

1972 Eleanor Clarke Slagle Lecture

Occupational Therapy: *A Model for the Future*

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Introduction

Occupational therapists repeatedly throughout our history have demonstrated concern for the individual and a strong belief that through involvement in the occupational therapy process, those individuals who cannot contribute to or fully participate in society's marketplace can determine the quality and style of life they seek and can thereby influence their health. Mrs. Eleanor Clarke Slagle associated such concern and belief with occupational therapy when she refused an offer to go to France in 1918 to head a hospital for "shell-shock cases." Instead, she elected to remain in Chicago where she had started courses in occupational therapy as she felt her efforts could best be devoted to meeting the needs of wounded veterans in that fashion.¹

While concern for the individual has been demonstrated consistently, our knowledge of individual behavior and social behavior has expanded so that our efforts to promote and support man's desire for health through the occupational therapy process have shifted from sole focus on the individual to recognition that equal focus must center on helping man learn to achieve a satisfying interaction with his social system or environment.

Defining the occupational therapy process has been difficult. Early in our development we found success when we employed the concepts of "moral treatment" with psychiatric patients.² Within this framework we were concerned with the whole man, and we attempted to provide wide-based, health-oriented services to individuals which were consistent with and responsive to society's needs. At the same time we were able to retain our belief in the individual and to demonstrate the value of his involvement in occupation to restore function and promote healing.

At other times we have lost sight of man as a whole and have concentrated on mechanics, media, or techniques, usually in an effort to influence pathological processes.³ When we put aside our strong orientation toward health, we seem to be less successful and to harbor more doubts about the viability of occupational therapy.

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At this point in time, we, as a profession, are faced with the challenge of making critical decisions which may well determine not only our success—but our survival—as a profession in the future.

This presentation will attempt to delineate a model to serve as a guide in our decision-making process as we develop a strategy for the future. I will discuss five elements, all inter-related as part of our decision making process. I will also raise questions for our mutual consideration as we move toward decision-making.

The five elements in the decision-making process are: organizational behavior and societal change; the occupational therapy product; the marketplace for occupational therapy; the marketing process; personnel requirements.

The terminology and concepts utilized herein are derived primarily from business and biology, rather than from medicine, because we must examine many models before we can select those which are most appropriate for our professions.

Organizational Behavior and Societal Change

History reveals that our desire to provide services of professional status and quality has prompted us to accept and seek to fulfill the criteria of professionalism defined by medicine and also accepted as “the authority” by other professions, who also view the physician as the “professional par excellence.”⁴

Fidler⁵ and Yerxa⁶ in their respective Eleanor Clarke Slagle lectures identified and examined our progress in fulfilling these professional criteria in our educational and practice systems. Among the criteria they examined were the following:

- Acceptance by the profession of a body of knowledge, supported and substantiated by research;
- Establishment and enforcement of ethical standards for membership behavior;
- Acceptance of responsibility for making independent judgments and for operating autonomously;
- Establishment of and control over educational standards for admission of members into the professional association; and
- Identification of services associated by the public with occupational therapy.

Our desire to move from competence to excellence has been equated with fulfilling the above criteria of professionalism. This has led us to direct our primary attention to internal matters over which we could exert some degree of control. This behavior was demonstrated in an era in which professions were distinct and often isolated entities. Lawrence and Lorsch, in their studies of organizational behavior, found that this was a generally accepted pattern of organizational behavior and that it represented a method whereby organizations could find “the one best way to organize.”⁷

While we and other professions have spent most of our efforts and energy focusing on internal change and revision, and have erected organizational structures reflective of the past, the very foundations which govern all aspects of our lives have shifted. Drucker, among others, writes that in a very short period of time society has emerged from an era of experience

into an era of knowledge. One of the most dramatic changes resulting from this societal transition is that the requirement for every job—skilled or unskilled—will be knowledge-based. Schooling, rather than apprenticeships, will provide job foundations because the worker's productivity will depend upon his ability to employ concepts, ideas, and theories.⁸

The moon shots exemplify this point for we had no previous experience upon which to build as we sent men to the moon. Rather, we had knowledge and technology which enabled us to anticipate and approximate experience and consequences of decisions.

