

1979 Eleanor Clarke Slagle Lecture

## Remember?

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Being named an Eleanor Clarke Slagle lecturer brings many problems, especially for someone who is about to retire. The delight in being named for this high honor is tempered by the reality of the responsibility involved. Choosing a topic for the lecture is especially difficult. From the moment the letter from the President of the Association arrives with the news that you have been selected—asking whether you will accept—your mind races along trying to choose a topic that will be of general interest.

As most of you know, my last 15 professional years have been involved in hand rehabilitation. The 20 before that had been much more diversified. I went into occupational therapy in 1944 after nine years of teaching home economics. One might say that Lorna Jean King, last year's Slagle lecturer, and I are "late bloomers" since she, also, has had about 35 years of experience. Checking back over the list of recipients of the Slagle award I found that June Sokolov, who gave the second Slagle Lecture in 1956, had only nine years of experience in occupational therapy when named to the honor. Josephine Moore, the 1975 lecturer, had 11. The average number of years of experience of the 21 lecturers, so far, was 19.

During the period of time that I was struggling to decide on a topic for my Lecture, I was on one of my numerous flights to or from a city where I had been teaching. I was reading the magazine supplied at each seat and enjoyed an article entitled "Memory" reprinted from the August 1978 issue of *Fortune Magazine*. This helped me decide on the topic. I had been considering the idea of how important one's professional roots are and how much one is indebted to the people who have been influential through the years. In 1675 Sir Isaac Newton said: "If I have seen further . . . it is by standing on the shoulders of giants." It has been my good fortune to have many giants in our profession to boost me along the way. If you will indulge me, I would like to relate some of the meaningful memories I have accumulated these 35 years. It is said that one remembers things better and longer if they are pleasant, so the memories I relate will be the ones that brought pleasure.

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In general, my years in occupational therapy have been exciting and fulfilling, and I only hope that those of you who are young in the field will get as much satisfaction from your work as I did. My enthusiasm still runs high.

In 1944 I was happily teaching high school home economics only 30 miles from a large Army hospital in central Texas. World War II was raging. There was an announcement in the local paper asking for volunteers to help thread looms in the Occupational Therapy Department of this Army hospital. Since I had studied weaving in my home economics textiles courses, I drove over each Saturday to help out. Clinics were open six days a week then, and, in some instances, seven days a week in the psychiatric sections. While threading looms, I observed the other activities going on in the clinic and was quite intrigued. When the therapists informed me that the Army was setting up some war emergency courses to help relieve the shortage of occupational therapists, I applied and was accepted.

There were 30 Army hospitals at that time and all of them were in need of staff. Mrs. Winifred Kahmann, a lively lady who had been an occupational therapist since 1917, was recruited to set up the War Emergency Courses. Six hundred carefully selected students with degrees in related subjects were enrolled in seven schools of occupational therapy over the next several years. I was sent to the University of Southern California where I had my initial encounter with Los Angeles smog. Margaret Rood was head of the occupational therapy program at U.S.C., and that was an encounter of quite a different kind—a very exciting one. She and Mrs. Kahmann saw to it that we were well indoctrinated as to what occupational therapy was all about. A good foundation was laid and a good dose of enthusiasm for O.T. was given. I was in the first class, starting July 1944, and as far as I know I am the only person with a certificate in occupational therapy from one of those abbreviated, but intensive, courses who has been selected as an Eleanor Clarke Slagle lecturer.

I returned to Texas from California and had two enjoyable years working at the amputee center where I had been a volunteer. Several thousand soldiers were being treated there, so that I worked with many patients who had lost one or more extremities. Nothing can make one appreciate the marvelous instruments—the human hands—more than working with patients who have lost one or both. Could this have had an influence on the direction of my interests in later years so that I was led to work in the special area of hand rehabilitation?

In 1946 the amputee center was closed and I was sent to San Antonio to work at Brooke Army Hospital in the physical disabilities section. At that time, the occupational therapists in Army hospitals were civilians, classified as subprofessionals. The War Department, at Mrs. Kahmann's insistence, requested that Civil Service reclassify occupational therapists to professional status. This was done!

