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Transformation of a Profession

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During the past few decades occupational therapy has been in a state of identity crisis where the reality of occupational therapy and its proper place within health care systems is being questioned. Our profession must also question its value system, dimensions of practice, and educational requirements. In examining our place within health care systems, the profession must consider the current biomedical model, future trends for medicine, and the renaissance of the feminist movement. Our crisis should be recognized as a necessary impetus for the evolution that is under way. This crisis is our opportunity, not our pathology (1, p. 25).

Occupational therapy is in a period of transformation, a period of paradigm shift, which is a shift in ways of thinking about old concepts. Paradigm shifts are similar to upward spirals that transform perceptions of the present into new perspectives. During a paradigm shift, an evolution takes place, a move from one form of unity through a phase of disunity and on to reintegration at a higher level (2, p. 28). The disunity phase of an identity crisis can become positive in an emerging culture by shifting perspectives from static structures to perceptions of dynamic change. When we view evolution from the perspective of dynamic change, crisis becomes transformation (1, p. 71).

For example, as we question our philosophical base from a perspective of dynamic change, crisis over therapeutic media and methods will lead to new perspectives of *occupation* and *occupational*. As we question our allegiance to medicine, new perspectives regarding practice dimensions will be transformed from the medical model to a model of healthfulness where patients influence their own state of health. As we question competencies needed to enter professional practice, requirements and organization of our educational process will be transformed to prepare independent health professionals. Occupational therapy's paradigm shift, as a transformation process, will evolve into new understandings of the value of occupation and the patients' occupational process in promoting their own health. Our practices and education will be organized around our evolving value system.

Our present transformation is dramatic and stressful because the rate of change in society is too rapid for us to have time to react. Our current transformation is not just a paradigm change of occupational therapy, but a crisis of multiple dimensions. Occupational therapy is involved in a crisis affecting our professionals, profession, culture, health care systems, communities, states, nation, and world.

Through this transformation period, if occupational therapists operate within a closed system, we are doomed to regress. If we enlarge our awareness to include social, economic, and political factors; admit new information from a variety of sources; and take advantage of the capacity to integrate past and present perceptions and concepts, we will leap forward. Although dramatic and stressful, crisis can bring about a positive evolution in which we come to a new understanding of the present.

Transformation directs itself to the present and the future; however, occupational therapy's history cannot be ignored. To view our present as if there were no past would make a caricature of our profession. Our present achievements are not a museum of finished products but an ongoing progress that is three-fold: past, present, and future integrated into the upward spiral of our profession's evolution (3, p. 20).

To prepare for this upward spiral, we need a new recognition of some of the values we previously discarded. Two such values are the idea of patients' "doing" as the occupational process and our mission to provide services for severely and chronically disabled. We need to re-examine those conceptual models and professional principles that dominate our present, such as our allegiance to the biomedical model, physical disabilities and psychosocial disorders as a framework for education and practice, and principles of media and methods based on activity as an extrinsic force. We need to prepare ourselves for changes that go beyond educational readjustments that are based on physical and psychosocial disabilities and acute care. We need to go beyond the debate over particular theoretical orientations and models of practice to show how occupational therapists' attitudes and behaviors reflect a value system that underlies our culture. Also, we must acknowledge that our current changes are manifestations of a much broader cultural transformation that includes the impact of the feminist movement, transition from medical care to holistic health, and change from institutional care to self-care, and of an adjustment of our allegiance to rational knowledge to include the value of intuitive knowledge (2, p. 42). Through integration and examination of occupational therapy's past, present, and future, our profession's activities will show a constant flow of transformation and change.

In our past, conflict and struggle brought about important progress in our scientific foundations. Scientific progress will continue to be an essential part of the dynamics of change. However, research and science are not the only sources for paradigm change. Cultural aspects of our professional nature will also provide impetus for the profession's evolution. Additionally, social, economic, and political environments external to occupational therapy have boundless capacities for influencing our transformation. Among the many factors that affect change, three merit attention:

1. The shift in our values, dimensions of practice, and educational focus that forms the reality of occupational therapy;

2. The decline of our allegiance to the biomedical model; and
3. The slow, reluctant, but inevitable decline of patriarchy (2, p. 30).