A side effect, or consequence, of the emerging era of knowledge is the decreasing amount of isolationism and the increasing interrelatedness and interdependence which is found in all areas of life today. Individuals, as well as professions and organizations, are equally affected.

A case in point is that of the alcoholic whose life typifies complexity and interrelatedness in that his drinking affects his life, the lives of his family, and society at large. His behavior can endanger the lives of others. His children demonstrate more pathology than do children from nonalcoholic homes. His family as a whole seems to feel a greater sense of guilt than do other families. Ultimately, society may have to assume responsibility for both the alcoholic and his family.

Similar examples of increasing complexity, interrelatedness, and interdependence are found in the areas of health, ecology, conservation, and pollution, for we are learning that our behavior and actions may have consequences extending far beyond any which could have been conceivable in earlier times.

For example, the October 1, 1972 issue of the Washington, D.C., *Sunday Star and Daily News* reported that "thousands of men and women who worked in shipyards during World War II are threatened by a rare form of cancer stemming from exposure to asbestos . . . The disease, a tumor affecting the lining of the chest or abdomen—has only recently begun to appear, 30 years after exposure . . . until the last decade mesothelioma was so rare that it did not warrant separate classification as a cause of death . . . Now it is possible that 32,500 to 225,000 of the 3.25 million World War II shipyard workers still living could be killed by the disease . . . which is invariably fatal."

As demonstrated by the above examples, our lives are becoming more complex, more interrelated, and more interdependent. With the rapid advancement of technology and the availability of increasing amounts of knowledge, the importance of experience diminishes as we move into areas in which man has had no experience. It becomes necessary to rely upon knowledge to help us anticipate the future and predict more accurately the consequences of our decisions and behavior.

There are two direct and immediate implications for occupational therapy which emanate from the knowledge era. The first implication relates to an expansion of the populations which we can service. The second implication relates to our need to expand our concept of professionalism to meet criteria we establish and to develop an organizational strategy which enables us to relate to and interact with other professions and disciplines in positive, constructive ways, without sacrificing the concepts in which we believe.

Drucker supplies evidence upon which we can predict an expansion of the populations we serve when he says that our present manpower shortage will increase because marginal

and unemployed individuals frequently lack, and perhaps cannot acquire through the educational system, the habits, tools, and skills which are prerequisites for employment today.⁹

If we believe Reilly's hypothesis as proposed in her Eleanor Clarke Slagle lecture, "that man, through the use of his hands as they are energized by mind and will, can influence the state of his own health,"¹⁰ we have a responsibility to expand our service base. Dubos provides substantiative support for Reilly's hypothesis in that he proposes the distance of a direct relationship between meaningful occupation and health.¹¹ We as occupational therapists can offer valuable services to those individuals who are cut off from the main stream of society because they cannot effectively utilize our educational channels or compete in life's marketplace. These individuals need opportunities for experience, which are no longer readily available to them, to learn and to help them find an outlet for their skills and abilities.

The occupational therapist's knowledge of individual behavior, social behavior and occupational (or experiential) behavior as these components influence health leads to an understanding of the contribution of the occupational therapy process as it is relevant to present-day individual and societal needs.

The second implication emerging from the knowledge era is that it is not sufficient to attend to standards for the development of individual professional occupational therapists, as we have traditionally done. Now we must go beyond concern for the individual therapist to develop a strategy for the profession of occupational therapy as a whole. This strategy will need to be concerned with the interrelationships and interrelatedness between occupational therapy and other professions. It may also require that, as Lawrence and Lorsch suggest, we develop several different organizational characteristics and behavioral patterns, responsive to differing external conditions, if we are to be a successful organization in the context of societal change.¹² Finally, it may require us to develop our own criteria for professionalism and excellence.

In summary, we can utilize knowledge to anticipate and predict change in the larger social context and to identify the implications of those changes for occupational therapy as they affect our service functions and our organizational behavior. Examination of the social system thus enables one to take a fresh look at the product of occupational therapy.

