and contextual situations, and 3) share learning experiences with classmates in a safe, protected environment.</p>
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Deep Structure Definition	Example/legal	Occupational Therapy
Set of assumptions about how to best impart a certain body of knowledge and know-how	<p>Underlying assertion is that what is being taught is the theory of the law and how to THINK like a lawyer;</p> <p>The law is not necessarily</p>	Occupational therapy is based on the assumption that engagement in occupation supports (and is an integral part of) human

	black and white but it is the process of analytic reasoning that is fundamental; legal theory includes confrontation of views and interpretations; the case dialogue and pedagogy is competitive and confrontational	health and the effective performance of daily occupation/activity. Learning has traditionally used the apprentice method (mentor-mentee model, relational approach) together with experiential learning and case analysis methods to convey the knowledge, skills, and attitudes deemed important to the student learning the process of occupational therapy (assess, plan, intervene and achieve selected outcomes for and with clients).
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Implicit Structure Definition	Example/legal	Occupational Therapy
Moral dimension; set of beliefs about professional attitudes, values and dispositions	Tension in legal judgment which could be legally correct but not perceived as "fair"; in other words the focus is on learning the law and there is a distinction between legal reasoning and moral judgment;	Occupational therapy process can enable a client to promote, develop, restore, maintain or prevent loss of health and occupational performance as opposed to dysfunction/deprivation through engagement in (performance of) selected occupations that have intrinsic meaning and purpose to the client within the context (environment) in which the client lives on a

		daily basis.

What is missing in the signature pedagogy?	Example/legal	Occupational Therapy
	<p>In legal education the pedagogies of both practice and performance are not mainstream and not necessarily required</p>	<p>The classic learning approaches (“hands on,” “watch the master,” and “share experience with classmates”) are being challenged by the need to education and train more students. The classic approach requires small class size where the instructor can model to and monitor (test) each student individually. Distant education has to be planned to balance the need for “touchy, feely” kinesthetic learning with the observational and “textbook” learning. On-site educational programs must increase the number of laboratory sessions (and experienced instructors) to accommodate larger cohorts of students. More fieldwork sites must be identified which may be located in more remotely</p>

		<p>from the site of didactic instruction. In addition, the opportunity to problem solve complex case examples with an expert (master clinician) to gain practice in clinical reasoning must be maintained</p>
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A chapter by Schaber, Marsh and Wilcox in *Exploring More Signature Pedagogies: Approaches to Teaching Disciplinary Habits of Mind* (Chick, Haynie, & Gurung, 2012) makes the case for “relational learning and active engagement” as a signature pedagogy in occupational therapy.

Possible Considerations for Teaching and Learning in Occupational Therapy

Preparation for Uncertainty

In spite of the importance of both theory and practice, professions are not simply conduits for taking knowledge from the academy and applying it to the field. The process of judgment intervenes between knowledge and application. Human judgment intervenes between knowledge and application. Human judgment creates bridges between universal terms of theory and the gritty particularities of situated practice. And human judgment always incorporates both technical and moral elements, negotiating between the general and the specific, as well as between the ideal and the feasible. (Shulman, 2004, p. 534)

The challenges of professional education are summarized well here by Shulman (2004). In professional education we are constantly challenged to find balance in preparing graduates who know, apply, think, render judgment, and are able to manage the uncertainty of practice yet we live in a system that tends to favor emphasis on certainty and measures of accountability. We know that an academic knowledge base is important but not sufficient for practice. It is learning, learning for practice, and

learning from experience that makes all of the difference in professional education (Jensen & Purtilo, in press).

There are many explicit and implicit messages that are part of everyday culture in professional education.

- Professional students move as fast as they can through undergraduate courses in the liberal arts or humanities so they can begin with courses that really matter, the professional applied courses where they see the direct application of skills and knowledge to practice.
- With an increasing number of applicants for professional programs, there is a tendency to focus on more quantitative achievement measures that often favor performance in the science and technical courses over student achievement in the humanities.
- Faculty curriculum discussions about course credits and programmatic emphasis usually view the foundation science courses as essential, tough, and predictive of student success in contrast to the behavioral sciences or more humanistic components of the curriculum.
- When it comes to assessment of student learning and performance, assessments generally favor objective measures of performance such as multiple choice examinations over other assessments such as engaging students in their own self- assessments, creative work or narrative case creation.

Many of the health professions are engaged in exploring the learning from experience that occurs in the workplace, the community of practice. This workplace

learning involves relationships and interactions in the practice community. It is in the practice setting where social cultural learning theories that focus on the importance of situated learning is at work. Here the learning is participatory and interactive as there are meanings or social construction of knowledge created in these communities of practice (Harris, 2011; Webster-Wright, 2009). Again occupational therapy has much to offer in their understanding and experience in situated learning that is essential to professional preparation.

Challenges in Human Improvement

Cohen (2005) argues that professions of human improvement such as therapists and teachers share a common struggle. While expertise is essential to the practice, it is also inadequate as the outcome depends on human performance of the client/patient/student. This predicament of human performance also brings a certain amount of uncertainty to the practice environment. The practitioner's ability to mobilize and sustain the clients' commitment is critical to the success of the task and ultimate outcome. The practitioner cannot succeed without the patient working together to meet challenges. Given the strength of occupational therapy's focus on relational learning and active engagement of the client this may be an area of unique contribution?