Value System

Occupational therapy's reality lies in its culture. Culture is a synthesis of the objective and subjective contributions that make us a profession. Culture integrates our activities and behaviors, and provides a sense of direction for our practice. Culture has a powerful influence on what we do as occupational therapists because it is the driving force behind the development and success of our profession. Central to occupational therapy's culture is the science and art of the occupational process that facilitates meaning and order in the lives of persons with disabilities. Our culture, based on the use of occupation, includes the basic concepts and beliefs of our profession. Thus, values underlie our culture and form the heart of our profession.

In our day-to-day practices, "choices must be made and values are an indispensable guide in making them" (4, p. 22). Values become the essence of occupational therapy's philosophy because they describe what we do along with what is unique about our profession. Occupational therapy's values are reflected in the professions' belief in a person's ability to influence his or her own state of health through the use of occupation. Our value system emerges from our rational knowledge of occupation and our intuitive knowledge of the purposefulness of the occupational process. Because our profession's values have profound influence on what we do, they must be a matter of great concern for our profession and Association (4, p. 22).

During our transformation, our value system will change; however, we must not let external demands dictate those changes. Rather, *we should change because we continue to seek the truth of our values*. Professional values grow from the search for truth, and during our transformation we must act on the values of our history, and we must continue to seek the meaning and truth of our present (5, p. 211).

Occupational therapy had its roots in the belief that the health of individuals could be influenced by "the use of muscles and mind together in games, exercise and handicraft as well as in work" (6, p. 3). During the 1920s, Meyer's philosophy of occupational therapy proclaimed that human beings could maintain and balance themselves by being in active life and use. Meyer stated that the use humans make of themselves gives the ultimate stamp to their being (7).

Our early ideas of occupation and action were modified by the demands of both World Wars I and II, with wounded soldiers needing rehabilitation (8). Following the impact of the World Wars, occupational therapists' patient population changed and increased. Our early belief in games, exercise, handicrafts, and work (9, 10) evolved into beliefs in constructive activities, activities of daily living, work simplification, and training in the use of adaptive equipment, and prosthetic and orthotic devices. During the 1950s and 1960s our culture was based on sensorimotor rehabilitation techniques for physical dysfunction that were borrowed from physical therapy and on the concept of the therapeutic use of self in the treatment of psychiatric disorders, which was borrowed from psychology. In the 1960s

and 1970s the idea of purposeful activity emerged. The value of activity was based on a neurobehavioral or an occupational behavior orientation, or on the biopsychosocial model underlying our practice (6, pp. 4–6). During the past decade, the concept of adaptation as the unifying theory for occupational therapy began to appear in our literature (11, 12).

Recently, our Association adopted an official statement that proclaims our philosophy and directs our practice (13). In the statement our belief in activity is presented:

- Including its interpersonal and environmental components
- As a means to prevent and mediate dysfunction
- As a means to elicit adaptation
- As having intrinsic and therapeutic purpose.

We offered this philosophy to describe our belief system and to declare what we do that makes us unique. However, in our day-to-day practices, occupational therapists frequently find themselves without convincing responses. Our proclaimed philosophy does not appear to provide us with a certainty about the sense of direction for our practices. Our literature communicates an internal debate: We have supported our values in activity, but have questioned the efficacy and credibility of activity as a therapeutic medium.

We, in occupational therapy, suffer from a pervasive uncertainty about our values, an uncertainty that undermines our commitment and leadership. Uncertainty about our therapeutic media and methods along with the interrelatedness of our science and art are central to our identity crisis. Therefore, our uncertainty must be recognized as an opportunity for us to transform traditional knowledge of activity into new perspectives of occupation and occupational. To maintain our upward spiral, our profession must re-examine the scientific view and value system that has been the basis of present concepts regarding activity and focus on future concepts based on a science of occupation and an art of purposefulness.

Re-examination of past concepts of occupation and a patient's action, together with integration of past ideas with our present concepts of activity, will direct our paradigm shift. Our paradigm shift will transform our concepts of purposeful activity into new dimensions of the concepts of occupation and occupational.

