

1967 Eleanor Clarke Slagle Lecture

Professional Responsibility in Times of Change

Wilma L. West, MA, OTR

We are now convened for the final day of a conference in celebration of the 50th anniversary of our professional life. Behind us lie five decades of individual and group endeavor—endeavor to develop a profession, to define and refine a service, to improve an image and extend its acceptance, to recruit others to our ranks and train them for perpetuation of our ideals, to research new and better ways of accomplishing our goals.

At this milestone in our history, one could be tempted to look back through the years and analyze the functional relationship between endeavors and accomplishments. Such stock-taking would surely yield an inventory of assets in many areas of effort in which we might feel mutual pride. It would also, however, show liabilities for which we remain collectively responsible. Still other accounts might appear as outstanding or receivable, thus implying the necessity for continued effort in the commitment to further progress. Depending on the perspective and purpose of the individual doing the analysis, this measure of our first fifty years might be impressive, discouraging or inconclusive with respect to net accomplishment.

Santayana has warned that “He who neglects history will be condemned to repeat it.” However, awareness and understanding of effort input with reference to success or failure of outcome are most functional when new approaches are being brought to the solution of old problems. If, on the other hand, changing or new conditions prevail and hence a different set of problems is presented, there is diminishing value in more than brief review of the methods of other people and times. The example of the inadequacy of conventional defenses in a nuclear age is the obvious one, but professional personnel in medical and educational fields today face a dilemma equal to that of the military in recognizing that old ways of solving problems are no longer adequate.

Let us turn, then, from any comfortable reflection on our past to the infinitely more exciting exercise of projecting our future. Wisely approached, this can be as scientific as a retrospective analysis and surely it is a more dynamic course if we wish to have a part

in determining our future rather than merely accepting one on assignment or default of others.

One cannot be in the practice of any of the health professions today without being keenly aware of the many forces shaping his future roles and responsibilities. Nor can he neglect his duty to examine the implications of these forces in three dimensions: for himself as a professional person, for the profession of which he is a member, and for the professional organization which represents and promotes his individual and group interests. In brief, the questions currently confronting us are: What is happening in both our immediate and larger worlds? and, What does this mean to us?

The general stage for this discussion may be set by an analogy from another field that is strikingly similar to that of medicine. Francis Keppel, former commissioner of the Office of Education, Department of Health, Education, and Welfare, says that America is entering a third revolution in education. In the first revolution, education of the masses was achieved by the establishment of the public school system. Later, equality of education for all people became the rallying cry for school reform. Now the astounding advances in technology demand specialized and high-quality education for all regardless of race, creed, or social class.¹

Today this country is well into a similar multistaged reorganization of health and medical care in which equal availability and high quality of health services are sought for all people. The bipartisan endorsement of providing services to meet two of man's most fundamental needs—for education and health care—has removed the question from the arena of welfare and politics and placed it in the larger domain of basic human development.

Whether one agrees with these trends wholly, partially, reluctantly, or not at all, one fact is virtually undeniable today: comprehensive health care, among others of man's needs, is beyond individual attainment for far too many people. If we accept this fact, we can accept the organization of increasingly costly and complex programs designed to reduce disease and disability among victims of economic disparity and to raise the health standards of our country as a whole.

"Governmental involvement (then) in the financing and organization of health services is here to stay and there is every indication that it will increase."² I submit, however, that governmental participation and individual responsibility are neither incompatible nor mutually exclusive. In fact, we must go even further in pursuit of a rationale that is in tune with both our changing times and a high standard of personal and professional integrity. I therefore tend to agree with another commentator on this subject who has said that "placing health in the category of the rights of man involves the transformation of a social desire into a moral imperative."³ This imperative has been stated as follows by the New York Academy of Medicine: "That *all people* should have . . . *equal opportunity* to obtain a *high quality* of *comprehensive health care*."

It is difficult to see how anyone could mount an argument against the humanitarian elements of this high goal. In the sense that the primary orientation of the professions is to the community interest, there *must* be concern for all people on the basis of equal opportunity

and with a standard of the highest possible quality that it is within our ability to provide. Implications of most of the key phrases in this all-encompassing objective are clear. However, the last dimension—comprehensive health care—bears elaboration because it is with reference to this focus that we will examine how our profession can best adapt its philosophy and practice to future requirements.