Multiple Frames of Reference

One of the findings that the Carnegie studies have continued to advance is the importance of connecting a strong liberal arts preparation with professional education as foundational to developing practical reasoning skills. This liberal arts preparation provides the learner with the ability to understand meaning, see multiple frames of reference, and engage in a narrative mode of thinking – all of which is essential for

practical reasoning. Preparation in the humanities provides a means of understanding and interpreting the complexities of purpose and meaning. William Sullivan (2005) has continued to argue that practical reasoning, not critical thinking, is foundational to professional practice across all professions. Sullivan (Sullivan & Rosin, 2008) describes practical reasoning as a three-fold movement or pattern of thinking. For example, in health care, there is usually a process between the patient and the provider that involves a “rhythm of moving back and forth from engagement with the concrete situation, through observation and analysis, and then back again to the more informed engagement with the person and the situation. It is the therapeutic purpose that creates the “imperative for clinical judgment.” A health care provider must decide what course of intervention is good for a particular patient, at a certain time, and in this situation. While scientific analysis and problem solving are important skills in professional practice, the ability to engage and learn through the social process - interactions and relationships of practice or apprenticeship is just as important. Sullivan would further argue that liberal education is also concerned with teaching judgment and complex reasoning in uncertain and changing situations.

Appendix C

Question 3: Does the profession have autonomy in decision-making in practice?

Background and Literature Review by Kathlyn Reed, PhD, OT, FAOTA, MLIS

Professional Autonomy in Occupational Therapy

Clarifying the Question

The recommendations and statements below are based on the following assumptions:

- That the question of autonomy is addressed primarily to the profession of occupational therapy as a whole (group, aggregate, organization) and secondarily to individual autonomy in decision making by individual members
- That the term “professional autonomy” of the organization (AOTA) and of the profession of occupational therapy is the major areas of concern
- That the question is focused on issues of both technical (knowledge and skills) and socioeconomic significance to occupational therapy practitioners as opposed to ethical autonomy (rights) of clients
- That the term “decision-making” is aimed at issues related to decisions to be made by the AOTA, rather than at the level of an individual practitioner for a particular client or service program, and can be interpreted broadly to include both technical (knowledge and skills) and socioeconomic issues in professional autonomy
- That a review of terminology concerning autonomy is needed to clarify what is being discussed, because the word “autonomy” is used in many different contexts which can be confusing to the reader.
- That a short review of characteristics of a profession and the history of professional autonomy in occupational therapy is needed to clarify the current position and status.
- That recommendations for actions to be taken by AOTA to increase or broaden the professional autonomy of occupational therapy and occupational therapy practitioners should be included.

Terminology

- *Attitudinal autonomy*: The belief that one is free to exercise judgment in decision making, reflects the way individuals feel and view the work of a profession (Wade, 1999, p. 311)

- *Autonomous* (physical [occupational] therapist) *practice*: Characterized by independent, self-determined professional judgment and action. Physical (occupational) therapists have the capacity, ability and responsibility to exercise professional judgment within their scope of practice, and to professionally act on that judgment (APTA, 2003). The World Confederation for Physical Therapy (WCPT) believes that physical therapists, as autonomous professionals, should have the freedom to exercise their professional judgment and decision making, wherever they practice, so long as this is within the physical therapist's knowledge, competence, and scope of practice (WCPT, 2011). Note: The word "Occupational" was added to the definitions to provide an example of what the wording might entail from the occupational therapy perspective.
- *Autonomy*: The quality or state of being self-governing, self-directing; freedom, moral independence, or a self-governing state (Mish, 2003, p. 84)
- *Consultation*: The practice of inviting a colleague to participate in the appraisal of the client's need and/or in the planning of the service to be rendered. (Greenwood, 1957)
- *Countervailing Force*: A social force that is limiting or preventing a social change such as a policy revision from occurring (Sandstrom, 2007, p. 106). Example: Current policy edict (MEDPAC) which reinforces the role of the physician (expert on pathology) as gatekeeper to therapy services that address impairments and functional limitations (activity and participation limitations).
- *Deprofessionalization*: The social process by which the professions are losing the characteristics of a profession, including autonomy (Sandstrom, 2007, p. 106)
- *Direct/Unrestricted Access*: The physical (occupational) therapist has the professional capacity and ability to provide to all individuals the physical (occupational therapy) services they choose without legal, regulatory, or payer restrictions (APTA, 2003) Note: Occupational and occupational therapy added as examples only.
- *Disablement*: Focuses on addressing the impairments and functional limitation. In International Classification of Function (ICF) terminology activity and participation limitations. (Sandstrom, 2007, p. 102 based on Guccione, 1991.
- *Dominance* (professional, occupation): The ability of a profession to control the terms of another profession's work (Sandstrom, 2007, p. 106). The authority to direct and evaluate the work of others without in turn being subject to formal direction and evaluation and ... is sustained by the *dominance* of its expertise in the division of labor (Freidson, 1970b, p. 136)
- *Functional Autonomy*: The degree to which work can be carried out independently of organizational or medical supervision and can attract its own clientele independently (Freidson, 1970a)