In 1909, C. Floyd Haveland said, "The therapeutic value of occupation for the insane is axiomatic and is based upon sound psychological laws" (8, p. 8). Treatment by means of occupation was termed *humane treatment* or *ergo-therapy* or *moral treatment* or *habit training* (8, pp. 6–7). In 1914, the term *occupational therapy* was first used by George Barton at a conference of hospital workers in Massachusetts. The term ran like a contagion, and earlier terms were dropped (14). By 1917, the objectives of the Association were formed, and statements of principles adopted occupational therapy as a method of treatment by means of purposeful occupation (8, p. 8).

Although the term *occupational* has been used since the early 1900s, we have not defined it. We have instead discussed terms such as activity, work, play, self-care, and most recently, human occupations, but we have neglected to examine the concept of occupational. Through re-examination of our early ideas, a value system based on the dimension of occupational will emerge.

Occupational is defined as a process of action in which a person is the action agent or the “doer.” Our philosophy will be based on occupation as action with the events of the environment and occupational as the action process. Values of “doing” or “action,” and the “doer” or “action agent” are the integrating force that will bring the science and art of the therapeutic purposefulness of occupation into focus.

Values are not rules of conduct, but concepts that group together certain modes of behavior (4, p. 14). Therefore, occupational therapists’ scientific activities generate values that unite our practice and practitioners. Values provide unity and become the unifying force in our philosophy.

Our profession has been pleading for a generic or unifying theory. However, we must realize that unity may not mean a single theory, but rather a system of theories. Because theories are approximations of reality, occupational therapy needs a variety of scientific theorems, because each would be valid for a specific range of phenomena (2, p. 10). There cannot be a unified or universal description of occupational therapy in a single closed theory. During our transformation, we must not expend our resources developing a generic or single theory of occupational therapy, rather we must synthesize our concepts into a unifying system of values.

In the science of occupation no concept or belief can be considered final; concepts have been made and will be remade with new ideas becoming part of a broader understanding. Thus, the science of occupational therapy becomes an endless process of analysis. Also, although science analyzes experiences, scientific analysis does not provide the total picture of the world of therapy. It provides the materials for the picture. Human imagination synthesizes the materials to provide a more coherent picture of the world. Thus, through scientific activity and human imagination, the value system of occupational therapy will evolve (15).

Imagination is the common quality in both science and art. In science, imagination organizes experiences into concepts, and in art imagination allows us to enter into human experiences (5, pp. 18–20). Science offers explanations and rational knowledge, whereas art carries an awareness or intuitive knowledge. Science of therapy is a creation to explain, and the art of therapy is a creation to relate, one where the patient receives and recreates in his or her own image.

Therapeutic art is not an external giving by the therapist; it is an internal receiving by the patient. *It is through internal receiving that occupational experiences become purposeful.* Through science, the therapeutic value of occupation can be predicted and explained, but purposefulness of an occupational process cannot be measured and explained through research. Thus, the purposefulness of occupation will always remain as our art.

Society judges occupational therapists by the outcomes of our activities and behaviors. Therefore, our day-to-day practices must reflect our value system. Our lifelong learning process must also be designed to facilitate learning of and belief in our values. Study of values continually clarifies the power of our profession, and at the same time recognizes that the profession and society are in a continual interactive process. As occupational therapists we can view ourselves as professionals, freely controlling our own practice, or as adaptive therapists “at the beck and call of others” (16, p. 20).

A system of values is our key to professionalism. Without a value system we will continue to be dependent on others. Conformity, the need for external approval and reliance on directions from others, characterizes an adaptive therapist. Independence, creativity, and self-directiveness characterize an integrated professional.

As an independent profession we must promote an integrative approach to our practice. Occupational therapists who argue against the effectiveness of activity are being forced to be adaptive. Arguments against the use of activity have appeared in our literature. West (17) has summarized these arguments:

1. Length of stay in acute settings is insufficient to show progress through activities.
2. There is pressure from physicians, administrators, and third-party payers to demonstrate cost-effective and objective measurable improvements.
3. Use of activities jeopardizes reimbursements.
4. Requirements for quality assurance reduce the use of crafts for substitutions that are reliable standardizations.
5. Crafts can be negative reinforcers to a patient who has lost skills.
6. Use of activities limits practice in the area of physical dysfunction.
7. Activities may be too complex for many of our low functioning patients (p. 16).

