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1980 Eleanor Clarke Slagle Lecture

Occupational Therapists Put Care in the Health System

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I address you today with a sense of pride and great thanks for your recognition for this most singular honor. I am also thankful for the opportunity to have experienced the year of growth the responsibility of this honor imposed.

I hope to share with you my perspective of occupational therapy and its position in the health system. Occupational therapists' tremendous commitment to Man and to his ability to shape his destiny through activity and accomplishment puts us in a very favorable position because we provide a service that the health care system is reorganizing to assure it is delivered. Our responsibility as a profession is to implement a broader perspective of health care delivery—one that places its values on individuals as they accept the responsibility for their own health status.

To accomplish this task, I want to lead you through a process of assessment, recognition, and strategy development. For my framework, I will use the process each of us uses daily in our service delivery.

The Referral Has Been Received

"The health care system must be directed at improving the health of the American people by encouraging health, providing constructive behavior and improving the effectiveness of our medical care system" (1, p. iii). This mandate (our referral) came from President Jimmy Carter in his introductory remarks in the Department of Health, Education, and Welfare's publication *Health and United States,* 1978 (1).

The Problems Requiring Management. 1. High quality health care at a reasonable cost is often inaccessible. 2. Health care is beyond the means of many. 3. The system is focusing on hospital acute care rather than ambulatory and preventive care. 4. Technology has been exploited. 5. There is poor distribution of medical personnel. 6. Human beings are not allowed to control their own health status (2).

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The Goal. Organize and humanize the system.

Requested Service. Develop a plan for implementation to effect change as quickly and as simply as possible.

To meet this challenge our profession must develop a plan—thus we need a "treatment plan."

We always perform an assessment before establishing a plan. Only when we have a sense of the total picture can we have vision. The health care system is very complex and involves many characters. Our first process, that of assessment, involves seeking to understand each of the characters and their contributions to the current health care dilemma.

The Characters

I. The consumer. As a framework for the consumer, I have chosen the work of Hadley Cantril (3). He describes humanistic characteristics that must be considered by Man in relating to Man. Man requires that his survival needs be satisfied and wants security in physical and psychological meaning to provide orientation and integration through time. Security protects gains made and allows Man to look to the future. It is also important to have enough order or certainty in life to enable Man to judge with some accuracy what will or will not occur. Human beings have the capacity to make choices. People perceive only what is relative to their choices and make choices accordingly. Humans require the freedom to exercise the choices they are capable of making. Humans must know they are valued by others. The individual must have values and beliefs to which he or she can commit himself with some certainty (3).

These are the humans who get sick, have accidents, and appear at the door of the health care system. They are in jeopardy of losing control of themselves and they are afraid. As professionals we must recognize their tremendous vulnerability and offer them services in which they have choices and control.

To describe the consumer, I would say: . . . some are saved, . . . some are used, . . . some are passive, . . . some want control, . . . some are sick, . . . some are well, . . . some are disabled, . . . some are crocks. Yet ALL are HUMAN and ALL are INDIVIDUALS.

Consumers feel that health care has become a right. The current situation is governed by a "more is better" attitude—that is, more resources, more facilities, more manpower, more of what it will take to provide what "I" need with no thought to how the services will be paid for. Human life is considered priceless and no amount of money is too much to devote to "my" life (4).

II. The federal government. The federal government is a multibillion-dollar operation organized to protect the consumer at the expense of the consumer. Federal involvement in health care began in 1907 when the Hygienic Laboratory was formed to work toward the eradication of public health problems in food and water. From this laboratory, the National Institutes of Health (NIH) were developed. The NIH is the biomedical research center of the country. It houses 11 institutes that study specific diseases and organ systems. The NIH is the main support of the majority of medical teaching institutions. Medical schools' dependence on federal subsidies encourages specialization and emphasizes technology as the answer to

health problems (4). The public health service no longer focuses on health promotion and disease prevention.

The following represents the major dates that led to the current federal regulation of health care.

- 1935—The Social Security Act of 1935 put the federal government in the health business. It gave grant-in-aid to states to provide Maternal and Child Health Assistance and Assistance to Crippled Children. It has led now to more than 1,000 specialized programs.
- 1940—The start of third party reimbursement—basically so that hospitals and doctors would be assured of being paid.
- 1943—The start of Health Manpower training, with grants to educational institutions to prepare manpower.
- 1946—Hill Burton construction grants were initiated and to date have totalled more than 4 billion dollars.
- 1959—Government employees were given health insurance.
- 1960—Medical schools were having difficulty surviving so that the government provided support through manpower funds, thus increasing revenue to the schools.
- 1965—Medicare and Medicaid provided help to the poor and elderly to obtain health service.