In 1947, through Mrs. Kahmann's influence and a resultant Act of Congress, commissions were granted occupational therapists in the Army. Since it was optional, I chose to remain a civilian, and had five memorable years there at Brooke.

Soon after I arrived, Virginia (Ginny) Bond Scardina came. She had been at the University of Southern California working on her master's degree and was all fired up. In her inimitable fashion she organized an in-service training program for the staff. She assigned topics and we studied hard to be prepared to present our material to our co-workers. There was a

large staff with unequal knowledge bases so that this program was beneficial to all of us. Ginny's leadership ability assured its success.

During my years at Brooke the burn unit was set up in the section where I had a clinic. Before that we had treated the few burn patients on the wards. If they had survived severe injuries, they were among the most difficult patients with whom to work. There had been no way to control infections until the introduction of antibiotics in the late 1940s. The odor around a badly burned patient before the advent of antibiotics is a memory I cannot erase. It was always a difficult decision for me to make regarding whether I would go to see such a patient before lunch and ruin my appetite, or go after I had eaten and lose my lunch. The management of the burn patient has undergone numerous changes through the years, but nothing else has had the impact of antibiotics. It was a welcome change.

Another challenge that came about while I was at Brooke Army Hospital was to pioneer in setting up a cerebral palsy treatment unit for dependents of Armed Forces personnel. San Antonio in the late 1940s had no facility for treatment of these children. One of the medical residents who wanted a pediatric residency in the Army approached me to work with him on such a project. None of us knew how far-reaching this project would be. Dr. George Deaver, a consultant from New York, came to speak to the staff, and he arranged for me to visit various facilities in the New York area. As a civilian attached to the Army, I could get time off, but it was at my own expense that I flew up to the big city to start learning the necessary details of how to set up a cerebral palsy treatment program.

With the help of a talented aide and several volunteers, we soon had the essential equipment constructed, space was made available, and patients were waiting to be treated. The Army extended the use of the facility to Air Force personnel in the vicinity as well as to the children of civilian employees on the bases. We had an active half-day program underway quite soon. A physical therapist who had been working at the Kabat Kaiser Institute in the Washington area came to Brooke to do her two-week reserve duty. Sharing her experiences with the early neuromuscular facilitation concepts, which were associated with the Institute where she had worked, helped us in handling some of our more difficult patients. We managed to have her two-week stay extended to more than a month. This was a marvelous learning experience. I studied hard, returned to New York to take a course offered by United Cerebral Palsy, and was active in the State Crippled Children's Society. Although the cerebral palsy treatment program was only on a half-time basis, it was very engrossing, and for more than two years I made a special effort to be an effective therapist with this group, in addition to carrying on the regular treatment program.

Before I conclude the discussion of my years with the Army program, I would like to pay tribute to Col. Ruth A. Robinson, whom I was fortunate to get to know since she came to Brooke soon after I arrived. The Army hospitals had very liberal budgets and plentiful supplies for occupational therapy. We even had sterling silver for our patients to use. But Col. Robinson taught us all to use the supplies judiciously. Her favorite statement: "Remember, this is the taxpayers' money," has influenced me through the years. True, we should have a budget for equipment and supplies in our work, but we should never overestimate

the need for expensive equipment and supplies since they are not necessarily indicative of a good treatment program.

After I left the Army program, working with polio patients was my next challenge. As you may recall, it was through Franklin D. Roosevelt, himself a victim of polio, and his influential friends that the Warm Springs, Georgia, treatment center for poliomyelitis was organized. The annual March of Dimes brought in funds to use for research, for payment for treatment, and for stipends that were made available to doctors, nurses, occupational and physical therapists, and social workers so that they could attend courses where special training prepared them for work with polio patients. I applied for the Georgia Warm Springs course, was accepted, and began in October 1952. There was an epidemic of poliomyelitis in the world then, and the hospital was full. Patients came from all over the United States and from many foreign countries. Therapists and doctors from other countries came to take the course, also.