- *Insularity*: An internal process by which a profession focuses on its own needs to the detriment of larger social needs and responsibilities (Sandstrom, 2007, p. 106)
- *Individual (Client) Autonomy*: In ethics “the governing of one’s self according to one’s own system of morals and beliefs or lifeplan” (Veatch & Flack, 1997, p. 277). Includes confidentiality, right to accept or refuse treatment, informed consent, moral independence. Not the focus of this document. Provided for clarification only.
- *Individual (Practitioner) Autonomy*: Ability to control the conditions of one’s [professional] work. This definition is a secondary focus of the discussion
- *Medicalization*: A process by which disablement is viewed as a problem centered in the person (pathology) and the solution to be controlled by a medical provider (Sandstrom, 2007, p. 106)
- *Profession*: An occupation that regulates itself through systematic, required training and collegial discipline; that has a base in technical, specialized knowledge; and that has a service rather than profit orientation, enshrined in its code of ethics (Starr, 1982, p. 15)
- *Professional (Group, Occupation, Aggregate) Autonomy*: [Professional] autonomy is a negotiated, social contract between a profession and policy elites based on the public trust in a profession to act in the best interests of the society. A core purpose of professional autonomy is to preserve the individual autonomy of people... [Professional autonomy] is an outcome of a trust relationship established between a profession and society...[Professional] autonomy is a privilege and allows the profession to have greater influence over the everyday terms of his or her work than comparable freedoms available to other workers (Sandstrom, 2007, p. 99). [Professional] autonomy is the ability of a reflective practitioner to make independent judgments; open to initiate, terminate, or alter physical therapy intervention (APTA, 2004). The most critical...elements...are related to the organization of practice and division of labor (Freidson, 1970, p. 133)
- *Professionalization*: Refers to the process by which an occupation, once it has emerged, takes on the characteristics of a profession as an ideal type of occupation (Maxwell & Maxwell, 1984, p. 336)
- *Rationalization*: The social process by which human work behavior is organization into bureaucracies through the development of rules and protocols (Sandstrom, 2007, p. 106) Rationalization affects professional autonomy by organizing professional work into systems that can be controlled by policies and managers. Trust, instead of existing in the patient-provider relationship, is placed in the organization and its rules and procedures in order to ensure high-quality, cost-effective care (Sandstrom, p. 101)

- *Referral*: Practice of affording colleagues access to a client or an appointment (Greenwood, 1957)
- *Socioeconomic Autonomy*: ability of the worker to ascertain and allocate the economic resources needed to complete his or her work (Freidson, 1986, pp. 24-25). Limitations are “related to the increasing costs of health care, public perception of insularity of the professions and increased public confidence in government and capitalistic enterprises [such as] changes in reimbursement policy (managed care) for example” (Sandstrom, 2007, p. 100)
- *Sponsorship*: An occupation may create and sponsor another occupation in the status struggle within a differentiating occupational structure. Such sponsorship will likely have a different effect on the recipient group than if that group were to struggle on its own under conditions of “pure” competition (Maxwell & Maxwell, 1984, p. 331).
- *Technical (knowledge and skills) Autonomy*: right to use discretion and judgment in the performance of work (Freidson, 1986, p. 154). Technical autonomy is regulated by standards of practice, accreditation, and licensure...[which] act to define the technical autonomy of a profession (Sandstrom, 2007, p. 100)

Characteristics of a Profession (Greenwood, 1957)

- Systematic body of knowledge (element of superior skill)
- Professional authority (extensive education)
- Sanction of the community (accrediting process, licensing system)
- Regulative code of ethics (commitment to the social welfare)
- Professional culture (organizations, associations, careers)

Sequence of Professionalization (Ritzer, 1977, p. 47) with occupational therapy history added in brackets

- Full-time occupation (uncertain who was employed full-time but definitely by 1918, Walter Reed Hospital) Note: Reconstruction aides were civilians, not federal employees.
- Change of name, which becomes the occupation’s exclusive domain (1914, Barton; change from occupational aide or occupational worker to terms “occupational therapy/therapist”). In 1948 psychiatrists wanted to change the name to “occupational therapy technician” which was rejected because the government pay would have been less.
- National association (1917, Clifton Springs, NY, National Society for the Promotion of Occupational Therapy, changed to American Occupational Therapy Association in 1921 and in Articles of Incorporation, 1923)

- Training school (1907-1918). Chicago (Lathrop, Taylor, Slagle), Jamaica Plain, MA (Tracy), Boston, Milwaukee, Philadelphia, St. Louis plus many shorter lived courses as Reconstruction Aides
- Code of ethics (1977) (Educational standards established, 1923; Accreditation process with AMA, 1933; Accreditation standards, 1938; Standards of practice, 1968)
- Political agitation to win popular and legal support (numerous articles in newspapers in New York and Maryland, articles in professional psychiatry journals, 1921 US government public health service, 1970s state licensure).
- Other: Professional journal edited by OT: 1947 (Charlotte Bone); First president to be an occupational therapist: 1947 (Winifred Kahmann, although technically Slagle was an OT in 1919); Control of registry: 1932; Control of accreditation/education: 1994. Military status: 1947.

Statement of Policy (AOTA, 1961, p. 24) and current status stated in brackets

- Maintain and control the voluntary registration of its practitioners. (Functions of registration and certification transferred to the American Occupational Therapy Certification Board, 1986 which changed its name to National Board for Certification of Occupational Therapy, 1996)
- Regulation, in conjunction with the Council on Medical Education and Hospitals of the American Medical Association (AMA), the education of occupational therapists to prepare them for their treatment function (relationship with AMA discontinued 1994 and transferred to the Accreditation Council for Occupational Therapy Education [ACOTE])
- Establish and maintain standards of clinical practice in occupational therapy which will improve patient treatment (Standards of Practice for Occupational Therapy, 2010)
- Foster continuing growth in the professional competence of occupational therapists (Standards for Continuing Competence, 2010; AOTA Press publications; continuing education courses)
- Protect the standards of occupational therapy and the environment in which the occupational therapist functions (accreditation, licensure and model practice act, updated documents on definition of occupational therapy, model practice act, ethics, practice, and continuing competence)
- Strongly oppose and protest any administrative policy or structure which ignores or weakens the treatment function of occupational therapy (response to proposed changes in Medicare and other federal and state regulations)