As expenditures for health care increased so did the government's concern, and eventually its involvement shifted from purely contributory to regulatory. The major controls placed on the health industry today are:

The Occupational Safety and Health Act (OSHA) enacted in 1970 was designed to protect the worker in the work environment. It has provided some protection, but it has also increased costs.

The Professional Standards Review Organization (PSRO) initiated in 1972 also had a humanistic goal—to assure that appropriate care was given to individuals by qualified professionals. This program has had a major impact on delivery of services by imposing control, restricting access to care, and increasing costs.

In 1974, the National Health Planning Resource Act (HSA) presented in law the concept that health care is a "right." Its impact has been on the control of capital expenditures, and the creation of a political football game with providers and consumers on opposing teams. The government serves as referee, and occasionally can be accused of making poor calls on the plays.

The transition from public health promotion and disease prevention to a high technological mode has been influenced by the federal government in the following ways:

- The sponsorship of high technology biomedical research
- The sponsorship of programs to produce specialization
- Money for training nearly 200 health professionals
- The construction of facilities.

III. The physician. Early health care was concerned with the individual. Public health and prevention were emphasized and dominated most thinking until the early 1900s. Until that time, the state of medicine was primitive and lacked a scientific base. Also, health

problems were primarily a result of poor sanitation, poor living conditions, and contaminated water.

Health care has changed because medicine has become a scientific discipline as well as a political force. Specialist societies were formed for scientific and educational purposes. Most physicians initially were general practitioners, but focused on a specialty part time. A particularly strong influence for change in medicine was the publication of the Flexner report in 1904, where the disparities in the quality of education and the standards of performance in teaching institutions were exposed. This led to the development of medicine as a science.

Physicians are generally trained to think science and to think "sick." Most are dedicated to saving life at all costs. Few are oriented to the humanities and social sciences. The profession requires a tremendous time commitment to ensure competence.

The physician is the person each of us turns to for guidance and direction when we have a health problem. Physicians are in powerful positions and play a critical role in the delivery of care and in any changes in health care delivery.

IV. Medical school. Medical schools for the most part continue to separate the art and the science of medicine. They remain elite and do not use community resources for health delivery. The schools continue to prepare specialists and do not emphasize the social and behavioral sciences.

V. The health care administrator. This individual is taught to be decisive and in control, and the measurement of his or her performance is best described by the following "want ad" for a health facility administrator:

Wanted: H*ealth* F*acility* A*dministrator*

> The position requires a person with the ability to maintain an average occupancy rate of at least 96% on medical/surgical nursing units, 63% on ICU/CCU units, and 63% on obstetrics units, while scheduling all emergency surgical patients and, on the average, 21 out of the 100 medical patients each week. No more than 5 scheduled patients out of every 1,000 can be cancelled and no more than 15 out of 1,000 ICU/CCU patients, 5 out of 1,000 OB patients, or 10 out of 1,000 emergency patients can be turned away.
>
> In addition, the person in this position is responsible for allocating nurses to each of these nursing units (1) so that an average of 5.0 hours of nursing care is maintained for each patient each day, (2) so that registered nurses, licensed practical nurses, and aides are assigned to each unit to utilize their skills fully, (3) so that the nurses' individual work stretches with or without 3-day weekends, and (4) so that quality nursing care is provided.
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> Applicants must have knowledge or skill in setting up systems for physicians to control patient placement in appropriate levels of care, and to control medical necessity of patient services (5).

These are the people who run our systems and our resources for implementing our concepts. They manage a complex system and are rarely trained or oriented in the concepts of human service delivery.

VI. Allied health professionals. This group in general is striving for professional status and is very competitive in the health services market place. The knowledge base of most allied health professionals has grown to the point that they seek recognition as independent health

practitioners. The skills of the allied health professional are rarely used fully to support the delivery system. In our assessment process I will look in depth at one of the allied health professional characters; namely, occupational therapists.

Our profession started with the basic premise that Man has control over his health status by having control over his use of time, body and mind. In the early 1900s, when our profession was conceived, society did not have specific knowledge in biochemistry, neurology, or behavior. Modern medical science was in its infancy when the original paradigm of occupational therapy was developed. By today's standards, the body of knowledge was minute and, although research had begun to be a part of medicine, it was greatly limited. In the second half of the 19th century, the bacterial origin of many infectious diseases had been demonstrated. This led to the concept of asepsis, which made surgical management a possibility. From World War I to World War II, progress in medical science quickened. The sulfonamides were introduced in 1934, and penicillin was discovered in the 1930s. After WW II, the antibiotic era came into its own. A by-product of this era was the realization by the American people of the impact of research on the creation of knowledge. As a result, the public's expectations about medicine changed dramatically (6).