The first three months of the course were devoted to acute care, and the second three months to functional training. Again, my good fortune held and I was exposed to some excellent instructors. The polio virus usually affects only the anterior horn cells in the spinal column, so patients with poliomyelitis had intact sensation and very discrete muscle involvement. In order to work effectively with these patients, one needed detailed knowledge of anatomy and kinesiology, refined muscle testing techniques, and, in addition, ability to relate to these people in a way that helped them adjust to their period of restricted activity. Protection of the affected parts was considered most important during the acute phase. The temptations the patients had to carry on with functional activities, even though such activities called for abuse of the involved muscles and substitution patterns that were detrimental, required stern discipline by the therapist. In so many areas of treatment we urge patients to become more functionally independent, but in treating the acute polio patient, much of our emphasis was on the curtailment of physical activity. Supportive and protective devices were applied to restrict undesirable motion. The psychological impact was devastating, so that every therapeutic skill was recruited.

I was asked to serve as instructor in the post-graduate courses at Warm Springs and stayed on after completing my six months of training. The upper extremity was mainly the responsibility of the occupational therapists, so that teaching these units was fun. After two years, I moved back to Texas to work with respiratory polio patients in Houston. Warm Springs did not accept patients who required breathing aids, so that this was an added dimension to the problem. I became accustomed to working with patients who slept in an iron lung or on a rocking bed and were made mobile by donning chest respirators so that they could come to occupational therapy in wheelchairs. This group was wonderful to work with, and taxed every bit of ingenuity one could muster. John Gardner's book, *No Easy Victories*, describes so well the way I felt when working with these severely involved patients and the way I feel about occupational therapy today. "What could be more satisfying than to be engaged in work in which every capacity or talent one may have is needed, every lesson one may have learned is used, every value one cares about is furthered?" (1, p. 32)

Fortunately, the Salk vaccine was perfected during the years I worked at Warm Springs. The intensive public effort to vaccinate everyone paid off and polio is now a rarity. However,

the recent outbreak in an Amish community in Pennsylvania is cause for renewed concern and effort toward prevention.

By late 1956, the vaccine had polio under control so that the acute need for therapists in that specialty area waned. I then moved to the Houston Veterans Hospital and had a small clinic where hand cases were treated: fractures, and other types of trauma, peripheral nerve problems, and numerous quadriplegic patients. All my experience to date was made use of in this particular setting.

I had been there a year when AOTA announced that a grant-financed position was being established for a Field Consultant in Physical Disabilities. That was just the job I wanted and that was just the job I got! AOTA offices were in New York during that period and Marjorie Fish was the executive director. Establishing that new service would have been impossible without her able guidance. Helen Willard and Wilma West, as presidents of AOTA during those years, gave their support and assistance. Many other therapists helped me, also. My sincere thanks go to all of them for their willingness to advise and consult along with me. Frequently, I merely served as a means of getting the ones who wanted help in touch with therapists who could supply the needed guidance.

The entire United States was my territory, and I was presented with an enormous range of problems within the field of physical disabilities in occupational therapy. Many of the problems we have today are the same ones that we had when I was a consultant. I doubt that the profession will ever be problem-free. Again Gardner's *No Easy Victories* offers the premise that problems serve to stimulate and spark us toward our best performances. A life with no problems would be so dull that an intelligent person would go out and set up a situation that would provide him or her with a problem—a challenge. That, according to Gardner, is why people play golf or other sports. Artificial problems sought out by the bored person do not call upon one's full resources, though. The problems in occupational therapy certainly do. They "interest the whole mind, the aggregate nature of man more continuously and more deeply." (1, p. 32) Isn't it consoling to think that all our problems might be quite therapeutic for us!

I had taken this job as consultant for three years and stayed on for five. At the end of those five years I felt somewhat drained, and I took a year off to go to Europe. What a rejuvenating year that was! I had promised myself that I was on a vacation, but was tempted from time to time to look in on some interesting occupational therapy programs. My first three months were spent in the deep snows of southern Switzerland, in the French-speaking section. Friends of mine had a cerebral palsy treatment center in a small Swiss village where I was. They used Bobath methods in their treatment program, and it was all I could do to keep from becoming involved. How I wished I could have known about some of their interesting concepts during the years I had worked with children with cerebral palsy. Instead of working in the therapy sessions, I volunteered to mend and sew for them. That gave me more freedom to take off on a beautiful sunny day to ride the lift to the top of a ski area nearby. Needless to say, I rode the lift back down the mountain, too. I tried skiing, but since I was 50 that year, my better judgment made me give up the idea because I was afraid I would break a leg.