The Product

Occupational therapists share a common goal in their desire to influence occupational performance in the knowledge that the individual's involvement in occupation bears direct relationship to the state of his health. Occupation is defined as any goal-directed activity meaningful to the individual and providing feedback to him about his worth and value as an individual and about his interrelatedness to others. Occupational performance consists of components of emotional, biological, cognitive, and social behavior. Each of these behavioral elements can be viewed separately, but to fulfill the goals of occupational therapy the components must ultimately be viewed in terms of their interrelatedness. Dubos lends his support to this approach by saying that the most pressing problems of humanity can be resolved only as we study "systems as a whole in all of the complexity of their interactions."

He also challenges science to move from an atomistic, reductionist approach to one which deals with the responses of the "total organism to the total environment."¹³

Because occupational therapists have traditionally viewed man as a total organism seeking to influence his state of health through occupational pursuits, we have also been able to see the need for the occupational therapy process to be concerned with individuals, their social systems, and their occupations. The client and the therapist participate in a collaborative process or transaction whereby the therapist provides an experiential learning environment in which the client can initiate or participate in occupational performance meaningful to him. As a result of this learning experience, the individual should develop a sense of competence and mastery as he learns to cope with, adapt to, and conduct negotiations and transactions with his social system, thereby facilitating mutual change.

The crucial test comes when the individual is required to perform in his own social system. If we have fulfilled our responsibilities adequately, the individual should succeed for it will be possible for him and the social system to produce changes and adaptations necessary for compatible coexistence. In summary, through this process man learns to make decisions about the quality and style of life he seeks to achieve and to influence his health.

Viewed in this light, occupational therapy is an applied social science, eclectically drawing upon the biological, social, and behavioral disciplines for our basic understanding of man, occupation, and social-organizational systems.

- In summary, our product is basically a service, emanating from the following knowledge:
- That each individual has some capacity to be involved in meaningful occupational performance;
- That occupational performance provides feedback, conveying a sense of dignity, worth, and competence to the individual; and
- That through the use of occupations and his attitude toward them, the individual can determine his life style and influence his state of health.

The opportunity for individuals in our society to learn from experience is diminishing and may be gone. Through the services provided by occupational therapists, those individuals who require experience to acquire and utilize knowledge can continue to have opportunities which enable them to make decisions about their lives, and to cope with, adapt to, and negotiate with their social environments.

The above description of our product is broad and purposefully aimed at the commonalities in our professional activities. This was done in the belief that attitudes about roles and functions should be built upon a professional foundation rather than predicating the profession's future upon the role of the therapist in any given marketplace.

The Marketplace

Given the fact that our product is a service, where should we market it?

Traditionally, the hospital has been our marketplace. Should we continue, in light of the changing social context and the product as it may be defined, continue to be hospital-based and medically related?

Will the changing structure of hospitals permit us to remain there even if we wish to do so? Will our own professional goals permit us to retain our primary affiliation with medicine?

Two particular changes occurring within the spectrum of health care prompt me to question the retention of our primary ties with medicine. In the first instance, there is increasing discrepancy in health needs and expectations as identified by the public and in the needs identified by medicine. Until recently, the scope of medical care (with the exception of public health) was limited by the "germ theory." Theoretically, this theory suggested that the cause of illness or disease was a germ. If the germ could be identified, a cure could then be effected through medication, surgery, or some other prescribed regime.¹⁴

In contrast, the concept of illness now extends to include persons with social or behavioral problems. These problems, once considered to be of a legal or moral nature, were handled by judges or ministers who prescribed punishment or forgiveness. Now persons with such problems are candidates for health care.

The second change occurring within health care is the emergence of a new relationship between the "patient" and health professionals. The relationship involves (1) a difference in degree of patient involvement in the treatment process; (2) a movement away from the dependence and compliance required earlier of patients; and (3) a desire on the part of the patient to know more about the rationale for and consequences of the treatment program. Perhaps this change results from the greater incidence of chronic conditions and the different approaches required to change behavior.