Occupational therapy was initially associated with and today continues to be a profession closely allied with medicine. We are not a medical model profession but we do have a medical base. The scientific inquiry in medicine as a science has had a major impact on our profession. Rather than take an active role in the scientific inquiry, we have relied on the work of others to provide direction to our principles. Thus by not directly addressing the concepts of activity and its impact on the nervous systems, behavior, or the cardiovascular system, we have not based our principles on the scientific movement.

We must do more than speak about our theories. We must develop a rage for knowledge and document our principles as a scientific discipline.

In 1969, the President of AOTA (Ruth Brunyate Wiemer) challenged the profession to address questions that would document the relationship between

- Deprivation or affluence of play and teenage aggression
- Deprivation of work or enforced retirement and the onset of illness after age 65
- The lack of work and recreation and the apathy of the slow learner
- The inescapable uselessness of the terminally ill and longevity (7).

Do we wish to continue to talk about the effect of activity or do we wish to do something about it? Now 11 years later, if we want to make a mark in both the humanistic and scientific movements, we must address questions like these and support the people who ask them.

As a profession we are not to date unlike the Bakhtiari Tribe of Persia. This is a nomadic tribe of goat herders who daily move their entire tribe to new grazing land. They have taught us that a group cannot refine a culture on the move. The Bakhtiari life has changed very little since 10,000 B.C. They have only the simple technology that can be carried on daily journeys. The simplicity is not romantic, it is a matter of survival (8). In applying this analogy to Occupational Therapy, I have to ask the question, when are we going to stop following the grazing trail and develop the technology to plant our own fields?

As a profession we have seen our nearly singular roles in vocational rehabilitation, basic living skills, and use of activity come and go. Other professions have implemented what initially were our roles, but we have survived! This means that the health care system is looking to us for a special emphasis on health care delivery. We must internalize this positive concept of us. I think we can develop a fertile strain that will allow our fields to be very fruitful. We have something very unique to harvest. We must master our own product, understand it, and use that understanding to mold the living environment.

Within our profession there are many capable people in education and clinical practice yet we have difficulty developing a master plan for and getting started on a program to define our practice in scientific terms. I want to share with you my perspective of a conflict that I think has our profession at a standstill and is preventing us from developing our "fertile strain."

Our professional organization, the American Occupational Therapy Association (AOTA), has supported the development and continuance of a structured pluralism with education and practice being separate in structure and function. Two prevailing thoughts have developed out of this relationship.

The first thought is:

> Because occupational therapy educators do not practice clinical occupational therapy, they do not have the knowledge, attitude, or skill to produce students trained in current practice.

Since the middle 1960s, therapists in clinical practice have been working their way into the changing health system. To do this required the following eight activities:

- Acquire third party reimbursement
- Establish collaborative working relationships with other professionals involved in direct service
- Define practice standards for professional review
- Establish cost effective services
- Identify patient populations and develop services to support program implementation
- Develop treatment methodologies that can be included in short term care facilities
- Establish networks for referral of the patient to long term or community services to obtain maximum benefit for occupational therapy
- Design activities and intervention that support the theory of occupational therapy.

Treatment interventions have been established by practitioners to provide remediation to impaired areas of function as well as to promote healthful behaviors. For us to gain identity as a scientific discipline each area of function must be supported by research supplied from the basic sciences.

Some of the fields that relate to *motor and sensory-integrative function* are neuropathophysiology, neurology, anatomy, physiology, neurophysiology, neuroanatomy, chemistry, and physics. Some of the fields that relate to *cognitive, psychological and social function* are psychology, sociology, psychopathology, and chemistry.

I think therapists in practice have stimulated their own growth by graduate study in areas to support understanding of function—not exclusively relying on advanced occupational

therapy education to provide it, possibly because occupational therapy educators are not publishing information to answer the basic questions needed to be answered about the body systems' ability to respond to the demands required to function in these areas. The professional dialogue for practitioners is primarily with others in clinical practice through publications and continuing education experiences. Because of this I believe practitioners have adopted the following notion:

> Because occupational therapy educators do not practice clinical occupational therapy, they do not have the knowledge, attitude or skill to produce students trained in current practice.

Now I will describe the second thought that has developed.