These arguments are worthy of our attention, but we must also be aware that they reflect the reality of external forces, the profession's conformity to external approval, reliance on directions from others, and our need for survival and immediate recognition. Arguments presented also subscribe to a narrow perspective of activity. Through transformation, a broader perspective of occupation and occupational will emerge, and declaration of our value system will promote an integrative approach to practice.

Scientific knowledge of occupational therapy is not a notebook of facts about occupation or therapy; rather, our rational knowledge is an imaginative arrangement of concepts that are a creation of the human mind. Our scientific knowledge is a responsibility for the integrity of what we are, primarily of what it is we value. Our values come from our experiences, from testing what does and does not work; values are modified through the development of our profession and the environment and culture of our time. As occupational therapists, we cannot maintain our professional integrity if we let others direct our values while we continue to live out of a "ragbag of morals that come from past beliefs" (3, p. 436).

Dimensions of Practice

Within the changing milieu of the 1980s, there are two environments for which occupational therapy must focus its actions, medical and educational. Medical and educational arenas will have a direct impact on the dimensions of our practice. Occupational therapy's allegiance to the medical model has historic roots dating back to our beginnings. Our need for acceptance and survival within the medical world, our orientation to short-term gains, and society's acceptance of patriarchal authority have been major factors in our development as an allied medical field. However, legislation in the 1970s delineated one aspect of occupational therapy services as an education-related service, not a medical service (18).

The term *related service* has had important influences upon the changing concepts of our profession and the implementation of educational services. Introduction of the term *related service* has been a major impetus for change in both definition and concept of occupational therapy and education.

Implementation of related services has been a problem for our traditionally endowed public education systems and our medically based practitioners. Factors that present problems within educational systems include:

1. Occupational therapy services have traditionally been available from medical systems and therefore should not be offered through educational systems.
2. Educational personnel have neither been trained nor do they consider themselves qualified to deliver related services. School personnel should not supervise and have legal responsibilities for occupational therapists.
3. Problems of interagency coordination have too often been compounded with traditional health agencies refusing to assume responsibility for health care services that are now defined as educationally related.
4. Services are costly, which puts pressure on local school budgets that have been only partially funded by federal reimbursements. Thus, the ratio of therapist to students has been too large to provide services.

These factors are real. Thus, it is not surprising that educational systems have tried to protect their limited resources by searching for appropriate limits on related services. Educational organizations have tried to do this by attempting to define various services as not being educationally related at all; that is, they claimed that occupational therapy provided care to persons with conditions not educationally related but medically related.

Education's attempt to limit related services led to critical judicial decisions. Most notable was the expansion of the term *education* to encompass those self-care areas important for children with handicaps. Federal courts emphasized that education for handicapped children may be directed to achievement of "self-sufficiency or to some degree of self-care" (19, Connecticut, 1977). Thus, basic skills such as eating, walking, talking, and dressing, which come easily to nonhandicapped children, represent a high level of educational gains for some children. In effect, education is no longer defined as what schools have traditionally done; rather, education may include programs that have the capacity "to equip a child with the tools needed in life" (19, *Fialowski vs. Shapp*, Pennsylvania, 1975). As summarized in the Delaware Supreme Court in 1980: ". . . education is concerned with much more than simply the 3 R's—the definition would include instruction to teach one to dress oneself, toilet training, eating skills and other self-help skills" (19, p. 26). The net result is that federal laws, expanded by federal court decisions, have adopted broad definitions of both "education" and "relatedness," and as such the laws have defined occupational therapy as an education-related service. Efforts to limit the extent of related services run counter to legal precedent. In fact, the major limitation to the concept of "relatedness" is not in the law or courts, not in regulations or policies, not with educational administrators, but within ourselves. Occupational therapists' concept of related services appears limited to direct treatment programs. Our need to hang on to our traditional medical model

service delivery patterns not only presents education with questions of our medical relationships, but introduces a further dilemma with our own professional identity.

