

Occupational Therapy

Values and Beliefs: PART IV

A Time of Professional Identity, 1970–1985— Would the Real Therapist Please Stand Up?

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This fourth in a series continues the process of identifying and organizing the beliefs, values, and ideas gleaned from the historical foundations of the profession.

“The value system which underlies our therapeutic practice with...clients is often in conflict with our values regarding what the...profession ought to do...to have a greater impact upon society” (p. 26).¹

In this 1979 quote, Elizabeth Yerxa is suggesting that the profession of occupational therapy needs to place the same value and effort on promoting the profession to society as it does on tending to the needs of clients. She is referring to the value that occupational therapists place on clients actively participating in controlling their own therapy. At the same time, she recommends that occupational therapists need to become more assertive in controlling the direction of their own profession. The dichotomy of self-control (internal) versus external control of the profession typifies the issues and conflict of values during the period from 1970 to 1985. These issues and values include autonomy, visibility, research, professionalism, and role delineation.

AUTONOMY VERSUS EXTERNAL CONTROL

The value of professional autonomy, self-regulation, and self-sufficiency had been at the forefront of activities of the American Occupational Therapy Association (AOTA) for many years. The Association had prided itself on the accomplishments of setting educational standards,² credentialing therapists through registration,³ and defining the practice of occupational

therapy.⁴ During the 1970s, external pressures decreased the effectiveness of such self-reliance. For example, after many years of viewing state licensure as undesirable for occupational therapy practitioners (based on many concerns, such as being too medical or under the control of physicians), in 1974 the Representative Assembly (RA) passed a resolution for AOTA to promote state licensure.^{5,6}

Despite initial fears about the effects of state licensure, it had positive effects on the profession, leading to recognition by private payers, improved recognition in public programs, and creation of a legal definition of occupational therapy.

However, state licensure also had an effect on AOTA membership. State licensure law became the legal authority, whereas registration with the Association (later changed to certification) was voluntary. In 1985, AOTA's Executive Board formally separated membership from registration and certification.⁷ (Later, initial certification would be separated entirely from the Association to an autonomous group because of legal concerns related to self-policing both education and certification, which could become antitrust issues.) Removing certification set the stage for AOTA to create more member-based services to enhance the value of membership.

Under the leadership of AOTA President Florence Cromwell, who had supported state licensure, the Association was able to gain an autonomous voice with state legislatures by devel-

oping a Model Occupational Therapy Practice Act in 1975. The Model Practice Act helped practitioners write their state licensure acts.^{8,9} In 1968, Puerto Rico was the first jurisdiction to be licensed.¹⁰ The first states to enact licensure acts were Florida and New York, in 1975.

Despite the move to a standard federal description of occupational therapy, federal legislation sometimes included descriptions and definitions of occupational therapy that occupational therapists had not developed or written. For example, in 1975 the Education for All Handicapped Children Act¹¹ described occupational therapy as a “related service” to help children with disabilities to benefit from special education,¹² but did not delineate specific roles. The model of delivery was to be based on the transdisciplinary approach, not on the typical hierarchical approach that therapists experienced in the health care system.¹³ However, the legislation was viewed as a great victory for the Association because occupational therapy was included in the act when it was adopted by Congress. In contrast, when the Rehabilitation Act of 1973 Amendments¹⁴ were passed in 1978, occupational therapy was not mentioned even though the major focus of the amendments was independent living, a concept occupational therapists had long valued.¹⁵ Due to a growing social consciousness about rehabilitation in the late 1970s, between 1972 and 1982 the number of occupational therapists increased from 10,981 to 25,754

(135%), and the number of occupational therapy assistants increased from 2,149 to 6,419 (199%).¹⁶ Among the 6,276 reporting hospitals, 2,627 or 41.8% had occupational therapy services in 1982.¹⁶ Between 1970 and 1981, the number of accredited occupational therapy educational programs increased from 37 to 55, and the number of occupational therapy assistant programs increased from 22 to 48.¹⁶