> The practitioner is ignoring his or her responsibilities and compromising the field of occupational therapy by collaborating with other professionals and not demonstrating occupational therapy as an independent health profession.

In 1977, a report of the Ad Hoc Committee on Education was submitted to the Executive Board of the AOTA and eventually published in *The American Journal of Occupational Therapy* (9). The stated purpose was to raise issues that influenced our attempt to become a fully recognized profession. I will present the education description directly from the Ad Hoc Committee Report.

Issues in Education

I. Faculty characteristics and responsibilities. Faculty are operating autonomously with minimal involvement with university missions, which undermines efforts to continue association with these institutions.

Faculty generally give up patient treatment and remove themselves from the practice of occupational therapy.

Faculty engage in repetitive and time-consuming requirements for accreditation that deprive faculty of valuable time, some of which might be spent in research, scholarly activities and other endeavors, expected of all university faculty members.

II. Faculty shortage. There is a serious shortage of qualified faculty members at every academic level. The Association efforts and resources are focused on baccalaureate and associate degree entry-level preparation and exclude resources to clinical specialization and graduate education.

III. Multiple entry routes leading to certification as an OTR. Our multiple entry points serve to support the thesis that occupational therapy is a semi-profession or a technical profession. The value of our educational preparation is negated by multiple entry routes that do not rely upon a liberal arts base. "The processes of acquiring and assuming the knowledge . . . unique to occupational therapy, are seldom the priorities of our educational programs, ..."

IV. Lack of research. "The lack of research related to hypotheses supporting our theoretical foundations, treatment modalities, and modes of intervention seriously impedes all aspects of education and practice."

V. External influences and forces. "Actions and decisions made by external agencies continue to have a negative influence and impact on our development." Examples cited are the limitation of funding of health programs, especially at the post-baccalaureate level, and the control that the American Medical Association has over our education programs.

VI. AOTA member readiness to decide on semiprofessional or professional status. The committee reported that members do not focus in either education or practice upon those functions and behaviors that are traditionally identified with the status of a profession. The authors state the following behaviors are necessary by the membership to reach professional status.

1. Willingness and responsibility for diagnosing problems;
2. Providing service without referral from physician;
3. Working without physician supervision or members of other disciplines;
4. Conducting one's own professional assessment;
5. Accepting the necessity for research to substantiate or refute the principles upon which treatment is based (9).

This completes the description of the Ad Hoc Committee on Education Report.

Thus we have documentation of the pervasiveness of the second idea:

> The practitioner is ignoring his or her responsibilities and compromising the field of occupational therapy by collaborating with other professionals and not demonstrating occupational therapy as an independent health profession.

I have now described those six I think are the main characters in the health system and described in depth my perception of the character of occupational therapy. From these descriptions, I perceive that the entire system is in conflict. Each character has its own values, knowledge, structure, and personality.

This causes the system, which should be a team of specialists organizing to develop a network of interactions, to be at a stalemate resulting in power struggles and strained communications.

The patient is frequently the victim of the isolation caused by this poor communication. The definition of a closed system is that the system is isolated from its environment and the final state is determined by the initial conditions. Certainly the health system is made up of many closed systems (10). The patients unfortunately become a closed system also because they have no mechanism for being in a dynamic state with their environment and in control of their own status.

The prejudices harbored by each of the characters in the health system seek to maintain the independent status of each character rather than focusing on the individual human being who is paying for the service to change his or her health status.

I have now completed the assessment process of our plan. I see three separate problems that the profession has to address to meet its responsibilities in organizing and humanizing the health care system:

The three problems are:

- A perceived conflict between occupational therapy practice and occupational therapy education, to actually destroy what I perceive as myths

- A focus on health services delivered within the acute care model
- The health system's lack of orientation toward the human being.

Now that we have completed the assessment by looking at the characters and identifying the problems, let us take each problem one at a time and develop our treatment plan.

Treatment Plan

Problem I. A Perceived Conflict Between OT Practice:OT Education

GOAL: *Resolve the conflict between practice and education.* It is important that our profession reduce the social distance between education and practice and move from pluralistic positions into one of integration. We need a link between education and practice with the purpose of further developing occupational therapy as a scientific discipline. This focus will remove the need for maintaining the conflict and move us toward integration and further away from fragmentation—thus, we will destroy the myths.