Educators and occupational therapists continue to argue that the specific services provided by and described as occupational therapy should be properly considered medical in nature and thus should be delivered in medical settings. However, medical services is a specific legal term in P.L. 94-142, the Education for All Handicapped Children Act. Despite common usage of the word *medical*, the law defines medical as only those services "provided by a licensed physician." Thus, any service that is education-related and provided by a non-physician is not a medical service under P.L. 94-142.

Although most handicapped conditions served by an occupational therapist can be described as medical in their origin, the effect and amelioration of the conditions are often educational, particularly under the broad concept of education. Thus, related services such as occupational therapy are an educational responsibility.

Through our transformation, occupational therapy services will continue to expand within educational systems. Federal courts and federal laws will continue to mandate related services. Educational and health care systems will need to collaborate in programs for children and youth. The concept of occupational therapy as an education-related service will be accepted by our professionals, the profession, our Association, and society.

Expanding related services within public school systems will inevitably tax existing resources. However, as a legal and, perhaps even more important, as a practical matter, efforts to limit related services seem destined to fail. Public schools are becoming a lead agency in services for handicapped children and youth; thus efforts to minimize legal interpretations of related services run counter to expanding concepts of education entitlement. Our energies must be expended in optimizing interagency cooperation, developing more efficient service delivery systems, reallocating funds and staffing resources, and generating additional resources whenever possible. Regardless of the direction of the future, legal, political, economic, professional, and organizational issues will influence our transformation. By recognizing both external and internal issues and by identifying strategies, we can influence our own future.

One of the major external forces to affect education-related services of occupational therapy will be the future of health care delivery systems. Because health care industries will influence our services, we must identify issues related to health so our profession can develop appropriate strategies for action.

Health care, now the third largest category of the gross national product, represents more than \$2 billion a year in costs (1). Health care has become too large, too complex, and too expensive for our practices to depend on traditional or conventional systems of providing services for persons with special needs. Health care professionals can no longer practice solo; solo practices of the past decades are too expensive. Health care services depend on collaborative efforts. Health care and educational agencies will collaboratively service children and youth, and health care and community agencies will service adults. Also, occupational therapists will find themselves practicing and providing services in collaboration with a variety of professionals.

In 1980, federal, state, and local public funds represented approximately 65 percent of medical payment, with 30 percent coming from third-party providers such as insurance companies. Less than 5 percent of health costs come from private individuals. Thus, third parties and taxpayers pay for medical care. Although the majority of the health care dollar goes to hospitals, physicians continue to decide how the dollar will be spent. However, as we move to a system of prospective payment, one that gives the hospital an economic incentive to be more efficient and less expensive in its management of patients, the incentives for physicians and health care providers may be in direct opposition to the incentives of hospitals. Prospective payment will influence the concept of acute medical care within medical establishments, and a transition to personal responsibility or self-care and home health programs will occur. Transition from institutional care to self-care will have a direct impact on service delivery patterns of occupational therapists.

Predictions for delivery modalities for the upcoming decade include:

1. Increased outpatient care
2. Increased home health services as an alternative to hospital care
3. Increased quality and quantity of long-term care for the severe and chronically disabled
4. Increased sensitivity to physical and emotional suffering of the aged
5. An increase in multi-institutional systems that provide cost-effective services and enhance use of personnel
6. Increased interaction and cooperation among systems, with increased competition for personnel, new markets, and access to capital and technology.

If these predictions prove correct, five assumptions seem appropriate for the delivery of occupational therapy services:

1. Occupational therapy will continue to be practiced through organizational structures with increased pressures to make these organizations cost effective.
2. New and more effective communicative networks must be developed to ensure continuity of care among the various health professionals.
3. Demands for interagency collaboration will be imperative.
4. Power and political issues operating within health and educational organizations will increase rather than decrease.
5. New service delivery patterns involving consultation and monitoring, and collaborative programming will be imperative.

Our literature suggests that many occupational therapists are frustrated because management concepts are not being used in practice and because students are not being taught management concepts and skills. Occupational therapists will have to learn skills associated with effective consultation, supervision, leadership, and communication. It is not enough to learn the theory and practice of occupational therapy. Obviously a problem occurs; predictions for the future suggest multidisciplinary interagency collaboration, which requires management, consultation, communication, and leadership skills. Our literature suggests we are not providing these skills for our practitioners. Thus, occupational therapy curricula must modify traditional approaches to course content to prepare professionals for the changing health care systems.