Steps to Professional Autonomy (Physical Therapy, Johnson & Abrams, 2005) with notes added in brackets

- Elevated entry-level educational preparedness (masters versus doctoral level entry)
- Expansion of knowledge and expertise (organization of theory-assessment-planning-intervention-outcome into science based publication)
- Maintenance of high standards of practice and self-regulation (state regulations up-to-date on occupational therapy practice guidelines and professional documents that reflect state-of-the-art practice)
- Growing expectation from physicians and other providers for their service as consultants (statements on what providers can expect from occupational therapy practitioners)
- Increase social need for advocates within the health care professions (increased older population, increase in number of children with complex health conditions, increased war wounded, increased recognition of mental illness and brain injury)

PROBLEMS LIMITING PROFESSIONAL AUTONOMY IN OCCUPATIONAL THERAPY

- *Bounty*: In the “give and take” between occupational therapy and the physical therapy physicians (newly called physiatrists in 1948), occupational therapy (along with physical therapy) was seen as bounty (part of a war chest) by the physiatrists – a way to instantly increase their power by controlling the education and registry of occupational (and physical) therapists (Colman, 1992). Occupational therapy leaders were opposed to being “forced brides” to physiatry and the “marriage” did not occur but the problem of being taken over and controlled by another profession or entity remains a threat to professional autonomy. The federal government, for example, could require the “bundling” of rehabilitation services so that only a certain number of rehabilitation treatment units were available to clients and the physician as gatekeeper would select how many treatment units were allotted to each service. Presently, under Medicare, occupational therapy is protected by a comma in the *Code of Federal Regulations* from being bundled with physical therapy and speech pathology. The comma could be removed.
- *Education versus Training*: As Esdaile and Roth (2000) point out, occupational therapy leaders must be mindful of any attempts to nationally control educational standards that encourage training in techniques rather than educating occupational therapy practitioners to think and solve problems. Specifically, liberal education should be preserved because it “prepares students to adapt to a changing world, rather than training them to perform set techniques” (p. 148). The conclusion is that techniques are often bound by the thinking and technology of a particular day and time. Occupational therapy practitioners need to be able

to adapt and change techniques that make use of current knowledge and technology and to abandon thinking and technology that is “past its prime.”

- *Evidence based practice and practice guidelines:* Evidence-based medicine and practice are part of a social movement aimed to strengthen the scientific based of healthcare and determine the effectiveness of interventions. The turn toward the concept of evidence-based was made in part, because studies documented the persistent variation of practice patterns across the country which undermined the credibility of health care practitioners and raise questions about wasteful spending (Timmermans & Kolker, 2004). Evidence based practice requires research studies. Researcher may not be a major career choice for many practitioners. Time for research and funding are additional obstacles. Guidelines based on evidence based studies, however, may act to restrict innovative problem solving and decision making which could benefit clients in terms of reducing or eliminating activity and participation limitations.
- *Gender:* Women may equate acting directly to attain own needs as selfish (Schutzenhofer, 1987). Women may tend to be passive and leave decision making to others. Social and religious values and laws in this country have strongly affected socialization experience and have historically limited the autonomy of women (Schutzenhofer, 1987). Values such as having a job but not necessarily a career may also limit concern for professional autonomy. Mahony (2003) citing Gardner and McCoppin (1995) maintains that occupational therapists in Australia have not been as successful as physical therapy in attaining professional autonomy because occupational therapy remains dominated by middle class women who are not prepared to engage in politics.
- *Governmental and state regulation:* The Medicare Payment Advisory commission (MEDPAC) continues to resist efforts by physical therapy to provide direct access and to require a physician referral. In turn, most insurance companies follow the federal guidelines. In addition, physician as gatekeeper can limit access and reimbursement for services such as home care, home modification, and driver evaluation. Some state practice acts require referral for all occupational therapy services even when no active pathology is involved. While regulations can be helpful in maintain quality of care such regulations can also restrict access. Initially Medicare did not provide for any occupational therapy services except in inpatient services as a “bundled” service.
- *Indifference/lack of concern/insularity.* Search of literature on occupational therapy and autonomy found zero documents on the database Cumulative Index to Nursing and Allied Health (CINAHL). (Actually one article, Esdaile & Roth, 2000, was identified that discussed professional autonomy although several mention the phrase “professional autonomy”). Same search on physical therapy in CINAHL netted 42 documents. AOTA has no documents which discuss and

explain professional autonomy or autonomous practice by occupational therapists. There is a policy statement adopted by the Representative Assembly (2003) that if physical therapy is granted direct access under Medicare guidelines, then occupational therapy should be granted the same privileges. The document on referral adopted in 1980 has been rescinded. Statements on referral in other documents are general and suggest consulting regulatory documents for specifics.