In many instances, the cure, eradication, or control of health problems becomes a function of the contract and relationship negotiated between the health professional and the individual participating in the service program. Many of these individuals do not require hospitalization, nor will the regimented schedules and dependency states fostered of necessity by hospitals produce the desired behavioral changes necessary to enable the individual to live in relative harmony with himself and his social system.

If we are to successfully provide our services to patients, we need time which is a commodity not readily available in most hospitals. Thus, we either have to seek to change the hospital system or move into other environments. There are many other changes in medical care which cause me to question whether we can even realistically see ourselves as desiring to retain a primary affiliation with medicine and hospitals, but these instances highlight my concern.

With the changing social context, the product as I have defined it, the needs of our potential service population, and the time required to produce behavioral change, occupational therapy's greatest contribution may be other than hospital settings. We might be located in sheltered environments where opportunities for experiential learning are provided or in the individual's own social system, whereby he learns to cope with its demands, adapt to its requirements, and enter into a transactional arrangement with it.

Thus, the most ideal marketplace for occupational therapy may be in community health centers, school systems, day care centers, early child-care facilities, institutions for the chronically ill or for persons requiring long-term care as a result of either biological, social, cognitive, or behavioral problems, industrial settings, environments designed to reverse the cycles

of poverty and welfare, vocational settings, or in specified medical settings where medicine and occupational therapy share or jointly seek common goals.

The decision or decisions related to the most appropriate marketplace have yet to be made, but we must explore, and evaluate all possible alternatives in order to determine whether our product can be effectively marketed in any of the marketplaces identified above.

Product Marketing

As we consider a change in the marketplace, one of our first orders of business will be to identify sources of financial support. Examination of the medical profession reveals that any movement toward a new service delivery system is accompanied by plans which insure a solid base of support for physicians. The interest in prepaid medical plans, as a means of insuring financial security, is so great that lawyers, dentists, and insurance companies are exploring the feasibility of utilizing this approach on a widespread basis.

Occupational therapy faces a more difficult problem than does medicine, dentistry, or law in that our name is not yet associated by the public with the services we provide. In reality many of the needs and problems identified by society are those for which we maintain that we can provide services. Yet a gap exists between our perception of our services and the public's ability to recognize those services as being provided by occupational therapy. Evidence also suggests that we are identified by our media, rather than by our goals and functions, and we seem to perpetuate this image by many of the advertisements which appear in our professional literature and at our professional conferences.

One of our greatest challenges is to clearly identify our product or services for ourselves and the public, particularly if we wish to achieve success in marketing them.

The inadequate solution to this challenge utilized by therapists moving into new environments has been to relinquish their professional identity to obtain jobs. It is only after they have succeeded in their jobs that they may admit that they were successful because their education and experience prepared them to contribute to the solution of certain problems. If we persist in this pattern, we run the risk of losing many excellent therapists. This is a loss we cannot afford.

We have made some inroads into marketing our product through our increased reliance upon public information systems, public relations, and development of educational brochures and materials, and our efforts to influence and utilize the legislative process. These have been tentative, hesitant steps, and we must find a way to more directly and more forcefully close the gap between our perception of our services and the public's perceptions of our services.

Drucker, in addressing the issue of marketing as business views it, defines it as the systematic purposeful organization of work to sell a product, deliver it to the customer, and receive pay for it. The purpose of marketing is to translate knowledge or technology into products or services which are economically productive. Questions he raises are: (1) What are the needs, satisfactions, and expectations of the customer? (2) What can the customer afford? and (3) Who is the customer?¹⁵ The purchaser of the service and the consumer of the service

may be different and the distinction is an important one. It certainly has relevance for occupational therapy because we have traditionally been paid by hospitals to provide services to patients—and the implications of this method of financing upon our professional behavior may not yet be clear to us. I tend to believe however that financial dependency does little to help therapists become either advocates or activists.

In essence, as we think of marketing our product, the questions proposed by Drucker may be important ones for us to consider.

