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THE CHANGING ROLE OF THE OCCUPATIONAL THERAPIST

by

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ABSTRACT

The purposes of this study were to identify both the role development of the occupational therapist and the factors which have influenced and directed the role changes. It was assumed that these identifications would assist both the profession and educators of occupational therapists to evaluate the trends as to how and why the profession is developing and to plan for appropriate professional and educational changes for the future.

The role of the occupational therapist, an allied health professional, has changed from that of a craft-oriented medical technician to that of a professional clinician, researcher, educator, and consultant. This contemporary therapist was found to be practicing in a number of areas both within and outside of the medical model of practice. The development of these new roles has resulted in considerable concern, both outside of and within the profession, as to whether or not the traditional craft-oriented medical model of practice is still valid. As well, occupational therapists in both the United States and Canada have expressed the need to re-evaluate their roles, their responsibilities, and their education in order to meet the needs of changing patterns in the organization and delivery of contemporary health services.

The study of the role development and identification of factors influencing the role changes was carried out through a review of literature published between 1922 and 1972 plus

a minimal number of unpublished papers related to the topic. A brief review of the 1970-1971 Canadian occupational therapy curricula was included in an attempt to indicate the influences educational programs had on the role development of the occupational therapist.

It was found that new roles developed in response to present and proposed government legislation, changing needs and demands of society in general, and changing emphases in medical education and health care delivery. It was also found that the educational influences of occupational therapy programs were minimal, if not inhibitory, to the role development of the occupational therapist.

Conclusions drawn from the review of the literature resulted in the establishing of eighteen recommendations concerned with the role development, research needs, and educational needs of future occupational therapists in Canada. It was felt that these recommendations represented guidelines for change which must be implemented by the individual therapists, professional associations, and educators if occupational therapy is to remain a viable health profession.

DEDICATION

To Dr. Bernice Russell Wylie

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INTRODUCTION

In 1962, an occupational therapy educator, Dr. Mary Reilly (133:4), stated that she had "little trust that we can continue to exist as an arts and crafts group which serves muscle dysfunction or as an activity group which serves the emotionally disabled. Society requires of us a much sharper focus on its needs."

During the following ten years these needs changed as the growing affluence in North America and the gradual introduction of new methods for financing health services lowered or removed financial barriers to the use of most health related services (25). Governments, in attempting to meet societies' health needs, have expressed concern about both the education of those in health service disciplines and the utilization of their services. According to the 1965 Federal Government's Royal Commission on Health Services (25), the expansion of community health services has emphasized the need to dovetail health services with other services in the community which have been drawn into the medical field. These new patterns of health care delivery, and the teaching of social or community medicine in the medical schools, are resulting in the recognition of the need of such services as occupational therapy to help round out health services.

Occupational therapists in both the United States and Canada have expressed the need to re-evaluate their education, their roles, and their responsibilities so as to meet the needs

of the changing patterns in the organization and delivery of health services (64, 160, 172). West (172) stated that the present role required is very different from the role of the traditional therapist of twenty years ago who brought crafts and creative activities to long-term ward patients. She emphasized the need to enlarge the concept of occupational therapy from that of being a therapist to that of being a health agent. In 1971, Reilly (135:245) supported this belief in the therapist as a health agent:

> The commitment and hence the capitalization in medicine is directed toward the reduction and prevention of pathology and the treatment of acute phases of illness. Occupational therapy makes its investment in the health residual which follows pathology and hence focuses on the chronic aspect of the illness and is concerned with health rather than pathology.

While some therapists believe that the present role requirements necessitate therapists being prepared to specialize as educators, consultants, and researchers as well as to practice as clinicians, belief in these new roles is by no means a consensus in the profession. Cromwell (35:17) clarified the problem when she stated that "occupational therapists are trying to decide whether the traditional role is still valid, and how the necessary resources can be mustered to alter roles".

Other health service personnel such as doctors, nurses, psychologists, and social workers express definite but conflicting opinions as to the expected roles of the occupational therapist (2, 6, 19, 53, 57, 66, 109, 120, 143). Occupational therapy educators have also expressed a concerned awareness of the changing role of the therapist. According to Reilly (134:222),

the future of the profession "will depend upon the adaptive responses which both the clinician and the professional association makes to the challange of new demands".

To date no comprehensive examination of the role change of the occupational therapist has been carried out in order to define the role as it has developed, nor have the roles, in the minds of many therapists, been legitimized.

PURPOSE OF THE STUDY

The purposes of this study are, through an examination of the literature, to identify the role development of the occupational therapist and to identify the factors which have influenced and directed the role changes. This study should then assist both the profession and educators of occupational therapists to evaluate the trends as to how and why the profession is developing and to plan for appropriate professional and educational changes for the future.

LIMITATIONS OF THE STUDY

In North America the profession of occupational therapy has been recognized for over fifty years. On the world scene there were twenty-three member countries in the World Federation of Occupational Therapists in 1970 whereas there were only ten founding member countries represented in 1952. Because of

the very nature of the profession, occupational therapy is growing and developing nationally, keeping in mind the individual needs of their societies.

As the public often appears unaware of the differences between occupational and physical therapy, it is emphasized here that this study concerns only occupational therapy and has nothing whatever to say about the separate, independent profession of physical therapy.

Canada and the United States have been co-leaders in the development of occupational therapy, and the education of therapists in these countries has followed parallell lines (93). In Canada the number of university programs in occupational therapy has increased from one in 1950 to nine in 1971. Because of this rapid growth of occupational therapy in Canada and the parallel professional developments in Canada and the United States, this study will be limited to the examination of the changing roles of the occupational therapist in those two countries. The major emphasis, particularly that concerning educational developments, will be on the changing role of the occupational therapist in Canada.

DEFINITION OF TERMS

At this point in the study eight terms will be defined. Although there are several definitions for the term occupational therapy (5, 26), two definitions have been chosen as they represent the earliest and the latest definitions available at

this time. The term physical therapy has been defined only to clarify the difference between physical and occupational therapy.

Occupational Therapy:

i. Earliest Definition: "any activity, mental or physical, definitely prescribed and guided, for the distinct purpose of contributing to and hastening recovery from disease or injury." (178:323)

ii. Latest Definition: "that discipline which concerns itself with the assessment of occupational behaviour, and which guides the reconstitution or development of occupational roles to produce new skills in living. It may further be defined as the art and science of directing man's response to selected activity to promote and maintain health, to prevent disability, and to reduce or eliminate incapacity resulting from physical or psychosocial dysfunction or environmental stress." (160:6)

Physical Therapy: is that science of treating physical disability through the use of such physical modalities as heat, electricity, water, and exercise.

Role: is the sum total of the cultural patterns associated with a particular position - the attitudes, values, and behaviour ascribed by society to any and all persons as occupants of that position. It is a pattern of activity - what a person has to do (or thinks he has to do) in order to validate his eligibility for the position he holds (96).

Community Health Service: is "the total of all health services in the community including the hospital." (25:39)

Health Team: is a group of health professions with their respective associated technologists, technicians and other essential personnel, whose overall goals are the promotion of health, the prevention of disease, the diagnosis and treatment of illness and the alleviation of suffering (181).

Occupational Role: is a social role assumed by every individual which is a part of his life cycle (163).

Occupational Behaviour: is the developmental tasks required by every individual as he assumes an occupational role (163).

Technician: A person skilled in a branch of training that depends more on specific practice than on general principles.

CHAPTER II

HISTORICAL INTRODUCTION

Although the history of occupational therapy as an independent profession begins early in the present 20th Century, the background of the profession can be traced as far back as the 20th Century B.C. The purpose of this chapter will be to provide a brief overview of the historical development and influences which lead to the recognition of occupational therapy as an independent health profession.

Pre-19th Century Influences

The theory that manual occupation or mental diversion was beneficial to the sick is one that has appeared from time to time throughout the history of medicine (6, 69, 178). About the 20th Century B.C., the Egyptians dedicated temples where "melancholics resorted in great numbers", games and recreation were instituted and "all the patient's time was taken up by some pleasurable occupation" (69:1). In the 9th Century B.C., Greek medicine appeared to recognize and utilize some principles underlying current approaches to the treatment of mental illness. By the 4th Century B.C., Egyptian medicine had anticipated much of the present day therapeutic community concepts by providing their mentally ill patients with pleasant surroundings and organizing programs which emphasized constant occupation, entertainment, and exercise. About 30 B.C., Seneca recommended employment for any kind of mental agitation, and in A.D. 172, Galen, the Greek physician, wrote "employment is

nature's best physician and is essential to human happiness" (69:2).

With the collapse of classical civilizations the standards of care for the mentally ill declined steadily in all but a few regions. One of these rare examples was the Colony of Gheel in Belgium. This 13th Century project's humanitarian approach and extensive use of "occupational therapy" did much to maintain the positive therapeutic features of the classical era (6).

The dark ages of psychiatric care did not begin to brighten until the latter half of the 18th and early 19th Centuries when occupation was used as a form of treatment by Pinel in France as well as others in Italy, Spain, England, and America.

19th Century Moral Treatment

According to Bockoven, it was undoubtedly the 19th Century that produced the greatest impetus for the development of occupational therapy as a profession today. He noted that "the history of moral treatment in America is not only synonymous with, but is the history of occupational therapy before it acquired its 20th Century name of occupational therapy" (19:223).

The concepts of "moral treatment" and "occupational therapy" were based on respect for human individuality and on what Bockoven considered to be a fundamental perception of the individual's need to engage in creative activity. The legacy of moral treatment was the belief that the mentally ill person

could best recover his reason in the company of mentally sound, kindly individuals who would help the patient by joining him in daily life activities. Because of the agricultural orientation of 19th Century society, moral treatment hospitals were equipped with a variety of craft shops and indoor recreational areas, garden areas, and outdoor game areas that were surrounded by farm land cultivated by the patients. Considering its era of introduction and growth, moral treatment could be described, both philosophically and practically, as a comprehensive occupational therapy program.

Bockoven felt that the philosophy of moral treatment was a result of the political, cultural, and religious attitudes of communities established primarily in the north-eastern United States and Upper Canada. These attitudes were based on a belief that everyone should take part in all aspects of the political and religious life of the community. Driver (41) felt that such attitudes were probably influenced by such humanitarian writers and thinkers of the time as John Stuart Mills.

Moral treatment is generally considered to have disappeared in the United States before the 20th Century because of social, institutional, and medical changes. There was an increase in ethnic prejudices in reaction to the large numbers of immigrants to America who began making up the large bulk of mental hospital patients. The institutions themselves enlarged in a few years to five to ten times their previous size making personal patient-staff contact almost impossible. On top of these difficulties, the medical profession itself shifted its

view from a moral-emotional basis of mental illness to a belief that cellular brain pathology was the only scientific basis of treatment (19).

19th Century Canadian Innovators

There is evidence that moral treatment did not entirely disappear in Canada during the 19th Century, and through the use of moral treatment one doctor could be considered to have pioneered occupational therapy. The London, Ontario, Lunatic Asylum opened in 1870, and in 1883 the Medical Superintendent, Dr. Bucke, hired a female attendant to work on one male ward. The asylum Inspector wrote in his minute book of March 6, 1883, that "since this lady's coming to the Asylum, a great tidiness in person, a greater activity in employment, and a general brightening of the condition of those in the male ward is perceptible" (66:80). The Inspector authorized purchases of materials to permit such activities as cane seating, shoemaking, knitting, and mat-making, and empowered the Superintendent to hire two more ladies to continue the comfort and health-promoting work being done. Before 1900, a similar type of occupational work was introduced to the Mountain Sanitorium for Tubercular patients in Hamilton, Ontario.

Re-Birth of Moral Treatment

The re-birth of moral treatment in the 20th Century was, in part, supported by the psychiatrist, Sigmund Freud, who claimed that "work has a greater effect than any other technique of living, in the direction of binding the individual

closely to reality; in his work at least he is securely attached to a part of reality, the human community" (6:119).

The re-birth of moral treatment did not produce an identical philosophy to that of the original moral treatment. Driver (41) observed influences in this period which not only had an impact on the pre-occupational therapy re-birth of moral treatment but also on present-day occupational therapy treatment. She pointed out that early moral treatment hospitals hired occupational workers to guide patients in normal community activities such as farming, gardening, hospital industries, and recreation. With the new moral treatment era one finds a shift from realistic work settings and activities to activities such as cane-seating, basket-weaving, knitting, and sewing that could take place in occupational rooms within the institution. Driver's hypothesis was that this change from realistic work to a dependence on arts and crafts was at least partially a result of a change in social thinking brought about by such writers as Carl Marx. The exploitation of the patient as a worker was to be deplored and rejected, and as a result, arts and crafts were emphasized since they were, at that time at least, significant to and an integral part of normal living in a semi-mechanized society. This socially-influenced change of the therapist to an arts and crafts worker is an image therapists are still trying to diminish, and it is a major philosophical problem both inside and outside of the profession of occupational therapy.

World War I Influences

The re-birth of moral treatment was only one of two forces that led to the formal beginnings of occupational therapy. The second force was the return of a vast number of severely wounded soldiers from the First World War. It was the elite of the medical profession who joined the forces and caused the military to develop rehabilitation programs for wounded servicemen. One American doctor, F. Williams, went to Washington to ask for "occupational therapists" to go overseas with his unit, but already an unfavourable image of occupational therapy had been established. Dr. William's request was denied because the military "could not understand that he wanted a program of vocational training rather than basket-weaving" (182:227).