- *Medical Control and Supervision*: Physicians, especially physical therapy physicians (now physiatrists) wanted to control occupational (and physical) therapy beginning in the 1930s. Example: “In order that physical and occupational therapy may be employed to the best advantage and properly correlated, it is essential that there be adequate medical supervision. This means a single physician with training in physical medicine to direct the departments” (Watkins, 1943, p. 117)
- *Medicalization* (orthopedics, physical medicine, pediatrics, and psychiatry): Most of the conditions (diseases, disorders, injuries) seen by occupational therapists are under the medical management of physicians. Physicians are the most frequently mentioned team member. Occupational therapy practitioners use detailed referral forms which ask the physician to spell out in detail which media, modalities, goals, and outcomes are expected from occupational therapy. Because physicians control prescription of drugs they have control over disorders that might otherwise not require medical management.
- *Models of Practice/Frames of Reference*: During the early years of occupational therapy’s existence, occupational therapists practiced under models derived from medicine. Physicians had to filter and explain how occupational therapists “fit into” the model and what they should do in actual practice. See Watkins, 1943 as an example. Beginning in the 1960s occupational therapists were able to explain how occupational therapy could contribute to client care, and share knowledge of how to enhance and facilitate care of persons with a variety of diseases, disorders, and injuries.
- *Private Practice*: Relatively small number of occupational therapists are in private practice where direct access and referral could be helpful in securing clients. The lack of private practice probably contributes to the lack of concern by members about professional autonomy.
- *Psychiatry*: The loss of occupational therapy practice in psychiatry may be an example of deprofessionalization of occupational therapists and illustrate a failure of the profession to monitor and act to protect professional autonomy. In the 1960s federal legislation was initiated to change the care of mentally ill persons from large institutions to local community care facilities. States were dismantling state hospitals as too expensive and warehousing rather than rehabilitating

persons with mental illness. The status of many clients was changed from inpatient to outpatient or day client as clients were released from the state hospital. The focus was changed from emphasis on symptom control to facilitating function in everyday life. Textbooks in occupational therapy, however, continued to stress symptom control and management. Should/could the AOTA have taken a more active role in shaping the educational preparation of students and the continuing education of practitioners to assume the new roles and apply for the new positions? Are there lessons that should be reviewed and learned from the experiences in loss of professional autonomy in psychiatry for occupational therapy practitioners?

- *Role and Function:* Before the 1960s physicians explained to occupational therapists what role and functions occupational therapy would fulfill in various medical models of practice (physical medicine, orthopedics, psychiatry, pediatrics). As occupational therapy models and frames of reference developed, occupational therapists were able to explain to physicians and administrators the role and function of occupational therapy based on expert knowledge of occupation and its relationship to human health, well being, and participation in daily life. Occupational therapy practitioners must continue to be able to explain the role(s) of occupational therapy to others – and avoid having others explain occupational therapy roles and functions to occupational therapy practitioners.
- *Sponsorship and Control:* Originally occupational therapy was associated with social work (Jane Addams, Julie Lathrop, and Graham Taylor in Chicago who influenced Eleanor Clarke Slagle, a founding member) and nursing (Susan Tracy in Massachusetts). Early training courses were done in collaboration with both groups in the United States. Susan Tracy, a founding member, felt that all occupational therapists should be first trained as nurses that would have resulted in sponsorship and control by nursing. However, Dr. William R. Dunton, a founding member, was a strong proponent of medical sponsorship and control. The original principles of occupational therapy in 1919 include a statement that “treatment should be administered under constant medical advice and supervision” (Dunton, 1919). “Occupational therapists tended to look for doctors’ direct sponsorship to give therapeutic outcomes to the use of manual crafts.” (Prud’homme, 2011, p. 77). In the 1930s physical therapy physicians began to take control of hospital based occupational and physiotherapy (physical therapy) programs which had started in the 1920s as hospitals were established across the U.S. In 1948 occupational therapy avoided being sponsored by physical medicine. The AOTA asked AMA to help with accrediting schools in 1931, motion was adopted in 1933. Accreditation with AMA continued until the 1994 when the ACOTE was initiated. The AOTA had a medical advisory board for many years.

SUGGESTIONS FOR INCREASING PROFESSIONAL AUTONOMY IN OCCUPATIONAL THERAPY

- Stress differentiating medicalization of pathological conditions which require medical management from conditions of disablement (activity and participation limitation).
- Stress deconstruction of the ties to medicine in education, practice, and research except where active pathology is a major factor
- Stress to regulators that disabling conditions which result in activity and participation limitations may exist when no active pathological state exists. Medical management is not needed or necessary if no active pathology exists.
- Stress that activity and participation limitation may result in greater cost to society than the cost to reduce or remove the conditions (not based on active pathology) that restrict activity and participation.
- Stress that activity and participation limitations may be reduced or removed by changing the environment , occupation, individual or any combination thereof – and that occupational therapy practitioners are experts in making such changes happen. Changes in the individual can occur by means other than drugs, surgery and medical advice based on pathology and pathological conditions. Examples include changing body position (sitting versus standing), changing use of body parts (use left hand instead of right), changing motivation level (use more or different reward system).
- Stress that disablement (activity and participation limitations) occurs/exists without evidence of active pathology. Example: Person with cerebral palsy does not have active pathology but does experience disablement. Other conditions may include arthritis, stable spinal cord injury, stable (chronic) stroke, multiple sclerosis, Parkinson's disease, autism spectrum disorder, attention deficit disorder and others.

STRATEGIES FOR CHANGE TO INCREASE PROFESSIONAL AUTONOMY

Membership and Association Policy

- Develop a policy statement on autonomous practice (professional autonomy) for occupational therapy similar to the APTA and WCPT statements.
- Clarify in official documents the difference between medical management of pathology and intervention to decrease activity and participation limitations (disablement)
- Inform through *OT Practice* articles why autonomous practice is desirable for occupational therapy and expands the use of occupational therapy knowledge, skills, and services.