PROFESSIONAL VISIBILITY VERSUS OBSCURITY

The value of being recognized as a beneficial service to patients and clients had been important to the profession from its inception. When Medicare and Medicaid were created with the Social Security Act Amendments of 1965,¹⁷ occupational therapy services were included as part of the general inpatient service, which was considered a victory for the profession. However, coverage for occupational therapy in home health services and extended care could only be ordered in conjunction with physical therapy or speech-language pathology, suggesting a second-class ranking among other rehabilitation professions.⁵ In other words, occupational therapy was dependent on other professions for its visibility to potential clients outside the hospital setting. In 1980, the status of occupational therapy was upgraded to a primary or qualifying service that could be ordered as a single service for home health services, and it was included as part of the services offered in a freestanding comprehensive outpatient rehabilitation program.¹⁸ Status as a freestanding Medicare service also opened the reimbursement door to private practice occupational therapy.

In 1968 the Association, supporting President Ruth Brunyate's suggestion, contracted with a lobbying firm in Washington, D.C.,¹⁰ to represent the Association to members of Congress when legislation was discussed that had a potential impact on occupational therapy practice, education, or research. Brunyate, working closely with Washington, D.C., insider and occupational therapy leader Wilma L. West, helped promote a political presence for occupational therapy. Regular updates regarding legislation

were made to members via a column in the Association newsletter. As a result of the lobbyist's reports, Association members were able to have a broader influence on new and amended federal legislation that had an impact or potential impact on occupational therapy practice.

During the 1970s, the issue of visibility and recognition of occupational

ing the maximum level of independent function by mobilizing those capacities which remain after accidents, disease, or deformity" (p. 341).²² Occupational therapy is described as a "professional health care service which, when properly used, can be instrumental in decreasing hospital confinement, disability, and the ultimate cost of health care" (p. 343).²² According to

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therapy as a reimbursable service became a major concern.^{5,19,20} Insurance coverage was an important topic, and central to this issue was the discussion as to whether occupational therapy should be considered a medical, a health, or a social services profession.¹⁹ Reimburseurs would only cover occupational therapy services if the profession could convince the insurance industry that these services were medically necessary. In 1973 Blue Cross and Blue Shield (BC/BS) of Illinois agreed that occupational therapy services could be covered, but each hospital would have to be formally approved separately by the BC/BS office.²⁰ The major concern of reimburseurs was that occupational therapy needed to be a "functional," not a "diversional," service. Each director of occupational therapy in hospitals that wanted to bill to BC/BS of Illinois had to submit the departmental policies and procedures manual, including a copy of the referral form, and a description of the services provided. In 1982, Connecticut passed the first state-mandated coverage of occupational therapy law, which required BC/BS and other Connecticut commercial health insurance providers to pay occupational therapists for services.²¹

Because of AOTA advocacy, in 1977 and 1984 the Health Insurance Association of America issued a statement on occupational therapy. The 1984 statement describes the goal of occupational therapy "to assist the patient in achiev-

this statement, the primary difference between physical and occupational therapy

lies in the treatment modalities used and in the specific focus of treatment. The physical therapist uses modalities such as heat, hydrotherapy, ultrasound, massage, and exercise to improve general neuromuscular function and coordination. The primary tool of the occupational therapist is the active involvement of the patient in specifically designed therapeutic tasks and activities which, while improving function, also help the patient learn to apply the newly restored or impaired function to meeting the demands of daily living, including vocational activities. (pp. 341-342)²²

Occupational therapy was becoming a more visible profession worthy of being a reimbursable health care service.

RESEARCH EMPHASIS VERSUS SUPPORT

Although research was included in the aims of the profession in the Constitution of the National Society for the Promotion of Occupational Therapy adopted at the founding meeting in 1917,²³ research activities always lagged behind practice activities. In the early decades, therapists tended to view research as a task done by others—such as physicians and scientists—

and not as an integrated part of practice. Understandably, the emphasis also lagged because of the limited number of occupational therapists with advanced degrees, including doctoral preparation in techniques necessary to conduct research. Additionally, the American Occupational Therapy Foundation had minimal funds to support research on a larger scale. The first serious efforts to support research activities began in 1979, when the Foundation started to award research grants to Association members through volunteer contributions; in 1983 the RA passed a motion for AOTA to provide funds to AOTF to further support these efforts.²⁴ In 1982, a long-range research plan for occupational therapy was adopted.²⁵ The following year, members of the newly formed Research Advisory Council within the Foundation decided that the highest