In investigating methods to resolve the conflict, I went to C. P. Snow's lecture on "Two Cultures." Snow perceives that there is conflict between the scientist—who believes that literary intellectuals are totally lacking in foresight, peculiarly unconcerned with humanity—and the nonscientist—who has a rooted impression that the scientist is shallowly optimistic and unaware of man's condition (11). I wondered whether occupational therapy housed any scientists, so I found myself engulfed in *The Search,* also by C. P. Snow, a novel that describes the scientist through a number of behaviors ranging from unending curiosity to the need to understand things even if they can't be controlled (12). It became clear to me that the educational preparation of the occupational therapist does not encourage the scientist.

For the profession to ascend, we will need to produce true professionals who are skilled in inventing, inferring, and analyzing, and who can communicate with basic researchers in a collaborative relationship to investigate areas of our clinical practice as well. We must prepare professionals who possess the humanistic qualities to relate to an individual who requires our service. Since these qualities are not mutually exclusive, the educational preparation of the occupational therapist must develop both qualities.

As I became more aware of the lack of basic scientists in our profession, I explored ways to approach the production and distribution of knowledge.

According to Machlup, a profession must be responsible for producing two types of knowledge: 1. internal knowledge, which answers questions to measure the effectiveness of our service—this knowledge is developed by daily dialogue with each other and through our newspapers and journal—2. new knowledge that assists society in expanding its understanding (13). I believe the profession must contribute societal knowledge in the following areas:

1. The activity process and activity's effect on the human body.
2. The process of adaptation and its effect on the human body.
3. The process of integration of human function through activity and adaptation.

To produce discoveries through inventing, inferring, analyzing, or evaluating is not enough (13, p. 30). For discoveries to be valuable, they must be conveyed. Knowledge is produced in three basic ways, all under the general category of research.

- *Research* is defined as a systematic intensive study directed toward fuller knowledge of the subject studied.
- *Basic research* is directed toward the increase of knowledge. It is research where the primary aim of the investigation is a fuller understanding of the subject under study rather than the practical application thereof.
- *Applied research* creates directly applicable knowledge. The researcher looks for results which promise to be of ultimate use in practice.
- *Development* is the systematic use of scientific knowledge directed toward the production of useful materials, systems methods or process (13, pp. 146–147).

Within the profession two of these three types of research can and are being accomplished—applied research and development. Our greatest lack is in basic research. To do basic research requires a scientist with not only the scientific approach, but also the scientific background. I do not know of a profession that performs basic research entirely for themselves—certainly medicine does not—and I do not know why we should continue to struggle with the idea of performing our own basic research to the detriment of our educational process.

I propose that educators and clinicians formulate collaborative relationships with social scientists to address the social, cognitive, and psychological aspects of function and with biological scientists to address the motor and sensory integrative aspects of function.

A research team should inspire a collaborative relationship between the occupational therapy educator, the basic scientist, and the clinician or clinicians. The occupational therapy educators must assume the role of coordinator and facilitator of research projects. The clinician should function as a clinical scientist who logs observation and inferences, and communicates with the educator who can organize teams to design and implement research to answer pertinent questions.

One reason these research teams have not yet developed is that educators and practitioners have not been interested in addressing common questions. The stability and then the ascent of our profession depends on the establishment of common goals for research and a commitment on the part of the educator and the clinician to collaborate on research questions of interest to both. By including the appropriate basic science researchers the gap in the basic sciences on the part of both the educator and the clinician can be narrowed so that questions can be addressed as they relate to the human body and mind and its response to activity.

We can no longer afford to destroy each other with words and lack of action. The profession must make a commitment to action using a team collaborating for the outcome of producing internal knowledge for the benefit of our patients and societal knowledge for the benefit of mankind. We must develop the skill and accept the responsibility to critically analyze our work and not react defensively to criticism but realize that criticism will help the profession grow.

We must recognize that too few of us have the skills or resources to do basic scientific research. However, it has to be done if we are to attain a credible status with the public in the subject areas we do know—that of adaptation and integration. I predict that, through the experience of collaborative relationship with the basic scientist, many of us will develop the skills necessary not only to do the basic research ourselves, but also to teach these skills to others within our profession. I think we would then attract more students interested in a scientific discipline. We also would have greater strength as a profession in relating to other groups who are infringing on our territory because we would have a strong theory base for our service delivery. Our confidence would be strong knowing that we are the profession to deliver our services—this would be built into our images of ourselves as professionals. The issues from the practice arena and the issues from the education arena would all be given a tremendous boost and be closer to resolution if the credibility of our profession was housed in research methodologies that are strong. It is important for clinicians and educators to recognize the extreme pressures facing each group as each works to gain a stable position within the health system. Perhaps we can all feel that we are approaching the problems together. It is critical that we channel our energy away from conflict and into research. I believe funding for research would be forthcoming from the government for coordinated projects that demonstrate a link with the basic sciences.