- Recommend, encourage, and support occupational therapists as members of regulatory boards at both the state and federal level.
- Encourage members to report perceived or real threats to professional autonomy of occupational therapy to the AOTA on a regular, ongoing basis but particularly at the Annual Meeting and meetings of the Representative Assembly

Regulatory Boards

- Support the concept that medical referral is not needed for conditions that do not have active pathology or in which active pathology is not the focus of occupational therapy intervention.
- Encourage change in regulatory rules so that medical referral is not required for changes in environmental conditions (home modification, vehicle modification, addition of computer in the classroom) since disablement, not pathology, is the major focus.
- Encourage change in state regulatory policies and procedures (rules) to permit occupational therapists to enter cases without referral from a physician in which active pathology is not a major consideration.
- Encourage change in state regulatory rules to permit other licensed professionals to directly refer clients to occupational therapy such as, but not limited to, nurses, physical therapists, dentists, speech pathologists, and psychologists
- Encourage change in reimbursement policies (rules) to differentiate between conditions requiring medical management due to presence of active pathology as opposed to those conditions that do have active pathology or in which the needs of the client are not based on active pathology.
- Encourage formation of regulatory boards concerned with occupational therapy that are independent of medicine and state medical control or are equal in level of authority to control the scope of occupational therapy practice.

Practice

- Encourage and support the concept of cooperation, consultation, and communication with medicine and physicians in an equal, not subordinate relationship
- Encourage the use of hospital and clinic referral forms that allow the physician to refer clients with active pathology to occupational therapy without requiring details regarding use of specific media or modalities (dosage).

Research and Publication

- Encourage research studies and publications that differentiate situations in which activity and participation limitations are the primary focus as opposed to conditions in which decreasing the effects of active pathology is a major focus.

- Encourage research studies and publications that illustrate the cost effectiveness of reducing activity and participation limitations in situations/conditions where active pathology is not a major contributing factor.
- Continue to support, along with the Foundation, the development of knowledge about occupation as a theoretical base of occupational therapy and use of occupational therapy practice models and services to facilitate and enhance participation of activities of daily life.

Education

- Encourage formation of educational programs outside the domain and control of schools of medicine.
- Encourage educational programs to prepare students to think, problem solve, and plan ahead to a changing world and not to limit training students to performing techniques that are learned by rote and repetition.

Inter-professional

- Work collaboratively with APTA, ASHA, and other professional organizations as needed, to support changes in public policies regarding physicians as gatekeepers to service provision.
- Support changes in regulations that permit access, and increase access, to occupational therapy and other rehabilitation services

Appendix D:

Question 4: How does the profession accept “power” and make decisions to move forward?

Background and Literature Review by Christine Peters, PhD, OTR/L, FAOTA with Terminology contributions from Reed Kathlyn Reed, PhD, OT, FAOTA, MLIS

Over time, the profession accepts power cautiously, conservatively and acts slowly or not at all to move forward. There is a “rigid adherence to status quo” (AOTA 2006, p. 2). This is related to a lack of a definition and understanding of power. Changing leadership patterns occurred gradually, shifting from male medical authority during the founding years of 1917 to the first female President of the AOTA, Constance Kahmann. Kahmann, who was elected to office and served from 1947-1952, broke the glass ceiling in the organizational leadership and shifted a power focus internally from medicine to occupational therapy and from male to female volunteer leadership. It is important to note that physical therapy, whose roots paralleled occupational therapy as Reconstruction Aides in World War I differed in organizational management. Unlike occupational therapists, who were led by physicians for years at the organizational level, in the accreditation of the educational preparation of physical therapists and in clinical settings, female physical therapists assumed the role of organizational Presidents from their founding years. For example Mary McMillan, President of the American Physical Therapy Association stated; “One of the most important tasks of all our members of the National Association is to set a standard for physiotherapy and neither in act, word, or deed, lower that standard.” Physical therapy President Inga Lohne 1923-1924 noted. “In unity lies strength; it is only by getting together to talk over our problems and build up our standards that we can grow into useful organizations in

our community” (Wynn, 1996, p. 58). Similar to the power elite in occupational therapy, these physical therapists showed independence, and made their voices known when advocating for the place and needs of their nascent profession.

The conservative culture embedded in occupational therapy historical roots emerge from a white Protestant upper middle class ethic, who were women altruistically doing good for the needy (Peters, 2011). Thus rose the image of occupational therapy and like professions such as nursing and dietetics as the “helping professions” (Scott, 2009). It can be argued that imbedded in that altruistic “helping” lays a savvy power source of progressive promoters. Slagle made astute connections with Eleanor Roosevelt through parlor room teas and luncheons to promote occupational therapy’s future in the health care market.

Slagle and colleagues Wade and Willard, and with peers Fidler, Bing, Brunyate, Gilfoyle, Wells, and West were power negotiators in their time. These leaders created educational programs, such as Willard, at the Philadelphia School of Occupational Therapy, and Wade at the University of Chicago, Illinois. West, working for the Department of Health, Maternal and Child Health also spearheaded grant funding opportunities that supported occupational therapy academic and institutional growth. The landscape sixty years ago of occupational therapy currently lingers today; the profession lacks a diverse membership. Diversity is perceived as the culture, class, race and gender of the membership of an organization. Diversity and gender issues also influenced how occupational therapy was and is viewed as a powerful profession in a global society (Black, 2002).

Current efforts which focus on cultivating occupational therapy “power and influence” ranges from leadership development in faculty and clinical managers (AOTA, 2012) to students through the AOTA’s and American occupational Therapy Foundation’s (AOTF’s) Annual Student Conclaves to leadership development extended weekends where students are mentored by the profession’s most established therapists who have contributed to occupational therapy and to a greater society. Leadership development and mentorship, using a modeling method has been the approach of choice to shape and mold the upcoming generation of occupational therapy practitioners. Sharing expert knowledge, experience and strategies to career maturity, the Student Conclaves have a rallying influence to inspire and charge the students attending to see themselves as change agents to the future.