Despite this problem, he was able to get some women prepared to do rehabilitation work in his unit under the category of "scrubwomen". Within weeks their work became obviously invaluable and the Surgeon General cabled for a thousand more aides as soon as they could be made ready. As a result, 116 women, nurses, physiotherapists, dietitians, and civilian aides were assembled, trained with three lectures on the meaning of the word "neuropsychiatric", and sent overseas to establish programs to rehabilitate the wounded (182).

Development of Educational Programs

As Canada also made preparations to suppy similar aides to help rehabilitate the wounded servicemen, the problem of education of the aides arose. According to Haworth and

McDonald (69), up to the time of the First World War there had been little in the way of occupational treatment except in the hospital industries. The successful attempt by a few individuals to treat patients through the use of occupation led authorities in various hospitals to consider the necessity of definite training for these workers.

The first school in the United States was the School of Occupational Therapy in Chicago. It opened in 1914 under the direction of Mrs. Eleanor Clarke Slagle (43), and its first course was six weeks in length. The first course in Canada was given at Hart House, The University of Toronto, in 1918. The outline of this first six week course was drawn up by Professor Haultain and a committee of the Faculty of Applied Science and Engineering. Each succeeding course was extended to three months in length and included a large number of manual skills and hospital etiquette (94). These first "ward aides" soon became known as "vocational aides" because of the skills they acquired in these early courses. Over three hundred women were trained in 1918 and 1919, and were sent to military hospitals across Canada.

The admission requirement for women entering the first University of Toronto courses is probably unique in the history of Canadian universities. The requirement was that the students had to have "charm", a requirement that perhaps inadvertently implied that male students would not be considered (43). Later qualifications for the newly-named "reconstruction aides" included general education from a secondary school but Normal School and college graduates were preferred. Personal

qualifications were mainly those of good teachers (154). Not until the two-year course was established at the University of Toronto in 1926 were the admission requirements the same as for the Faculty of Arts (36).

Professionalization of Occupational Therapy

The identity of occupational therapy was developed gradually over a period of two decades in Canada. The occupational therapy "aides" formed two organizations: one initiated in 1920 at the Toronto Curative Workshop and a similar, short-lived, Canadian Society of Occupational Therapy of Manitoba in 1921. In 1921, the Ontario Society of Occupational Therapy obtained its charter as a professional organization existing for the therapists rather than for service to patients. This group was responsible for the formation of the Canadian Association of Occupational Therapy which held its first annual meeting in 1930, published its first journal in 1933, and obtained a Dominion Charter in 1934.

The Canadian Association was formed because of the activity of the early aides while the American Association was formed through the activity of other professionals. In 1915, Dr. William Rush Dunton published a book, Occupational Therapy, A Manual for Nurses. This was read by George Barton, an architect and tuberculous patient, who had already become convinced of the curative value of patient occupation. Barton contacted Dr. Dunton regarding the possibility of establishing an American association for occupational therapy. Thus, Barton can be credited with establishing the official name for the

profession and Dunton credited with establishing the American Occupational Therapy Association in 1916 (165).

In both countries it was felt that the new discipline needed the prestige of the medical profession. For most of its first thirty years the American association was led by physicians with the exception of Mr. Barton, the first president, and Mrs. Slagle, the president from 1919 to 1920. The Canadian association presidents were physicians until 1966: Howland from 1930 to 1948; Campbell from 1948 to 1960; and Swanson from 1960 to 1966. In 1966, an occupational therapist, Mrs. Thelma Cardwell, was elected the first therapist-president of the Canadian Association of Occupational Therapists.

The Struggle for Recognition

By 1925 doctors had assumed the leadership of the profession in Canada and they were strongly supported by the Ontario Government which was aware of the need for expanding occupational therapy services in Provincial mental hospitals (94). Dr. Goldwin Howland, President of the Canadian association for many years, led the fight for the recognition of occupational therapy as a profession. This desire for recognition was evident many years before official sanction was given to occupational therapy. In the July 14, 1923, issue of the Winnipeg Evening Tribune, an article generously proclaimed, "War Experiment Now Ranks as a Profession" (166); however, present therapists might doubt that the following content of the article truly supported the promise of the headline:

> Occupational therapy teaches work for work's sake. . . . It conceives of man as a doing animal, and perceives that idleness is an abnormal condition. . . . "No life is complete without work" an occupational therapist said to the Tribune. "In order to keep life's balance, there must be work, rest, and play. If the work is very agreeable, less play is needed."

Despite this early enthusiasm, it was not until 1944 that Dr. Howland felt occupational therapy had attained professional status. He and the Board of Directors of the Canadian association had fought for two principles: (a) that all occupational therapists must be graduates of a school recognized by the Canadian association; and (b) that the scope and field of this form of treatment must be primarily therapeutic and not recreational. He claimed that

> . . . these two principles have been definitely established amid many difficulties, with considerable opposition arising both outside and inside our organization. But now with the dawn of 1944, you may rest satisfied, knowing that the battle is won and you occupational therapists are regarded both today, and for all future time, in your proper spheres as members of a recognized profession (80:3).

This professional recognition was re-enforced when Dr. Howland convinced the Government of Canada to allow occupational therapists to enlist as fully commissioned officers during World War II. From 1943 to 1946 over 70 therapists enlisted, almost half serving with the Canadian Army Overseas (41).

The Struggle for Independence

Despite the claim by Dr. Howland that occupational therapy was now a recognized profession, it was apparent that a tradition of unequal relationship with physicians was well established in the years between 1910 and 1929. Woodside (182:229) clearly pointed out that the physicians were administratively helpful but praised the therapist's heart while questioning her knowledge and skills:

> The early journals illustrated how tenaciously the doctors clung to the necessity of a medical prescription and/or referral to an occupational therapist for their patients. . . . Most of this time they presided over the national association and undoubtedly occupational therapists profitted much from their vast organizational and medical knowledge while still being very much subservient to their leadership. Forty years later, therapists are still feeling the effects of this long established hierarchy and are struggling for the right to work with doctors rather than under them.

The profession's dependence on the medical profession and lack of autonomy was based on a need for status. Now, despite uncertainty within the profession, the desire for autonomy and the recognition of an earned status is gradually spreading across the country. Trider (160:3) claims that "our traditional dependency status is being rejected as an unnecessary burden by Big Daddy (organized medicine) and our intellectual and academic achievements are being exposed for what they too often are, the posturing of a would-be profession still in many ways clinging to an outmoded pre- and post-war aura of gentility and lady-like-ness". She further claimed that

"this debuntante syndrome is hardly appropriate for a profession purporting to be a useful part of the tough-minded, scientific health industry of today".

The image and role of the occupational therapist as the "craft-lady" was established very early in the development of the profession. Later years saw the role of the therapist develop new patterns of behaviour and responsibility and a number of specialized roles emerged for the occupational therapist.

CHAPTER III

DESCRIPTION OF THE ROLES

The role of the occupational therapist has evolved from that of a medically-oriented therapeutic technician to the more sophisticated roles of clinician, educator, consultant, and researcher. The purpose of this chapter will be to describe the evolution of these roles and indicate the internal factors which have either encouraged or inhibited the development of the new roles.

THE CLINICIAN

According to Dr. Anne Cronin Mosey (118:235), until the 1960's "occupational therapists functioned as technicians, not as professional persons.. . . An ancillary, almost handmaid of the Lord, role seemed to be willingly accepted.. . . There is still little change in our manner of functioning as we enter the '70's."

This early role as clinician was at least partially defined in 1922 by Dr. Hubert Hall (67:163):

> Occupational therapy's first concern is to arouse ambition in those who are discouraged or apathetic. Its final purpose is through the use of light handicrafts to develop patience and application, so that even the inertia of quite severe handicap may be overcome.

The early literature indicated that the therapist worked only under the direct guidance of a physician, and the des-

cription of treatment media indicated the technical nature of the therapist's role. In 1940, Bickle (16:81) explained that the physically or mentally disabled patient "received treatment through such crafts as rug making, basketry, chair caning, papier mache and needlework" as well as weaving, leatherwork and woodwork. However, the early therapist was not considered to be only a teacher of crafts. Heaton (71:60) added to the description of the therapist's occupational role when he described her as "a student of occupational methods, record keeper, vocational counsellor and placement officer". The emphasis on the occupational therapist's role as being production and craft-oriented continued for many years (50, 54, 140); however, the descriptions of the role were as varied as the descriptors. For example, a psychiatrist (7:14) described the occupational therapist as an "instructor in arts and crafts and tutor in special work", while a nurse (53) felt that the therapist's purpose was to stimulate interest, ambition, confidence, and the desire to accomplish.

Despite the evidence of the 1930's and 1940's supporting the therapist's role as a craft-oriented, institutionalized technician, there were a few individuals who presented a different point of view. McGhie and Myers (103) felt that the therapist had to do more than teach handcrafts; that there was no longer any excuse for placing emphasis on the finished product. Instead, they felt that the emphasis of the therapist should be on the creating of an environment to improve the mental health of the patient. LeVesconte (93:12) emphasized community involvement and felt that sheltered workshops for

the physically disabled should be called community centres. Smith (147) questioned the use of handcrafts as being appropriate in some treatment situations. She described the new 1940 treatment program for injured workmen in which they were offered not crafts, but exercise which approximated as closely as possible the type of work to which they would return.

As early as 1933, Dr. Howland (73) emphasized that there had to be an advance in the scope of occupational therapy if it were ever to become a principal therapeutic method of treatment, and it appears that his advice was taken to heart by the profession.

The literature of the 1940's, 1950's, and 1960's indicated that the scope of occupational therapy increased to such an extent that the role of the clinician became definable only in terms of the individual's position and function, a situation recognized as one likely to cause confusion in role identification (73:34). Attempts to define the role of the therapist in the 1960's produced descriptions which indicated the confusion and nebulous character of the therapist's role. For example, Jones (84:6) stated that the "occupational therapist no longer has only the role of a technician teaching certain manual skills to patients but uses in addition her personal attributes as actively and flexibly as possible". De La Charite (38:101) indicated the inability to define the roles noting that "the role of the occupational therapist as a team member . . . must be defined by the whole team . . . that sits down and defines the total needs or losses of each

individual patient".

This problem of identifying role becomes even more evident in the literature as it indicated that the clinician appeared to be everything to everyone. The therapist was expected to have expertise in supervision and/or administration (8, 34, 97, 171); assessment and/or diagnosis (13, 32, 104, 115, 120); home care and/or community therapy (9, 10, 82, 112, 174); vocational rehabilitation (14, 39, 77, 83, 117); architectural and/or environmental change (36, 63, 146, 155, 171); group therapy (32, 49, 56, 84, 138); education (62, 64, 83, 117, 142); evaluation (34, 63, 146, 155, 171); and leisure-time activities and/or diversional therapy (70, 81, 115, 146). The occupational therapist was also considered to be a counsellor (23), a consultant (77, 83, 97, 171), a researcher (63, 64, 83, 117, 171), and an orthotist and inventor (37, 112, 117).

Thirty years after Howland encouraged an expansion in the scope of occupational therapy, Burke (23:4) commented on the resulting role confusion: "Yet this very broadness and multifaceted competence has contributed in a large manner to much of the present confusion that envelopes occupational therapy in the 1960's."

In spite of the confusion, the late 1960's and early 1970's produced a number of attempts to cut through the confusion and point out trends and areas of concern to contemporary therapists. A review of eight points which reflect current thinking may help the profession re-evaluate and clarify the present problems and furture roles of the occupational therapy clinician.

The first point is an evaluative statement concerning the therapist-patient relationship. Medical practitioners such as Nichols (120) and Burke (23) as well as therapists such as Cromwell (34) and Moore (117) agree on the concept that because of the occupational therapist's broad type of educational background, this therapist is the practitioner best prepared to see, understand, and participate in the holistic approach to patient care.

The second point involves the re-evaluation of the relationship of the occupational therapist to the rehabilitation movement. Mosey (118:235) explained that the rush of the therapists to be a part of the rehabilitation movement was an action "typical for a group that lacks a strong identity and seeks recognition". As varying degrees of role blurring occurred, Mosey claimed that it was a sign of "uncertainty regarding one's appropriate role, poor training, and/or a way of avoiding the issue of responsibility". At the same time that Mosey was explaining why therapists joined the rehabilitation movement, Reilly (135:224-225) was in the process of evaluating this same movement. In her opinion, "rehabilitation, of which occupational therapy is considered to be a substructure, has no organized body of knowledge and no profession concerned with its ethnics. It has no rational preparation for its practice and no monitoring of its aftereffects." Reilly felt that therapists "must disentangle themselves from the unconscious associations they have made with the rehabilitation movement because it is now regressed to a low-grade substitute for the health care of the

chronically disabled".

A third point under consideration by contemporary therapists is a review of the dependency relationship between occupational therapists and the medical profession. Peake (127:407) described this relationship as follows:

> We have experienced within the areas of physical medicine and rehabilitation, an uncomfortable relationship with the physician. . . . Our primary role has been . . . under the administrative and professional control of the physiatrist . . . a role in which we have been forced to function . . . as a "technician" to the physician; unrecognized in our basic professional preparation as individuals prepared to function as allies to many medical specialties, and to other health professions.

Peake further states that "a truly collaborative, professional relationship does exist in some working relationships, but generally, this is not the case".

Dr. Nickel indicated that the practice of requiring detailed written prescriptions from the doctor has supported this dependency status of the therapist and inhibited the application of the therapist's knowledge. He believed that "such prescriptions have been, and are, a millstone around the neck of the occupational therapists as well physicians" (121:87). Dr. Bockoven (19:224), on the other hand, clearly lays the blame for the continuation of the dependency relationship at the feet of the therapists:

> It would be most unfortunate for all society . . . if occupational therapy were to limit itself by continuing to be satisfied with running dinky little sideshows in large mental institutions. . . . It is time for occupational

> therapists to listen to the idea that their profession has been the child of medicine long enough and to consider that it is ready to go off on its own as the next step toward full maturity and full social effectiveness.