At our annual conference in Minneapolis last year, the theme was “Dimensions of Change.” Many of us, I am sure, recall the message of several thoughtful speakers who helped us read signs among today’s maze of medical plans and programs that are as complex and confusing as the newest multistory interchange of highways around our large cities. I hope we also recall the repeated emphasis on *health*, as well as illness, on *prevention* of disease and disability, in addition to seeking the cures not yet discovered, on *maintenance and promotion of well-being*, not just being satisfied that there is an “absence of infirmity,”⁴ on *continuity of care*, in lieu of only episodic attention to emergency conditions, and on *comprehensive health services* that must replace the diagnostic or categorical approach of conventional medicine.

The trends in these directions are unmistakable. They are also irreversible. To recognize them, however, is only the first step. We must also interpret their meaning for each of our specialty areas and aggressively adapt or redesign our roles to provide a more viable future service.

No one person can or should do this for all facets of his profession. Each must, however, do it for his own focus of interest and with all the professional outlook and insight he can muster. I can best relate these changing trends and their implications to the field of pediatrics, with which I have been most closely involved in recent years. I shall attempt to do so in the general framework of comprehensive health care for children and, more specifically, with reference to selected groups which present us with some very challenging opportunities to develop a preventive role for our profession. I shall conclude with some thoughts on the implications of these and other changes for the profession as a whole.

Comprehensive Health Care for Children

What is meant by comprehensive health care for children? This is a term that is variously defined, but on the conceptual level, I prefer the following statement to all others that I have read: “By comprehensive, we mean a constellation of health services that focuses on the patient as an individual human being rather than as a collection of assorted organ systems, some of which are diseased.”⁵ On the practical level, we believe this ideal must be translated into programs which include health supervision in the various parameters of growth and development and the regular use of specific devices for screening deficits and dysfunctions. Comprehensive health care for children, we feel, is committed to enhancing normal development as insurance against disease or, failing that objective, to the earliest possible casefinding of those conditions which have their origin in prenatal causes or in the disabling illnesses of infancy and the preschool years.

Both the number and scope of programs designed to provide health care for children are greater today than ever before. The idea behind them, however, is hardly a new one. For it was in 1890 in France that the first nursing conferences and milk stations were established to provide preventive health services for lower socioeconomic segments of the child population. At that time the motive was to reduce the enormously high infant and preschool child mortality, but from these early beginnings, clinic services of similar types have developed throughout the world. In the United States, the milk stations of the World War I era subsequently became known as well-baby clinics and today, in many areas, are called child health conferences.

It is interesting to trace the broadening philosophy of these forerunners of modern comprehensive health care for children. Since such enterprises were designed to provide health supervision of well children, one of their primary functions was to screen children for evidence of abnormality or illness that might warrant referral for care.

A classic text on preventive medicine and public health⁶ tells us that the child health conference was originally necessary because a large segment of the population was unable to pay for health supervision. However, it also goes on to point out that even today such services cannot be transferred to the private practitioner. The reason, the authors state, is that education and training of medical students is still largely oriented to the patient with cellular pathology, with the result that many practitioners today have limited interest in and knowledge of the principles and techniques of health supervision of growing children. Furthermore, child health personnel even in recent years have been largely preoccupied with the development of treatment and training programs for handicapped children.

And so, it seems, have occupational therapists in pediatrics. Thus we, too, have been slow to develop a role in prevention that might greatly enhance our total professional contribution to health care. Although our traditional commitment to medicine and our orientation to illness and treatment are understandable, our greater development of a preventive role, which is "an integral part of all medical practice, wherever it may be and under whatever auspices"⁷ is long overdue.

There is even a sense of urgency to the situation that cannot be escaped. Consider for example the number and diversity of settings in which new health care programs for children are constantly being developed. The well-child clinics or child health conferences that have already been mentioned are standard services of state and local health departments, but they are only one of several locales where continuing health supervision of children is assuming ever greater importance.

Probably the best known among others that I will discuss here are the Head Start programs that have received extensive publicity in the brief two years since their inception. Although the initial focus of these efforts was on enrichment of experience in preparation for school, a spin-off benefit of major importance has been identification and treatment of health deficits. It is of significance to us that the range of these deficits goes far beyond the dental and nutritional problems inevitable in the target populations and includes a high incidence of retarded or deviant physical and psychosocial development. As we well know,

the chances for remediation of many such problems are infinitely better at age three or four than at beginning school age which, until now, has provided our earliest largescale screening opportunity.