When I returned to the United States I went to the AOTA offices to check on positions available in North Carolina. During my five years of consulting I had gone to nearly all of the states and had selected the Chapel Hill–Durham area as a favored location. I could hardly believe it, but there was an opening in Chapel Hill for a therapist to work with a hand surgeon. That sounded pretty good to me. So my start in hand rehabilitation was not a premeditated move on my part, but an act of fate. It does illustrate that, with our broad basic preparation in occupational therapy, if, in the drama of our professional lives, the casting director should put us in one particular role or another, we can perform adequately. At times we may be fortunate and have preparation meet opportunity. This role in hand rehabilitation suited me as an individual and suited my talents, I grew in it, and it continued to provide challenges for 15 years. The flexibility made possible by our broad humanistic base in occupational therapy enables us to build up into peaks of professional excellence or into specializing at times. The base should not be ignored, even though attention might be temporarily focused on the elegant points of the peaks.

In 1958, Carlotta Welles had an article in *The American Journal of Occupational Therapy* with the intriguing title “DaVinci is Dead! The Case for Specialization.” She stated that Leonardo daVinci had been dead for more than 400 years and that he was possibly the “last single individual to possess a significant portion of existing knowledge.” (2, p. 289) Today there is so much to be known about such a wide variety of subjects. The quantity of published information rapidly increases: libraries keep expanding; information is put on microfilm in order to consolidate it for storage. Ideas used to outlive people. Now people often outlive ideas. There is a proliferation of new ideas—some good and some bad. Keep in mind the questions that T. S. Eliot asked in his poem *The Rock*, “Where is the wisdom we lost in knowledge? Where is the knowledge we have lost in information?” (3, p. 81) What we need is a good system to filter this mass of information so as to capture the knowledge that will be beneficial and to screen again to help select those things that will make us wise, at least in one area of concern.

Acquisition of new knowledge might well rank below the formulation of a new attitude toward, or a better understanding of, old knowledge. Many so-called specialties in occupational therapy are nothing more than a special arrangement of things that are already familiar to us, or a reorganization of our services to meet the needs of a specific group. How often I have found this to be true in my own career. In the first issue of the Physical Disabilities Specialty Section *Newsletter* last summer, there was an open letter from Louise Elfant expressing her concern about the danger of overspecialization. She feared that one might sometimes trade off treating the whole person for treating the parts more effectively. This, in my opinion, will not happen if one remembers to consider what the illness or trauma means to the patient. The therapist’s special competence must be combined with compassion at all times. An extremity with a slight residual deformity might well serve, but a warped and crippled mind or personality can never be useful. Helping the patient put an injury or illness into proper perspective is fundamental to occupational therapy. We would be remiss in our responsibilities if we neglected this important aspect of treatment, even though we might be concentrating on a particular segment. We know full well that patients must

become involved and rehabilitate themselves. This is impossible unless we help them understand and adjust to their conditions.

Being a clinician has been my way of functioning as an occupational therapist. We clinicians are on the front line and are more often than not the ones from whom the public formulates an image of our profession. This is quite a responsibility and one that I have never taken lightly. Flexner, when addressing a national conference on social work in 1915, stated the criteria by which a profession could be identified (4). He also developed the thesis that what matters most is professional spirit. He thought that trades carried on with such spirit might rise toward the professional level. Conversely, accepted professions might sink toward the trade level if people within the group lose such a spirit. That really emphasizes the importance of the role of the clinician and the spirit in which the duties of the clinician are carried out.