Educational Focus

The nature of our education determines essential aspects of occupational therapy practices. Attempts for paradigm change or transformation must include changes in our educational focus and certification requirements. Accreditation with the American Medical Association has established a link between medicine and occupational therapy, and this link has dominated our educational system ever since. The biomedical model's influence on education is reflected in our academic and fieldwork divisions of physical dysfunction (treatment of the body), psychosocial dysfunction (healing of the mind), and pediatric and geriatric age groups (facilitation of development). We promote an artificial division within our profession by educator's attention to a particular age group or to the body or mind. Certification to practice ensures successful mastery of knowledge of physical dysfunction and psychosocial dysfunction, not the ability to promote a patient's care of self and meaningful life through the use of occupation. Our educators must begin to base curricula on our value system of occupation and the occupational process, and on the science of occupation and the art of purposefulness. We must also address our allegiance to holistic and ecological concepts of health, and our relationship to education. In addition, management, leadership, and consultation skills need to be included in our curricula.

Transformation of our educational focus, together with our reexamination of concepts, will provide impetus to solve our identity crisis. Along with these activities, we must also examine our entry-level requirements for professional practice. Currently our entry-level requirements are inadequate for dealing with the major problems of our times and predicted demands for future practices. Predicted increases in home health practices, transition from medical to holistic health care, declaration of our profession as an education-related service, new dimensions of service delivery, and an increase in our scientific activities are but a few of the many aspects of transformation that need to be addressed by our entry-level preparation and requirements.

Decisions and recommendations related to our educational focus and requirements must be based on careful study, but they must begin immediately. Transformation of our profession is underway; our emerging culture with its new perspectives must be reflected in our educational preparation processes. Official bodies of our Association, particularly the Commission on Education, Executive Board, and Representative Assembly, must recognize the crisis in our education preparation and determine resolutions.

Occupational therapy reality will include transformations of our value system, dimensions of practice, and educational focus. Crisis of our reality will evolve into new perspectives of our profession. Although our paradigm shift occurs within, society's decline of allegiance to the biomedical model and to patriarchal authority have significance to occupational therapy's practice within health care systems.

Decline of Patriarchy

In *The Aquarian Conspiracy*, Ferguson proclaimed: "The power of women is the powderkeg of our time" (1, p. 221). Feminism has become a major force in our culture.

Because 95 percent of our professionals are women, it is imminent that the women's movement shall play a pivotal role in the transformation of occupational therapy. A renaissance of feminist ideals is creating new images of women and men. New modes of thinking and value systems are emerging. Role shifts and sharing of responsibilities are bringing about far-reaching changes in society's attitudes and behaviors. Our culture has been based on the belief that self-assertive behavior is ideal for men and submissive behavior is expected from women. Self-assertion was manifested through power, control, and domination of others. Competitive behaviors characteristic of self-assertion have been highly regarded and promoted in our society. Women have been expected to be submissive and to fulfill the needs of others, and to perform those services that make life more comfortable. Society has expected women to "create the atmosphere for the competitors to succeed" (2, p. 45).

In the past, science and technology have been based on the belief of male supremacy and dominance. Medical societies in particular have not respected women's contributions to science and technology; rather, the culture of medicine has expected women to provide the caring, not the knowledge to understand the cure or the process to heal. Masculine supremacy has led to a medical high-tech dissonance. We are going from forced masculine technology to a balancing of "high tech/high touch." As Naisbitt (20) pointed out, high-tech dissonance is being transformed to balance with high touch. High tech/high touch is part of the balancing of feminist and masculine values. With this balancing, more respect for women's contributions to medicine, health, and education will occur. The allied health fields, dominated by women, will be recognized not as allied but as independent health professions. Transformation to an integrative power of technology and touch within medicine will further shake the foundations of occupational therapy.