Another very new program of the Office of Economic Opportunity which was launched late this past summer could provide an even richer locus for occupational therapy in a preventive role. This is the development of Parent and Child Centers that is currently taking place in thirty-six American communities to provide services for disadvantaged families who have preschool children. A prime objective of these centers will be the use of techniques and processes both to prevent deviations and deficits and to stimulate development to the maximum potential. Among the skills and experience sought for staff are the ability to recognize and understand the developmental stages of young children and prescribe a plan for progress to meet each child's individual needs.⁸

To pediatric occupational therapists who have been concerned with the larger objective of optimal child growth and development as well as with restoration of impaired function, the possibilities inherent in these new centers must indeed be exciting. Think, for example, of the broad range of activities that could be used to provide multisensory input directed to the development of intellectual, emotional, social and physical skills. The graded and guided use of activities for such purposes is so integral a part of occupational therapy that this would seem to be a most fitting application of our skills to plan, elicit, interpret and modify both performance and behavior.

There are other groups of children for whom health surveillance could provide either prevention or earlier treatment. Sparked by the increasing prevalence of daytime employment of both parents or the absence of one parent and employment of the other, day care facilities have become a way of life for thousands of young American children. The larger of these, the day care centers, are units with seven to seventy-five or more children, a staff of one or more persons, and an organized program. In these settings today, ages of children usually range upwards from two and a half years, this being the minimum age for most children to participate in group play or other organized activities. What an opportunity there is here to prevent, restrict or retard development of problems we now see only when they are entrenched and disabling, often to a severe degree.

A final example is a group of children which has received special attention during the past year and is already providing the occupational therapist with a role in screening, evaluation and programming as well as in treatment. This is the group served by the Children and Youth projects sponsored by the Children's Bureau.

Organized in areas of economic and social disruption, these projects are designed to provide comprehensive health care for large numbers of children who, under existing circumstances, have only marginal opportunity to develop a healthy mind and body. Now, however, a broad range of health professionals is being assembled to provide services which should greatly improve their future outlook.

Included in the authorized core staff for children and youth projects is an occupational therapist whose job description reads quite differently from the specifications for other pediatric roles. If a few of these promising new positions can be filled by therapists

with vision as well as skill, there are few limits on the extent to which they will be permitted to develop a broader role. For example: in New York City, two pediatric neurologists on a children and youth project added an occupational therapist to assist them in screening for neurological deficits; in Dallas and in Denver, pediatricians directing diagnostic clinics use their therapists to evaluate motor performance and behavior adjustment and to participate in programming based on team findings and recommendations; and in several other areas of the country, therapists are involving children in activities which permit assessment in numerous areas of function and providing selected experiences to promote development of neuromuscular, emotional and intellectual competencies of children.

These, then, are some of the programs made possible by the federal-state alliance to extend and improve health services for increasing numbers of people. They require of all professions a careful appraisal of changes that may be necessary as we jointly seek creative and workable solutions to both old and new problems. Although we have centered attention on one specialty of our profession, it is intriguing to think about how the number and kinds of changes in pediatrics today will inevitably, in time, affect every other age group and specialty field of occupational therapy.

Furthermore, there are equally radical changes occurring simultaneously in patterns of delivering health and medical services to all people. Witness, for example, the burgeoning community mental health programs and consider the implications of trends in that specialty of our profession. Are there not elements here, paralleling the new kinds of community-based services in pediatrics, which are dictating programs concerned with the maintenance and promotion of health as well as the treatment of illness? And hence, are there not here, too, strong indications for increased emphasis on the preventive role of occupational therapy?

Of course there are, and many progressive occupational therapists in both these and other specialties of our profession have already taken steps to keep pace with trends that require new or expanded roles. Furthermore, they have done so with such effectiveness that they have created roles and functions that greatly improve the image of our profession. In a sense, therefore, my commentary only reflects what I consider to be the best abroad in practice today, with a few thoughts on where, how and why it seems particularly urgent that we intensify our efforts in these directions and at this time.