In seeking a vision for occupational therapy’s future the AOTA Centennial Vision is often quoted, but seldom acted upon by occupational therapy practitioners. The Centennial Vision (AOTA, 2006), envisions the profession as a *powerful*, widely recognized profession.... What lacks in this document which introduces this statement is a definition or framework. Interestingly, in this same document, “power to influence” was identified as the second most important strategic element needed to change the profession. There again, a clear understanding and discussion of strategies and what power to influence means is not identified. In October 2003, the Board of Directors of AOTA initiated a strategic planning initiative process where more than 1500 participants contributed specific recommendations. In January 2006, the Association leadership, including representatives from all of AOTA’s component bodies, AOTF, NBCOT, special caucuses, networks and students, practitioners, educators, scientists, and staff

participated in a strategic visioning retreat. Following further review of the profession's mission, barriers that potentially undermined power or change include occupational therapists "capacity to lead" as well as "unclear professional language," and as mentioned in the first paragraph, maintaining the familiar or status quo (AOTA 2006, p. 2). That said, there has been some social media attention spotlighting and supporting an interest in power, including AOTA's past Presidential Blog entitled; "Your President Immersed in Military Culture: The Transformation Power of Occupation." Identifying Clark's participation in the Joint Civilian Orientation Conference sponsored by the Department of the Defense (AOTA Presidential Blog, 2012). In a more scholarly tone, Clark (2010), has argued that members of powerful professions have the capacity to obtain leadership positions reviewing the nursing and medical professions successes.

TERMINOLOGY

How is Power Defined?

Power is "the capacity to influence others, even when they try to resist the influence" (VendenBos, & American Psychological Association [APA], 2007, p. 718). In human relations, power is perceived as "the ability to control, persuade, coerce, force, or manipulate others" (Corsini, 2002, p. 745). To summarize it is the "ability to control others, events, or resources and to make happen what one wants to happen in spite of obstacles, resistance, or opposition (Johnson, 2000, p. 234)

Social power refers to the assumption that people are controlled by their expectations of what they think that others expect of them (Corsini, 2002, p. 916). Social power derives from a number of sources (VendenBos & APA, 2007, p. 718). Examples of social powers are:

- Reward power: “Control over rewards” (VendenBos & APA, 2007, p. 718).
- Coercive power: “Control over punishment” (VendenBos & APA, 2007, p. 718).
“Lacks social legitimacy and is based instead on fear and use of force” (Johnson, 2000, p. 234)
- Referent Power: “Others’ identification with, attraction to, or respect for the power holder” (VendenBos & APA, 2007, p. 718).

Professional power is the ability to retain jurisdiction when forces imply that a profession ought to have lost it based upon competition. It has two aspects: the first is an ability to win jurisdiction by means not connected with strength of subjective jurisdiction but rather by “interprofessional force” or those interactions that occur between professions, and the other is related to system disequilibrium internally in a profession. Power is not “only a matter of winning contests, but also one of preventing contests from arising at all” (Abbott, 1988, p. 136). Friedson (1986), another social historian who examines professions has identified expert knowledge as power or the salient ingredient to professionalism. Examples of professional power terminology are:

- Legitimate or authority power: “A right to require and demand obedience” (VendenBos & American Psychological Association [APA], 2007. P. 718).
Authority is a form of power that is socially defined as legitimate, which means it tends to be supported by those who are subject to it (Johnson, 2000, p. 234).
- Expert power: “Others’ belief that the power holder possesses superior skills and abilities” (VendenBos & APA, 2007, p. 718).
- Informational power: “Power holder’s access to and use of informational resources” (VendenBos & APA, 2007, p. 718).

Personal power involves “individual power that is not associated with the occupancy of a social status.” Control is “based on individual characteristics such as physical strength or the ability to argue persuasively” (Johnson, 2000, p. 235).

Feminist power is based on the capacity to do things, to achieve goals, especially in collaboration with others and stresses the potential of cooperation, consensus, and equal rights.

Additional Terminology

Power base is the interpersonal origin of one individual’s capacity to influence other individuals.

Power elite, originally a term coined by sociologist C. Wright Mills, is the concept of a small number of powerful individuals, especially corporate, political, religious, or military leaders, who hold the highest position of authority in their respective institutions and share a common outlook and values. This elite not only controls vast economic resources but is thought to shape the agendas of government, business, education, and the media through its actions and attitudes. Powerlessness is a “state of mind in which individuals feel they lack control or influence over factors or events that affect their health (mental or physical, personal lives, or the society in which they live” (VendenBos & APA, 2007, p. 718).

In summarizing terms, there appears to be four types of social power categories that pertain to Question 4 Category 1: *jurisdictional or political power* (power over), reward, coercive and referent. The second category is *professional power* (legitimate, authority, expert, informational). Category 3 is *personal power* which is intrinsically driven, and the last category is *feminist power* which is hybrid of power over coming

from political equality roots and intrinsic motivation or personal power. *To illustrate occupational therapy's path, in terms of these concepts, legitimate or authority* (dominance by medicine) creates power over (dominance) occupational therapy and means occupational therapy personnel are controlled by the authority of others. *Referent* power occur when occupational therapy personnel identify with and show respect to other professionals and professions such as physicians and the practice of medicine, nursing, architecture, psychology, vocational education, etc. *Expert* power occurs when certain people within and without occupational therapy are identified as having specialized (valued, useful) knowledge, skills and abilities. *Informational* power involves developing and controlling the message(s) about occupational therapy (what media are used: letters, telephones (cell phones) journals, newspapers, radio, TV, film, video, email, social media, webpages). *Knowledge* power occurs as the studies about occupation as a theoretical/conceptual model and occupational therapy (practice or applied models) are published. The *feminist* perspective (power on) occurs when occupational therapy personnel identify what they can do, what goals can be achieved, what consensus can be developed, and with whom they can collaborate and cooperate.