Time is a problem for all of us. However, well designed and funded research projects should provide resources to support the clinician and educator in research activities. We have to organize and order our priorities to accomplish basic research for the sake of professional stability. Looking outside the profession, I find that similar conflicts between education and practice are not uncommon. Survival of the profession is an issue whether one is from the university structure or a clinical facility. The missing link in destroying this conflict is collaborative research with a commitment to the growth of our profession. Some persons might not agree that the social or biological scientist must enter the picture, but I am now convinced that the skills and attitude of those individuals are critical for the process to proceed.

Now we must develop a treatment plan for the second problem.

Problem II. The Health Services Delivery Primarily Within the Acute Care Model

GOAL: *Expand the delivery of occupational therapy service from the acute care model of service.*
Hospitals initially were a shelter for the socially unfit whether due to severe disability, mental illness, or indigence. The hospital was set apart from the medical community. This was the population served when occupational therapy was initiated as a profession. Private patients were not treated in hospitals until the turn of the century. Insurance did not pay for hospital care until the 1930s and then for only a few. Not until the late 1950s was there a major breakthrough in third party reimbursement. Social forces and the scientific revolution have produced many changes in hospital care. These forces have grown so strong coupled with government regulations and escalating costs that a new organizational structure for hospital systems has been mandated. Hospitals are being forced to become more and more responsive to community health needs, and more accountable to the community for their performance (14).

The economic forces of high cost, capital equipment obsolescence, cost containment directives, reimbursement, and government control are generating pressure on hospitals to share services within a geographic area.

The social forces of population shifts to the cities while health resources move to the suburbs, the push for consumer rights, the increase in the elderly and chronic disease population coupled with a declining birth rate have forced consideration of role modifications in hospitals.

Political forces of government involvement, more pressures to achieve regionalization, cost containment, and the requirement for quality control ensure more comprehensive services. We can expect to see an alteration in the thinking of institutions that will yield a more effective and accessible delivery of care for consumers (15). This means for occupational therapy that we can assist our institutions in their survival while expanding our services into a community model that supports the basic concepts of our profession.

We have many hospital-based occupational therapy programs currently functioning within the community model of occupational therapy service delivery. Two that we can use as models are Memorial Hospital in Sarasota, Florida, directed by Louise Sampson, OTR, and Research Medical Center, Kansas City, Missouri, directed by Sharon East, OTR, and Gloria Scammahorn, OTR. Both programs are in community hospitals of 600 to 700 beds.

At Memorial Hospital, the occupational therapy department contracts with the county school system, Head Start, the Public Health Department, the Home Care Team, the Guidance Center, two extended care facilities, and an outpatient rehabilitation center. Groundwork has been laid for the community's outpatient dialysis unit. Future programs include a private facility for the mentally retarded, day care centers, service programs for the elderly, and a hospice.

At Research Medical Center, the occupational therapy department contracts with schools, nursing homes, and small rural community hospitals. Future programs include industry and home health services.

I asked each of these program directors to respond to the following questions: How do you view outreach in terms of your philosophy of Occupational Therapy practice?

Louise Sampson: *I believe that a hospital-based program is the most effective way to provide "outreach" occupational therapy services. If services are planned and accomplished properly, we do not have to remain a "medical model" and can serve the expressed needs of the community. I feel that the solid base has many advantages including decreasing the fragmentation and isolation of therapists, being cost effective with full utilization of staff and equipment providing more flexible opportunities for professional growth and a general consistency otherwise unavailable* (16).

Sharon East/Gloria Scammahorn: *The outreach concept has certainly facilitated the growth and expansion of occupational therapy into new markets. Our association with a medical center has been an important aspect to the success of occupational therapy's involvement in outreach. Had there been no association with the medical center, I feel certain occupational therapy's efforts would have been stifled early on.*

The whole outreach approach has provided so much stimulation and remotivation for the staff involved that regardless of the outcome the experience for the staff has been well worth all the effort.

That is not to say that we're not concerned with the outcome—we still maintain the same standards and quality of care for the outreach contracts as we do for the patients at our facility (17).

The outreach concept provides a stability for services that promotes creativity. It also will assure the continuance of our profession in modern economic times. It expands occupational therapy concepts into a community model with the hospital functioning as the base unit. It reduces the fragmentation and isolation of therapists, it is cost effective, it fully uses staff and equipment, and it promotes professional growth. It allows therapists with specialized skills to use their skill to fill contract hours using their expertise. It also allows facilities that otherwise would not have occupational therapy to obtain the services to fulfill needs.