Occupational therapists as well as medical practitioners see this dependency as inhibiting to professional progress, but Mosey (118) feels that, in spite of seeing the situation, occupational therapy has been passively uncritical in its acceptance of the close ties with medicine. Moore (117:23), in denouncing this state of passive dependency, stated that "if the occupational therapist is responsible to a physician for her practice, she will remain a 'technician'". As early as 1966, Johnson and Smith (83) felt that therapists were already decreasing their dependency on medical supervision. There appears now to be no significant disagreement that only by being responsible for their own activities will occupational therapists progress as professional health workers.

Despite the desire of doctors and therapists to break the dependency relationship, there remains the problem of legal responsibility which therapists must consider. Friedmann's (57) statement that the doctor had to have the sole moral and legal responsibility for the well-being of the patient was challanged by Siller, who felt that Friedmann's perception of legal responsibility was a result of his "looking where his associate disciplines were rather than where they are," and that this legal responsibility originally grew from the need to protect the public from quackery (143:411-412). Siller spoke for many occupational therapists when he claimed that "although

the formal training requirements for the other rehabilitation professions may require fewer years than for medicine or psychology, the principle of systematic learning, ethical operation, and professional accountability should operate for all".

A fourth point being considered is the growing emphasis on prevention as a legitimate service of occupational therapy. A number of therapists (64, 160, 171) point out that emerging patterns of health care delivery are leading to the need for new settings, new methods, new services, and a new emphasis on the prevention of dysfunction. West (174:231) stated that although therapists are now functioning in new settings and are developing restorative and secondary preventive services, occupational therapists "have not as yet fulfilled a potential role in primary prevention". She felt that the therapist's involvement in primary prevention services would be new to the profession, yet "entirely consonant with one of our oldest philosophies - that occupational therapy is concerned, not only with the individual's physical abilities, but also with his mental, emotional, social, and economic needs".

The fifth area of review relevant to the changing role of the clinician concerns the medical versus the non-medical model of practice. Therapists such as Gordon (64) and Reilly (135) state emphatically that occupational therapy is concerned, and always has been concerned, with health rather than pathology of illness. West (172:14, 174:227) clarified this concern:

> There is an increasing need to identify with the field of health, thus broadening

> our traditional, more limited identification with medicine; to enlarge our concept from that of being a therapist to one of functioning as a health agent . . . with some responsibility for identifying environmental as well as biological causes of disease and dysfunction, for participating in the planning of health services, and for helping to ensure normal growth and development.

Rerek (137) felt that a critical period of development in occupational therapy occurred during the 1930's when the profession accepted the idea that only the medical model was available to them. Since the occupational therapist is concerned with health rather than illness, Rerek claimed that the use of the medical model for the delivery of health services, by definition, militates against the development of the health-oriented services of occupational therapy; that through the medical model "growth can only be in the direction of services to the sick, or 'sick services'" (137:232). Diaso (39:239) believed that "occupational therapists took a grand step away from the medical model when they defined function and dysfunction as their professional parameters of concern".

Occupational therapists have not completely discarded the medical model, but they are questioning its validity for their profession and suggesting model alternatives. For example, Mosey (118) has suggested that education might provide a more useful model to follow than medicine, while Diaso (39) noted that many therapists in graduate schools found they could relate more to the behavioural science model than they could to the medical model. Diaso (39:239) claimed that "this change in emphasis . . . reinforced more strongly than before the

conviction that patients' or clients' problems could not be cast solely in medical terms". Despite these statements of opinion on the occupational therapy versus medical model relationship Rerek's (137:233) question remains to be answered: ". . . Can we disengage ourselves from institutions for the delivery of 'sick services' that prevent us from our delivery of health services?"

A sixth area of concern to the clinicians' role is the re-evaluation of the traditional modalities of treatment. Conte (32:149), a physician, expressed his concern and interest:

> The activities used traditionally in occupational therapy should be re-evaluated in terms of their meaningfulness in the newer social-psychological-cultural approach to programming. There needs to be an increased awareness of what kinds of activities have meaning and therapeutic value in the daily living experience of patients.

Therapists are now examining the whole subject of treatment modalities. It is felt that most curricula emphasize too many crafts (176); that there is a trend toward functional, less craft-oriented programs (83); and that standards have already shifted from arts and crafts to the basic sciences (118). Shimeld (142:10) reflected much of the current thinking on the re-evaluation of traditional modalities of treatment:

> It will be important that we learn to use the therapeutic potential of a much broader range of human activities than the standard repertoire of arts and crafts. In doing so, we will have to collaborate with others possessing the skills we wish to use to help our patients. No longer will it be possible for the therapist to be proficient in all the activities used as treatment media for patients.

The seventh area of consideration is that of the image of the therapist and occupational therapy. Trider (60) and Cardwell (27) express concern about the therapist's image of both himself and his profession, but it is Diazo (39:240-241) who has most full examined this image: ". . . Many occupational therapists continue to hold a damaged self-image of their profession despite the advances of the '60's . . ." and the damaged image is at least partially the result of the lack of professional development. Diazo asserts that this lack of development is a result of "undeclared contracts" which therapists must break. The first such contract involved the position of the therapist within institutional power structures. Diazo felt that the more experienced therapists were finding that their achieved roles outran the roles ascribed to them, a situation leading to frustration among those therapists not allowed to innovate or use their full range of skills. Diazo anticipated a problem in that a change in this inhibitory contract would likely be seen as threatening to the system as a whole.

Diazo's second undeclared contract involves the relationship of occupational therapy to organized medicine. She sees this as a double problem involving, primarily, the fact that the national medical associations still control the occupational therapy curricula, and secondly, a role conflict within the medical profession:

> The majority of physicians remain unaware of the occupational therapist's training and skills . . . yet most would still assert the need to control 'paramedicals'.

Despite assertions by the medical profession (57, 68) that doctors are now much better educated as to the roles of the other professionals, the 1969 study by Tuminelly (161) concluded that over one-third of the final-year medical student respondents were not at all aware of the role of the occupational therapist and most of the students had received very little, if any, information about the profession in medical school. The role conflict of medicine, then, concerns the doctor believing that he should, and does, know enough about another profession to control it, while senior medical students admit that, in fact, they learn almost nothing about this profession they will traditionally expect to control. Diazo's point is that "occupational therapists must become aware of these role conflicts if their co-optation by medicine is to cease" and the second undeclared contract broken or abolished.

Diazo's third undeclared contract concerns occupational therapists holding second-class status as professionals because their organization is comprised primarily of women. As well as all orders and decisions being made by a male dominated medical profession, she asserts that "throughout our history until recent times, the submissiveness and conformity so strongly reinforced in occupational therapy roles, paralleled expected sex-role behaviour in society". Not only did this role stereotyping influence the therapists behaviour, but Diaso (39:240) felt it also influenced the use of treatment media:

> Training schools, hastily set up for women only, had a strong influence in moving therapists away from the wide scope of educational, recreational,

> vocational, and other activities that characterized the early history of occupational therapy. . . . Viewed historically, a sole emphasis on arts and crafts in occupational therapy represented a temporary aberration derived partially from the sex-role stereotyping.

Despite this traditional stereotyping, Diazo felt that, in fact, there was no theoretical or logical reason why occupational therapy should ever have been considered a woman's profession.

The eighth area of concern in the re-evaluation of the present and future therapist's role is that of the trend to move occupational therapists out of institutions and into the community. As recent as 1966, therapists working in the areas of both physical dysfunction, such as Johnson and Smith (83), and psycho-social dysfunction, such as Conte (32), confirmed that the trend to community-based treatment had begun. According to Conte, this trend meant that therapists would have a broader range of treatment requirements to handle an increasing number of patients. Shimeld (142:10) reflected a growing philosophy concerning the therapist's role in the community:

> As therapists, we must open our eyes and our minds to the world to which we are trying to help our patients return. Our treatment has to carry over into that world, and the patients' "mastery of his environment" has to extend beyond the walls of the clinic and hospital.

Reilly (135:246) enthusiastically supported these community service trends: "For the young therapist, the real action in the 1970's will be the conversion of the occupational

therapists' services from the hospital to the community."

It would appear that the return of the therapist to community service will not come about effortlessly. Moore (117) felt that therapists would not be able to expand to any extent into the community because there would not be adequate numbers of clinicians available to meet the community needs. She recommended that therapists should specialize in one of only two or three areas instead of the dozens of areas they are trying to be specialists in now. Johnson and Smith (83) concluded that as therapists provide services to community programs they would require improved skills in specialty areas such as education, research and consultation. These areas of specialization are presently being implemented and evaluated by the profession.

THE EDUCATOR

Although many therapists consider themselves to be medically-oriented, treating only pathology or psycho-social dysfunction, Gallagher (58:29) re-inforced one of the earliest beliefs in the role of the occupational therapist as an educator when he asserted that "our aim is to educate, not merely to provide humane treatment for the handicapped". That therapists accepted this role as early as 1918 was established by a paper, "The Remuneration of the Teacher", presented at the second annual meeting of the National Association for the Promotion of Occupational Therapists (22).

Over the years doctors (2), psychologists (130), nurses (86), and therapists (142) referred to rehabilitation as being the personal learning experience taking place following the medical correction of the physical disability. The aim of therapy is to direct this learning experience, and numerous therapists referred to their function as that of teaching the child or his parents, the hemiplegic, the aged or the amputee patient (60, 86, 115, 130, 157). As well as general references, there are specific references to the teaching role of the occupational therapist. Dunlop (44) stated that in order to practice occupational therapy successfully one must know how to teach and use her knowledge of teaching as a means to therapy. Gillette (62) said that although occupational therapists are seen as teachers, they are improperly seen as teachers of activities rather than teachers of behavioural change.

Despite references to the therapist functioning as a teacher, there has been little attention paid to the actual skills required by this therapist in order to teach. In one of the few references indicating the specific knowledge therapists should have in order to teach, Peters (129) indicated the need for therapists to know about how adults learn since the involvement of the patient in the learning process was the basis for a successful treatment program.

Therapists see their role not only as educators of patients, but also educators of other professionals, members of para-medical professions, the community, and student interns within their own profession (82, 83, 85, 149, 168). Johnson and Smith (83:270-271) attempted to look at the future role

of the occupational therapist as an educator. They predict that hospitals will function as "educational health centers", and all clinical occupational therapists will be teaching in whatever role they fulfill. As the role of the occupational therapist expands to include a specialized role of educator, these writers emphasize that the education of the therapist must be changed; the modern curriculum should include methodology of education and the psychology of learning.

In both the United States and Canada the national professional associations have accepted direct responsibility for education of therapists or therapy assistants. Between 1959 and 1967, the Canadian Association of Occupational Therapists sponsored a two-year Special Course in Occupational Therapy to qualify therapists quickly at a time when there was a shortage of both therapists and educational facilities for therapists in Canada. The American Occupational Therapy Association accepted the responsibility for setting standards and objectives for a training program for occupational therapy assistants. They were able to do this with the assistance of M. Ritvo, a training consultant at the Human Relations Center, Boston University, and Dr. Malcolm Knowles, professor of education and general consultant in adult education at Boston University (33).

Little has been written concerning the educational preparation of the university faculty teaching occupational therapy. There were, in 1970-1971, two two-year teaching diploma courses at Canadian universities, only one of which required education courses from a Faculty of Education. No

university program in occupational therapy in Canada requires a teaching diploma for faculty members. The usual requirement to be a full-time educator of occupational therapists is a variable number of years experience, demonstrated ability, and a desire to teach. Those faculty members with teaching diplomas have found that university administrations generally do not consider it to be of value when evaluating the faculty member's qualifications for promotion or tenure. Whether it is because of a lack of motivation or lack of opportunity on the part of the educators, a higher teaching qualification is one of the major areas of deficiency when considering the specialist role of the occupational therapist as an educator in Canada.

THE CONSULTANT

The specialized role of the occupational therapy consultant is not emphasized in the literature until the middle of the 1960's. West (170, 173) stated that since health care moved increasingly from the institution to the community, the role of every occupational therapist had a consultative function. Ainsley (1), Howe and Dippy (77), and Johnson and Smith (83) support Cromwell's (35:17) opinion that the education and role of the occupational therapist must change and emphasize consultancy "in order to produce contemporary therapists prepared to meet future demands". She felt that these future demands would include more patients,

hospitals, schools, chronic illnesses, leisure time, public medicine, community medicine, ambulatory care, and more emphasis on prevention in health care, all indicating an increased need for consultants.

Howe and Dippy (77) indicated that the trend points to therapists becoming increasingly concerned with health and prevention of dysfunction in terms of individuals, families, groups, communities, and society as a whole. They report that therapists are now functioning as consultants to community centre activity programs, community care homes, half-way houses, adult education programs and youth groups. They also felt that private-practice consultants have helped develop the growth of occupational therapy as a profession. Erhardt (47) illustrated this growth in her description of occupational therapy consultants' practice in North Dakota which she felt had expanded occupational therapy beyond the traditional medical model of practice. Therapists there function as consultants in three school programs for children with perceptual handicaps. They accept referrals from Public Health Nurses, vocational rehabilitation, schools, clinics, and hospital social service departments as well as direct medical referrals.