Rather than thinking of myself as a specialist, I prefer to rank myself as a master clinician. There have been numerous suggestions through the years favoring the use of such a designated title, and I find it rather pleasing to the ear and to the ego. One does not become a master of anything without putting forth some concentrated effort in the right direction. One needs to become more deeply committed and to make an effort toward acquiring definitive knowledge in the particular sphere selected. As Martha Moersch quoted (from Richard L. Kenyon) in her summary of the Curriculum Revision Study in 1966, “. . . academic training is the base for founding a professional career and it is the quality of growth thereafter that builds the professional.” (5, p. 57) Continuing education as a means of growth, whether it be by reading extensively, by attending workshops and courses, or by communicating with others personally must be an active ongoing process. One statement that sticks in my mind is that continuing education is active exercise, not massage. An accumulation of intellectual facts is of little value. One must absorb the material and have a change in attitudes and behavior in order to grow. Every single day one should give oneself a chance to be a good occupational therapist—the very best! In anticipation of an unusual problem a patient might present, therapists should be confident of their ability to deal with that problem. If they feel inadequate, they should make a concerted effort to read a ready reference or call in a consultant to help them solve the problem—to grow professionally. A patient or client will more likely be impressed by the honesty of the therapist who admits to an inadequacy and demonstrates a desire to get help than to have the therapist attempt treatment in an area in which the therapist lacks competence. All of us have had times when we needed to turn to someone for advice. The less experienced the therapist is, the more important it is to be working in a clinic under supervision. Help is readily available then. Getting out on one's own too soon or going into a specialty area of practice prematurely may put one in a compromising situation and arrest professional development. One should give serious consideration to these matters as one embarks upon a career.

As I said in my introductory remarks, being named the Eleanor Clarke Slagle lecturer is quite an honor. I have never aspired to national acclaim. My main goal has been to work with patients to help them improve and to help them assume responsibility for caring for themselves. I have never felt guilty about working in a medical setting. Much of what I do

is preventive in nature, even though it might be categorized as secondary rather than primary prevention. The medical setting enabled me to save energy and time since case-finding was simplified. The people who needed my services were gathered in one spot. I always did enough community work to let it be known what my program entailed, and at the Hand Rehabilitation Center I could take direct self-referrals. In this way, people could come to a convenient location to have services rendered. I was comfortable in this environment and I am sure that helped me to be productive.

All I did was "to do the common things uncommonly well," as some advertisement has said. That is what brought success. May I give an example of how only one aspect of treatment was developed with some measure of success?

When there is edema in the hand, we know that reducing it is of primary concern. The small joints of the fingers cannot tolerate the presence of this scar-producing fluid in and around the soft tissues that surround these compact joints. Limited motion results and the stiffness that follows can turn an otherwise delicate instrument like the hand into a clumsy tool.

Through the years we have had an opportunity to study the effectiveness of a variety of ways in which edema reduction routines have been carried out in both occupational and physical therapy. Methods of monitoring the size of the hand such as water displacement, as suggested by Dr. Paul Brand (personal communication), as well as circumferential measurements by tape or ring size, have enabled us to determine the effects of various treatment approaches. Massage, heat, cold, whirlpool, application of the Jobst intermittent pressure unit, active exercise, exercise in elevation, elevation alone, and a variation on string wrapping have been among the approaches evaluated. Some patients reacted adversely to massage and the same was true of the Jobst unit or other approaches.

If we found that any one of these modalities led to an increase in volume, it was discontinued in favor of one or more of the other more effective techniques. As a general rule, we found that warm whirlpool was most often detrimental but active exercise in an elevated position was most effective in edema reduction. Sanding projects positioned at or above shoulder level, cord knotting similarly placed, and leather lacing with a long strip of lacing are ideal occupational therapy projects. Close supervision is essential to get the correct routine established. The combination of fine motion of the fingers that involves use of the intrinsic muscles of the hand as well as movement of the entire arm so as to get active involvement of forearm and upper arm muscles will bring the best results. The contraction of the muscles is what gets the pumping action started to mobilize the fluid, and the elevated position facilitates flow from distal to proximal areas of the arm.