Personnel Requirements

As we consider a reorganization of the delivery of occupational therapy services, the personnel required to market the occupational therapy product becomes a primary focus of consideration. We must decide how to provide, maintain, and retain experienced practitioners who provide service, and we must decide whether we will attempt to provide manpower to fill all of the positions or first try to identify and fill critical positions.

Our profession has been slow to recognize the true value of our practitioners, and while we establish standards to improve the level of practice, we have done little to increase the prestige, status, financial rewards, or opportunities for advancement within the clinical field of our experienced therapists. Our competent practitioners have to leave clinical practice to advance or to fulfill the goals of occupational therapy. Our most distinguished researchers have difficulty obtaining grants and financial support to conduct the studies to substantiate professional knowledge. If this trend continues, the most vital component of our profession—the practice of occupational therapy—may be left in the hands of young, inexperienced, or unknowledgeable therapists, of assistants and aides, and of therapists who may be competent with competence but who do not aspire to excellence.

This is a critical problem for which we must find resolutions quickly. We must create opportunities within areas of clinical practice so that clinicians can move up in terms of professional responsibility, financial reward, and prestige without having to “move out to move up.” Part of the solution to this problem may well relate to the identification of our marketplace and our ability to find sources of economic support and financial security for occupational therapists.

If clinical practice is to be assured of its rightful place within our profession, our educators have special responsibilities. We need to overcome “town-gown” attitudes of medicine for we do ourselves and our profession a serious disservice when we indulge in such negative attitudes. These attitudes are reflected in the form of criticism, frequently without apparent recognition of the fact that clinicians are the product of our educational institutions. If our clinicians fail to meet our expectations, we must examine the criteria against which we are judging their performance. We must ask why, in view of the knowledge we have imparted to them, they do not meet our expectations. Perhaps we fail to help students learn to identify for themselves, the external forces to which they must be responsive, the occupational therapy product, the marketplace in which services can be delivered, and ways of seeking financial support for our product or service.

We may fail as educators, just as therapists fail with their patients, when we focus on the product and forget the market. The patient must be able to survive in his social system. He must find a sense of satisfaction, a sense of achievement, a sense of mastery and competence—much of which is fed back to him through his occupational performance. The clinical therapist (as well as the administrator, the researcher, or the educator) must also find these satisfactions in his social system through occupational performance, and thus it behooves us to help them learn how to transact the necessary negotiations with the system in which they live and/or work in order to provide the full benefit of our services to patients.

The second way in which we demonstrate negative attitudes toward clinical therapists is perhaps most evident but not limited to university teaching hospitals. We utilized two sets of standards in hiring academic and clinical faculty and the salaries may reflect a considerable differential between academic and clinical faculty members. There is frequently reluctance on the part of academic faculty members to include the clinical faculty members in the decision-making process concerning the curriculum and the educational process. There are differing recognition and reward systems for academic and clinical faculty members. I appreciate the fact that funding for these two groups of faculty members frequently comes from different sources, but that does not relieve us of the responsibility for attempting to find alternatives and resolutions.

Clinical occupational therapists are the core of our profession—they provide the services which we value and in which we believe. It is to educate clinical therapists that our educational system exists. Research becomes necessary to improve the quality, content, and direction of practice and education, and administrators provide the facilities and other resources needed by our practitioner.

We must find ways to enable our most experienced clinical therapists to remain in the field and this is a challenge for the whole profession.

Other personnel-related issues to be anticipated as change occurs in our product, our marketplace, and our marketing process include change in professional behavior and increased conflict as we come to grips with the occupational therapist as generalist or the occupational therapist as specialist. Freidson, in studies of the medical profession, found that the nature of practice determines physician behavior. More specifically, he identified “client-dependent” and “colleague-dependent” practices. In the “client-dependent” relationship, the physician must be responsive to patient needs and expectations if he wishes to retain his patients and his income. In the latter instance, the “colleague-dependent” physician (the radiologist, pathologist, etc.) receives patients by referral from other physicians and so he is primarily responsive to their expectations, rather than the expectations of the patient.¹⁶ This concept has relevance for occupational therapists in that we are just recognizing the implications for our behavior that are inherent in the constraints imposed by the marketplace in which we work and the source of financial support for our services. Certainly movement into new areas, often with loose or few affiliations to medicine, may be reflective of the fact that it is necessary to be employed by, or in, an environment in which there is a shared philosophy and a shared goal—or in which there is opportunity to create with others the goals which are to be