Although there is a growing need for therapists who can accept the specialist role of consultant, many therapists will not formally accept this role. Leopold (90) has examined the role of the consultant and explained that the consultation relationship differed from the therapist-patient relationship in that the consultant generally lacks the opportunity for deep personal gratification available to the

clinical therapist. Many therapists would be unable or unwilling to lose this part of the therapist's identification, the core of their professional lives.

Mazer (111) sees the ideal consultant's role as one demanding skill and knowledge of the occupational therapy treatment process, awareness and skill in the supervisory relationship, a conviction of the need for research, and a high degree of skill as an educator. Such a consultant may well be considered a therapist to the community rather than to the individual patient.

The new role of the occupational therapist as a consultant has been well established over the past fifteen years. General acceptance of this role requires a change in the education of therapists (83), and Gordon (65) suggests a core curriculum essential to future consultants. This curriculum includes human relations, communications, research and statistics, teaching and curriculum construction, counseling, and administration. Moore (117:24) presented a challange to educators of future consultants when she said that the "present education is no longer enough to prepare occupational therapists for the variety of roles we have chosen to perform".

THE RESEARCHER

In 1961, Sommers (152:25), a research psychologist, said that "no profession can rely indefinitely on members of another profession for concepts and a theoretical foundation. In the

next decade the need will be for occupational therapists to engage in research as an integral part of the occupational therapist's job". Sommers was not the first non-therapist to encourage occupational therapists to engage in research. As early as 1922, Dr. Burnette (24:182) commented that, since the First World War, occupational therapy in Canada had "done little but regress in terms of scientific advances in treatment of the mentally ill". He suggested that what the profession needed was some "quiet, earnest research work".

Over the decades that followed, little was accomplished in what might be called research, but a great deal more was written on the need for research. The University of Toronto graduating class of 1940 wrote a paper on the need for research into suitable occupations or recreation for men in submarine crews (166), a problem which therapists are now looking into in terms of the manned space programs (29).

There appears to be no lack of advice as to possible areas of research for occupational therapists. Fisher (55), a psychologist, suggested that occupational therapists could contribute to the field of learning by working out a taxonomy of psycho-motor skills, and Reilly (134), one of the few occupational therapists with a doctorate who remained in the profession, emphasized that research is necessary to provide a theoretical basis of occupational therapy.

A number of Canadian therapists have carried out and published small studies on such diverse subjects as colour preference of older psychiatric patients (36), treatment of patients in groups (48), and the electromyographical study

of neuromuscular activity (144). Despite some attempts to carry out research, West (168, 170) felt that, generally speaking, most therapists are content to proceed professionally on a largely empirical basis. She observed that often both physicians and therapists felt that occupational therapists had no role in research, however, West believes that occupational therapists are now obtaining higher degrees, training, and knowledge of research design and methodology which will help overcome the problem which Cross (36:11) defined so accurately: "Occupational therapists have always been urged to undertake research regardless of the fact that the majority have no training in research and statistics."

There has been some attempt to alleviate this deficiency at the undergraduate level in some Canadian university programs in occupational therapy, a small indication of professional acceptance of the role of the occupational therapist as a researcher.

The development of specialized roles for the occupational therapist occurred gradually over a fifty year period, mainly through the efforts of individual therapists rather than the profession as a whole. The role of the clinician has expanded to a point where it is impossible to define the role of an occupational therapy clinician. On the other hand, the specialized roles of educator, consultant, and researcher are only beginning to be developed, but already appear to have the approval of the profession as being legitimate areas of professional development.

CHAPTER IV

FACTORS INFLUENCING ROLE DEVELOPMENT

Although new roles for the occupational therapist have developed and expanded the profession, the development would probably not have taken place without the pressures of influences outside of the profession. The purpose of this chapter is to give a brief overview of some of legislative, social, and medical factors which have influenced the role development within the profession.

LEGISLATIVE INFLUENCES

In Canada and the United States both present and future legislation has had, and will have, an effect on the practice of occupational therapy. Such United States legislation as Title XVlll, Medicare, has, in effect, forced the therapist to extend his services to the patient's home, and increased the need for services in such agencies as nursing homes, penal institutions, and extended care facilities (74). Such progressive legislation does produce some difficulties since no comparable legislation has been introduced to make provisions for increasing the supply of personnel to staff these new programs (172).

The introduction of a universal medical-care plan in Canada has resulted in similar difficulties. There is an increase in the use of health services, and areas previously

considered to lie entirely within the spheres of social adjustment, subject to education or correction rather than health services, have been drawn into the medical field (25). This has meant that the few available occupational therapists had to attempt to expand services into many areas that had not earlier been considered a legitimate area of practice (123).

In Canada, both Provincial and Federal Governments have, or plan to have, legislation effecting the practice of occupational therapy. Three provinces, namely Manitoba, Nova Scotia, and Saskatchewan have legislation making the provincial occupational therapy associations the liscencing bodies for the profession. In Ontario, legislation is about to be presented which appears will result in the establishing of a College of Occupational Therapy which will be responsible for liscencing practitioners in that province.

At the National Conference on Education of Health Manpower held in Ottawa in October, 1971, speakers at the ministerial and deputy-ministerial levels indicated that recommended future federal legislation would have an effect on the practice of occupational therapy (160). They stated that, in the future, the delivery of health services would take place to an increasing degree in the community rather than in chronic and acute care institutions; that federal money would increasingly go to predominately out-patient community health centres.

The area of the education of health workers was not omitted from the Federal Government's area of concern. They

felt that a far greater emphasis would be placed on prevention in health services, and educationally there would be proportionally more emphasis on the behavioural sciences while the emphasis on the physical sciences would be reduced. Of interest to occupational therapists is the fact that the Federal Government proposes to be involved in standards of education. Trider's (160:4) report on the National Conference mentioned that "the roles of all health workers will be redefined according to the need for their services and their competency to provide the services".

The Federal Government of Canada has also indicated concern with the present accreditation of all health professions. That occupational therapy as a profession will be included in helping to form Federal Government policy is indicated in a letter of April 21, 1972, from the office of the Deputy Minister of Health to the President of the Canadian Association of Occupational Therapists (C.A.O.T.) in which the Minister explained that he was writing "to seek your advice and comments on means by which accreditation activities in education in the health disciplines and provision of health services may be improved, with a view to achieving national standards, portability of qualifications and credits, and improved services in the public interest".

In July, 1972, the President of the C.A.O.T. indicated that the C.A.O.T. was seriously considering the implications of future Federal intervention in accreditation procedures. The present Basis of Approval of occupational therapy programs

was drawn up jointly by the C.A.O.T. and the Canadian Medical Association about 1959, and is in need of review in any case, thus presenting a timely opportunity for discussion between the Government and the C.A.O.T.

An area of legal concern to occupational therapists can best be introduced by Dr. Friedmann's (57:405) thesis that "it is important for the man morally and legally responsible for the care of the patient to be the man controlling the care". This thesis has been accepted as fact by many therapists; that doctors are legally responsible for all professional actions of the therapist and therefore the therapist is obliged by law to work under medical direction (43). However, consultation with a lawyer* indicated the fallacy of this commonly held belief. In fact, there is no statute, as such, in the United States or Canada, making the physician legally responsible for the actions of an occupational therapist. In case law or common law, "tort law" deals with the responsibility of the individual and civil wrongs. In tort law, the doctrine of respondeat superior relates to the responsibility of a principle for the actions of his agent. However, this responsibility is true only when there is very close control and supervision of the agent by the principle, and in the courts such responsibility is decided on an individual basis. Thus, according to tort law, a physician is responsible for the actions of an occupational therapist only if it can be shown

* Personal communication.

that there has been very close control and supervision of the therapist by the doctor, in practice, an uncommon working relationship. If this very close supervision and control is not present, it is most probable that the therapist himself could be held responsible for his own actions and may be held accountable in a court of law in case of malpractice. According to tort law, Dr. Friedmann's claim that physicians alone are legally responsible for all aspects of patient care must be re-evaluated by therapists and the resulting implications recognized.

SOCIAL INFLUENCES

Throughout the early developmental years of occupational therapy, the professional roles and functions adapted to the changing pressures and needs of society. Some of those pressures were: the two World Wars (39, 43, 154, 182); the 1930 depression years (39, 154); industrialization and urbanization (18, 35, 118); and the increasing financial requirements for public health and welfare programs (84, 118, 154, 171). The later developmental years of occupational therapy were influenced by society re-examining its own needs in terms of the rights of the individual (25, 148, 159, 164, 171); attitudes toward work and leisure (39, 83, 142, 166); and new social-medical responsibilities (25, 146).

The First and Second World Wars produced some similar influences on the development of occupational therapy roles.

The large numbers of wounded servicemen created the impetus for the profession not only to increase its numbers but to increase and develop new skills and techniques for treating both the physically and mentally disabled who were surviving because of improved medical care. Following the acute-treatment post-war periods, large numbers of therapists were no longer required in the military hospitals. They moved out into mental hospitals, general hospitals, and community sheltered workshops where further new roles had to be developed.

Shortly after the First World War, there was an era of economic prosperity and enlightened social conscience. This, combined with the improvement in medical sciences, resulted in the establishing of large institutions to care for the increasing numbers of physically or mentally chronically ill, and further challenged the development of occupational therapy roles.

The depression years of the 1930's were troubled years for the developing profession. Although the number of therapists increased, budgets were cut and many therapists could not be hired, particularly by small institutions. As a result, many therapists temporarily volunteered their services to larger institutions in order to prove their value as potential employees. After the depression, therapists were established mainly in large mental institutions, sanitoriums, and general hospitals.

The Second World War casualties again encouraged therapists to re-evaluate their roles and develop new

methods and techniques of treatment. By the end of the war they found themselves in a new role; no longer were they the sole activity generalists, but instead, one of many ancillary therapists specializing in the area of physical medicine under the direction of a new medical specialist, the Physiatrist. As a result of war influences, the therapist's role had become narrow and controlled; she now treated a part of the patient's body and provided a part of his activity needs, thereby relinquishing both part of the patient to others and much of her previous service to him as a human being.

Industrialization and urbanization, and the concomitant rising cost of medical care, resulted in the clustering of major medical facilities in the larger metropolitan areas. Large specialty institutions, such as rehabilitation hospitals, were developed, and therapists developed new specialty roles to fit the needs of the institutions. According to Mosey (118), these large institutions came into being in reaction to a breakdown in established social institutions such as the family, the school, and organized medicine. The new urban mobile family could no longer provide custodial care to aged or disabled family members; the educational system was not oriented to managing or teaching the handicapped child; and organized medicine's primary concern was the specialist's treatment of acute illness. As a result, the individual therapist's role grew, and he flourished as a specialist in whatever new situation he found himself.

Concern with the rising costs of health and welfare

services was also responsible for changes in health care services and delivery, both influencing role development. The rehabilitation movement, of which occupational therapy is and was a part, was encouraged in its development by insurance carriers, governments, and private agencies for largely financial reasons. New drugs and surgical techniques were saving lives but producing disabled individuals who had to be financially supported, often by the public. It was observed that if the handicapped could be rehabilitated, many of them could be removed from public maintenance programs and become independent, contributing members of society. Agencies such as the Workman's Compensation Board found it economically to their advantage, even as early as the 1920's, to establish rehabilitation centres in order to get the injured workman back on the job as quickly as possible and off compensation. These new developments opened other areas in which therapists developed new roles and techniques.

To a large extent financial considerations were responsible for the development of delivery systems such as day-care hospitals and community health programs, all new areas of occupational therapy involvement. Although there were other factors contributing to the changes in health care delivery, in economic terms the changes were considered a good social investment which would help to break into the poverty-sickness cycle and decrease the potential financial costs to society.

The financial factor has not been the only consideration as to why society is encouraging and supporting changes in

health care delivery. A more recent phenomenon is that of increased social awareness of the health and social needs of the individual, regardless of his ability to pay, and an increased social re-evaluation and acceptance of new medical problems and social ethics. For example, society has now accepted as a medical responsibility such problems as drug addiction and alcoholism, both previously considered legal responsibilities. As a result, occupational therapists (146) are attempting to develop new therapy practices to assist with the problems of heroin detoxification. Therefore, occupational therapy, having become involved in new community programs, is now concerned with the health need of the individual as a social being, a situation reminiscent of the moral treatment era.

Another social influence is the present examination of work and the work ethic in contemporary society. Diazo (39) pointed out that technological advances are having a marked effect on society and have implications for all occupational therapists, particularly those working in the areas of vocational rehabilitation. It now takes a considerable length of time to acquire marketable work skills, and even then they quickly become obsolete; there are pressures for earlier retirement from work and an increase in leisure time even for those who are working. According to Diazo, by 1980, the half of the population under twenty-five years of age and twenty percent of the population over retirement age will all be consumers, not producers, in society. Martin (108:26) has presented occupational therapists with some

guidelines for working with patients or clients in the light of technological advances:

> If we set our goals correctly, automation and any other advances will fall into perspective. . . . The most important of these goals are enhancement of motivation, individuality and creative use of leisure time. The handicapped will then fit in the community be it at the level of open employment or leading a satisfactory existence within his capabilities.

These changes have encouraged society to re-evaluate the old traditional values of achievement through work. Particularly concerned with the work values are the younger members of society who feel that "tools and machines man uses are no more, and not meant to be more, than extensions of his personality; and that with these tools man should only reach beyond the range of his limitations to serve human values" (142:9). The question put forth is whether occupational therapy can keep in tune with such changes in social thinking which will continue to change in the future. To date, these social influences have had "profound implications for the kinds of services occupational therapists provide for patients or clients because of the close relationship with patterns of work, leisure, and various role-related and developmental activities that define occupational therapy practice" (39:238).