Decline of Allegiance to the Biomedical Model

As medicine transforms to be in keeping with society's demands, our allegiance to the current biomedical model will decline. Modern scientific medicine has been based on a biomedical model that views the body as a machine. Disease, illness, and handicapping conditions represent malfunctions of the body machine's mechanisms. Only the physician knows how to correct malfunctioning, because he or she has been the one with scientific knowledge and technology. Authority and responsibility have been delegated to the physician who intervened and fixed the machine. Society has been spellbound by the mystique of medicine (2, p. 158).

Americans are losing faith in medical establishments and physicians because the increase in medical costs far exceeds the effectiveness of care. Although human life expectancy has increased and many types of illnesses have been controlled, the health of our population has not improved. For example, there are increases in learning disabilities, child and adult abuse, mental illnesses, and suicide among youths. Medicine's dependence on high technology has increased problems of health, with biomedical interventions having little impact on the health of entire populations (2, p. 138).

Current medical therapy is based on principles of intervention. The medical profession has relied on outside forces such as drugs and surgery without viewing the patient as a responsible individual who has a healing potential within and who can initiate the process of getting well (2, p. 152). Principles of intervention have also dominated the practice of occupational therapy. For example, we have based our philosophy and research on the outside force of activity or the effects of adaptive equipment or devices. Although these are important, we must not forget the values that are inherent to our profession: the patient's intrinsic motivation to "do" and the "doing" aspect of healing.

Transformation of the biomedical model is underway with the paradigm shift based on an awareness of the "essential interrelatedness and interdependence of all phenomena—physical, biological, psychological, social, and cultural" (2, p. 265). Concepts of prevention, relationships of physical and social environments, and the interplay of body, mind, and environment in the healing process are beginning to influence medicine. Medicine's paradigm shift is opening up new areas in search of a health orientation. Medical science now acknowledges that the art of healing is essential to all health care. With new emphasis on the human aspects of health, there will be an increased move from the medical establishment (institution) to personal responsibility (self-care and home health).

Occupational therapy has been a profession that has based its values on a paradigm of wellness. We consider patients active participants in their own care. We believe people are able to influence their own health and recognize the interplay of body, mind, and environment. With transformation of the biomedical model to a holistic health model, our profession must proclaim these values and communicate our philosophy. Medicine and society are catching up with us, but we must not let them pass us by.

Summary

Professional evolution includes a period of disunity, a phase when old values and concepts are being examined, and new perspectives emerge. Disunity can be a positive impetus for dynamic change. Transformation provides a higher level reintegration through which new understanding and progress unfold. Occupational therapy's transformation is now; it is time for careful analysis and creative synthesis.

Transformation is a three-fold process of integration of past, present, and future into an upward spiral of professional development. Transformation is a constant flow of activities influenced by both internal and external factors. Although there are multidimensions that influence occupational therapy's transformation, three major components are inherent in the profession's paradigm shift: (1) society's decline in patriarchal authority; (2) decline in allegiance to a biomedical model; and (3) shift in values, dimensions of practice, and education that form the reality of occupational therapy.

Transformation of our profession will be a paradigm shift:

- In our value system of purposeful activity to a new perspective of occupation and occupational

- In our quest to develop a unifying theory for recognition of the unifying force of values
- In our concepts and theories to include the science of occupation and the art of purposefulness
- From total allegiance to scientific knowledge to include intuitive knowledge
- From being an allied medical field to an independent health profession that is both educationally and medically related
- From a biomedical model to a paradigm of wellness
- In balancing of feminine and masculine values of human nature
- In organizing educational curricula and entry-level requirements that reflect our value system and predicted practice dimensions.

As Naisbitt said, “We are living in the time of parenthesis, the time between eras” (20, p. 249). Occupational therapy has not left the past behind, but it has not quite embraced the future either. Thus, our profession is in a time of parenthesis that brings us many uncertainties. Uncertainties, however, can be our opportunity. We need only make use of the challenge and possibilities that are part of our dynamic present. Transformation is a time to direct our own future. “We stand on the brink of a new age, the age of an open world, a time of renewal when a fresh release of spiritual energy in the world culture may unleash new possibilities. The sum of all our days is just our beginning” (1, p. 42).

We have reached our turning point. We have the means to solve our crisis and continue our transition to higher dimensions. However, we must *choose* to do so.

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