I fear, however, that there are yet too many among us who do not sufficiently appreciate current trends and who therefore are not lending their efforts to hasten and make credible more functional roles throughout the profession. The platform at a general session of our Annual Conference and assured publication in our professional journal lend temptation to speak frankly to one's colleagues. And, the occasion of a golden anniversary provides a good point at which to cross the treacherous terrain of prophecy and hazard a glimpse of where our best future directions may lie. He who does so will always run the chance of suggesting some wrong turns, but he who does not has missed both an opportunity and a responsibility to share with others his views on areas of mutual concern.

We Are Committed to Our Profession as a Whole

I would like, now, to discuss some ramifications of these thoughts in terms of the profession as a whole rather than in the framework of any one or more specialty areas of practice. For, regardless of our individual concerns with separate fields, it is to the whole profession that we are jointly committed and for which we must cooperatively work. My remaining remarks will explore some of the reasons why it seems important that this be so.

What is the relevance to us as a professional group of the changes I have discussed, of other changes that are taking place in patterns of providing health services, and of the implications these have for traditional and transitional roles in our profession? Is it enough that there is a growing number of clinicians in each of our specialty fields who are continually sharpening conventional skills and also developing new ones? Can we rely on the work of a small but increasing number of researchers among us to confirm the scientific basis of our practice? Does the greater sophistication of today's authors sufficiently raise the level of our professional literature? Will the growing number of our members who are obtaining graduate degrees insure a higher quality of performance in the future? Are changes that are being effected by the more progressive among our educators adequate to the preparation of tomorrow's therapists? In short, will the leadership of these and other significantly contributing individuals suffice? Indeed, should it have to?

Decidedly not. What is absent from this kind of thinking is the concept of group responsibility—responsibility for awareness and interpretation of those changes which affect any part of our profession, and responsibility for whatever group action is appropriate to facilitate or hasten adjustment to change. Thus, although we clearly recognize that “All occupations are dependent on the individual contributions” of those who practice them, we must also realize that “the effectiveness of an occupation is not gauged by individual efforts alone; the total efforts of occupational members working together with some degree of cooperation must also be considered. The public image of an occupation, then, is in part individual and in part collective. . . . Moreover, the goals of an occupation are only in a limited sense individual, for the individual responsibility of practitioners and a consciousness of the aims of the occupation are very much a function of collective action.”⁹

There are, of course, many terms for the kind of collective action here referred to. Among them is what I shall call professional consciousness and responsibility. This is an attribute that we in occupational therapy have to a quite considerable degree. It has served us well in the fifty years of our professional development to date, primarily, I believe, because we have used it more in the sense of professional responsiveness to public interest and need than for purposes of protecting or promoting our constituent individuals and groups. These two major purposes of a profession—meeting external obligations to society on the one hand, and internal loyalties to members on the other—may often be in conflict. That they have not created serious problems or dichotomies for us up to this time may be viewed as a mixed blessing, for readings in the sociology of development of the professions make it clear that it is only a matter of time until they do. Factors which may have delayed this apparently inevitable process

include our extremely small size and the relative homogeneity of a profession with only incompletely developed specialties.

Trend Toward Decreased Professional Unity

With the passage of time, however, we are experiencing both an increase in size and a proliferation of special skills among our members. As these two dimensions grow, we become increasingly subject to the influence of factors which will tend to decrease professional unity and promote segmentation in accordance with divergent interests and strengths as they develop among us. Although it will undoubtedly create some problems, this trend is by no means undesirable. On the contrary, it usually brings with it both an improved service, which results from increased knowledge and skill of specialists, and a growing professional influence which can be used to improve the status of those who provide that service.

There are signs that the era of segmentation is already upon us; witness for example, the increasing number of special interest meetings and concurrent sessions scheduled at this year's Annual Conference. While neither deploring the problems nor lauding the advantages an increase in this trend will bring, I hope that we will retain an attitude of general professional consciousness and concern for as long as we exist. Conviction of the need for this lies in the belief that "the chief factor . . . in the accomplishments of any profession is the unified, aggressive efforts of its members."¹⁰

Numerous theories have been put forth to explain why persons pursuing an occupation come together and associate in a formal manner. These include everything from the likely initial motivation for exchange with those doing the same work, to such presently accepted objectives as raising standards of competence, formulating codes of ethics, improving education, undertaking protective and promotional activities, and many others. The activities of associations as major interest groups which participate in planning and policy decisions on matters of concern to them are generally thought of as a development of recent years undertaken to counter the influence of governmental regulations on professional activities; in fact, however, these date back at least three centuries when, as one writer says, "it was characteristic of the times that powers and duties of so extensive a nature were granted to vocational associations that they may be regarded as organs of the state."¹¹ Thus they are illustrative of the influence a well-organized profession can have on public decisions and policies.