What does not show up in the literature is the construct of organization or organizational power as a free standing construct, although Friedson (1986) identifies professional organizations as a requisite for a profession to be bonifide. The development and support for a professional group such as AOTA or state association to carry out power moves and directives that professional group members in an ethically way will lead to strength through the gaining of organizational power .

Other Professions

Other health professions have discussed and studied professional power. Some examples will be given from nursing, dietetics, and paramedics because of either their maturity or emerging status. Nursing, highly established, and one of the founding occupations of occupational therapy has identified characteristics of a powerful professional practice (Ponte et al., 2007). Nursing, aligning with expert knowledge, identifies its unique role in the provision of client centered and family centered care. Other characteristics are a commitment to continuous learning through education, skill development, and evidenced-based practice. Professionalism and power also includes collaboration and partnering with colleagues in nursing and other disciplines. That said, there is a concern regarding the need to position themselves to influence decisions and resources. Nursing strategies include paving the way for novice nurses with recognized nurses' voices being heard. Finally, there is a reflective evaluation of power at the department level in organizations and to commitment to enhancing the power of diverse perspectives. Although there are overlaps in this thinking with the AOTA's Centennial Vision, nursing articulates guidelines more clearly for transitioning novices, for changing boldly while using a unique identity and an expert power base.

Dietitians similar to occupational therapists sought military pathways for professional opportunity. By World War II, Public Law 80-36 (April 16, 1947) authorized Regular Army commissions for dietitians, and physical and occupational therapists. Scott (2009) argues that dietetics served as a portal for women's access to higher education in science and medicine. The military service in the U.S. Women's Medical Specialist Corps was critical to the professionalization of women's labor; expand their access to professional resources and political power. Peters (2011) has made a

parallel argument that the military served as a training ground for leaders and scholars, including West, Reilly, Cromwell, Welles, and Fidler during World War II. With rank dictating power, profession, and gender followed suit. These beginning roots in dietetics as well as occupational and physical therapy flourished from Reconstruction Aides to today's science driven professions that developed individually.

Strategies for political power of Paramedics are the last and least developed profession that will be discussed and paralleled to occupational therapy. Mahony (2003) used a sociological historical analysis reviewing political and economic influences that paramedics used for professionalization. Outlining five political strategies for gaining power, paramedics made a case for autonomy. The first strategy is to develop a role and expertise difference and be independent (from medicine). Drawing from parallels in nursing and physiotherapy, Mahony (2003) states those professions were female dominated and provided the hand maidens for a male dominated medical fraternity. The second strategy to gain professional autonomy is to recognize and capitalize on experience and skills. This is viewed as moving tacit knowledge into explicit knowledge. A third strategy is to protect and maintain occupational boundary encroachment. The author cites occupational therapy as unsuccessful in protecting encroachment boundaries, when one views the roles of activity therapy personnel in geriatrics. The fourth strategy identified in professional power development is controlling the technology of the profession. For example, nurses knowledge and administration of medication is an example of knowledge as power, or professional turf. The final strategy is for the professional association to take control of education, qualification, and registration. The author states the professional association is the body

to decide the knowledge base necessary and experience necessary before a person can practice as a paramedic. In summary, Murray argues that the health care occupational communities who have been successful in attaining autonomy, engaged in professional politics, extricated themselves from medical dominance, and found their occupational niche.

Transformational Education

Gilfoyle (1984) exclaimed that occupational therapy was in a crisis, and needed to question its philosophical base from a perspective of dynamic change. She projected a period of disunity, and a phase when old values and constructs are examined, followed by an opportunity for transformation with transformation being viewed as an integration of past, present, and future. She suggested a transformation in occupational therapy from purposeful activities to occupation, from allegiance to scientific knowledge to include intuitive knowledge, and from a biomedical model focus to inclusion of wellness. In addition Gilfoyle stressed the need to re-organize educational curricula to reflect the profession's value system and to predict practice. This declaration shook the status quo of the time. Gilfoyle addressed feminism as a major force in occupational therapy culture, projecting that the self-assertive woman will emerge as powerful in the profession. Therefore, two decades ago, Gilfoyle challenged some directions that occupational therapy has continued to furrow deeper into, including an allegiance to scientific knowledge while shifting to include intuitive or tacit knowledge. Gilfoyle's past recommendations could be viewed in current time to support evidence based practice using the methods of science while also embracing qualitative and philosophical inquiry into occupation and occupational therapy.

In a time of hyperchange, a term used by Hinojosa (2007) who challenged occupational therapy status quo. transformation and paradigm shifts are needed to continue refueling a profession on the move. These paradigm shifts include what information is most relevant and compatible to occupational therapy's core values.

In conclusion, how does the profession accept power and make decisions to move forward? Occupational therapy has had a cohort of power elite who have challenged the profession. However, due to lack of clarity of direction, and definition, as well as a tradition of conservatism, the profession does not move forward easily. Growth spurts exist, due to societal needs; however, occupational therapy remains traditional and reactionary. What is needed is a re-evaluation of new thinking and embracing rather than perceiving power as a negative. Expanding to a grass roots level, and moving from local to global, while investigating other quick growth industries will assist in suggesting new models.

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