During waking hours, rather than have the patient place the arm in a sling, which would encourage inactivity of the arm muscles, we found that it was far better to teach the patient to elevate the hand above the head frequently, using his or her own muscle power; to rest the hand on top of the head, up on an elevated surface or door frame; as well as to use a cane or crutch to position the hand at the desired level. Most patients watch television for several hours daily throughout their convalescent period. One speaker I recall suggested that the patient should be instructed to raise the arm toward the ceiling each time a

commercial came on. Actively making a fist and relaxing it while the hand is in elevation during these numerous times works wonders to control edema. What a simple approach to a complicated problem!

All of us are aware of fluid accumulation during sleeping hours. Eyes get puffy, fingers feel stiff upon awakening, and some time is required to mobilize the so-called normal hand. Think how much more difficult it is to mobilize the hand when one has any pathology. We tried various things to help keep edema out of the hand while the patient is in bed. One was a special sling into which the arm could be strapped. It held the hand elevated with the elbow flexed and the forearm in a vertical position. Bunk beds in our center facilitated hanging the sling since it could be attached to the upper bunk, but I.V. stands, hat racks, or constructed L-shaped frames with one section to slip in under the mattress could be provided for home use.

Another item suggested for night use was some type of external pressure. The company that makes the intermittent pressure unit also makes custom-fitted gloves from two-way stretch fabric. These gloves are fine but they are expensive and it takes some time to order and have them delivered. Since I am so cost conscious I found that used surgical gloves, which were available to us free of charge from the nearby hospital, sufficed. Too, the Thrift Shop had stretch nylon gloves at a minimal cost. The colors of the gloves did not matter since they were to be worn at night, and if only one of a pair was available, that was fine, also. A patient usually needs only one. If my supply of gloves consisted only of those for the left hand and my patient had an injured right hand, I would turn the glove wrong-side out. This proved to be fortuitous since the seam on the outside made it more comfortable for the patient. Necessity is truly the mother of invention. A word of caution here: do not put a glove that fits too snugly on the edematous hand since circulation might be impaired. Always try the glove for at least 30 minutes, then remove it to check on the circulation in the fingertips.

Another way to provide external pressure is to make a Temper-foam sandwich splint. Two pieces of Temper-foam, a NASA by-product, can be used next to the hand and heavy cardboard can be put outside, top, and bottom. The splint can be strapped together around the hand. This type of external pressure is excellent for use with any hand with the combined problem of edema and a tendency toward flexion contracture. The hemiplegic's hand responds well since this splint reduces edema as well as holding the fingers in extension. It also provides neutral warmth which, according to Miss Rood, encourages relaxation.

I have gone into some detail in discussing this aspect of treatment to point out how unsophisticated these methods are, but how very effective. Occupational therapy is commonplace and unsophisticated often, and therapists are frequently apologetic about this aspect. Instead, we should take pride in our use of the ordinary and commonplace to bring about desired results when more sophisticated modalities have failed. I take frank delight in being innovative.

None of us has any idea what the world, and specifically occupational therapy, will be like in 2020 AD. About that time a beginning therapist of today will have reached my age. Remarkable changes have taken place during my time—television, jet airplanes, credit cards, computers, synthetic fabrics, frozen foods, drug abuse problems of great proportions,

Medicare, too many people, Blue Cross–Blue Shield, Velcro, transplantations, space travel, holography, bio-plastics, antibiotics—the list could go on and on. Some of these things affected me and my profession directly—others indirectly—but the shocks came in small, adaptive doses. We were hardly aware of how important each one was.

The young will more than likely face as many or more changes in their lifetimes. Their opportunities will be cleverly disguised with seemingly insoluble problems. I only hope that we can all help them to grow and handle their futures. In my senescence—notice that I am avoiding the use of the term senility—I want to volunteer my efforts along the way.

In conclusion, I would like to quote an excerpt from a poem written by another occupational therapist, Edward Dunning. This appeared in the December 1973 *AJOT*:

. . . *We've better things to do than reruns of old projects,  
Better scripts to write than catalog the past  
Or lose the present by condemning it.  
You've got a future to invent! How about it?* (6, p. 472)

## References

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