MEDICAL INFLUENCES

As a health profession closely allied to medicine,

occupational therapy could not remain untouched by developments and changes within the practice of medicine. One change occurred in the 1940's when emphasis on medical specializing produced a new role within the medical profession itself. The increasing number of patients with physical disabilities and increased skills required to treat them produced the physiatrist, or specialist in physical medicine and rehabilitation. This new specialist depended to a great extent on the support of various kinds of therapists to carry out his directions for treatment of the patient. The physiatrist was the back-bone of the rehabilitation movement and therapists, including the occupational therapist, were, and are, the back-bone of this medical specialty.

A review of the literature has indicated three further major areas of change in medical practice which have influenced parallel changes in the practice of occupational therapy: 1) changes and developments in the scientific practice of medicine; 2) changes and developments in the philosophical practice of medicine; and 3) changes in methods of health care delivery.

According to Spackman (154), a number of scientific advances in medicine following the First and Second World Wars stimulated the development of new occupational therapy roles and practices. For example, the discovery of a vaccine for poliomyelitis in 1955 resulted in an almost complete drop-off in the number of acute polio patients requiring treatment. Prior to this major scientific discovery, the most common form of treatment involved surgical procedures

followed by a prolonged 'rehabilitation' period. Within ten years of the cessation of polio epidemics, few working therapists ever saw an acute polio patient. The medical discovery of antibiotics in the 1930's and 40's also affected the development of occupational therapy. The use of antibiotics resulted in an increase in the life-span of the general population and an increase in treatment and care required for both the well and chronically-ill aged. Antibiotics and improved surgical techniques also produced major problems which had not previously been in evidence to any extent. They saved lives which might previously have been lost, and what was left was often maimed bodies and minds of quadraplegics, paraplegics, severe stroke patients, and cerebral palsied children, most of whom are now a treatment responsibility of the occupational therapist. The increase in the production of new medical-pharmaceutical products produced the infamous thalidomide tragedies which occupational therapists are attempting to treat. Insulin saved lives but resulted in more amputees for the therapist to treat. Medical-technical developments such as home dialysis units for renal patients have moved therapists from the institution into the patients' home (88).

The development of large numbers of drugs used to treat mental illnesses has resulted in both a greater number of treatable psychiatric patients for the occupational therapist and a need for the therapist to develop improved methods of treatment in collaboration with an increasing number of other types of treatment personnel. Reilly (133) pointed out

studies on sensory deprivation which indicate the need of an efficiently functioning mind for constant environmental stimuli, a discovery that both she and Shimeld (142) agree "is a basic need that occupational therapy ought to be serving". Medical scientists' research in neuro-physiology and the psychologists' research into learning have resulted in a new function for occupational therapists treating perceptual motor dysfunction and learning disabilities. These are only a few of the obvious scientific advances in the practice of medicine which have had great influences on the growing and developing roles within the practice of occupational therapy. From these examples, it would appear that occupational therapy developed to a large extent as a solution to the many new and different problems arising from scientific advances in the practice of medicine.

The changes and developments in the philosophical practice of medicine have also had considerable influence on the practice of occupational therapy. The two words, "prevention" and "community" might be considered the central core of concern in new medical philosophy. According to the report of the 1965 Royal Commission on Health Services, "prevention in the form of physical and mental fitness is gradually evolving as a responsibility of the health services . . . " (25:11). It also reported that with new emphasis on home care and community care "the objectives of modern general practice . . . seem to merge gradually with those of social medicine, preventative medicine, and the newly emerging concept of what traditionally has been referred to as public health" (25:13).

Zamir (185:193) pointed out that one significant concept in the new philosophy as it influences occupational therapy is "health professions ceasing to be medical professions devoted to treating patients in institutions, but rather . . . expanding to health services to members of the community in a variety of social, educational, and professional settings". Wiemer and West do not see this prevention and community-oriented model of practice as either a substitute or replacement for the traditional medical model. Instead, they see it as "an extension of occupational therapists' traditional role consistent with parallel extensions of traditional roles of medicine and contemporary with consumer needs as they are now identified" (178:327). It is pointed out that despite the fact that medical specialists such as pediatrics and psychistry are already moving in the direction of the community and prevention, physicians, as yet, are not unanimous in the desire to implement these approaches to medical care. However, many therapists are moving with the medical innovators into the areas of community and prevention. Therapists who may feel that this new model does not concern them might well consider McWhinney's (106) admonition to medical students that if they fail to meet the demonstrated needs of the public, society will find a way of meeting the need by turning to practitioners outside of medicine.

The third influence in medicine which has affected role development in occupational therapy is that of health care delivery. As early as 1964, the Canadian Association of Occupational Therapists became concerned that changing patterns

of patient care were changing the role of the occupational therapist (105). Traditional health care has been concerned with large, short-stay, acute-care general medical or surgical institutions and large, long-term chronic-care psychiatric institutions (35). There are at least three apparent reasons for the change in emphasis from this traditional method to newer methods of health care delivery. Two have been mentioned, namely, the change and advances in medical sciences and technology, and the change in the philosophy of the practice of medicine. The third reason for the change in emphasis involves financial costs of health services. According to Nixon (123:190), the new health insurance plans or socialized medicine "dramatize and exacerbate the inadequacies of the existing delivery systems and its painful shortages of manpower and facilities". It became obvious that for financial reasons not everyone needing medical treatment could, or should, be admitted to acute care hospitals or even emergency departments or out-patient clinics. The less costly solution appeared to be that of taking the services to the people where they lived (178).

A number of methods of implementing the required new health care delivery systems have been suggested and tried. The most common method involves a central medical centre surrounded by "outreach" clinics and services not considered to be a part of acute care facilities (59, 35, 178). Satellite clinics, neighbourhood service centres, group and family practice centres, nursing homes, and home care teams are new health care delivery areas in which the modern

occupational therapist is finding a role.

Occupational therapy, in line with the new realities of medical care programs and health care delivery systems, is moving away from a sole concern with institutionalized medicine. In order to do so, occupational therapy has had to develop new roles to keep its services viable. Some therapists have rejected these roles, believing that occupational therapy is moving away from medicine while other therapists express enthusiasm at the role developments, understanding that occupational therapy is moving with medicine into the community.

Wiemer and West demonstrate a profound understanding of and respect for the many experienced therapists who are finding the new, developing roles of the occupational therapist hard to accept. The new definition of occupational therapy implies a professional scope for which neither their education nor experience have prepared them. The emphasis on health, prevention, and community roles are undoubtedly foreign concepts to many of these experienced therapists. However, . . . it is in relationship to other medical and health related professions and their evolving roles in the health partnership that occupational therapists will mark out the boundaries of their true purpose and confirm the wisdom of the traditional, newer, or as-yet-unwritten definition of occupational therapy" (178:324).

EDUCATIONAL NEEDS

Legislative, social, and medical factors have influenced the role development of the occupational therapist in such a way as to result in the emergence of specialty roles such as consultant, educator, and researcher. They have also had an influence on directing the clinician back into the community and have decreased the emphasis on the medical model of practice. The educational programs are responsible for preparing therapists to function within these new roles and functional settings. A brief examination of the 1970 - 1971 educational programs in Canada will give some indication as to whether or not these programs are fulfilling the educational needs of future occupational therapists.

Traditional Clinical Requirements

An examination of the 1970 - 1971 university calendars would indicate that all eight university programs are teaching clinical therapeutic techniques appropriate to the traditional role definition of the occupational therapist (see Table 1).

New Role Requirements

An examination of the new, developing roles indicate new areas of learning which are necessary to prepare therapists to fulfill the requirements of these new roles. These areas of learning include community and preventative occupational therapy skills and the effect of environmental influences on the practice of occupational therapy; research methodology and/or statistics; teaching methods; learning theory; techniques of consultation; and increased emphasis

TABLE 1

EDUCATIONAL PROGRAM CONTENT
RELATED TO ROLE REQUIREMENTS

	New Occupational Therapy Roles Requirements*					Old Role Requirements*
University	Community, Prevention, Environment	Research and/or Statistics	Teaching Methods	Learning Theory	Techniques of Consultation	Clinical Therapeutic Techniques
Alberta	no	yes	no	yes	no	yes
British Columbia	no	no	no	yes	no	yes
Laval	no	no	no	yes	no	yes
Manitoba	no	no	yes	yes	no	yes
McGill	no	no	no	yes	no	yes
Montreal	no	yes	yes	yes	no	yes
Queen's	no	yes	no	yes	no	yes
Toronto	no	no	yes	yes	no	yes

* All information taken from official 1970-1971 university calendars.

in the area of the social sciences.

1. Community, Prevention, and Environment:

In 1970 - 1971, no Canadian educational programs indicated any emphasis on teaching students skills specifically related to community or preventative occupational therapy or the effects of environmental stress on the practice of occupational therapy (see Table 1).

2. Research Methodology and/or Statistics:

In 1970 - 1971, only three of the eight professional programs in Canada indicated that the teaching of statistics and/or research methodology was part of the curricula (see Table 1).

3. Learning Theory:

In 1970 - 1971, all eight university programs indicated that their curricula included at least one course involving the teaching of learning theory (see Table 1). The majority of these courses were given by the psychology faculty.

4. Teaching Methods:

In 1970 - 1971, only three of eight programs indicated that they included teaching methods in their undergraduate curricula (see Table 1).

5. Techniques of Consultation:

In 1970 - 1971, no educational programs indicated the teaching of techniques of consultation to their occupational therapy students (see Table 1).

6. Emphasis on Social Sciences:

In 1970 - 1971, the percentage of hours in the

TABLE 2

SOCIAL SCIENCE HOURS IN
OCCUPATIONAL THERAPY CURRICULA

University	Total Number of Curriculum Hours[c]	Number and Percentage of Social Science Hours	
Laval[a]	3024	0	(0%)
Toronto[b]	2639	103	(4%)
British Columbia[ab]	2270	144	(6%)
Queen's[a]	2731	270	(9%)
Manitoba[a]	2910	330	(11%)
Montreal	1568	240	(15%)
Alberta[a]	2795	429	(15%)
McGill[a]	2538	450	(17%)

a Options available which could be in social sciences.

b Combined physical-occupational therapy programs.

c All numbers are approximate as credit hours vary slightly.

social sciences as compared to the total curriculum hours during the school year varied from zero percent to seventeen percent (see Table 2).

It would appear that the Canadian educational programs are filling the needs of the traditional occupational therapist. However, the majority of the programs are doing very little, if anything, to fill the new and developing needs of the contemporary therapist. An experimental occupational therapy program* initiated in 1971 appears to be making a greater attempt than the traditional programs to fill the new needs of the therapist. Its 1971 - 1972 calendar indicated the following:

a) Twenty-four percent of its curriculum was devoted to social science content.

b) Emphasis is placed on community, preventive, and environmental occupational therapy.

c) Both teaching methods and learning theory were included in the curriculum.

d) Research statistics and methodology were included in the curriculum.

e) The teaching of traditional therapeutic techniques has been partially replaced by the teaching of occupational role and behaviour analysis and the social, psychological, and kinetic analysis of activity.

* Program in Occupational Therapy, the University of Western Ontario, London, Canada.

The present plan of the experimental program is to revise its curriculum as necessary in its attempt to fill the educational needs of therapists who will be carrying out the new and changing roles of the occupational therapist as demanded by social, medical, and legislative factors.

Although new roles for the occupational therapist have been developed by a minority of individual therapists, it would appear that these individuals have reacted, to a great extent, to factors outside of the profession even more than to internal influences. Social, legislative, and medical influences have indicated the need for change which relatively few therapists and few educational programs have recognized. It would appear that the profession will remain viable only so long as it recognizes and reacts to the changing needs and requirements of society and the profession.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

In both the United States and Canada there has been considerable concern expressed over the changing role of the occupational therapist. There is presently no consensus within the profession as to the appropriateness or legitimacy of the roles as they appear to have developed. Both therapists and non-therapists have expressed the need to examine and re-evaluate the roles, responsibilities, and educational programs for occupational therapists.

SUMMARY

The purposes of this study were to describe the role development of the occupational therapist, and to identify some of the factors which have influenced and directed the role changes.

An examination of the literature indicated that both generalist and specialist roles of the occupational therapist have evolved or developed in response to changing needs within society. It has been shown that social, legislative, medical, and educational factors, and the evolutionary changes of these factors to meet new social conditions and needs, have strongly influenced the legitimate role changes of the occupational therapist.

It was assumed that if these role changes and their

influencing factors could be identified, this study would then be of value to both the profession and the educators of therapists. Such an identification could assist them 1) to identify and evaluate trends influencing the role development; 2) to identify some areas in need of immediate research; and 3) to give some temporary guidelines as to changes that may be required in the profession if it is to remain viable.

OBSERVATIONS AND RECOMMENDATIONS

An analysis of the review of the literature on the changing role of the occupational therapist has resulted in observations and recommendations which have implications for both the professions and the educators of the professionals. These will be discussed under three headings: 1) role development; 2) research needs; and 3) educational needs.

Role Development

Observation 1:

Within the medical model of practice, the physiatrist is only one of the many medical specialists with whom the occupational therapist can work. There is no evidence indicating any valid reason why therapists must work under the direction of a physiatrist rather than with him except that it has been tradition to do so. It is to the physiatrists' advantage to stress this tradition as it supports them in their own role conflict situation.