the 1970s, several writers suggested that occupational therapists needed to consider whether they valued the idea of occupational therapy becoming a “true” profession or if the semi-professional status composed primarily of females with limited societal and political authority was good enough.^{29–32} As a result, several steps toward professionalization were taken. The Association developed a professional Code of Ethics that codified professional values and beliefs about practice and its relation to recipients of service, colleagues, and society.^{33–35} The Philosophical Base of Occupational Therapy project was initiated to search for the underlying philosophical values, beliefs, and knowledge of the profession.^{36–38} A dialogue began about the importance of philosophy and research within occupational therapy, as leaders of the profession grappled to seek direction for the

uniqueness of occupational therapy as a discipline.^{43–46}

ROLE DELINEATION VERSUS ROLE CONFUSION

As more occupational therapy assistants were trained, the need to differentiate the technical and professional levels of practice became more acute. Abbott pointed out that division of labor is often an issue in professions.⁴⁷ This bifurcation continues to have ramifications today, particularly in regard to the role of the occupational therapy assistant when the occupational therapist is practicing with an entry-level master’s degree. A 2-year study, “The Delineation of the Role of Entry-Level Occupational Therapy Personnel,”⁴⁸ was published in 1981 as part of the process of identifying the differences in role performance between occupational therapists and occupational

therapy assistants. The RA subsequently approved the first “Entry-Level Role Delineation for OTRs and COTAs.”⁴⁹ A related issue was laddering, or career mobility—the process by which a person

trained at the technical level could become a professional.^{50,51} The career mobility program was controversial. Letters to the editor of the *American Journal of Occupational Therapy* suggested that the program needed refinement.^{52,53} Therapists educated at the professional level were not pleased to see that technically trained personnel (OTAs) could become professionals (OTs) simply by sitting for examination without obtaining any additional college credits.

CONCLUSION

A predominant concern for occupational therapy between 1970 and 1985 was a shift in professional identity. Various routes were explored, including autonomy, legislation, visibility, reimbursement, philosophy, research, professionalism, specialization, and role functions. This period also included changes in theory development and discussion about the role of graduate education.⁵⁵ Clearly the question

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priority should be “studies designed to operationalize occupational therapy concepts through the development of new instruments” (p. 699).²⁶ This priority was based on the assumption that occupational therapy theory and knowledge would develop primarily through the identification of concepts of interest to the profession. Although the amount of a typical grant was small (about \$2,000), the investment of membership dollars to research studies was a new trend that showed a commitment to research activities on the part of occupational therapy practitioners.

PROFESSIONAL VERSUS SEMI-PROFESSIONAL STATUS

Occupational therapy developed through the apprentice model, in which experienced practitioners, mostly women, pass on to young apprentices what has been learned from experience.²⁷ The “do as I do” method was also a carry-over from instructional techniques used in nursing.²⁸ During

profession.¹⁰ However, the Philosophical Base project derailed over a period of years, losing its original purpose and momentum. Additionally, debate occurred as to whether the practice of occupational therapy should focus on specialized or generalized areas of application.^{39,40} In other words, should occupational therapy practitioners be specialists or generalists? Implicit in the debate was whether occupational therapy should adopt the medical model of specialty practice areas or whether occupational therapists have a philosophically more integrated and holistic view of practice.¹ One outcome of the debate was a stronger commitment to research and scholarship. For example, practitioners began to develop a more scientific approach to testing standards in the development of evaluation instruments.^{41–42} At the same time, a deeper understanding of the philosophy fostered the development and publication of new models of practice that attempted to identify the

for the time period was “Will the real occupational therapist (or occupational therapy assistant) please stand up?” ■

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FOR MORE INFORMATION

Occupational Therapy History: The First 30 Years, 1900–1930

By V. A. M. Quiroga, 1995. Bethesda, MD: American Occupational Therapy Association. (\$29 for members, \$42 for nonmembers. To order, call toll free 877-404-AOTA or shop online at store.aota.org. Order #1132-MI)

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