shared. To be employed, without an opportunity to influence or negotiate with one's social system, is seldom satisfying. Thus, as we seek new marketplaces we may anticipate change in professional behavior, reflected by our determination to define for ourselves the standards of professionalism we wish to attain; change in our professional behavior will also reflect our growing ability to exert force, influence, or political power to see that our clients have access to adequate services. Increased conflict as an anticipated issue may arise in response to the argument to prepare generalists versus specialists. This issue has plagued occupational therapy for years, and the prospect of expanding our horizons into new service areas may intensify the conflict.

One alternative to a discussion of the merits of the generalist versus the specialist is suggested by Lawrence and Lorsch, and Dubos, respectively, as differentiation and integration or universality and diversity. Drawing from systems theory, we know that as organizations grow, they differentiate into parts which must be integrated if the entire system is to be viable. In biology, the human body follows a similar process through its differentiation into various organs, all of which are integrated through the nervous system and brain. Each system, whether in business or biology, is concerned with differentiation, integration, and adaptation to the outside world in order to survive. Both differentiation and integration are necessary for successful interaction with and achievement in any given environment, but the unavoidable consequence is conflict. According to organizational researchers, the organization's success ultimately depends upon how well it tolerates and resolves conflict so that integration is facilitated without sacrificing the need for differentiation.

For us, as occupational therapists, it will be necessary to think of our common goals as our point of integration, while specialization may be centered upon the behavioral components (biological, social, emotional, or cognitive) of occupational performance—or related to the areas in which to work. Again, our own future success may well depend upon our ability to tolerate and resolve conflict in order to facilitate integration without sacrificing needed differentiation within occupational therapy.

These issues—retention of experienced practitioners in the service areas, changes in professional behavior, and conflict resolution—demand attention now and will continue to occupy our time and energy, particularly as changes occur in our product, marketplace, and marketing process until we can find appropriate solutions to them.

Summary

In summary, I have raised several challenges to which I believe our profession must respond:

1. How can we utilize knowledge, rather than rely solely upon experience, to help us predict social change and anticipate the consequences of such change for occupational therapy?
2. Can we develop a strategy and organize ourselves, as a profession, so that we can conduct negotiations and transactions with the larger social system in which we exist, thereby ensuring the provision of our services to those who have need of them?

3. Can we identify clearly—for ourselves and for the public—the product or services we can provide? Can we identify the purchasers of our services, and can we, in actuality, provide those services?
4. Can we decide where our product should be marketed, and can we anticipate and plan for the changes which might occur as we move into new environments? In relation to this, can we define for ourselves the criteria for professionalism we seek to fulfill?
5. Finally, can we ensure the necessary support for clinical therapists who represent our larger corporate body?

The challenges I have identified are ones for which I have no ready answers—but recognition and awareness often precede problem-solving. I cannot help but believe that the wider our base of operations, the more responsive we will be to social needs, and the more responsible and accountable we will become. Furthermore, if we can identify our services as meeting identified public health needs, support may be forthcoming from many sources: from school systems, industry, proprietary as well as voluntary agencies providing a wide variety of human health services. Possibly even physicians and insurance companies will contract with us to deliver specific services to their patients. I feel that economic independence may not only facilitate but promote the move toward professional growth if we can identify how we wish to market our product. I also believe that the answers for a profession come not so much from individuals as from collective attempts and wisdom to identify problems, to resolve the conflict inherent in them, and to consider and select the alternatives which offer the most appropriate solutions.

In conclusion, I feel comfortable leaving these challenges unanswered because I believe in the ability of occupational therapists, based on demonstrated convictions about the worth of occupational therapy to clients, to help in the process of finding answers to these challenges.

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