Recommendation:

a) That therapists who submissively support this tradition, inhibiting their own professional development and that of the profession as a whole, examine their attitudes and seriously consider the necessity of supporting not only therapists, but the many physicians, official medical associations, and governments who support official recognition of occupational therapy as an independent profession. Attempts by tradition-bound therapists to inhibit the profession in its attempts to acquire independence from the medical profession can only be a result of a misunderstanding of the true situation.

b) That therapists must become more aware that the medical model of practice is only one of several models in which the occupational therapist can now function. Although the medical model is not obsolete as an area of practice, therapists can help enhance their image by acknowledging the fact that they have chosen to work as professional equals in this area of practice rather than in another available area of practice.

Observation 2:

Occupational therapy is an eclectic profession, taking knowledge from many fields and disciplines to develop new areas and theories of therapeutic treatment. Although some therapists are disturbed because occupational therapy does not appear to have a distinctive and unique body of knowledge, it must be noted that no developing profession today has a unique basis for its existence. To develop and grow, each must learn from the theory of other disciplines.

Recommendation:

Since occupational therapy, as an eclectic profession, is well suited to grow and to develop its own roles by drawing on knowledge of many other, more established disciplines, therefore occupational therapists must become more aware of developments in fields other than medicine if they are to grow as professionals and develop their legitimate roles.

Observation 3:

Changes in institutional administration are necessary if the profession is to develop fully.

Recommendation:

That once Chiefs of Occupational Therapy Services expect to be, and are, responsible to institution administrators, the Chiefs should be responsible for encouraging professional development of therapists. In this way the problem of achieved roles outrunning ascribed roles could be overcome.

Observation 4:

Sex-role stereotyping of the occupational therapist has been largely the responsibility of the profession itself, and it will be up to the profession to change this attitude, both within and out of the profession.

Recommendation:

That as therapists become less submissive and conforming, occupational therapy should be less concerned with the necessity of recruiting males to the profession and more

concerned with recruiting the best individuals, regardless of sex, in order to improve the image of occupational therapy.

Observation 5:

Health care delivery systems are changing. There is little indication that anyone will approach occupational therapy asking for services if he is not aware of the potential services of the therapist.

Recommendation:

That there is a need for occupational therapists to evaluate their own services which could be implemented in community programs, community clinics, and family practice units. It will be a responsibility of the profession to point out to administrators and governments the services therapists have to offer which would help round out health services to their clients.

Observation 6:

The changes in social attitudes towards the importance of work indicates a need for the re-evaluation of therapists' attempts to prepare the severely handicapped to take a vocational place in a society which has accepted a remarkably high rate of unemployment among the non-disabled.

Recommendation:

That the theory behind, and the purpose of, rehabilitation or sheltered workshops and the concomitant role of the occupational therapist, must be re-evaluated. The literature appears to indicate a need for less emphasis on unrealistic

attempts at vocational preparation and more emphasis on leisure and developmental activities.

Observation 7:

Ethnical operation and professional accountability is as true for occupational therapy as for any other profession. Trends indicating that therapists will be moving into the community and into private practice indicate a need for therapists to be aware of professional responsibilities in realation to the law.

Recommendation:

That one indication of professional acceptance of this responsibility might be the willingness of the professional association at the national level to support a group malpractice insurance plan for therapists throughout the country.

Research Needs

Observation 8:

At present all curriculum revisions, and they are made all too infrequently, can be based only on an experimental and empirical basis which cannot be considered a solid foundation for the building of a developing profession.

This study has indicated two major professional areas requiring immediate research. The first is in the area of establishing a theoretical basis for occupational therapy. Once this has been established, the second area of research must be carried out, that of curriculum development for

occupational therapy programs. Until a theoretical basis has been established, there will be no means of establishing, even theoretically, what content, or how much of what content, should be included in any occupational therapy curriculum.

Recommendation:

a) That university programs and faculty co-ordinate their efforts to do basic and applied research in occupational therapy.

b) That the primary emphasis in research be the establishing of a theoretical basis for occupational therapy followed by research into curriculum development.

Observation 9:

Most therapists are not qualified or capable of carrying out valid research which is the life-blood of a developing profession. Both the lack of professional research and the lack of opportunity for therapists to learn how to do research would indicate that the educational programs have been for too long followers of, rather than leaders in, professional development.

Recommendation:

a) That educational programs must consider ways and means of including research methodology and statistics in their curricula as soon as possible.

b) That faculty members of university programs have a responsibility to do research that will assist in both their own development and the development of the profession.

c) That further opportunity for professional research be

established in the development of graduate programs at the Masters level in occupational therapy in Canada. These programs will not be established until the present programs are upgraded to honours level standing within the universities.

Educational Needs

Observation 10:

Although it has been established that the occupational therapist is an educator however he functions, at present the education of the therapist as an educator appears to be inadequate.

Recommendation:

That teaching methods and skills as well as principles of learning be incorporated in all undergraduate programs.

Observation 11:

The present shortage of potential occupational therapy faculty is exacerbated by the attitudes of experienced therapists who feel that they do not know how to teach and therefore have no interest in teaching.

Recommendation:

That students at the undergraduate level become more aware of the fact that, while carrying out any function as a therapist, she will be fulfilling the role of an educator, or teacher. If this concept were emphasized by educators, more therapists might be willing to consider the role of educator as a logical area of occupational therapy specialization.

Observation 12:

Of the two Diploma teaching courses functioning in 1970 - 1971, one had obligatory courses for students within the Faculty of Education while the other appeared to have a learn-by-doing orientation.

Recommendation:

That post-graduate programs in occupational therapy have closer ties to university education and/or adult education departments so that the experienced therapists may have access to the learning opportunities necessary for capable and confident teaching.

Observation 13:

Accreditation procedures for educational programs are now best carried out under the direction of the national administrative body for occupational therapists.

Recommendation:

That an accreditation advisory body should be composed mainly of therapists, but with representation from other health professions and the community.

Observation 14:

As the therapist's roles expand, the number of therapists required to fill these new roles is increasing. There presently appears to be no adequate system for educating the numbers of highly qualified therapists that are required to fill the role of consultant. The skills of the consultant require a specialized breadth of knowledge. Few skills

required by the consultant are being taught in the traditional educational programs.

Recommendation:

That students be prepared at the undergraduate level to participate to a greater extent as potential consultants. As a consultant, one therapist could provide a service to several facilities instead of to one. With a background of theoretical knowledge, experience, and skills in education and consultancy, the therapist could teach many other non-professionals to carry out part of the services that the therapist would previously have attempted to do alone.

Observation 15:

Schools and educational programs have encouraged sex-role stereotyping in the past. A number of programs have made it known that they do not have facilities for male students and most have emphasized the teaching of therapeutic activities which themselves were considering to be stereotyped, female occupations.

Recommendation:

That educators seriously consider the possibility that they may be attempting to produce therapists in their own image, thus inadvertently encouraging the sex-role stereotyped image so common to the profession.

Observation 16:

There is a need for more emphasis on the behavioural sciences and less on the physical sciences for future health

science practitioners.

Recommendation:

That an assumption be made that there are no longer valid reasons why a therapist must wait for an opportunity to carry out postgraduate work in the social sciences in order to fill a basic need he has found in his professional experience.

Observation 17:

The continually raised question of the need for professional programs to assign hundreds of hours to the teaching of arts and crafts skills must raise serious doubts in the minds of the educators. To continue to emphasize the need for students to learn how to skillfully construct products from beginning to end reinforces the role of the therapist as a technician rather than a professional. A non-arts-and-crafts trend has been emphasized in the literature, but to date only the experimental course has implemented theoretical and practical kinetic-analysis in its curriculum in place of the emphasis on teaching expertise in specific craft skills.

Recommendation:

That to educate the student in the principles of social, psychological, and kinetic analysis would appear to be a sound policy which would better prepare the student to focus on the needs of the patient or client. It would also free hundreds of curriculum hours which could be used to incorporate previously indicated new content requirements.

Observation 18:

There are both legislative and social indications that the future emphasis in the health sciences will include prevention, community services, and the education of competent general practitioners.

Recommendation:

That occupational therapy examine and re-define its role and function in the community and adapt its educational programs to prepare more students to be competent in the growing community service programs. If this self-examination does not take place, someone else will do it and find occupational therapy lacking in competencies to join with the other medical or health professions in community health services.

CONCLUSIONS

The roles of the occupational therapist are changing in response to legislative, social, and medical influences. Although the clinician, or generalist, is acknowledged to be the backbone of the profession, it has been found that specialist roles, such as educator, researcher, and consultant, are becoming more prevalent. These specialist roles have developed in response to social and professional needs which cannot be filled by the present inadequate numbers of clinicians.

It has also been found, particularly in Canada, that

professional programs have not adequately educated therapists to fill these new roles. The administrators and faculty of educational programs appear to be reticent in introducing changes in their curricula which, reflecting present and future trends, might better prepare the future therapists to fill the new and developing roles. Of the eight programs in Canada in 1970 - 1971, none contained content related to community, prevention, or the environment. Only three programs include statistics and/or research methods, three include content on teaching methods, and none include any content on techniques of consultation. On the other hand, all eight spend hundreds of hours teaching specific "therapeutic techniques", or craft skills which, according to the literature, are becoming obsolete modalities of treatment for occupational therapists.

It becomes increasingly evident that the profession, the individual therapist, and particularly the educators, must re-examine their roles in the light of the new legislative, medical, and social trends in society. Professional and educational changes must take place soon if occupational therapy is to remain a viable health profession.

SELECTED BIBLIOGRAPHY

1. Ainsley, J.; Barnes, S.; Grove, E.; Johnson, T.; Koorman, C.; and Stephens, C. "On Change," American Journal of Occupational Therapy, 23:186-189 (1968).

2. Aitken, A.N. "Rehabilitation Therapy in a Sanitorium," American Journal of Occupational Therapy, 1:10-17 (1947).

3. American Occupational Therapy Association. Descriptions of Function in Occupational Therapy, New York: The American Occupational Therapy Association, 1969.

4. American Occupational Therapy Association. Professional Reactivation in Occupational Therapy, Dubuque, Iowa: Kendall-Hunt Publishing Company, 1969.

5. American Occupational Therapy Association. "Occupational Therapy: Its Definition and Functions," American Journal of Occupational Therapy, 26:204-205 (1972).

6. Andrews, W. "Occupational Therapy Programmes and the Psychiatrist," Canadian Journal of Occupational Therapy, 32:119-120 (1965).

7. Angus, L. R. "Some Newer Methods in Occupational Therapy as Practiced at the Neuro-Psychiatric Institute of the Hartford Retreat," Canadian Journal of Occupational Therapy, 1:9-16 (1933).

8. Aranoff, P. "Occupational Therapy and Child Psychiatry," Canadian Journal of Occupational Therapy, 34:5 (1967).

9. Arkansas Rehabilitation Research & Training Center. "Community Involvement," in Report of Current and Future Trends in Rehabilitation as They Affect Occupational Therapy in Rehabilitation, Arkansas, p.70 (February, 1967).

10. Baker, F.; O'Brian, G.M.; and Sheldon, A. "Reference Groups of Occupational Therapists: Role Orientation in a Mental Hospital," American Journal of Occupational Therapy, 22:197-202 (1968).

11. Bannister, H.F. "Legislative Changes and Their Implications," Report of Current and Future Trends in Rehabilitation as They Affect Occupational Therapy in Rehabilitation, Hot Springs National Park, Arkansas, pp.13-19 (February, 1967).

12. Barager, C.A. "Occupational Therapy as Seen by a Psychiatrist," Canadian Journal of Occupational Therapy, 2:3-9 (1934).

13. Bayne, J. "The Role of Occupational Therapy in Sheltered Workshops," Canadian Journal of Occupational Therapy, 37:108-112 (1970).

14. Bernd, Joan. "The Challenge of Rehabilitation Workshops," Canadian Journal of Occupational Therapy, 34:151 (1967).

15. Berteling, Mary K. "Occupational Therapy at Walter Reed General Hospital," Canadian Journal of Occupational Therapy, 12:4 (1945).

16. Bickle, Mildred, R. "The Hamilton Workshop," Canadian Journal of Occupational Therapy, 7:81 (1940).

17. Biddle, B. and Thomas, E. Role Theory: Concepts and Research. New York: John Wiley & Sons, Inc. 1966.

18. Bockoven, J.S. "Challenge of New Clinical Approaches," American Journal of Occupational Therapy, 22:23-25 (1968).

19. _____. "Legacy of Moral Treatment - 1800's to 1910," American Journal of Occupational Therapy, 25:223-225 (1971).

20. Brackett, E.G. "Scope of Occupational Therapy," Archives of Occupational Therapy, 1:(1922).

21. Brown, Lawrie. "Rehabilitation Foundation for the Disabled," Canadian Journal of Occupational Therapy, 31:19-21 (1964).

22. Brunyate, Ruth. "Powerful Levers," American Journal of Occupational Therapy, 12:195 (1958).

23. Burk, Richard D. "General Trends in Rehabilitation Centres," Report of Current and Future Trends in Rehabilitation as They Affect Occupational Therapy in Rehabilitation, Hot Springs National Park, Arkansas, pp.4-7 (February, 1967).

24. Burnette, Norman L. "The Status of Occupational Therapy in Canada," Archives of Occupational Therapy, 2:179-182 (1922).

25. Canada. Emerging Patterns in Health Care, edited by Robert Kohn, Royal Commission on Health Services, Ottawa: Queen's Printer, pp.3-68 (1965).

26. _____. Canadian Census Classification, Professional and Technical Occupations, Ottawa: Queen's Printer, 1961 (revised, 1967).