Public Law 93-641 of 1974, the Health Planning and Resource Development Act, establishes the following priorities for national attention:

1. The provision of primary care services for medically underserved populations, especially those in rural or economically depressed areas.
2. The development of multi-institutional systems for consideration of institutional health services.
3. The development of medical group practices, especially those services that are appropriately coordinated or integrated with institutional health services and health maintenance (18).

Occupational therapists, we have a mandate: break down those walls. We have been accustomed to patients coming to us—we have to go to them. Let us establish occupational therapy as a viable community service implementing the basic philosophy of our profession and help our hospitals survive in the process. The challenge is here now—let us respond and further develop our profession in the process.

Now we will develop our treatment plan for problem three.

Problem III. The Health System Is Not Oriented Toward the Human Being

GOAL: *Develop human oriented programs encouraging man to explore his potential in producing a change in his own health status*. The human that enters the health system has little knowledge of this situation and the health professional little of the individual's situation. We are nothing more than a bystander in the life of that individual until a relationship is formed.

Our service delivery is initiated by assessment with a resulting relationship that has the potential of making impact on that individual.

It would be difficult to expect an individual to be at home in a sterile and unfamiliar environment that has produced chaos. The individual must establish some control over the forces of chaos. In establishing control the client demonstrates a variety of behaviors, either by an internal mental operation or by external activity (19). Occupational therapists have the skills, attitude, and knowledge to provide the relationship and the structure through activity to introduce meaning to that individual and thus give him control.

In *Anatomy of an Illness,* Norman Cousins tells of a personal experience with Pablo Casals that had a profound impact on him. I want to share it with you because it so poignantly expresses activity and its ability to produce meaning in the human.

I learned that a highly developed purpose and a will to live are among the prime raw materials of human existence. I became convinced that these materials may well represent the most potent force within human reach. . . . About Pablo Casals.

I met him for the first time at his home in Puerto Rico just a few weeks before his ninetieth birthday. I was fascinated by his daily routine. About 8 A.M. his lovely young wife Marta would help him to start the day. His various infirmities made it difficult for him to dress himself. Judging from his difficulty in walking and from the way he held his arms, I guessed he was suffering from rheumatoid arthritis. His emphysema was evident in his labored breathing. He came into the living room on Marta's arm. He was badly stooped. His head was pitched forward and he walked with a shuffle. His hands were swollen and his fingers were clenched.

Even before going to the breakfast table, Don Pablo went to the piano—which, I learned, was a daily ritual. He arranged himself with some difficulty on the piano bench, then with discernible effort raised his swollen and clenched fingers above the keyboard.

I was not prepared for the miracle that was about to happen. The fingers slowly unlocked and reached toward the keys like the buds of a plant toward the sunlight. His back straightened. He seemed to breathe more freely. Now his fingers settled on the keys. Then came the opening bars of Bach's Wohltemperierte Klavier, *played with great sensitivity and control. I had forgotten that Don Pablo had achieved proficiency on several musical instruments before he took up the cello. He hummed as he played, then said that Bach spoke to him here—and he placed his hand over his heart.*

Then he plunged into a Brahms concerto and his fingers, now agile and powerful, raced across the keyboard with dazzling speed. His entire body seemed fused with the music: it was no longer still and shrunken but supple and graceful and completely freed of its arthritic coils.

Having finished his piece, he stood up by himself, far straighter and taller than when he had come into the room. He walked to the breakfast table with no trace of a shuffle, ate heartily, talked animatedly, finished the meal, then went for a walk on the beach.

After an hour or so, he came back to the house and worked on his correspondence until lunch. Then he napped. When he arose, the stoop and the shuffle and the clenched hands were back again. . . . As before, he stretched his arms in front of him and extended his fingers. Then the spine straightened and his fingers, hands and arms were in sublime coordination as they responded to the demands of his brain for the controlled beauty of movement and tone. Any cellist thirty years his junior would have been proud to have such extraordinary physical command.

Twice in one day, I had seen the miracle. A man almost ninety, beset with the infirmities of old age, was able to cast off his afflictions, at least temporarily, because he knew he had something of overriding importance to do. There was no mystery about the way it worked, for it happened every day. Creativity for Pablo Casals was the source of his own cortisone. It is doubtful whether any anti-inflammatory medication he would have taken would have been as powerful or as safe as the substances produced by the interaction of his mind and body. . . . He was caught up in his own creativity, in his own desire to accomplish a specific purpose, and the effect was both genuine and observable (20).[1]

We all can recount of patients with strong wills. With the introduction of activity, we too have seen miracles.