I make no case for our professional association to aspire to this degree of power. I do, however, believe that both as individuals and as a professional group we should be assuming a far more frequent and contributing part in the planning of health services. It will, in fact, be mandatory that we do so if, as I said earlier, we are to have a part in shaping our own development.

Izutsu believes that "it is not too late to achieve positions of leadership that will determine the future" of our profession.¹² However, he also lists several steps that we must take if we are to remain equal to changing patterns in the organization and delivery of health services. Among these are the development of leaders not only to plan for therapy but to think in the broad spectrum of social planning; training of therapists in public health principles

and procedures; and exposure, in our training, to community-oriented settings and other health team members in lieu of training primarily in hospital settings.

Professionally, We Often Resist Change

I do not suppose any of us knows, with any degree of certainty, the ideal future course for our profession. We do, however, see many signs that it must keep changing if it is to stay abreast of the larger world of which it is a part. Change is seldom easy or comfortable. Yet there is little about the world in which we live today that is more characteristic of it than the continual and fast-moving changes which transcend every aspect of our lives.

Although each of us makes the necessary adaptation to these changes as they affect our personal concerns and activities, we are slower as a group to adjust our professional directions and developments to that which is new. We are often, in fact, resistant to the suggested need for change and all that it implies in the necessity for new learning and the establishment of new roles and functions. We are also reluctant to explore new potentials, to experiment, to take an occasional risk.

From Therapist to Health Agent

Increasingly, today, I believe we should identify with the field of health services, thus broadening our traditional, more limited identification with medicine. We should enlarge our concept from that of being a therapist to one of functioning as a health agent with responsibility to help insure normal growth and development. We should think more about roles in prevention as well as in treatment and rehabilitation, about socioeconomic and cultural as well as biological causes of disease and dysfunction, and about serving health needs of people in many other settings than the hospital.

One occasion on which this was expressed in a very effective way by a number of our colleagues was the conference on research in occupational and physical therapy held last February in Puerto Rico. In one of the discussion groups there was studied avoidance of the term "patient," which many felt limited their concern to illness, and a plea for consideration of health as only one aspect of the developmental process of man which should not be isolated from other factors impinging on life. This kind of thinking and discussion culminated in the group's consideration of its topic in the framework of what they called "the continuum of health services which reflect the needs of man in his environment."¹³

A broad frame of reference? Admittedly, but it is also entirely in keeping with our traditional philosophy of concern for the person rather than just his disability. For us, therefore, the idea possesses what might be called "instant validity." It now needs rapid if not instant implementation.

We are living today in a world that is vastly different from that when occupational therapy began. It matters not so much that it has taken fifty years to reach this day, as that the next fifty see more, and more rapid, progress than the last. It matters less that we are still struggling to define our profession than that we build a broader base for the better definition that

will one day be written. It matters most of all that we recognize the responsibility of the profession to change with changing demands for its services, to adapt via new approaches, to assume different roles, to develop the preparation for them and to recruit in a new mold rather than by recasting the prototype of an earlier time.

On the eve of her retirement from active work in our national organization, Eleanor Clarke Slagle was paid the following tribute:

Those of us who have been privileged to follow the winding trail of those years know of struggles, of courage in facing criticism, of disappointments and rewards, of patient waiting, persistent faith and devoted work. The questing youth of our profession accepts both with commendation and condemnation what has been so painstakingly accomplished through this quarter century. But when they too can look back over an equal span of service in this field, they, and occupational therapy, will still be moving to the measure of the thought of Eleanor Clarke Slagle.¹⁴

That "equal span of service" has now passed so we, too, are looking back over the second quarter of a century which immediately precedes the present day. It seemed fitting that we do so in the context of both our practice to which she gave so much, and our professional association which she helped to organize, served as an officer in four capacities, and directed as its executive for many years. I, for one, hold to much that she obviously held high among her goals for the profession. Among those goals, I feel sure, was one related to the need for professional responsibility at all times. In times of change such as these, that need and our response to it will be of great importance in determining the next fifty years of our professional life. At the turn of the 21st century, when yet another generation looks back on these times, may they see that ours was a dynamic posture of professional consciousness and responsibility.

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