27. Cardwell, Thelma. "President's Address," Canadian Journal of Occupational Therapy, 33:139 (1966).

28. Carpendale, M.T.F. "Does Rehabilitation Work?," Canadian Journal of Occupational Therapy, 32:132 (1965).

29. Catterton, Marianne M. "Dimensions of Occupational Therapy," Canadian Journal of Occupational Therapy, 32:153-164 (1965).

30. Charters, A.N. "Continuing Education in the Professions," Handbook of Adult Education, New York: The MacMillan Company, pp.490-491 (1970).

31. Colbert, James N. "Philosphia Habilatus," Journal of Rehabilitation, pp.18-19 (Sept.-Oct. 1969).

32. Conte, W.R. and Meuli, A.L. "Occupational Therapy in Community Mental Health," American Journal of Occupational Therapy, 20:147-150 (1966).

33. Crampton, M.W. "Educational Upheaval for Occupational Therapy Assistants," American Journal of Occupational Therapy, 21:317-320 (1967).

34. Cromwell, Florence S. "Occupational Therapist - Observer or Evaluator?," Canadian Journal of Occupational Therapy, 33:63 (1966).

35. _____. "Trends in Occupational Therapy," Proceedings of Workshop for Improvement of Educational Techniques of Occupational Therapy Clinical Supervising Personnel, University of North Dakota, Grand Forks, N.D., pp. 17-21 (January, 1971).

36. Cross, D.S. "Colour Preference of Older Patients," Canadian Journal of Occupational Therapy, 27:9-11 (1960).

37. Dancey, Freda K. "Have You an Idea?," Canadian Journal of Occupational Therapy, 31:51 (1964).

38. De La Charite, Sister Jean. "The Neglected Phase of Rehabilitation," Canadian Journal of Occupational Therapy, 29:101 (1962).

39. Diasio, Karen. "The Modern Era - 1960 to 1970," American Journal of Occupational Therapy, 25:237-242 (1971).

40. Dilly, H. "Changing Patterns of Health Care Services," American Journal of Occupational Therapy, 24:403-408 (1970).

41. Driver, Muriel F. "A Philosophic View of the History of Occupational Therapy in Canada," Canadian Journal of Occupational Therapy, 35:53-60 (1968).

42. _____. "Seek we Status or Stature," Canadian Journal of Occupational Therapy, 34:57 (1967).

43. Dunlop, W.J. "A Brief History of Occupational Therapy," Canadian Journal of Occupational Therapy, 1:6 (1933).

44. _____. "The Occupational Therapist as a Teacher," Canadian Journal of Occupational Therapy, 2:11-12 (1934).

45. _____.; LeVesconte, H.P.; de Brisay, A.; et al. "Report of Committee on Education," Canadian Journal of Occupational Therapy, 7:82 (1940).

46. Ebner, J.; King, L.; Monical, B.; Monkhouse, E.; Schlorff, V.; and Wallace, L. "A Statement on Occupational Therapy and Physical Therapy in Community Health," American Journal of Occupational Therapy, 24:46-47 (1970).

47. Erhardt, R.P. "The Occupational Therapist as a School Consultant for Perceptual-Motor Programming," American Journal of Occupational Therapy, 35:411-414 (1972).

48. Ernest, Marilyn. "Occupational Therapy Study on Treatment in Groups," Canadian Journal of Occupational Therapy, 33:148-150 (1966).

49. _____. "Continuing Education and Occupational Therapy," Canadian Journal of Occupational Therapy, 37:69-70,76 (1970).

50. Farrar, C.B. "Rehabilitation in Nervous and Mental Cases Among Ex-Soldiers," Canadian Journal of Occupational Therapy, 7:25 (1940).

51. Fidler, Gail S. "A Guide to Planning," American Journal of Occupational Therapy, 18:240-243 (1964).

52. _____. "Learning as a Growth Process," American Journal of Occupational Therapy, 20:1-8 (1966).

53. Fidler, N.D. "Occupational Therapy from the Nursing Standpoint," Canadian Journal of Occupational Therapy, 2:114-117 (1935).

54. Fields, B. "What is Realism in Occupational Therapy?," American Journal of Occupational Therapy, 10:9-10,34 (1956).

55. Fisher, Lawrence. "Upheaval in Education," American Journal of Occupational Therapy, 21:362-367 (1967).

56. Friedland, J. and Murphy, Marge. "A Group Approach in Psychiatric O.T.," Canadian Journal of Occupational Therapy, 32:110 (1965).

57. Friedmann, Lawrence W. "Medicine, Nursing,and Physical Therapy," Archives of Physical Medicine and Rehabilitation, pp.404-406 (Sept., 1971).

58. Gallagher, James. "Cooperation for Service," Journal of Rehabilitation, p.29 (Mar.-Apr., 1969).

59. Garfield, S. "The Delivery of Medical Care," Scientific American, Vol. 222, No. 4, pp.15-23 (1970).

60. Gaylard, Anne. "Treatment of Children with Perceptual Problems. An Introduction to the Role of the Occupational Therapist," Canadian Journal of Occupational Therapy, 33:53 (1966).

61. Gibbon, Marion. "History of Occupational Therapy in the Maritimes," Canadian Journal of Occupational Therapy, 7:73 (1940).

62. Gillette, N.P. "Changing Methods in the Treatment of Psychosocial Dysfunction," American Journal of Occupational Therapy, 22:230-233 (1967).

63. Goble, Rita E.A. "The Role of the Occupational Therapist in Disabled Living Research," American Journal of Occupational Therapy, 33:145-152 (1969).

64. Gordon, Beth. "Why Occupational Therapy?," Canadian Journal of Occupational Therapy, 37:141-144 (1970).

65. Gordon, D.W. "The Function of a Consultant," Nursing Outlook, 1:575 (1953).

66. Greenland, Cyril. "What's New? Occupational Therapy in 1883," Canadian Journal of Occupational Therapy, 29:80 (1962).

67. Hall, Herbert J. "American Occupational Therapy Association," Archives of Occupational Therapy, 1:163-165 (1922).

68. Harwood, J.H. and McLaughlin, B. "Nature, Extent and Scope of the Health Needs in North Dakota and Resources Available to Meet These Needs," Proceedings of Workshop for Improvement of Educational Techniques of Occupational Therapy Clinical Supervising Personnel, University of North Dakota, Grand Forks, N.D., pp.10-11 (January, 1967).

69. Haworth, Norah A. and MacDonald, E. Mary. Theory of Occupational Therapy, London: Bailliere, Tindall & Cox, pp.1-5 (1940).

70. Heath, Sheldon. "Uses and Misuses of Psychiatric O.T.: O.T. as a Haven," American Journal of Occupational Therapy, 22:19-22 (1968).

71. Heaton, T.G. "Occupational Therapy for the Tuberculous," Canadian Journal of Occupational Therapy and Physiotherapy, 4:54-61 (1937).

72. Hebert, B.; Beaudoin, J.; Hutchison, J.; and Janelle, C. "Problems Physiques et Psycho-Sociaux des Hemiplegiques Ages," Canadian Journal of Occupational Therapy, 34:113 (1967).

73. Henry, Nelson B., ed. The Dynamics of Instructional Groups, National Society for the Study of Education, Chicago: The University of Chicago Press, pp. 33-34 (1960).

74. Hightower, Mae D. "The Extensions of Occupational Therapy Services into the Community," Report of Current and Future Trends in Rehabilitation as They Affect Occupational Therapy in Rehabilitation, Arkansas, pp. 37-42 (February, 1967).

75. Hood, Margaret, R. "Report on the Fourth International Congress of the World Federation of Occupational Therapists," Canadian Journal of Occupational Therapy, 33:151 (1966).

76. Houle, Cyril O. "The Role of Continuing Education in Current Professional Development," American Library Association Bulletin, 61:263-264 (Mar., 1967).

77. Howe, M. and Dippy, C. "The Role of O.T. in Community Mental Health," American Journal of Occupational Therapy, 22:521-524 (1968).

78. Howland, G.W. "President's Address," Canadian Journal of Occupational Therapy, 1:4-6 (1933).

79. _____. "President's Address," Canadian Journal of Occupational Therapy, 7:60 (1940).

80. _____. "President's Address," Canadian Journal of Occupational Therapy, 11:3 (1944).

81. Huston, J. "Occupational Therapy in the Field of Physical Disabilities," Canadian Journal of Occupational Therapy, 33:101 (1966).

82. Jenson, Inez. "The Occupational Therapist in a Home Care Program," American Journal of Occupational Therapy, 20:288-301 (1966).

83. Johnson, Terry, and Smith, Margaret. "Changing Concepts of Occupational Therapy in a Community Rehabilitation Center," American Journal of Occupational Therapy, 20:267-273 (1966).

84. Jones, Arthur M. "Occupational Therapy in a Day Hospital," Canadian Journal of Occupational Therapy, 27:5 (1960).

85. Kahmann, W.C. "Organization and Administration of Occupational Therapy," Canadian Journal of Occupational Therapy, 3:69-74 (1935).

86. Klorke, Toben. "The Role of Nursing Management in the Behavioural Change of Hemiplegia," Journal of Rehabilitation, p.24 (July-Aug., 1969).

87. Kovell, Joyce. "A Home Care Program," American Journal of Occupational Therapy, 18:255-259 (1964).

88. Lake, Susan. "The Kidney Dialysis Center and the Role of Occupational Therapy," American Journal of Occupational Therapy, 22:269-274 (1968).

89. Laurencelle, P. "An Analysis of the Social and Sociological Implications of Rehabilitation," American Journal of Occupational Therapy, 22:329-331 (1968).

90. Leopold, Robert L. "Consultant and Consultee: An Extraordinary Human Relationship," American Journal of Occupational Therapy, 22:78-81 (1968).

91. Letchworth, Alice. "Committee Report: Registration Committee," American Journal of Occupational Therapy, 1:38 (1947).

92. Le Vesconte, H.P. "The Place of Occupational Therapy in Social Work Planning," Canadian Journal of Occupational Therapy, 2:13-16 (1934).

93. _____; "Expanding Fields in O.T.," Canadian Journal of Occupational Therapy, 3:4-12 (1935).

94. _____. "The American Occupational Therapy Association Celebrates its Thirtieth Birthday during 1947," American Journal of Occupational Therapy, 1:37-52 (1947).

95. Lind, A. "An Exploratory Study of Predictive Factors for Success in the Clinical Affiliation Experience," American Journal of Occupational Therapy, 24:222-226 (1970).

96. Linton, Ralph. The Cultural Background of Personality, New York: Appleton-Century Co., 1945.

97. Llorens, Lela A. "Changing Methods in Treatment in Psychosocial Dysfunction," American Journal of Occupational Therapy, 22:26-29 (1968).

98. Lynes, P.G.; Kingsmill, E.; and Greenland, C. "Remotivation Project," Canadian Journal of Occupational Therapy, 28:5 (1961).

99. MacBain, Patricia. "O.T.'s on Wheels," Canadian Journal of Occupational Therapy, 37:63-68 (1970).

100. McCordick, Lyn. "Education and the Future Role," Canadian Journal of Occupational Therapy, 38:37 (1971).

101. McCreary, J.F. "Address to Canadian Congress of Physical and Occupational Therapists, Vancouver, 1960," Canadian Journal of Occupational Therapy, 27:70 (1960).

102. McDonald, Ladd. "Psychiatric Rehabilitation, Resource in a Revolution," Journal of Rehabilitation, pp.21-23 (July-Aug., 1969).

103. McGhie, B.T. and Myers, E.R. "Occupational Therapy in a Mental Hospital Service," Canadian Journal of Occupational Therapy, 1:11-12 (1933).

104. McLeod, Mary. "Psychiatric Refresher Course - 1963," Canadian Journal of Occupational Therapy, 30:153 (1963).

105. McQueen, Margaret E. "Education Committee Report," Canadian Journal of Occupational Therapy, 31:167 (1964).

106. McWhinney, Ian R. An Introduction to Family Medicine, Preliminary ed. London, Ontario: University of Western Ontario, 1970.

107. Mansfield, N. "The Occupational Therapy Assistants' Course," Canadian Journal of Occupational Therapy, 26:51-54 (1959).

108. Martin, J.K. "How Automation Will Affect the Future Vocational Goals of the Multiply Handicapped Child," Canadian Journal of Occupational Therapy, 34:22-27 (1967).

109. Mase, Darrel J. "The Dimensions of Change," American Journal of Occupational Therapy, 21:129-136 (1967).

110. Master and Servant. Medical Post (Oct., 1969).

111. Mazer, June L. "The Occupational Therapist as Consultant," American Journal of Occupational Therapy, 23:417-421 (1969).

112. Mendoza, Norma. "The Role of an Occupational Therapist in a Home Setting," American Journal of Occupational Therapy, 23:141-144 (1969).

113. Messick, H. Elizabeth. "The Future of Occupational Therapy in the Army," American Journal of Occupational Therapy, 1:26 (1947).

114. Mial, H. Curtis. "What is a Consultant?," Public Relations Journal, (Nov., 1959).

115. Michaels, L. "Rehabilitation in Patients with Strokes. The Role of the Physician," Canadian Journal of Occupational Therapy, 32:18-19 (1965).

116. Minard, Christopher M. "The Occupational Therapist as an Innovator," American Journal of Occupational Therapy, 22:190 - 194 (1968).

117. Moore, Josephine C. "Changing Methods in the Treatment of Physical Dysfunction," American Journal of Occupational Therapy, 21:18-28 (1967).

118. Mosey, Anne Cronin. "Involvement in the Rehabilitation Movement - 1942-1960," American Journal of Occupational Therapy, 25:234-236 (1971).