As a profession, occupational therapy harnesses will and gives the individual control through activity. That is human, that is care. We are respected by physicians and the health

[1]*Excerpt reprinted from* Anatomy of an Illness, *by Norman Cousins, with the permission of the publisher, W. W. Norton & Company, Inc., New York, New York. Copyright ©1979 by W. W. Norton & Company, Inc.*

care system for that caring, perhaps because we have a strong background in the physical and biological dimensions of life, as well as the psychological and social. Most importantly we have respect for the human and the unknown. This is empathy.

Brian Hall describes empathy as:

> *The capacity for one person to enter imaginatively into the sphere of consciousness of another, to feel the specific contour of another experience, to allow one's imagination to risk entering the inner experiencing process of another.* (19, p. 162)

Through our professional relationships we reach out and with empathy show that we care hoping that from this caring that the person will find his or her own strength.

The humanistic approach to patient care is the initial reason most health professionals entered their respective careers. Each of us is supposed to remember why we entered the human services system rather than have coursework that would intensify our commitment to the human being by the introduction of theories of humaneness, motivation, and values. I would like to see our curricula increase their program content in the area of values and motivation.

There are other groups of professionals, especially medical sociologists, who are trying to work their way *into* the health system to effect change from within. They desire the position that fields such as occupational therapy hold—that of a primary service, professionally recognized by physicians and reimbursed by third party payment—because we are in the position to implement a total concept of health, a concept of caring. Also we are a recognized part of the health delivery system.

Those who do understand and support the humanism of health delivery must exert their control and influence in shaping the system in that direction. Health programs must be designed that support the patient's need to have control of his life, especially while he is receiving health care. Clinical studies can be designed by occupational therapists relating to the outcome of care when the individual has control over his environment and is valued for his contribution to his care as opposed to giving up control.

A growing body of evidence indicates there are limits to what medicine can be expected to accomplish. There are still many unknowns. There is still healing, there is still coping, and there is still the individual who must survive with dignity.

The major chronic conditions must be dealt with and outside the strict medical model. Improvements in these conditions require significant changes in personal life style, habits, and environmental conditions.

Roger M. Battistella, in his essay "The Future of Primary Health Services," states:

> *A strong foundation of simple and inexpensive services, for the treatment of routine illness and the care of illness apart from the relief of suffering, is essential.*
>
> *The importance of personalized relationships for the treatment of illness in which psychological and physical factors are heavily interconnected, the necessity to influence life styles in the management of chronic illness, and the compelling obligations for the humane care of the incurable long-term ill and dying indicates that the relationship between the patient and the health professional displaced by progress in scientific medicine has to be restored. . . .* (21, pp. 315–316)

We must move prevention *into* the curative model as we contribute our skills and performance to the population served by the medical care system.

A humanistic health care system is possible—the possibility, however, requires much out of each professional, which decreases the probability. Occupational therapists have unique skills and a tremendous commitment to Man and his abilities. We must show great confidence in implementing our concepts of caring.

I have now presented strategies for three problems the profession must address.

By directing professional energies toward solving these problems we will:

- Develop our services as scientific discipline, thus gain a stronger position with a strong professional identity
- Increase the dialogue of educators and clinicians toward common goals
- Expand the acute care model of service to include an ambulatory and health prevention model
- Extend occupational therapy manpower by expanding services into intercity and rural delivery through multihospital systems
- Assist the individual in gaining control over his health status by having control of his environment and engaging in activity.

I want to share with you a very important thought of Bronowski's, from *The Ascent of Man.*

> Man is a singular creature. He has a set of gifts which make him unique among the animals so that, unlike them, he is not a figure in the landscape. He is a shaper of the landscape. . . . His imagination, his reason, his emotional subtlety and toughness, make it possible for him not to accept the environment, but to change it (8, p. 19).

This thought is true for us. It is true for each patient or client we serve. Are we a profession that supports change? I believe so.

Another quote from Bronowski:

> *We are all afraid—for our confidence, for the future, for the world. That is the nature of the human imagination. Yet every man, every civilization, has gone forward because of its engagement with what it has set itself to do. The personal commitment of a man to his skills, the intellectual commitment and the emotional commitment working together as one, has made the Ascent of Man.* (8, p. 438)

As a profession and as professionals, let us put our resources, intelligence, and emotional commitment together and work diligently toward the ascent of our profession. The health care system, the clients we serve, and each of us individually will benefit from our commitment.

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