119. Munroe, A. "Occupational Therapy and the Child with Congenital Deformities of the Upper Extremity," Canadian Journal of Occupational Therapy, 28:71-75 (1961).

120. Nichols, P.J.R. "The Place of Paramedical Personnel in Clinical Research," Annals of Physical Medicine, 10:7 (1969).

121. Nickel, V.L. "The Orthopedic Surgeon and the Occupational Therapist," American Journal of Occupational Therapy, 22:86-88 (1968).

122. Nixon, Russell A. "Rehabilitation - Human Reinforcement in a Troubled World," Journal of Rehabilitation, p.14 (Mar.-Apr., 1969).

123. _____. "The Crisis and Challenge of Human Services in the New Decade," American Journal of Occupational Therapy, 25:187-192 (1971).

124. Overs, Robert P. "Attitudinal Barriers to Using Research Findings," Journal of Rehabilitation, p.22 (Sept.-Oct., 1969).

125. Owen, Carolyn M. "An Analysis of the Philosophy of Occupational Therapy," American Journal of Occupational Therapy, 22:502-505 (1968).

126. Parker, Ardythe, A. "Institute on Child Prosthetics," Canadian Journal of Occupational Therapy, 30:115-116,124 (1963).

127. Peake, Laurence N. "Occupational Therapy, Nursing, and Physical Therapy," Archives of Physical Medicine and Rehabilitation, pp.406-408 (Sept., 1971).

128. Per Mentem et Manus ad Sanitatem, Canadian Journal of Occupational Therapy, 31:4 (1964).

129. Peters, Henry N. "Learning as a Treatment Method in Chronic Schizophrenia," American Journal of Occupational Therapy, 9:185-189 (1955).

130. Pincus, Allen. "New Findings on Learning in Old Age: Implications for Occupational Therapy," American Journal of Occupational Therapy, 22:300-302 (1968).

131. Pochert, Lois. "Our New Role Challenge: The Occupational Therapy Consultant," American Journal of Occupational Therapy, 24:106-110 (1970).

132. Reilly, Mary. "The Role of the Therapist in Protective and Functional Devices," American Journal of Occupational Therapy, 10:132-133 (1956).

133. _____. "Occupational Therapy Can Be One of the Great Ideas of 20th Century Medicine," American Journal of Occupational Therapy, 16:1-9 (1962).

134. _____. "The Challenge of the Future to an Occupational Therapist," American Journal of Occupational Therapy, 20:221-225 (1966).

135. _____. "The Modernization of Occupational Therapy," American Journal of Occupational Therapy, 25:243-246 (1971).

136. Report of the First Student-Faculty Conference on Interprofessional Education, Vancouver, British Columbia: University of British Columbia, p.4 (1968).

137. Rerek, Margaret D. "The Depression Years - 1929-1941," American Journal of Occupational Therapy, 25:231-233 (1971).

138. Richards, L. "Group Therapy in a Rehabilitation Centre," Canadian Journal of Occupational Therapy, 33:141-147 (1966).

139. Roberts, C.A. "Healing the Sick, Responsibility or Privilege, for the Patient or the Professional Therapist," Canadian Journal of Occupational Therapy, 29:5-14 (1962).

140. Rood, Margaret S. "A Program for Paraplegics," American Journal of Occupational Therapy, 1:22-25 (1947).

141. Schoen, K. "A Climate of Expectation," American Journal of Occupational Therapy, 26:119-124 (1972).

142. Shimeld, Arlene. "Youth of Today and Their Influences on the Practice of Occupational Therapy," Canadian Journal of Occupational Therapy, 38:3-13 (1971).

143. Siller, Jerome. "A Summary: On the Delineation of Boundaries of Professional Practice in Rehabilitation," Archives of Physical Medicine and Rehabilitation, pp.410-412 (Sept., 1971).

144. Simard, Therese. "Electromyographie du Membre Superieur," Canadian Journal of Occupational Therapy, 37:55-62 (1970).

145. Slagle, E.C. "Development of Occupations for the Insane," American Journal of Occupational Therapy, 12:196 (1958).

146. Slobetz, F.W. "The Role of Occupational Therapy in Heroin Detoxification," American Journal of Occupational Therapy, 24:340-342 (197).

147. Smith, Hetty V. "Workmen's Compensation Board, Occupational Therapy Workshop," Canadian Journal of Occupational Therapy, 7:26 (1940).

148. Snider, A.J. "Nursing Home Speed Death of Aged Patients, Panel Says," The Vancouver Sun, p.3 (Nov.19, 1970).

149. Sokolov, J. "Working as a Team," American Journal of Occupational Therapy, 9:270-271,296 (1955).

150. Solomon, Alfred P. "Occupational Therapy, A Psychiatric Treatment," American Journal of Occupational Therapy, 1:1 (1947).

151. Sommer, Robert. "A Model Experiment in Occupational Therapy," Canadian Journal of Occupational Therapy, 27:103-104 (1960).

152. _____. "Professionalization and Occupational Therapy," Canadian Journal of Occupational Therapy, 28:25-28 (1961).

153. Spackman, C. "The World Federation of Occupational Therapists: 1952-1967," American Journal of Occupational Therapy, 21:301-309 (1967).

154. _____. "A History of the Practice of Occupational Therapy for Restoration of Physical Function: 1917-1967," American Journal of Occupational Therapy, 22:67-71 (1968).

155. Stacey, Beverley. "Industrial Therapy," Canadian Journal of Occupational Therapy, 30:105-106, 114 (1963).

156. Stevenson, G.H. "Modern Methods in Occupational Therapy in Mental Hospitals," Canadian Journal of Occupational Therapy, 11:7-10 (1944).

157. Sutherland, J. "Suction Socket with an Above-Elbow Amputee," Canadian Journal of Occupational Therapy, 27:75-76 (1960).

158. _____. "Occupational Therapy in the Re-Establishment of the Physically Handicapped," Canadian Journal of Occupational Therapy, 31:143-144 (1964).

159. Szasz, G. Second Interim Report of the Committee on Interprofessional Education in the Health Sciences, Vancouver, British Columbia: University of British Columbia, 1968.

160. Trider, Margaret F. "The Future of Occupational Therapy," Canadian Journal of Occupational Therapy, 39:3-8 (1972).

161. Tuminelly, Carol. "Result of Questionnaire on Medical Students' Concept of Occupational Therapy," Unpublished student paper, University of North Dakota, Grand Forks, pp.1-6 (1969).

162. United States Department of Health, Education and Welfare. "Teacher Influence, Pupil Attitudes and Achievement," by Ned A. Flanders. Cooperative Research Monograph, No. 12, Washington, D.C.: Government Printing Office, p.6 (1965).

163. Verner, Coolie and Booth, Alan. Adult Education, The Center for Applied Research in Education, Inc., New York, pp.22-23 (1964).

164. Vineberg, Shalom. "Rehabilitation: A Means to What End?," Report of Current and Future Trends in Rehabilitation as They Affect Occupational Therapy in Rehabilitation, Hot Springs National Park, Arkansas, pp.32-34 (February, 1967).

165. Wallace, La Verna. "Educational Functions of Occupational Therapy in a Multi-Disciplinary, University-Based Home Care Program," American Journal of Occupational Therapy, 20:286-287 (1966).

166. War Experiment Now Ranks as a Profession. Winnipeg Evening Tribune, July 14, 1923.

167. "War Therapy: Occupational Hints for Submarine Crews." Canadian Journal of Occupational Therapy, 7:46 (1940).

168. Watanabe, Sandra Gold. "The Developing Role of Occupational Therapy in a Psychiatric Home Service," American Journal of Occupational Therapy, 21:353-356 (1967).

169. Welles, Carlotta. "Administration," American Journal of Occupational Therapy, 16:72-73 (1962).

170. _____. "The Implications of Liability; Guidelines for Professional Practice," American Journal of Occupational Therapy, 23:18-26 (1969).

171. West, W. "The Occupational Therapist's Changing Responsibility to the Community," American Journal of Occupational Therapy, 21:312-316 (1967).

172. _____. "Professional Responsibility in Times of Change," American Journal of Occupational Therapy, 22:9-15 (1968).

173. _____. "Statement to the Committee on Health Manpower," American Journal of Occupational Therapy, 22:89-93 (1968).

174. _____. "The Growing Importance of Prevention," American Journal of Occupational Therapy, 23:226-231 (1969).

175. West, W. and McNary, H. "A Study of the Present and Potential Role of Occupational Therapy in Rehabilitation," American Journal of Occupational Therapy, 10:103 (1956).

176. _____. "The Present and Potential Role of Occupational Therapy in Rehabilitation," American Journal of Occupational Therapy, 10:150 (1956).

177. Whitten, G.B. "Effects of Automation on Handicapped People," Rehabilitation, No. 71, pp.21-26 (Oct.-Dec., 1969).

178. Wiemer, Ruth B. and West W. "Occupational Therapy in Community Health Care," American Journal of Occupational Therapy, 24:323-327 (1970).

179. Williams, D.H. First Annual Report on Continuing Medical Education, Vancouver, British Columbia: University of British Columbia, 1961.

180. _____. "The Physician and Life-Long-Learning," The Journal of Education, No. 10, Vancouver, The University of British Columbia, p.63, 1964.

181. _____. First Annual Report, Continuing Education in the Health Sciences, Vancouver, British Columbia: University of British Columbia, 1969.

182. Woodside, H.H. "The Development of Occupational Therapy 1910-1929," American Journal of Occupational Therapy, 25:226-230 (1971).

183. World Federation of Occupational Therapists. Establishment of a Program for the Education of Occupational Therapists, Glasgow, Scotland: Council of the World Federation of Occupational Therapists, 1958.

184. Zamir, Lelia. "The Consultative Process," Physical Therapy, 68:777-779 (1968).

185. _____. "Perspectives in Occupational Therapy Education," American Journal of Occupational Therapy, 24:192-195 (1970).

186. Zimmerman, T.F. "Laddering and Latticing: Trends in Allied Health," American Journal of Occupational Therapy, 24:102-105 (1970).

APPENDIX

In 1926 the first two year course in occupational therapy was established at the University of Toronto. For over twenty years it was the only educational program for occupational therapists in Canada. The following pages are duplicates of the original Preliminary Circular of Information which is presently the only known Preliminary Circular remaining in existence. This rare document was made available for duplication and inclusion in this study as an item of interest to all Canadian Therapists through the courtesy of the present owner of the document, Miss H. P. LeVesconte, Toronto, Ontario.

To Howland:-
Please look this over & suggest emendations and additions. I am sending a copy to Mr. Chester & Miss Stewart.

University of Toronto

(The Provincial University of Ontario)

Department of University Extension

Preliminary Circular of Information

on the

Two-Years' Course

in

Occupational Therapy

Should those interested wish to ask any questions, the answers to which are not contained in this preliminary circular, they should write at once to W. J. Dunlop, Director, University Extension, University of Toronto. Toronto 5, Canada. Correspondence is invited.

UNIVERSITY OF TORONTO

(The Provincial University of Ontario)

Occupational Therapy

Beginning with the University Session, 1926-27, the University of Toronto proposes, if there appears to be a reasonable demand for it, to offer a course in Occupational Therapy. The purpose of the new Course is to train young women so that they may be qualified to act as therapists in government institutions, asylums, homes for incurables, and general hospitals.

The work of a duly qualified occupational therapist consists in rehabilitating patients by providing them with interesting occupations designed not only to exercise and so to restore limbs which may have been injured but also to ~~keep~~ the mind ~~engaged~~ and so to ~~prevent the patient becoming~~ morose. By expert attention to these two allied aims injured men, women and children are frequently brought back to health and have been able to resume their regular occupations when otherwise a ~~physical and mental~~ recovery would ~~not~~ have been possible.

Occupational Therapy is, therefore, a valuable supplement to the work of the physician and surgeon and the demand for qualified aides seems to be growing. Here it must be pointed out, however, that, while offering the training for this work, the University of Toronto does not in the least degree undertake to secure positions for those who complete the course.

The details of the Course in Occupational Therapy are as follows:—

1. The course is to cover two academic years.

2. Complete Pass Matriculation, or the academic equivalent thereof as determined by the Registrar of the University of Toronto, is the entrance requirement.

3. Subjects of study:

   First Year: (a) Anatomy, Physiology, Hygiene, Physical Drill, French, English, Sociology and Psychology.

   (b) Art, Applied Art, Woodwork, Weaving, Basketry, Needlework, Leatherwork.

   Second Year: (a) Medical subjects, Psychology, Sociology, Kinesthetics, Remedial exercises, French, English.

   (b) Art, Metal, Bookbinding, Modelling and cord work.

   (c) Clinical work in hospitals and asylums.

4. Students will attend the regular classes in University subjects already established in Arts, Social Service, and Public Health Nursing. Lectures and practical work will occupy both forenoons and afternoons throughout the Session.

5. Annual fee—$100 payable in advance, or, if paid in instalments, $50.00 on or before October 15th and $51.00 on or before January 15th. A penalty of $1.00 per month is imposed if fees are not paid on dates specified. Student will be required to purchase such materials as may be necessary for practical work. The cost of these will be approximately $60.00.

6. The course will be given if a sufficient enrolment is secured, and may be discontinued at any time in the future if the demand for aides seems to have been satisfied.

7. The course will commence on September 28th. In order that the necessary arrangements can be made in good time, applications should be sent in as early as possible, and in no case later than August 15th, 1926.

For the form of application and further information write to W. J. Dunlop, Director, University Extension, University of Toronto, Toronto 5, Ontario. Trinity 5000.